



## JOINT INSPECTION (ADULTS)

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

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October 2019

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Healthcare Improvement Scotland works with healthcare providers across Scotland to drive improvement and help them deliver high quality, evidence-based, safe, effective and person-centred care. It also inspects services to provide public assurance about the quality and safety of that care.

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## Contents

Contents.....	3
About this inspection .....	4
East Renfrewshire Context.....	6
1. Performance .....	7
2. Strategic Planning and Commissioning.....	11
3. Leadership and Direction .....	26
Evaluations and Areas for Development .....	32
Evaluation Summary .....	35
<b>Areas for Development</b> .....	<b>35</b>
Conclusion .....	36
<b>Appendix 1 – Quality improvement framework</b> .....	<b>37</b>
Appendix 2 –Inspection Methodology.....	38

## 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<sup>1</sup>. This includes how integration authorities plan, commission and deliver high-quality services in a co-ordinated and sustainable way. In this inspection the focus was on how well the partnership had:

- Improved performance in both health and social care
- Developed and implemented operational and strategic planning arrangements and commissioning arrangements, 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 the partnership has made in health and social care services that are provided for all adults.

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

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

The East Renfrewshire Health and Social Care Partnership (HSCP) for adults services comprises all social work and social care services for adults (including substance misuse services) and primary health care services for adults. This is referred to as "the partnership" throughout this report.

NHS Greater Glasgow and Clyde manages acute hospital services. Some community based services such as physiotherapy, podiatry and sexual health

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<sup>1</sup> 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.

services were hosted by other health and social care partnerships, but with local delivery arrangements in place.

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

## East Renfrewshire Context

East Renfrewshire Health and Social Care Partnership was established in 2015 under the direction of East Renfrewshire's Integration Joint Board. The partnership comprises social work and social care services for adults, services for children and justice services. It includes primary healthcare services and hosts in-patient services for adults with learning disabilities on an NHS Board wide basis. The Health and Social Care Partnership also manages the Scottish Centre for the Communication Impaired on behalf of the NHS Board.

The East Renfrewshire Health and Social Care Partnership area has a population of 95,170 and covers 174 square kilometres. The population density is 544 people per square kilometre. The population has increased by 5.9% since 2008, while overall, Scotland's population has increased by 4.5%. Sixty per cent of the population are of working age, lower than the national figure of 64%, while 20% of the population are 65 or over (Scotland figure is 19%).

From the 2016-based population projections, the population of the East Renfrewshire partnership is due to increase by 8% by 2026 and increase by 17% by 2041. The equivalent Scotland figures are an increase of 3% by 2026 and an increase of 5% by 2041.

The population of those aged 65 and over is due to increase by 21% by 2026 and increase by 44% by 2041. The equivalent Scotland figures are to increase by 19% by 2021 and increase by 25% by 2041. More specifically, East Renfrewshire's 75+ population is due to increase by 27% by 2026 and increase by 82% by 2041. The equivalent Scotland figures are to increase by 27% by 2026 and increase by 79% by 2041.

The working age population of East Renfrewshire is due to increase by 2% by 2026 and increase by 9% by 2041.

East Renfrewshire Council area has been divided into 122 data zones and of these 4% (5) fall within the 15% most deprived data zones in Scotland. This mirrors the share of 4% (5) in 2012. One of East Renfrewshire's data zones fall within the 5% most deprived data zones in Scotland. This compares with 0 in 2012.

Seven per cent of the overall population of East Renfrewshire are income deprived while 7% of the overall population are considered employment deprived. Both figures are below the national averages of 12% and 11%.

The three most deprived data zones in East Renfrewshire are:

- Dunterlie,
- East Arthurlie,
- Dovecothall.

## 1. Performance

The East Renfrewshire partnership performed relatively well compared to other integration authorities in a number of key areas listed below. Its performance was measured from a range of nationally published performance datasets. There were other areas where the trend of its performance was improving and some areas where improvements in its performance were needed.

The partnership's performance was good for:

- Ensuring that patients, medically fit for discharge, were discharged in good time. The partnership's performance on minimising delayed discharges was consistently good over time.
- Technology enabled healthcare and telecare service provision that enabled people to live independently at home and helped them to keep as well as possible.
- Referral for post-diagnostic support for people with a diagnosis of dementia. There were positive outcomes for recipients of support following a diagnosis of dementia and for their unpaid carers.
- Proportion of allocated social care funding to direct payments or personalised managed budgets and the number of recipients of direct payments.

The partnership's performance was improving for:

- Most of the unscheduled care performance datasets – emergency admissions to hospital, admissions to hospital after a fall, readmissions to hospital – the partnership's performance was marginally better than the Scotland average. The partnership's own performance data (2018–19) showed improving trends for reducing episodes of unscheduled care.
- The percentage of time spent at home or in a community setting by East Renfrewshire residents in the last six months of their life had recently (2018–19) improved to around the Scotland average.

Areas for performance improvement were:

- Access to primary care mental health services.
- Access to initial appointment for psychological therapies. The partnership needed to take robust action to drive improvement in this area.
- Number of older people who received more than 10 hours per week care at home service (this indicator relates to the level of care at home support deployed to older people with intensive needs to maintain their independence).

The partnership had a published annual performance report for the period 2017–2018. This report clearly set out the performance information across national indicators and outcomes. The partnership’s well-constructed and accessible annual performance report for 2018–19 was approved by the Integration Joint Board in June 2019 and was available on the partnership’s website.

The strategic implementation plan included provision for detailed reporting to the performance and audit committee. The partnership established a clear link between strategic priorities and performance measures.

Performance reviews took place six monthly between the Chief Officer of the HSCP and the Chief Executives of the Council and NHS Board. They were well informed by a comprehensive dashboard of performance data. This enabled senior managers to bring about improvement activity when necessary.

The partnership’s performance measured against the Scottish Government’s integration indicators<sup>2</sup> was good for reducing unscheduled care episodes for all adults and minimising delayed discharges for all adults. It effectively used its performance data and benchmarking with the other partnerships within the NHS Board to improve performance on reducing episodes of unscheduled care. Performance was in line with the Scotland average for patients satisfied with their GP practice, percentage of carers who feel supported in their caring role and percentage of adults who feel safe. The partnership’s performance on proportion of adults supported at home who agreed their health and social care services were well coordinated was poorer than the Scotland average. As was the proportion of adults supported at home who agree that they had a say in how their help, care or support was provided<sup>3</sup>.

There was a coherent structure in place for governance of performance and clear reporting to the Integration Joint Board through the performance and audit committee. The partnership comprehensively benchmarked its performance against the other five HSCPs within the NHS Board.

The partnership had a comprehensive performance framework. There were clear systems in place to monitor performance against national and local data and on outcomes for people who used services. An example was the analysis of personal outcomes for people who used services, which showed an improving trend for most of the measures. The partnership acknowledged some of the results from the national health and care experience survey were below the Scotland average. Positively, an improvement in the data available at GP cluster level was available to inform quality improvement. The partnership had a clear data improvement plan for all its performance datasets.

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<sup>2</sup> Where data was available. Data was not available for all the integration indicators.

<sup>3</sup> People’s perceptions of their experience of health and care – Health and Care Experience Survey 2017 -18

The partnership generated a wide range of good quality performance data and used it effectively to sustain good performance and bring about performance improvement. Its generation and use of performance data at locality and team level was an area for improvement.

The partnership's data showed it had high numbers of people with dementia. It used this data effectively to develop comprehensive support services for people with dementia.

The partnership generated data to positively target more deprived areas, for example on the uptake of health screening. The partnership undertook good work to increase the uptake of health screening for people with learning disabilities.

Partnership staff advised that the purpose and use of data collected within the partnership was not always clear. Our staff survey showed 47% of respondents agree or strongly agree services are continually monitored and evaluated to support improvement – 38% disagree or strongly disagree and 15% did not know. The partnership had developed a data improvement plan to improve its data handling and data use.

The partnership has improved the quality of information available to staff about patients who were admitted to hospital and the range of supports deployed to people returning home from hospital. It successfully used information to enable timely discharge planning and establish an effective hospital to home pathway. Using this pathway, it sustained its good performance on delayed discharge. In May 2019, only two East Renfrewshire patients had their discharge from hospital delayed. This was the lowest number of delays for any of the Scottish mainland partnerships. The partnership sustained relatively low numbers of bed days lost due to delayed discharges.

The partnership worked well with care homes. This work had contributed to a reduction in residents' unplanned admissions to hospital. The partnership developed a data set of emergency hospital admissions and accident and emergency attendances from care homes. This showed improvement, with a 23% reduction in emergency hospital admissions from care homes in 2018–19 compared to 2017–18. There was a 21% reduction in accident and emergency unit attendances from care homes, over the same period. This was another example of the partnership using data to support successful improvement activity. This work also showed preparation of anticipatory care plans<sup>4</sup> for care home residents was an area for improvement and improvement activity was underway.

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4 An Anticipatory care plan (ACP) is a person-centred, proactive, "thinking ahead" approach, requiring services and health and care professionals to work with individuals, carers and their families to have the right conversations and set personal goals to ensure that the right thing is done at the right time by the right person with the right outcome. [Healthcare Improvement Scotland 2017]

The number of people in the partnership who used a community alarm, or other telecare service, was higher than the Scotland average. The use of telehealth was positive, with 100% of GP practices signed up<sup>5</sup> to remote blood pressure monitoring, saving 1355 face-to-face GP appointments. Across Scotland, around 30% of GP practices were signed up to remote monitoring of patients with high blood pressure. The partnership successfully used technology to improve the care and management of people with this long-term condition.

Community addictions services, community link workers and mental health services, carried out effective outcomes-focused self-evaluations. The results were positive.

People who used services and unpaid carers could express their views about health and social care services through local forums, the Carers Centre and at one off events. They considered events were a positive opportunity to share experiences.

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<sup>5</sup> At July 2019, 13 of the 15 GP practices in the partnership were carrying out remote blood pressure monitoring. This work had not yet commenced in the other two GP practices.

## 2. Strategic Planning and Commissioning

### Strategic Planning

The partnership clearly set out its shared vision and priorities in its strategic plan 2018–2021<sup>6</sup>. This strategic plan was well-presented, public-facing and outlined the partnership's high-level intentions. It helpfully included a summary of the needs profile, locality proposals, and health and social care expenditure. The strategic plan's priorities aligned well with other relevant strategies such as the East Renfrewshire local outcome improvement plan and the NHS Board's Moving Forward Together transformation strategy.

The partnership helpfully developed a strategy map, which showed how its own priorities linked to wider East Renfrewshire and national priorities. The partnership led on two community planning work streams – mental health and well-being and community safety and social connectivity. The partnership's cohesive work with the NHS Board and the council was characterised by shared understanding and inter-connected priorities.

The partnership prepared an annual implementation plan to show how the strategic plan's priorities would be delivered. The partnership developed some supporting plans in areas such as finance and workforce development. It had partially evaluated the resources and workforce requirements to effectively deliver its objectives in the strategic plan and developed a workforce strategy to implement this.

Operational service planning arrangements were not as well developed. Locality and team level priorities were not always reflected in strategic plans. Service plans that linked to strategic planning priorities were not fully developed. The partnership had an improvement plan in place to address these issues.

The third sector interface and external consultants led the engagement activity for the strategic plan. This was a welcome participative approach. Partnership's plans were co-produced through constructive and enabling discussions with stakeholders. The partnership's plans mostly had SMART<sup>7</sup> objectives and measurable success criteria, but were not always outcome focused. Some actions that supported the delivery of the strategic plan were not fully costed. The strategic plan was complemented by a draft commissioning strategy. Associated market facilitation processes were not yet well developed.

The strategic planning group had an inclusive range of stakeholder representation, but there were inconsistencies in membership attendance. This hampered the

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<sup>6</sup> The document setting out the arrangements for carrying out the integration functions and how these are intended to achieve or contribute to the achievement of the relevant national health and wellbeing outcomes for the population of the integration authority.

<sup>7</sup> Specific, Measurable, Achievable, Realistic and Time-bound

group's work and its capacity to exercise appropriate leadership. For example, the council's strategic housing body or independent sector representatives were not represented regularly. The strategic planning group did not always effectively inform the Integration Joint Board's decision making. The partnership recognised the role of the strategic planning group needed refreshed. The strategic planning group recently reviewed its remit, membership and practice. Improvements were in preparation but not yet implemented.

The partnership had reviewed the suitability of existing models of care. An on-going 'Fit for the Future' change programme included end-to-end operational service reviews and a review of organisational structures. It had encountered problems with its execution. There were delays with its implementation. The quality, frequency and effectiveness of communication with staff affected by implementation of this strategy were lacking.

The partnership was committed to involving and enabling the participation of a wide range of stakeholders. It did not always demonstrate that people who used services and unpaid carers were always fully and meaningfully involved in service planning. Many staff, at practitioner and team level, whilst aware of the general direction of travel, were not familiar with the detail of key strategic change agendas, such as the re-design of localities, learning disability or mental health services, the care at home framework review and changes in the approach to commission and contracting.

The partnership was one of the six health and social care partnerships within the NHS Board area. There were productive planning relationships with the NHS Board. Several planning forums at senior and operational levels took place regularly. The partnership benefitted from the added capacity and expertise available as part of the wider NHS Board and council planning arrangements.

Since 2016, the partnership hosted three NHS Board in-patient units for adults with learning disabilities (one eight-bedded continuing care unit and two assessment and treatment units)<sup>8</sup>. The partnership was strongly committed to improving inclusion and wellbeing for the patients. It planned to re-provide the continuing care unit, with patients placed in more inclusive settings to improve their wellbeing. It had successfully re-provided a similar continuing care unit. It secured agreement to its improvement plan from the NHS Board and its five associated HSCPs. Its improvement plans for the in-patient assessment and treatment units included minimising patients' length of stay and developing accommodation with support in the community. The partnership had successfully driven progress with this agenda.

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<sup>8</sup> At June 2019 none of the continuing care patients originated from East Renfrewshire. The partnership made low usage of the assessment and treatment units.

## **Strategic Needs Assessment<sup>9</sup>**

The partnership produced a detailed strategic needs assessment in 2017. This included supporting data to help inform the preparation of the strategic plan 2018–21. It contained useful demographic, socio-economic and care activity information. The partnership had drawn on its community planning and Scottish Government health data and its own management information to produce detailed locality and GP cluster level information. It constructively employed external consultants to identify areas for further development in data collection and analysis.

The strategic needs assessment had strong data analysis. Much of the data was recent and was analysed to locality level. The strategic needs assessment was not co-produced with a wide range of stakeholders, to draw on their knowledge and experience. Some did not know the strategic needs assessment existed.

## **Locality Planning**

The partnership was striving to realise its aims to deliver its services based on the local needs of its residents. It had changed from a three-locality structure based around the three GP clusters – deemed too complex – to two localities. These were the Barrhead locality and the Eastwood locality. It was at an early stage of locality planning and commissioning and did not have comprehensive locality plans.

The Fit for the Future change programme aimed to develop a comprehensive locality infrastructure for the partnership to maximise the involvement of communities and local staff in planning and decision making. This work was at an early stage of implementation.

The partnership realigned its operational teams to the two localities. Each of the two localities had an integrated team for older people, that only served the specific locality. The other teams were aligned to a locality but delivered services across the partnership. The partnership was working to set up locality planning groups. It had not identified locality budgets.

The partnership produced locality and GP cluster profiles. These included health and social care service activity data. Such profiles would enable each locality to use data to identify and prioritise local need for service design and delivery.

The partnership's ambition was for commissioning to take place at a locality level. It had not started this work as the planning and commissioning team's redesign was not yet fully implemented.

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<sup>9</sup> A strategic needs assessment analyses the needs of local populations and informs and guides the commissioning of health, wellbeing and social care services within the area

## **Building Capacity in Communities**

Building capacity in primary and community care was a key theme in the draft commissioning strategy. The partnership cooperated with the third sector<sup>10</sup> to develop several valuable initiatives. It had made good progress to build community capacity and resilience and deliver this through co-production approaches. The partnership was committed to developing health improvement activities that supported people to keep well.

The partnership acknowledged the important role local communities played in providing support for people who needed it. The partnership made good progress encouraging third sector involvement in the delivery of health and social care services. Talking Points<sup>11</sup> aimed to support people to access information, early intervention and prevention support in the community. It set out to:

- offer a person-centred approach to those seeking advice/support
- provide quicker access to appropriate supports
- offer volunteering opportunities
- increase capacity through partnership working
- avoid unnecessary referrals to statutory services
- allow partnership staff to focus on more complex cases.
- make best use of limited public funds.

The partnership showed ambition and desire to innovate by working alongside the National Development Team<sup>12</sup> to put Talking Points in place in 2016. It worked with the third sector to redesign the ways people accessed support and to implement Talking Points across localities. It had met challenges with its implementation. This initiative temporarily halted for periods as different approaches were trialled. There were issues with the recording of the Talking Points sessions, there was no system to measure outcomes for people who used this service and in three years, there was no formal evaluation of this initiative. The partnership planned an evaluation of this initiative.

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<sup>10</sup> Third sector bodies include non-commercial providers of health and social care, representative groups, interest groups, social enterprises and community organisations.

<sup>11</sup> Talking Points in East Renfrewshire was an extensive initiative to provide people across the partnership area with information about health and social care services and signpost them to community supports

<sup>12</sup> The National Development Team for inclusion is a not for profit organisation that aims to help people at risk of exclusion due to their age or disability to live the life they choose.

The partnership and its third sector partners developed a range of service options that used community assets. These services focused on prevention and early intervention. For example, community link workers, linked to GP practices, gave people with psychological wellbeing issues useful information and signposted them to appropriate community supports. This increased social prescribing<sup>13</sup> that helped to reduce demand for statutory services and reliance on pharmacological treatments. There were third sector led services to improve physical activity, reduce social isolation and create job opportunities.

The partnership was at the early stages of evaluating if third sector organisations evidenced delivery of intended positive outcomes for individuals. This was an area for improvement.

### **Engagement with People who Used Services and Unpaid Carers**

The partnership set up a service user and unpaid carer Your Voice group to strengthen accountability and shape the strategic planning of services. It had representatives on the Integration Joint Board, strategic planning group and the clinical and care governance group. The partnership effectively supported the Your Voice group and its representatives to take part in strategic planning, service planning and service redesign.

The group had a core membership of around 15 individuals with approximately 300 people on its mailing list. There were mixed views among the people who used services and unpaid carers we spoke with about the validity of consultation in some planning forums. Some unpaid carers and staff were unclear how the Your Voice group influenced the partnership's planning processes and decision making. Unpaid carers we met did not think the partnership fully involved unpaid carers in the development of its updated carers strategy.

In 2017, the partnership set up the Carers Collaborative, which successfully canvassed the views of around 300 people with "carer experience". This creditable initiative enabled unpaid carers who were not members of existing groups to express their views to the partnership. The partnership held a series of events for unpaid carers and local carers organisations to determine how engagement with unpaid carers and services for them might be improved.

There was less evidence of systematic engagement with people who used services outwith Your Voice. Less than half (42%) of respondents to our staff survey agreed that the views of people who used services and those of their carers and families were fully considered when planning services at strategic level. The consistent and

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<sup>13</sup> Social prescribing involves helping people to improve their health and wellbeing by connecting them to community services.

meaningful involvement of people who used services and unpaid carers in strategic planning was an area for continuous improvement.

### **Engagement with Partnership Staff**

The partnership had a range of approaches for engagement with its staff including email updates, verbal briefings, the staff forum, professional governance forums, large-scale engagement events and an iMatter annual staff survey.

Despite these activities, many staff reported they were not consulted on the strategic plan or the draft commissioning strategy. Most staff expressed negative views about the level of influence they felt they had in the design of services. Around a quarter of the staff (26%) responding to our survey agreed that their views were taken into account when planning services at a strategic level. Just over a third (36%) agreed that there was a strong connection between strategy, development and service delivery. These results of our survey were less positive than the partnership's own 'iMatter' survey. There was a need for improvement in the communication between senior staff and between senior staff and frontline staff.

Staff reported the Fit for the Future change process was poorly communicated and not well implemented. Senior managers did not make the implications of the changes clear enough to all the staff involved. The partnership had undertaken briefings with staff to explain the implications of Fit for the Future, but it needed to engage and communicate with staff more effectively.

### **Engagement with the Third and Independent Sectors**

The partnership relied on the independent sector and the third sector to provide care for people who used services. The independent sector provided care at home services to 37% of recipients of care at home services; 18% of recipients of care at home services were looked after by a combination of carers who worked the independent sector and carers who worked for the partnership's care at home service. Independent sector providers ran the majority (63%) of care homes in East Renfrewshire.

The third and independent sectors had contrasting experiences of their engagement with the partnership. Third sector providers enjoyed a positive relationship with the partnership and felt valued by it. The partnership showed a real commitment to engaging with its third sector partners to take forward the integration agenda. Voluntary Action East Renfrewshire, the local third sector interface<sup>14</sup>, had built up good relationships with the partnership and helped involve the third sector in service development. The third sector interface representative had a prominent role on the Integration Joint Board, the strategic planning group and wider service developments.

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<sup>14</sup> Third sector interfaces (TSI) ensure the third sector is supported, developed and represented.

The partnership's intention was for externally commissioned providers to have a greater focus on prevention and early intervention developments. The third sector interface acted as a conduit to the third sector on consultation, sharing and reporting feedback on plans, policies and service and strategic planning. The third sector interface contributed to the development of the strategic plan and led consultation events across localities. It had a major role in the development and delivery of prevention and early intervention services such as Talking Points.

The third sector was well represented on strategic and service planning groups but the independent sector was much less so. There were limited opportunities for independent sector involvement in service planning and commissioning. This was reflected in our staff survey, where less than half (45%) of respondents agreed that the partnership worked closely with health and social care providers when planning services at a strategic level. There were improving relationships with the independent providers through their representative body Scottish Care.

There were providers' forums for care homes and care at home services. These forums took place less frequently in 2019. Providers welcomed the forums, but they were unclear about their future remit. The partnership relied substantially on providers of externally commissioned services. A lack of successful communication and engagement across service areas, care settings and provider types were an on-going risk to existing and future service delivery.

### **Strategic Commissioning**

The partnership commissioned a comprehensive range of services for local communities. This included early intervention and prevention services, complex care and treatment and end-of-life care. The partnership prepared a draft commissioning strategy to complement its strategic plan. This set out the partnership's short and medium-term commissioning intentions. It did not include detailed financial information on all the resources required to implement its intentions or how it would deliver services using integrated budgets. The draft commissioning strategy did not have accompanying market facilitation processes. The partnership's knowledge and understanding of local social care markets was an area for improvement.

There were challenges in ensuring local supply, capacity, quality and choice across social care services. The partnership's directly provided services had a minority share in key care markets. Constructive relationships with third and independent sector providers were therefore essential.

The partnership commissioned some innovative projects and services. The Greenhouse Cafe, a community interest company café, provided employment opportunities for people with learning disabilities. The public social partnership with third sector organisations, was a productive enterprise that enhanced the development of person-centred community supports. Commissioning for some prevention services shifted the balance of care, from care delivered in hospitals and

residential settings to care and support delivered to people in their own homes and communities.

The partnership creatively used its reserve funds to disinvest in outdated services and invest in new services. It invested reserve funds to cover double running costs incurred in the transition to new services. For example, this approach was used to disinvest in the Mearns Kirk continuing care hospital and subsequent development of Bonnyton House's end-of-life care and intermediate care services.

The partnership commissioned a wide range of externally provided services. Overall, the Care Inspectorate evaluated a high proportion of them as good or better.

The partnership successfully commissioned, with the council's housing services, the care and repair scheme. It gave practical support to people to help them to live independently in their own homes, to enhance their wellbeing.

The partnership proactively used Scottish Government project development funding to commission services that delivered improved health and wellbeing outcomes for people who used services and unpaid carers. These included:

- Improvements in primary care, including the successful deployment of advanced physiotherapist practitioners to some GP practices.
- Working in partnership with the National Development Team to institute the Talking Points initiative, which mobilised community volunteers to signpost people to appropriate community supports. This demonstrated a prevention and early intervention approach.
- The My Life My Way initiative (2015–17) sought to use self-directed support funding<sup>15</sup> to enhance the lives of care home residents. Some care home residents used their self-directed-support monies to get out and about, improve their contact with family and friends, sometimes with the use of digital technology and take part in their chosen social activities. The project was subject to an extensive independent evaluation. Its overarching conclusion was *“the project had an overwhelming positive impact on those involved”*

## Care Homes

The partnership was at an early stage of adopting a whole-system approach to care home provision. The local care home sector was market driven. Care home developers entered the local care home market leading to increased supply of places for older people. This partly influenced the increasing levels of care home usage by older people. The partnership did not have a comprehensive understanding of local

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<sup>15</sup> Mainly SDS options 1 direct payment, 2 supported person chooses the specific service to meet their personal outcomes and 4 mix of the other options

needs and markets, including respite provision. It was not fully engaged with providers to help deliver its future intentions for care home provision.

One of the partnership's externally commissioned care homes was closed by a court in 2018 due to serious concerns about the safety of the residents raised by the Care Inspectorate. Senior partnership leaders acknowledged the partnership (and other partners) were slow to recognise the safety and wellbeing risks (adult support and protection risks) to the residents of the care home that was closed by the court. The partnership initiated an independent learning review of all the circumstances surrounding the closure of the care home. This was due to report in summer 2019. Another independent sector run care home was closed by a court in 2018 after it received poor inspection evaluations from the Care Inspectorate.

The partnership experienced some recent reversals in the direction for changing the balance of care for older people. For example, the level of the partnership supported care home beds for older people was increasing. The partnership had made good progress developing community-based support for people with learning disabilities, people with physical disabilities and people with mental health problems. It successfully shifted the balance of care, from looking after people in hospitals and residential settings to supporting people to live in more inclusive settings.

### **Care at Home**

The partnership did not have a whole-system approach to the commissioning of care at home services. There were significant challenges in the care at home market – staff sometimes found it hard to get care at home services for individuals. There were difficulties associated with the implementation of the 2016 care at home framework agreement. A review of the framework was underway. The partnership was dependent on externally commissioned providers, but there was as a lack of market facilitation. The partnership's engagement with care at home providers had recently reduced. This combination of factors led to on-going risks for the partnership for the delivery of care at home services.

In March 2019, the Care Inspectorate assigned poor inspection evaluations to the partnership's "in-house" care at home service. The risks to the partnership from the deficits in this critical service were considerable. It put a detailed improvement plan in place, appointed an external improvement consultant and committed additional funds for the care at home service. Senior managers needed to make sure the improvement plan for this service was quickly and fully implemented.

### **Commissioning, Contract Compliance and Monitoring**

The partnership did not have fully effective approaches to contract management to help deliver its commissioning intentions. There were deficits in the delivery of the partnership's commissioning and contracting function. These included not deploying sufficient resources to support the effective management of the current volume of contracts. The partnership acknowledged a temporary gap in delivering its

commission and contracting functions. It planned to reconfigure commissioning and contracting to address this.

Further areas for improvement included strengthening communication between commissioning and operational teams, developing better data and market intelligence from directly provided and externally commissioned services. This would enable the partnership to make better informed commissioning and procurement decisions.

The partnership's procurement and contract management frameworks needed updating. The previous governance arrangements were withdrawn but not replaced. Additional areas for improvement were revising the care at home and other services models to move away from time and task<sup>16</sup> specifications towards supporting the market to respond to individuals who wished to exercise more choice and control through self-directed support. Contractual terms and conditions needed updating to better reflect outcomes-based commissioning. Contract models did not always reflect the personalisation agenda and needed to offer more flexibility.

Contract staff previously used a contract management framework and risk assessment tool, to monitor and report on contract performance. As part of 'Fit for the Future' the partnership's contracts and commissioning function was redesigned. As a result, the partnership's contract monitoring activities were temporarily constrained. The partnership intended to implement its plans for commissioning and contracting. The commissioning and market facilitation officers would be assigned to locality teams to help shape the market and identify opportunities to create new businesses and social enterprises in localities.

In the interim, there were risks to the partnership's oversight on the delivery of externally commissioned services. The commissioning team was previously supportive and helpful to providers. Some third and independent sector providers were anxious about their current limited level of contact with the partnership. The performance of externally commissioned providers and issues identified from contract monitoring were reported to the senior management team but not reported regularly to Integration Joint Board and its performance and audit committee. This was an area for improvement.

The partnership effectively delivered its procurement services, through the council, using a productive business partner arrangement. The partnership made additional resources available to allow a greater focus on its business with the council's procurement service.

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<sup>16</sup> The care at home service agreement specifies the times of staff deployment and the tasks they are required to undertake.

## **Housing Agencies' Contribution**

Services that catered for housing and related support needs were an increasing focus of the partnership's strategic commissioning intentions. The council, as the strategic housing body, was encouraged, as and when required, to take part in strategic planning forums such as the Integration Joint Board and the strategic planning group. Partnership staff contributed to housing related planning forums.

The partnership's strategic plan housing contribution statement set out how housing agencies could contribute. The partnership had a good relationship with the strategic housing body. There was promising joint work with housing staff contributing to the strategic needs assessment, taking part in the Talking Points initiative and working with the third sector on optimising the use of sheltered housing communal areas.

## **Primary Care**

There was an improvement culture across primary care services. The partnership had a well-constructed primary care improvement plan. This helpfully showed how the partnership would aid the development of additional primary care services to help shift the balance of care and enable more integrated care service delivery in localities.

The partnership had productive relationships with GPs and successfully set up three GP clusters<sup>17</sup>. The clinical director and GP quality cluster leads worked closely to improve primary care services. For example, all GP practices agreed to implement remote telehealth monitoring of patients with high blood pressure.

Some primary care staff were involved in the preparation of the partnership's strategic plan and primary care improvement plan. They were making a prominent contribution to the work of the clinical and care governance group. Clinical leaders, including GPs, achieved impressive progress with implementation of the partnership's primary care improvement plan. Successes included:

- Flu vaccination programme for housebound patients.
- Thirteen of the fifteen GP practices had pharmacists involved in medication and treatment planning. This progress benchmarked favourably against other health and social care partnerships.
- Deployment of healthcare support workers in GP practices. They helped doctors and other health professionals to give high quality person-centred care.
- Creation of advanced professional roles with the appointment of an advanced practice physiotherapist with another post planned.

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<sup>17</sup> GP clusters are groups of GP practices in a close geographical location. Their purpose is to encourage GPs to take part in quality improvement activity with their peers and contribute to the oversight and development of their local healthcare system.

- The community link worker initiative led by Recovery Access Mental Health (RAMH). All 15 GP practices had access to a community link worker. Community link workers signposted people with psychological wellbeing issues to appropriate community supports. This initiative carried out a comprehensive, rolling evaluation that showed it was successful and delivered good outcomes for the significant numbers of people who received help from this service.

### **Intermediate Care and Technology Enabled Care**

The partnership productively developed services to prevent avoidable hospital admissions and support people to receive care within their community. These included reablement<sup>18</sup> and technology enabled health and social care. The partnership performed well for technology enabled health and social care compared to other areas in Scotland.

The partnership had a long-established reablement service. This provided good outcomes for people who used services following a hospital admission.

The partnership successfully worked with the other five Health and Social Care Partnerships within the NHS Board to decommission hospital continuing care beds for older people. The partnership was developing a local service to provide residential care, intermediate care, and end-of-life care, utilising the resource released from the hospital continuing care bed closure.

### **Self-directed Support<sup>19</sup>**

The partnership delivered more direct payments to individuals than the Scotland average – it ranked fourth out of thirty-one partnerships for this indicator (2017–18). It achieved a rising trend of recipients of direct payments.

The partnership's commissioning and procurement arrangements did not yet fully support the development and delivery of person-centred, personalised services. The partnership was developing its commissioning approaches to deliver a greater range of personalised services. Advice, information and brokerage support was available from the SDS Forum (an independent local organisation) and to a lesser degree East Renfrewshire Carer's Centre (carers' organisation).

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

<sup>19</sup> The Social Care (Self-Directed Support) (Scotland) Act 2013 placed a duty on local authority social work departments to offer people who are eligible for social care a range of choices over how they receive their support. Self-directed Support options were: direct payments (option one); individual chooses the service and the service provider and the local authority makes the arrangements (option two); local authority-arranged support (option three); and option four (a combination of the other options).

The further roll out of self-directed support was limited by a lack of care provider choice and capacity. This meant that the ability to select from the full range of options was constrained. The partnership recognised that it had some way to go to enable greater choice and it looked to learn from the experience of other partnerships.

The partnership piloted My Life My Way. This project explored the use of options one, two and four with people living in residential care or at risk of moving to residential care. The project's evaluation noted good personal outcomes for participants, but wider application of this promising initiative was limited.

### **Quality Assurance, Self-evaluation and Improvement**

The partnership had a coherent and effective clinical and care governance framework. There was a commitment to the meaningful involvement of stakeholders including people who used services and unpaid carers in the review and development of services. The partnership did not have a fully integrated self-evaluation and quality assurance framework. It did not regularly evaluate its engagement with stakeholders.

The partnership's clinical and care governance group's remit was to lead in quality improvement and assurance. This included shared learning from complaints, individual case reviews, reviews of adverse incidents, workforce assurance, public protection and risk management. The group's purpose was to ensure health and social care services were safe, effective and person-centred. Its membership consisted of a wide range of professional leads representing GPs, optometry, nursing, social work and pharmacy. There was unpaid carer and service user representation from 'Your Voice'. The work of the group evolved over time and its terms of reference were recently reviewed.

Clinical and care governance group reports were well focused on the Scottish Government's national health agendas on patient safety, clinical effectiveness and person-centred care. There were effective clinical and care reporting structures and liaison arrangements with appropriate links to the Integration Joint Board and relevant NHS Board forums.

The partnership undertook some purposeful self-evaluation activities. There were good individual examples of some services undertaking self-evaluations. This included mental health services, where a 'triangle of care'<sup>20</sup> method was used to inform future service improvement plans.

Annual adult support and protection case record audits led to service improvements. District nursing and rehabilitation teams carried out regular, purposeful audits of case records. Fit for the Future service review activity included case record audits and this

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<sup>20</sup> The 'Triangle of Care' is a working collaboration, or "therapeutic alliance" between the service user, professional and carer that promotes safety, supports recovery and sustains well-being.

informed the direction of service reviews. Case record audits also informed the directly provided care at home services improvement plan. Nursing services carried out a range of routine audit activity that helped to maintain practice standards and identify areas for improvement. The partnership had well-established systems for handling complaints that were mostly effective. It did not always meet its prescribed timescales for handling complaints. It usually carried out self-evaluation exercises in-house. It occasionally commissioned external independent bodies to carry out evaluations of its services. It did not have a systematic approach to self-evaluation and planning at a team level.

The partnership's independent learning review that emanated from the court's closure of a care home was evidence of the partnership's commitment to quality assurance. The reviews remit included lessons for future large-scale investigations of adult support and protection concerns. The review would report in summer 2019.

The partnership did not always involve a wide enough range of stakeholders to provide feedback on the quality of services. The partnership did not regularly collect and analyse feedback from people who used services and unpaid carers who received services from third and independent sector providers.

The partnership had effective lines of communication and professional accountability from frontline staff to senior managers and professional leads responsible and accountable for clinical and care governance. As part of Fit for the Future redesign the partnership strengthened its professional leadership in nursing and social work. It introduced a new professional social work supervision policy. It planned to review allied health professional roles and professional accountability.

### **Financial Planning and Sustainability**

The partnership had a commendable record of sound financial performance. The partnership worked collaboratively with East Renfrewshire Council and the NHS Board to set its budgets for health services and for social care services. The NHS Board undertook work to more accurately estimate hospital and acute (set-aside) services usage to provide a realistic set-aside budget for future years. The partnership's respective budgets for health and social care were aligned rather than pooled.

The partnership achieved a surplus of £0.449m in 2017–18 and it had a projected surplus of £0.33m in 2018–19. The current reserves levels held by the partnership was well within its reserve policy. Total savings targets of £3.1m had been identified for 2019–20 and the strategic plan had target areas for these savings. These targets included savings from phase two of the Fit for the Future change programme. Reserve funds would be needed to meet the growing service demand and deliver the anticipated year-on-year efficiency savings.

The 2019–20 budget papers advised the partnership would have significant challenges in trying to maintain its current level of service delivery into the future

assuming the existing identified cost pressures and funding levels. The Integration Joint Board identified possible savings options, including targeted cost reductions in some care packages. Savings targets for 'Fit for the Future' were regularly monitored as part of the routine revenue budget monitoring reports.

The partnership faced significant financial challenges including those presented by increasing demands due to demographic pressures. There was an ageing population with a higher life expectancy than the Scottish national average. Adult services provided services to deliver positive outcomes for increasing numbers of young people with complex needs who made the transition from children's services to adult services.

Budget monitoring reports were reported to all meetings of the Integration Joint Board. These reports provided good quality information to assist scrutiny and challenge by board members about the partnership's financial position. These reports were detailed and comprehensive, showing projected outturns against both partners' budgets, an analysis of key variances and planned proposals for dealing with potential funding gaps.

The partnership developed a medium-term financial plan for the 2018–24 period and the Integration Joint Board approved it in March 2019. This was a positive step in effective future planning for the partnership given the challenges it faced. The mid-term financial plan supported the strategic planning process and provided a financial context for decision making. This plan was not expressly linked to the main priorities in the strategic plan. This was due to the timing of the preparation of the respective plans.

The identification and achievement of recurring savings was essential to the long-term sustainability of the partnership's financial position. It needed to deliver its transformational change programme in good time to meet its savings targets.

### 3. Leadership and Direction

#### Leadership - Vision, Values and Culture

The East Renfrewshire Partnership had a clearly articulated vision, values and aims for health, social work and social care services. “Working together with the people of East Renfrewshire to improve lives.” was the inspirational strapline. It featured prominently in the partnership’s strategic plan and other key documents. Leaders worked purposefully to promote the partnership’s vision across all its staff and other stakeholders. It was strongly aligned to the national health and wellbeing outcomes<sup>21</sup>, the health and social care standards<sup>22</sup> and the integration delivery principles set out in the Public Bodies (Joint Working) (Scotland) Act 2014.

Partnership leaders were strongly committed to equality and inclusion. This was evidenced in the partnership’s strategic plan, the draft commissioning plan and other key documents. The partnership’s reshaping of services for people with learning disabilities was based on the principles of equality, inclusion and upholding of human rights for people with learning disabilities.

Positively, just under two thirds (64%) of partnership’s staff who responded to our staff survey agreed or strongly agreed that they were aware of the partnership’s vision for health and social care services. In addition, under one third (27%) disagreed or strongly disagreed that they were aware of the partnership’s vision. Third sector partners we met were aware of the partnership’s vision for health and social care services and felt included in it. This was less so for independent sector partners.

Partnership leaders presented compelling evidence that East Renfrewshire was a mature partnership where integration and collaborative working were well embedded. Collaborative working was the default position at both strategic and operational levels across the partnership. Leaders ensured this collaborative ethos extended to third sector partners. Engagement and involvement of independent sector partners was an area for improvement.

The partnership held several events that among other things promoted its vision, values and aims to the widest possible audience. There was a well-attended workshop for the newly refreshed strategic planning group and the partnership’s vision, values and aims featured prominently.

Partnership leaders created a structure of integrated, co-located teams for the delivery of health and social care services. Leaders embedded a complementary integrated management structure, whereby teams of health, social work and social

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<sup>21</sup> The National Health and Wellbeing Outcomes are high-level statements of what health and social care partners are attempting to achieve.

<sup>22</sup> The Health and Social Care Standards set out what we should expect when using health, social care or social work services in Scotland. They seek to provide better outcomes for everyone and to ensure that individuals are treated with respect and dignity and that the basic human rights we are all entitled to are upheld.

care staff were managed by one manager from either a health or a social work or social care background.

The partnership's staff were mainly based in two purpose-built health and care centres situated in Barrhead and Eastwood. These well-appointed buildings were co-owned by the NHS Board and East Renfrewshire Council. Partnership staff had a considerable say in the interior design of the Eastwood Centre<sup>23</sup> in particular. The result was a "state of the art" building, designed to enable integrated, collaborative working and extensive use by the local community.

The results of our staff survey on integrated working were positive. Four out of five respondents agreed services worked well together to support adults to live independently, whilst three out of four agreed they were encouraged to collaborate for integrated working and good practice.

At the time of our joint inspection, the partnership was undergoing significant structural change with the implementation of Fit for the Future across adult services. The partnership had already implemented this strategy across its children's services, in an earlier phase of change management. Many adult services staff were experiencing substantial changes to their team and their team's management.

There was a strong consensus among frontline health, social work and social care staff we met that senior managers had not communicated with them effectively about changes that affected them, their team and their service. Senior managers cited staff engagement events, newsletters and other bulletins as evidence of their efforts to communicate with their staff. Staff communication and effective management of change were areas for improvement.

Some of the results of our staff survey clearly reflected staff's negative views about the changes they were experiencing and their leader's management of the change. Between one in three to two in three respondents expressed negative views on change management, communication with staff and confidence in managers. Contrastingly, for the 2018 and 2019 iMatter<sup>24</sup> surveys, respondents expressed relatively positive views about communication and confidence and trust in their line managers, their involvement in organisational decisions and confidence in senior managers. This supported senior managers' assertion that the timing of our staff survey – at the point of maximum disruption for staff – adversely affected some of the results of our survey.

The Integration Joint Board provided effective leadership for integrated and collaborative working across the partnership and the delivery of positive outcomes for all people who used health and social care services for adults and unpaid carers. The settled, well-established Integration Joint Board strongly endorsed the partnership's

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23 The design of the centre has been adopted as the 'reference design' for new primary care centres across Scotland and sets the standard for affordable, quality and sustainable healthcare facilities for the future. Particular attention has been given to ensure this is a dementia friendly

24 Our staff survey achieved a response rate of 37%. The iMatter survey's response rate was 67%. The iMatter survey was administered to a wider group of staff than our survey – children's services and justice staff were included.

vision, values and aims. It was characterised by supportive, respectful and empathetic relationships among all its members. The partnership supported Integration Joint Board members with a comprehensive training programme.

The Integration Joint Board appropriately issued directions<sup>25</sup> to East Renfrewshire Council and the NHS Board. This included directions on the re-provisioning of an NHS continuing care unit, the development of intermediate care and end-of-life care, and the partnership's hosting of communication services for people with communication difficulties. It issued directions related to finance and budgets.

As a result, the Integration Joint Board was a strong role model for integrated, collaborative working and commitment to the delivery of the best possible outcomes for East Renfrewshire residents. The Integration Joint Board met in public and several members of partnership staff had either attended the Integration Joint Board to give a presentation or as an observer. The chair and other members of the Integration Joint Board were active outwith the board and attended several events for partnership staff and other stakeholders. This improved their visibility to partnership staff and other stakeholders.

### **Leadership of Strategy and Direction**

Leaders effectively oversaw the development of a range of strategies. These included the partnership's strategic plan and its associated commissioning strategy. Leaders drove the development of the extensive Fit for the Future change strategy and its ambitious aims to deliver health and social care services to the two localities – one relatively affluent and one with significant pockets of deprivation. Leaders managed the partnership's finances proficiently and delivered the exacting requirements of year-on-year efficiency savings.

The leadership and management for implementation of Fit for the Future Partnership lacked drive. Leaders needed to make sure that sufficient operational leadership and management capacity was available for the competent execution of strategic plans.

Leaders had a sound grip of many aspects of the partnership's performance using well-developed performance management systems, but they were slow to pick up the problems with the partnership's care at home services and take robust remedial action.

The partnership depended on the independent sector for delivery of its strategic plan and its draft commissioning strategy. Partnership leaders had not ensured the partnership engaged fully with the independent sector. This was an area for improvement.

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25 Integration Authorities require a mechanism to action their strategic commissioning plans and this is laid out in sections 26 to 28 of the Act. This mechanism takes the form of binding directions from the Integration Authority to one or both of the Health Board and Local Authority.

## **Clinical and professional leadership**

There was effective clinical leadership for the partnership. Clinical leaders had challenges progressing the primary care improvement plan. Recruitment and retention of staff to perform advanced clinical roles was a persistent issue.

The partnership ensured there was constructive professional leadership for all nurses who worked in the partnership. Clinical leaders oversaw the successful implementation of the district nursing review and its associated improvement activities. Clinical leaders endeavoured to make sure that all nurses who worked in the partnership received suitable professional supervision.

The partnership successfully delivered professional leadership for all social workers who worked in the partnership. It ensured there was diligent oversight and governance over all matters related to social work within the partnership – for example adult support and protection. It introduced a new professional social work supervision policy. It planned to review allied health professional roles and professional accountability.

## **Workforce Planning**

The partnership had an integrated workforce plan. It constructively set out plans for leadership development within the partnership. It identified areas for improvement with a commitment to early discussion with the joint staff forum about changes affecting the workforce. It had a narrow focus on statutory services, rather than the whole health and social care sector within the partnership.

The partnership undertook purposeful workforce planning with the NHS Board. This ensured a consistent approach to workforce planning across all six of the health and social care partnerships within the NHS Board.

The partnership acknowledged its rates of staff sickness absence were too high. Partnership staff who were NHS employees had a sickness absence rate of 8%. Partnership staff who were council employees had a sickness absence rate of 7%. Sickness absence rates fluctuated from month to month, with an upward trend for both NHS and council employees in 2018–19. Rates of staff sickness absence in the council's care at home service and the hosted in-patient units for adults with learning disabilities were well above the respective average absence rates – senior managers reported some recent reductions in sickness absence for these services. Leaders understood this was a critical area for improvement.

Leaders informed that staff absence management procedures were robustly but fairly implemented. The partnership had comprehensive data and analysis about staff sickness absence. The age of the workforce and associated health conditions were factors that influenced staff absence levels. The latest data (July 2019) showed some improvement to staff sickness absence levels for both NHS and council employees.

The partnership achieved a Healthy Working Lives Award<sup>26</sup>. It provided a range of activities, training and information for staff about their health and wellbeing. It focused on supporting staff who were most likely to experience health inequalities for example part time and manual staff. An occupational health nurse provided advice and support to staff.

## **Governance**

The Integration Joint Board afforded appropriate governance and oversight of the partnership on its own right and through its sub committees – performance and audit, clinical and care governance and the strategic planning group. The strategic planning group was essentially a forum to engage and consult with a wide range of stakeholders. It did not provide oversight for implementation of the partnership’s strategic plan. The partnership should make sure the strategic planning group adopts a more constructive oversight role for implementation of its strategic plan.

The Integration Joint Board’s performance and audit committee received comprehensive, informative and accessible information about the partnership’s health and social care performance – including financial performance and the Integration Joint Board’s strategic risk register. There was appropriate benchmarking data, with comparison among this partnership and the other five health and social care partnerships included within the NHS Board. There was limited data that showed how this partnership benchmarked against other partnerships across Scotland. This was an area for improvement. The performance and audit committee exercised cohesive governance over its domain and reported appropriately to the Integration Joint Board.

The Integration Joint Board was well informed of the problems with the partnership’s care at home service and the comprehensive improvement plan in place. The chair of the Integration Joint Board and other members had a sound grip on the issues and displayed a determination to make sure planned improvements happened timeously.

The partnership recently reconfigured its clinical and care governance arrangements following a review. It set up a clinical and care governance group to replace the clinical and care governance committee. It refreshed the membership of the clinical and care governance group to include two people who used health and social care services and two unpaid carers. The partnership made good progress conjoining clinical governance for health services and care governance for social care services.

Partnership leaders oversaw strong performance in areas such as minimising delayed discharges and technology enabled health and social care. They put coherent improvement plans in place, such as for the in-house care at home service. They ensured meaningful governance arrangements were in place to oversee the drive for improvement. Partnership leaders worked productively with the NHS Board and its other five partnerships. Senior leaders in the NHS Board strongly endorsed this view.

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26 Possession of a Healthy Working Lives Award means that the participant meets, at the time of the award being given, certain criteria set by Scottish Centre for Healthy Working Lives for the purposes of the Healthy Working Lives Award programme.

## **Risk**

The Integration Joint Board had a strategic risk register that was linked to East Renfrewshire Council's risk register and the NHS Board's risk register. The Integration Joint Board risk register was regularly updated and effectively used SMART methodology.

The Integration Joint Board's risk register was recently updated to reflect the significant risks associated with the poor evaluations assigned by the Care Inspectorate to the Integration Joint Boards care at home service – risk score 16, the highest level of risk. The risk register had actions to mitigate the risks. Senior partnership leaders informed the Integration Joint Board of the problems with the partnership's care at home service and the significant risks extant.

The strategic risk register had a cogent analysis of key risks for the partnership. It identified a possible adverse adult protection event as a risk and coherently set out all the mitigating actions, such as the appointment of a senior manager for adult support and protection. Other risks identified included the failure of a care provider and primary care services not having the capacity to meet the demand of the partnership's increasing population.

## 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's performance improvements for healthcare and social care had important strengths. They included effective performance management and comprehensive use of data to drive and sustain improvements. The partnership's strengths were balanced against areas for improvement, such as reducing the waiting times for primary care mental health services and psychological therapies.

The partnership had several areas where its performance was good. One example was minimising the number of delayed discharges. It successfully worked collaboratively to reduce unscheduled care episodes.

The partnership's provision of intensive care at home to older people and its waiting times for access to primary mental health care and psychological therapies were areas for improvement.

The partnership showed a clear link between improvement activity and sustained or improved performance. It adopted a positive approach to the use of telecare and telehealth, including the uptake of remote blood pressure monitoring.

The partnership generated relevant performance data and used it effectively to sustain good performance and bring about performance improvement. For example, it used data effectively to reduce unscheduled care episodes for care home residents. The use of performance data at locality and team levels was an area for improvement.

The Integration Joint Board exercised sound governance over the partnership's performance. The comprehensive, accessible suite of performance data and performance reports submitted to the Integration Joint Board, supported its governance role.

**Evaluation: Good**

## **Quality indicator 6: Policy development and plans to support improvement in service**

### **6.1 Operational and strategic planning arrangements**

### **6.3 Quality Assurance, Self-evaluation and Improvement**

### **6.5 Commissioning arrangements**

The partnership's strategic planning, commissioning and quality assurance had important strengths. They included a collaborative approach to strategic planning and commissioning, integrated clinical and care governance arrangements, sound financial management and good progress improving primary care services. These strengths were balanced against areas for improvement related to engagement with the independent sector, prompt implementation of its plans for the reconfiguring of commissioning and contracting services and the need to improve its in-house care at home service.

The partnership's strategic plan incorporated its compelling vision and its strategic priorities. It had constructive planning relationships with a range of stakeholders.

The partnership strived to secure the participation of people who used services unpaid carers, its staff, third sector and independent sector partners in strategic planning and commissioning. It needed to do more to involve the independent sector.

The partnership developed its draft commissioning strategy collaboratively. It focused on the development of person-centred services and shifting the balance of care from providing care in hospitals and residential settings to providing care and support for people in their homes and communities. It acknowledged it had given insufficient attention to market facilitation and had taken steps to remedy this through changing commissioning and contracting services. It needed to implement these changes timeously.

The partnership was reshaping its delivery of health and social care services around its two designated localities. Its approach to this was sound, but it had made limited progress and the pace of development needed to quicken.

The partnership had integrated and effective clinical and care governance arrangements. It had made good progress integrating the governance of social work and social care services into its clinical and care governance framework.

The partnership's care at home service was given poor inspection evaluations by the Care Inspectorate, resulting in significant risks for the partnership. Partnership leaders needed to make sure that its improvement plan for this service was quickly and fully implemented.

The partnership had a good record of sound financial performance. It managed its finances competently and well. It used its reserve funds creatively to develop new services to replace out-of-date services.

## **Evaluation: Good**

## **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's leadership and direction had important strengths, including the quality, depth and maturity of integration within the partnership. These were balanced against areas for improvement related to operational management capacity and change management.

Partnership leaders worked purposefully to realise their vision of a highly integrated partnership where staff worked collaboratively to deliver positive outcomes for people who used services and unpaid carers in East Renfrewshire. They put in place an integrated team and management structure, including co-located health and social care staff. The partnership's default position at all levels was integrated co-operative working among health, social care and third sector staff.

Partnership leaders worked constructively with the NHS Board and its other five health and social care partnerships. This ensured a consistent and coordinated approach for areas such as workforce planning and financial planning.

The Integration Joint Board provided sound governance for the partnership. It was strongly supportive of the partnership's work, while providing robust challenge when appropriate. The partnership had effective clinical leadership. It ensured coherent professional leadership for its staff was in place.

The partnership required additional operational leadership and management capacity to effectively implement key strategies and plans.

Partnership leaders acknowledged change management and related communication with staff were areas for improvement. As were the relatively high levels of staff sickness absence across the partnership.

### **Evaluation – Good**

## Evaluation Summary

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

Areas for Development	
1	<p>The partnership should improve its planning processes showing how:</p> <ul style="list-style-type: none"> <li>• strategic and locality needs information are updated</li> <li>• service and locality plans contribute to strategic priorities</li> <li>• priorities are to be resourced.</li> </ul>
2	<p>The partnership should improve its approach to meaningful involvement of a full range of stakeholders for:</p> <ul style="list-style-type: none"> <li>• strategic and locality planning</li> <li>• commissioning.</li> <li>• service redesign.</li> </ul>
3	<p>The partnership should work closely with a full range of stakeholders to develop and implement cross-sector market facilitation approaches.</p>
4	<p>The partnership should further develop its quality assurance and self-evaluation approaches to demonstrate how it identifies priority areas for self-evaluation and how these activities are co-ordinated to improve services.</p>
5	<p>The partnership should make sure that it has sufficient effective operational leadership and management capacity to fully implement strategies and plans.</p>

## Conclusion

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

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

We concluded that there was clear evidence that the partnership was improving its health and social services for adults. It had a culture of collaborative leadership, sound governance and a strong commitment to integration. The partnership's default approach for all its activities was integrated working. It had made commendable progress with technology-enabled care, whereby people were supported by communication technology to keep well and maintain their independence. It worked positively with its third sector partners to develop some innovative person-centred services that used community assets to deliver improved health and wellbeing outcomes for people who used services and unpaid carers. The partnership needed to do more to engage productively with the independent sector.

The partnership had collaboratively commissioned several services that delivered good personal outcomes for people who used services and unpaid carers. At the time of our joint inspection, the partnership was reconfiguring its commissioning and contracting services. It needed to implement its plans for these services promptly and effectively to minimise risk to the partnership.

In March 2019, the Care Inspectorate assigned poor inspection evaluations to the partnership's in-house care at home service. This is a critical service that delivers vital personal care to many older people and other individuals. This issue constitutes a considerable risk for the partnership. The partnership's governance and performance management systems did not pick up the significant problems with its in-house care at home service. There was no evidence of systemic problems with the partnership's governance and performance management systems. We found that from a strategic perspective the partnership had taken decisive improvement actions. The partnership needs to make progress implementing its improvement plan for its care at home service. This will depend on the effectiveness of the operational management of this service.

The partnership showed capacity for continuous improvement with its record of sound progress with the integration of health and social care services, supported by an integrated management structure and co-located teams of health and social care staff.

## Appendix 1 – Quality improvement framework

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

## **Appendix 2 – Inspection Methodology**

Our inspection of the East Renfrewshire 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 582 staff. Of those, 216 (37%) responded. We also carried out fieldwork activity over 7.5 days, during which we interviewed a number of people who hold a range of responsibilities across the partnership. The partnership offered a number of observational sessions, which inspectors attended where they had capacity.

### **Phase 3 – Reporting**

The Care Inspectorate and Healthcare Improvement Scotland 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.

To find out more visit [careinspectorate.com](http://careinspectorate.com) or [healthcareimprovementscotland.org](http://healthcareimprovementscotland.org).



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