



JOINT INSPECTION (ADULTS)
The effectiveness of strategic planning in
North Ayrshire Partnership

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March 2019

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1. About this inspection

Scottish Ministers have asked the Care Inspectorate and Healthcare Improvement Scotland to report on the effectiveness of strategic planning by integration authorities. 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 has:

- improved performance in both health and social care
- developed and implemented operational and strategic planning arrangements and commissioning arrangements,
- established a 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 joint commissioning) and we assessed the improvements the partnership has made in health and social care services that are provided for all adults.

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

North Ayrshire Partnership is a joint venture between North Ayrshire Council and NHS Ayrshire & Arran and is referred to as the partnership throughout this report. This inspection took place between August and December 2018. The conclusions within this report reflect our findings during the period of inspection. There is a summary of the methodology in Appendix 2. 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.

2. The North Ayrshire context

[Context provided by North Ayrshire Partnership within Position Statement received 19 September 2018.]

Geographical

North Ayrshire is located in the west of Scotland covering 885 kilometres square, and borders the areas of Inverclyde to the north, Renfrewshire to the northeast and East Ayrshire and South Ayrshire to the east and south respectively.

Demographic

In 2016 the National Register for Scotland captured that the total population of North Ayrshire was 135,890. The working age population (16-64 years) was 60.5% of the population (85,535). A total of 39.5% of the population were out with working age with 17.2% being children and young people (0 – 15 years) and 22.3% older people (65+).

Demographic projections

North Ayrshire's population is expected to both decrease and shift in composition over the coming years. North Ayrshire's total population is expected to drop by 3%, from 135,950 in 2017 to 132,092 in 2027. A decrease is predicted in the 0–15 years age group (from 17.2% of the population in 2017, to 16.8% in 2027) and the working age group (from 60.5% in 2017 to 55.8% in 2027). Over the same period, an increase of over 5% in the over 65s population is predicted (increasing from 22.3% of the population in 2017 to 27.5% in 2027).

Service demand impacts

The growing proportion of older people is likely to result in greater demands on adult health and social care services, alongside a reduced working age population and shift in composition over the coming years. New models of care are needed that focus on preventing ill health and where possible reducing the need for hospital based care. According to information provided by the Scottish Public Health Observatory, between 2015 and 2017, 6,277 (per 100,000 population) people in North Ayrshire aged 65 or over experience two or more emergency hospital admissions. This is above the Scotland average of 5,422.

In addition, demand for mental health treatment continues to increase, with over a fifth (20.6%) of the North Ayrshire population being prescribed drugs for anxiety, depression or psychosis. This compares with the national percentage of 18.5%. In 2016/17 North Ayrshire also had a higher rate of Alcohol and Drug related hospital stays than the Scotland average. There were 898.6 (per 100,000) alcohol related stays, significantly above the Scotland average of 690.8, with 342.3 (per 100,000) drug related stays, significantly higher than the Scotland figure of 146.9. In 2016, there were 35 drug related deaths in North Ayrshire, representing a significant increase on the year before and highlighting an area of concern for the partnership. In 2015, North Ayrshire had over 14,000 unpaid carers (roughly 10% of the

population), who delivered care, estimated to be worth approximately £321m. The support provided by local carers is invaluable and without available support provided by health and social care services, the demands placed on unpaid carers will increase. The partnership will continue to nurture carers in their supporting roles.

Political

North Ayrshire Council area contains 10 electoral wards and has 33 local councillors. Since 4 May 2017, North Ayrshire Council has been governed by a minority Labour Party administration. There are 11 Labour councillors, 11 SNP councillors, 7 Conservative councillors and 4 Independent councillors.

At the Scottish Parliament, North Ayrshire is represented by two Constituency seats, Cunninghame North and Cunninghame South, both represented by the SNP. At the UK Parliament level, North Ayrshire rests within two constituency areas, Central Ayrshire and North Ayrshire and Arran, again both are represented by the SNP.

Economic

North Ayrshire's current employment rate is 8% higher than its recessionary low point, and is 2% below its all-time (15-year) high. At 68%, North Ayrshire's employment rate is below that of Scotland (74%).

Inequalities

North Ayrshire is a place of sharp inequalities. Some residents experience high levels of deprivation and poor health. According to the Scottish Index of Multiple Deprivation (SIMD) 2016, 39% of the area's population live in areas identified as among the most deprived in Scotland. This equates to almost 53,000 people. These inequalities between communities are in part responsible for the significant health inequalities that exist locally.

In terms of overall life expectancy, men in North Ayrshire can expect to live to 76 years, this is around six months less than the Scotland average. The life expectancy for women in North Ayrshire is similar to that of the national average. However, within North Ayrshire, there are great variations in life expectancy for both men and women across localities.

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. In North Ayrshire there is a gap in male life expectancy of 18 years between deprived and more affluent areas. In North Ayrshire, levels of multiple -morbidity are higher in deprived areas. Levels of multiple-morbidity in localities with the highest level of deprivation are three times higher than in the most affluent localities.

Governance

The Integration Joint Board (IJB) is formed by four North Ayrshire Council Elected members and four NHSAA Non-Executive members. The IJB has a legal responsibility for the planning and resourcing of a range of delegated services as

detailed in the Integration Scheme. North Ayrshire HSCP has the lead partnership role for Mental Health inpatient services.

Financial position

The partnership is not alone in facing significant financial challenges. Services are delivered from a budget of £230m. Financial pressures in relation to health and social care services due to demographic growth and sustainability issues of traditional models of service delivery continue. In a number of areas demand is outstripping available resources, requiring a significant change agenda to be delivered by the integration of services, to meet demand, alongside constraints on financial resources. The change programme in 2018-19 alone required to deliver £6.6million of savings. These financial pressures are expected to continue in future years and are anticipated to direct the pace at which service change requires to be implemented.

It was against this backdrop, that North Ayrshire became the first formalised HSCP in Scotland on 2 April 2015.

3. Performance

North Ayrshire Partnership had made some progress in developing a performance reporting framework, informed by national and local indicators and aligned to the partnership's five strategic priorities. Performance information, including finance, were regularly reported to the partnership's senior management teams and the IJB. Operational performance was not presented in as much detail as financial performance and the reports received by the IJB did not include data on aggregated individual outcomes. A sub-group of the IJB was responsible for monitoring performance and highlighting areas where there was improvement or action required.

While it was evident that the partnership had made progress in developing its performance reporting structures, the system of reporting was not consistently found to support the use of some performance data to enable this to be integral to drive improvement. This was evidenced through managers and staff reporting that there was generally a lack of impact measurements to evidence positive personal outcomes for people receiving health and social care services in North Ayrshire.

The partnership was part of a National Health and Wellbeing Indicators 'family group'. The partnership had identified an improvement in its ranking from 2013/14 in seven of the nine measures and against all authorities in six out of the nine measures. However during our inspection, the partnership's performance within the family group was found to be relatively poor on more than half the comparative indicators. There was also no clear indication as to how the partnership was using this benchmarking to enhance performance. A well-established system of identifying baseline measurements and setting targets could improve performance tracking against the partnership's strategic intent and allow North Ayrshire to better identify areas where action should be focused.

The need for improvement in the use of data had been identified by the partnership and was being addressed through the Transformational Change Programme. The partnership had enlisted support from Information Services Division (ISD) and the Local Intelligence Support Team (LIST) in developing baseline measurements. These are aimed at improving how they could better understand and translate the national outcome measures into delivering improved outcomes for individuals. This was a positive development to support the use of performance data across the partnership.

There was duplication in performance monitoring and governance arrangements because of different reporting systems between health and social care services. To improve the effective sharing of information and to reduce risk from this, the partnership had developed the All Service Performance Information Review and Evaluation (ASPIRE) process. However, ASPIRE did not include performance data from the third and independent sectors, which was monitored through a separate

contract management process. The lack of this information was recognised and ASPIRE was reported to us as being a 'work in progress'. There was evidence of ASPIRE being used to provide a comprehensive performance monitoring process in the North Ayrshire Drug and Alcohol Recovery Service (NADARS). Performance data for all NADARS services or projects across all sectors were supplied to one central group. Outcomes were agreed and linked into the strategic plan. The central group screened performance data and provided feedback. This was a helpful structure which has the potential to provide a more comprehensive systematic approach to inform monitoring of performance of other services.

In conjunction with the National Health and Wellbeing Outcomes¹, the Scottish Government published a core suite of integration indicators² in 2017. These indicators were determined by asking for feedback from people who use services and also by looking at performance indicators. An example is the rate of delayed discharge. Against these criteria, the partnership had a number of performance measures indicating a very mixed performance compared to Scotland as a whole and measures where performance was either in line with or poorer than the Scotland average.

Emergency admission rates for adults aged 20-64 years was increasing; the rate of bed days used for admissions in this age group was worse than the Scotland average. There had been a less significant increase in emergency admissions for people aged over 65.

Bed days lost to delayed discharge in the 12 months to August 2018 increased for all adults to the highest level since 2012. The primary reasons for delay were the partnership being unable to meet the health and social care needs (over 75s) and being unable to make the necessary care arrangements and delays in securing funding (18-74 age group).

Delays due to adults awaiting place availability in a high level needs specialist facility and where an interim option is not appropriate, known as Code 9 delays, had also increased and remained higher among the 18–74 age group. Improving this was a priority within the plan for intermediate care which is covered in more depth later in this report.

A significant challenge was the prevention of unscheduled admissions to hospital and in achieving timely discharge from hospital once a patient was declared medically fit. The partnership had identified the provision of care at home as a major factor required to support an improvement in performance in both prevention of admission and reduction in delays in discharge. It was addressing this through a number of measures. For example, in an effort to reduce delays caused by waiting for care at home provision, daily monitoring of people in hospital awaiting this service

¹ <https://www2.gov.scot/Resource/0047/00473516.pdf>

² <https://www2.gov.scot/Topics/Health/Policy/Health-Social-Care-Integration/National-Health-WellbeingOutcomes>

had been introduced to improve communication between hospital and community services. A further effort to improve performance was the introduction of hospital discharge meetings. Managers and staff reflected that the implementation of these measures as well as collaborative working had resulted in improvements in the management of admission and discharge. Staff can now plan for discharge as part of the admission. Staff told us these initiatives have had a positive impact on reducing the number of patients waiting for care at home.

The rate of care at home provided by the partnership was good for the 18–64 age group where the rate of the population receiving care at home and intensive homecare were both higher than the Scotland average. Care at home and intensive homecare varied for the over 65 age group. The population of the over 65 age group receiving homecare was higher than the Scotland average and those (over 65) receiving intensive homecare was lower than the Scotland average.

There was evidence of investment by the partnership to support people to stay at home which included the use of tele-care³. The partnership provided better levels of community alarms and technology-assisted healthcare to older people than the Scotland average. To promote the independence of people with learning disabilities, there had been a successful pilot in the use of technology to inform the redesign of the overnight support service. There had also been an expansion of community link workers in GP practices to enable people to access a wider range of support options. Community hubs had also been developed in two sheltered housing schemes.

It was evident that the use of performance data within the partnership to drive improvement had progressed. However, we identified weaknesses in the funding approval process. For example the system to gain approval for funding was subject to delays both for discharge from hospital and to provide care at the right time. Staff told us that when funding was delayed this resulted in individuals deteriorating from the point of assessment with the consequence of requiring a higher level of service provision.

Planning and development of new ways of working was taking place across the partnership to improve performance in the delivery of national outcomes and indicators. There was evidence of progress and development in the reporting and use of data both at a service level and to measure effectiveness of strategic plans. The impact of these plans had not fully translated into improved performance at this stage.

³ Tele-care is a system used to support independence at home. <https://www.gov.scot/publications/supporting-empowering-scotlands-citizens-national-action-plan-technology-enabled-care/>

4. Policy development and planning

Strategic planning

North Ayrshire IJB has the lead role for mental health and learning disability services across Ayrshire. It also holds responsibility for health and community care, primary care, children, families and criminal justice services in North Ayrshire. The partnership acknowledged that going forward, delivering services in the same way will not be financially or operationally sustainable. We found that the most developed areas in terms of strategy and operational shift were in mental health, learning disability and addictions. These developments had included consultation with stakeholders. The strategic intent for services, for which the lead role had been delegated to other IJBs in Ayrshire, was not as well developed. For example, we were less confident about the approach being taken on the development of services for older adults. There was evidence of progress within individual work streams but, overall, the strategic shift for services for older adults was not as well developed as those where services were led by the partnership.

The partnership has a shared vision that: “All people who live in North Ayrshire are able to live a safe, healthy and active life.” This vision was informed by an overarching strategic commissioning plan which sets out the partnership’s five strategic priorities. The strategic commissioning plan outlines the actions and developments the partnership has agreed to implement during 2018–2021 to achieve each strategic priority⁴. These commissioning intentions were also grouped according to the broad service areas that the partnership is responsible for delivering. This structure provided a framework that had supported the development of clear, wide-ranging and diverse commissioning intentions against the wider vision and the partnership’s strategic priorities across the health and social care system in North Ayrshire. These included primary prevention and promoting self-management to improving primary care and social care, development of multidisciplinary teams, self-directed support (SDS) and specialist services.

The partnership took proactive steps to make sure that the strategic commissioning plan was co-produced. It was developed by a sub-group of the Strategic Planning Group (SPG) which included representation from a broad range of stakeholders. It had also been informed by a public engagement exercise. This engagement and consultation had supported the decision to carry forward the same strategic commissioning priorities from the 2015–2018 plan to the 2018-2021 plan.

The housing contribution statement demonstrated that there was an understanding of the importance of housing in achieving the partnership’s strategic priorities. The HSCP’s Director participated in the Homelessness Task Force which demonstrated the level of commitment to this work. During our inspection, it was highlighted that there was a gap in how housing was represented on the SPG. The local authority

⁴ <https://www.north-ayrshire.gov.uk/Documents/CorporateServices/ChiefExecutive/PolicyandPerformance/directorate-plan/2018/Strategic-Plan.pdf>

housing service was represented on the SPG but the Registered Social Landlords (RSLs) had not been invited to join the SPG. At the time of our inspection, we were advised that an RSL representative had been sought to join the SPG by senior managers in the partnership. There was evidence of difficulty in establishing a constructive dialogue between the partnership and the RSLs with a commitment to improve this expressed by both sides.

We could see the strategic plan had evolved over time. The plan was updated in 2016 and this had informed the development of the current plan. The partnership's performance and audit sub-committee monitors and evaluates implementation of the strategic commissioning plan. The absence of SMART⁵ objectives meant there was difficulty in determining if actions were delivered within intended timescales, were achievable, led to measurable improvements and were realistic.

Strategic needs assessment

The partnership's strategic needs assessment consisted of several discrete needs assessments. These had the advantage of ensuring that detailed and focused assessments informed particular developments such as rehabilitation and intermediate care. There was sufficient high-level population-based needs assessment to support the overall strategic priorities. The partnership had improved the strategic needs assessment which informed the strategic commissioning plan for 2018–2021. The updated version included greater analysis of service performance, demand and resources.

The partnership had not produced and published a single strategic needs assessment that pulled together all of the data used to inform the strategic commissioning plan. This increased the risk that the discrete strategic needs assessments would not be systematically updated within consistent time periods or in response to specific changes in demographic, demand or performance trends. It also limited the potential for this information to be used by partners, including the third and independent sectors, to inform the development of their services.

Strategic commissioning priorities in the strategic commissioning plan reflect key themes within the partnership's strategic needs assessment. The use of key themes within the strategic commissioning plan and improvement in the detail within the strategic needs assessment were good. This could be further strengthened through a single strategic needs assessment supported by a system to provide regular updates. The key themes included the area's relatively high levels of deprivation, increasing numbers of older people with complex needs and reductions in workforce and funding. These priorities were reflected in key high-level strategies such as 'bringing services together' and 'early intervention and prevention'. These are essential for health and social care integration to support improved outcomes, changes in workforce profile and available resources.

⁵ Smart, Measurable, Achievable, Realistic and Time-bound.

Locality planning

The partnership had progressed locality planning by establishing six localities in 2016. Locality Planning Forums (LPFs) existed in each of these and included members of the IJB who were also part of the SPG. This had the benefit of ensuring that localities could directly feed into the partnership's strategic commissioning processes. Each LPF had identified priorities for their locality and these were included in the partnership's strategic commissioning plan.

Locality priorities had been informed by high-level analysis of the health and wellbeing of each locality's population. This process had been successful in demonstrating important and significant differences in the characteristics of each locality and the need to develop local planning processes to respond to these. The partnership recognised locality planning would be better informed through the provision of information on service activity, performance and resources at locality level. This process was under development at the time of our inspection.

There was commitment to widening participation within the localities. There had been positive progress with a pilot of the new roles of Locality Engagement Champions and Locality Communication Champions. Public engagement pilots for locality forums over the period from November 2018 to April 2020 were planned.

The Community Planning Partnership (CPP) was well established prior to the formation of the partnership and its localities. There was some duplication across these forums which were under review. There was a clear recognition that each LPF had a distinct role to identify health and social care priorities within both the partnership and CPP. The third and independent sectors were represented on the CPP, but there were a range of views on the effectiveness of locality planning at the current stage of development. For example, we heard from some service users and carers that where there had been pan Ayrshire condition specific groups, these were perceived as having a stronger voice. At the current stage of development, the engagement with different care groups has not established confidence in representing all relevant interests at this time.

The partnership showed a commitment to supporting the role of LPFs and an increase of awareness through a planned process of engagement and provision of information. This was a positive approach and recognised the variations across Localities.

Priorities

The priorities of the partnership were clear at all levels and aligned with local authority and NHS board priorities. An example of this was the alignment of the partnership's strategic planning priorities with the CPP's Local Outcomes Improvement Plan. However, the commissioning intentions were not sufficiently aligned with the financial plans. Closer alignment would inform decisions relating to investment and disinvestment as they implement their plans.

Commissioning intentions

Strategic planning and commissioning processes for mental health services were well developed. The partnership has lead responsibility for mental health services across Ayrshire. This had supported successful developments such as the Woodland View mental health inpatient facility and the integrated NADARS. The partnership was working with the other Ayrshire HSCPs to develop and implement a pan Ayrshire mental health strategy to deliver the Scottish Mental Health Strategy 2017-2027.

The strategy for services for people with learning disabilities was also well developed. This included the challenges of increasing demand, limited resources and the importance of redesign and development of traditional services to support sustainable outcomes. One example of this was the successful pilot of the use of technology to support the independence of people with learning disabilities to redesign support during the night.

Good practice example – service redesign

Trindlemoss was a good example of shared investment to redesign services, as the capital funding required was agreed jointly between NHS Ayrshire & Arran and North Ayrshire Council. In addition, it was evident that there had been a proactive approach to involving people using services in the development of the project. This reinforced our analysis that the partnership has a strong commitment to engagement and consultation with stakeholders and feedback is being used to inform strategic planning and decision making.

Both the mental health and learning disability strategies were supported through the partnership's Commissioning Strategy Community Support 2018-2021 for people with learning disabilities, physical disabilities and mental health needs. This included a comprehensive and well-developed approach to evolving more personalised services. Overall, these detailed plans demonstrate a positive and coherent whole system strategy to provide more personalised services. The plan lacked detailed financial planning and did not identify areas of investment and disinvestment.

The strongest examples of effective strategic planning and commissioning of services for older people had been taken forward on a pan Ayrshire basis. These plans had been developed by a change team based in North Ayrshire Partnership and demonstrated that the partnership has developed capacity to deliver effective strategic planning and commissioning. The combination of a focus on a programme of discrete pan Ayrshire plans and an under-developed whole system perspective to support pan Ayrshire planning for older adults increased some challenges and risks in the partnership's ability to integrate processes with services and activities that operate at a partnership level. Examples included care at home and reablement services, equipment and adaptations, and third sector and community resources.

Care at home is covered in greater depth later in this report. Falls prevention is also relevant and is delivered on a pan Ayrshire basis and was described in the partnership's strategic commissioning plan as requiring further development. The partnership had challenges in maximising the potential benefits of providing equipment and adaptations. The plans in relation to the examples stated, were not developed to demonstrate clarity in terms of the assessment of need, demand, capacity and option appraisal, including modelling of different cost scenarios, expected outcomes and timescales for implementation. As a result of a lack of a whole system approach to older adult services there was no comprehensive or coherent strategy evident for older adult services.

The partnership had some commissioning intentions that were not clearly set out in the strategic commissioning plan or other detailed plans. The decision to maintain the majority of care at home provision in-house was an example of a decision that was prompted by five external providers exiting the North Ayrshire market. However, there was no evidence that this decision was supported by detailed financial planning, option appraisal (including adequate comparison with the costs of external provision) and risk assessment. Its absence from the strategic commissioning plan meant that there was no explanation as to how it would contribute to the partnership's overall strategy for older people.

An example of this was the waiting list for care home placements. One of the biggest areas of overspend incurred by the IJB was care home placements. Waiting lists were being used as a means of reducing this overspend. The impact of this was not fully risk assessed or evaluated to include impact on outcomes for individuals and the whole system. This demonstrated a lack of budget management strategies linked to strategic planning and commissioning processes which had led to the impacts of these budget strategies not being utilised to inform and refine future strategy. There was evidence that the financial implications of commissioning approaches and strategies had been factored into the medium-term financial plan.

Plans for care at home and care homes were not developed sufficiently to provide clarity in terms of the assessment of need, demand, and capacity and option appraisal, including modelling of different cost scenarios, expected outcomes and timescales for implementation. This approach had missed an opportunity to identify where individuals could have potentially been supported by alternative services and responses such as reablement, technology or intensive care at home or extra care housing. There were positive steps evident to develop a commissioning strategy for care homes with providers involved in this process. This work was at an early stage.

Early intervention and prevention

There was acknowledgement from senior managers that progress in the area of prevention had been limited. Although this was recognised as a strategic priority, it was difficult to focus on and we heard from senior staff that this was due to financial limitations. One example where further development was acknowledged as required

in the partnership's strategic commissioning plan was falls prevention which was delivered on a pan Ayrshire basis.

There was evidence of a positive development where a procurement and commissioning exercise was being undertaken for addictions services to work with the third sector to deliver early intervention and prevention. Third sector provision of early intervention had reduced due to a withdrawal of support of the Integrated Care Fund (ICF). Some services had been replaced with in-house services, including 'money matters'. The availability of link workers within GP practices was described as a positive resource in identifying resources within the community at an early stage.

The challenge of continuing to meet critical needs while identifying resources to invest in early intervention and prevention, as in other partnerships across the country, was recognised during our inspection as being a significant one which requires time to demonstrate. This applied to the rehabilitation and intermediate care development detailed below.

Rehabilitation and intermediate care

An area where there was evidence of good integrated planning and commissioning was the pan Ayrshire development of rehabilitation and intermediate care. Additional investment from the NHS board of £2.5m had been provided to enable a shift in the balance of care from hospital by investing in a new model for community services to prevent avoidable admissions. This model had been developed following a review of the evidence base for reducing emergency admission rates in Ayrshire. Plans described how development of rehabilitation and intermediate care services would deliver this. These plans provided a coherent description of how investment contributes to an integrated approach to the needs of older people and people with complex needs. The levels of investment were clearly identified with projections of the net levels of avoidable costs and clear time-specific implementation plans. Development of rehabilitation and intermediate care had also been designed to interface with the pan Ayrshire Primary Care Improvement Plan. This was a strength in terms of ensuring a consistent approach across primary care and rehabilitation and intermediate care.

Rehabilitation and intermediate care fit within a clearly defined vision for a comprehensive tiered model of support in the community.

Starting with the provision of community resources, other aspects of the model included:

- leisure activities
- technology enabled care
- exercise to support self-management
- anticipatory care.

At the next level were:

- multidisciplinary teams (organised around GP practices and clusters)
- community rehabilitation
- equipment adaptations
- intensive homecare
- enhanced intermediate care teams
- community hospitals
- step up/step down provision.

The final tier progression was to acute hospital care. This was a well-developed plan at the time of our inspection where the development of rehabilitation and intermediate care was focused on the reduction of emergency admissions and delays in discharge by investing in community services. There was a lack of detail and analysis evident on the effect of this plan on the delivery of long term care service delivery across the partnership. These services included care at home and care home provision. For both of these services there was insufficient detail evident to inform development. A specific example was the potential impacts of transition of an individual to receiving a long-term care at service. This was applicable where there was a need identified for a move to long-term care for an individual at the completion of a period of rehabilitation, having achieved their optimal level of independence. There was also an absence of clear identification of the potential risks to resources, skills and expertise within intermediate care and rehabilitation being used inefficiently, if they are required to continue to support people while waiting for long term support to be organised.

Pan Ayrshire plans for rehabilitation, intermediate, palliative and end of life care contained strategic commitments to develop joint plans in the future for community hospitals, frail older people and long term care in care homes. An example of a comprehensive approach was the palliative and end of life care plan which is under development and requires agreement by the three Ayrshire Integration Authorities. These were clear examples of commissioning intentions being underpinned by detailed plans and informed by a whole system approach. This programme approach was deliberate to mitigate the risk of progress being lost because plans were too complex.

Engagement and involvement

A focus on engagement and communication was evident and the strategy built on an earlier review of learning disability services and appreciative enquiry processes with staff. The partnership had agreed plans for the redevelopment of a significant proportion of its day services for people with learning disabilities, together with supported accommodation on a single site in Irvine called Trindlemoss, which we identified as an example of good practice during this inspection. Capital investment from both North Ayrshire Council and NHS Ayrshire & Arran had been aligned and

this reflected a collaborative approach that was evident in many areas of development.

Engagement with care home providers that continue to offer services in the partnership has followed a period of sudden change in this market and was viewed by some providers as reactive due to imminent reductions in capacity. The timing of this illustrated a lack of a whole system perspective which resulted in a loss of opportunity to identify the fundamental strategic risk to care home sustainability at an earlier point in time. For example we heard there had not been engagement to identify potential impacts and risks from the perspective of providers when the partnership took the decision to manage demand for places through waiting lists. At the time of the inspection, the partnership had made a positive commitment to begin to work with care home providers to address this.

Housing

There were well-developed commitments in the Strategic Housing Investment Plan (SHIP). These were developed and aligned with the partnership's strategic commissioning plan for supported housing for adults. Commitments in relation to adults included the promotion of independence, assisting in preventing demand for care and support services and realising financial savings for the partnership. The development of community hubs in existing sheltered schemes had progressed and presented a good opportunity to enhance prevention and early intervention. This was viewed as a positive development by staff. Senior managers indicated that the redevelopment of sheltered schemes and the development of supported housing for adults, with adjacent staff bases, had resulted in the potential for extra care housing for older people to be considered. This would exceed the current housing commitments in relation to older people and were focused on the redevelopment of sheltered housing. The contribution of housing was reflected in general terms within the strategic plan. More detail on the recognition of the need to support the partnership's vision and outcomes was evident within the Housing Contribution Statement and SHIP. This includes the role of housing in planning through representation at the SPG as discussed earlier in this report.

Asset based approach

Senior managers identified that moving to an asset based approach⁶ was essential to make sure that outcomes were maintained as demand increased faster than the available resources.

The asset based approach was consistent with partnership strategic plans relating to adults with learning disability, physical disabilities and mental health needs. It was less clear as to how it would fit into the range of strategies and initiatives that the partnership was developing in relation to older people. Staff told us about an example of where community assets had been identified to support people who were

⁶ "An asset based approach is strength based practice. It is practice based on a collaborative process between the person supported by services and those supporting them, allowing them to work together to determine an outcome that draws on the person's strengths and assets." <https://www.scie.org.uk/strengths-based-approaches/guidance>

waiting for a care at home service. However, while these were valued, there was no formal evaluation, assessment or monitoring of risk applied to community-based services. There was a lack of evidence of a link between the pan Ayrshire intermediate care strategy with partnership planning for community support.

There was no evidence of a systematic approach to mapping community assets in order to make sure that there would be sufficient capacity to support the development of an asset based approach. Senior managers planned to engage with the partnership's staff first to develop the asset based approach and then involve the third sector and other stakeholders. Involving the third sector and other stakeholders in this process at a later stage than staff potentially risks a lack of expertise and ownership from the third sector organisations in the development of the approach. Feedback from third sector organisations was mixed. They appreciated the opportunity for involvement in the SPG and IJB but they told us that there had been a reduction of services within the third sector as a result of reduced resources. Despite this there was capacity within communities that could be further utilised to support this approach.

While the commitment to an asset based approach was articulated across a range of staff groups and senior managers, the expectation and understanding was varied. There was a lack of evidence of information detailing what the approach will involve or how it will support greater sustainability. To address this, plans were being developed for an engagement programme to inform stakeholders.

There was a positive approach to delivering better personal outcomes through a move to an asset based approach. This was at an early stage within the partnership.

Developing more personalised services and maximising the flexibilities available through self-directed support was central to successfully moving from traditional service responses to an asset based approach. The partnership's strategic plan commits to; "help individuals to have better choice and personal control of their support at an early stage by reinvigorating self-directed support and the Partnership Charging Policy. "An implementation plan was agreed by the partnership's senior management team in 2017, including additional staffing for the self-directed support team. Senior managers highlighted that self-directed support has not been given significant priority up to now and opportunities to progress developments which could enable progress towards an asset based approach had been limited.

Financial position and sustainability

The IJB faced a significant funding challenge. Contributing factors included an ageing population, real term funding reductions and a history of overspending. There was a total deficit of £5.807m at the end of March 2018.

Following a financial review in August 2018, the IJB projected an overspend of £1.247m during 2018/19. In light of this projection, a financial recovery plan had been implemented with the intention of balancing funding and expenditure by the

year end. However, this depends on achieving all the savings identified in the savings plan in the year. This will require regular monitoring by the IJB. If the planned savings are not achieved there is a risk that any further actions taken to address any overspend will adversely affect service quality and performance.

The IJB had implemented a challenge fund to support service redesign. This funded a programme that created opportunities for services to make transformational changes to realise both the required North Ayrshire Council savings target and additional savings which could be re-invested in their newly designed service. The original projected level of gross savings of £6.416m by the end of March 2019 will not be achieved. The expected gross savings for phase one of the programme were £1.657m. Whilst the challenge fund did not create the level of savings originally desired, it was a positive step in creating more efficient services, financial savings and creating more sustainable service models. The fund allowed the partnership the freedom to trial new ideas and improvements with the ability to discontinue any projects that would not produce the required savings.

The partnership had made considerable improvements in ensuring that its activities would be financially viable through the development of its current Medium-Term Financial Strategy (2017/18 and 2019/20). The strategy and the five work streams that it was based on were included in the partnership's current strategic commissioning plan. The partnership recognised the need to refresh the Medium-Term Financial Plan from 2019/20 onwards and finance officers recognised the need for greater alignment with its strategic priorities and strategic commissioning intentions.

The IJB implemented a new financial framework for council budgets which provided more effective budget management. Variances in the budget were monitored monthly and areas where focus and intervention was required could be identified quickly. This was a positive step towards effective budget monitoring and financial sustainability. The framework was for application only for social care budgets in order to address concerns about the financial risk of volatile demand-driven social care services. While there are different challenges in relation to NHS budgets, further work was required to also improve the monitoring of these budgets.

It was intended that the greatest impact on the financial sustainability of the partnership would be the transformational change programme. The programme was led by the Chief Finance Officer in the role of Chief Finance and Transformation Officer. Having the Chief Financial Officer lead on transformation intended to demonstrate a commitment to the programme, together with a recognition that financial and service sustainability are inextricably linked. It was recognised that the post had been filled shortly before our inspection and the impact of this approach was not fully evident.

Over the next three years, the IJB intends to repay £1.5m to reduce the existing council deficit of £5.807m. If this plan to repay the debt is successful, along with the savings plan in place for 2018/19, then the financial position of the IJB will significantly improve. As with the 2018/19 savings plan, achieving this depends on regular monitoring and implementing contingency measures if monitoring shows the planned levels of savings are not being achieved. The plan is also dependent on the IJB having detailed financial and strategic plans in place to prevent future overspend and continue investment in service development.

Contract management, procurement and market facilitation

We learned that there were no service level agreements in place for NHS-hosted services, for example cancer care. The partnership relies on each NHS service for the provision of clinical and care governance arrangements and audit reports and there was no evidence of a system of assurance within the partnership for hosted services.

The partnership had agreed arrangements for ensuring contract management and continuous improvement of social care services procured from external providers. These functions were delivered by the procurement and contract management team, based in North Ayrshire Council. This team was valued by commissioners, managers and providers. The team assisted commissioners to develop effective service specifications. Team members had constructive working relationships with staff within the partnership who had commissioning responsibilities. The partnership's ability to support these integrated approaches was enhanced by the secondment of experienced NHS staff (with experience and responsibility for NHS third sector funding) to the North Ayrshire Council procurement and contract management team.

The contract management team had systematic monitoring arrangements in place. At the point of a contract being implemented, a contract management framework was put in place. The level of review was determined by the size of the service and the level of spend incurred. Six-monthly self-assessments were followed by annual visits by the contracts team to validate the self-assessment data. Contact with providers would be more frequent if, for example, there was a concern about the quality of the service being provided. Where concerns were identified through regulatory inspection, improvement plans were put in place and monitored by the contracts team.

An understanding of the potential issues and risks from a provider's perspective was not always translated from the contract management team to more senior managers in the partnership who attend the IJB. This increased the risk of the partnership's strategic commissioning plan and other plans not being informed by a whole system approach.

Positively, the partnership was delivering its immediate commissioning intentions effectively. The contract management team produces a market analysis to support each procurement exercise. There was a lack of evidence that the partnership had

yet undertaken market facilitation activities to develop its external markets to better meet the needs of its population in the future, either directly or through North Ayrshire Council. Further evidence of this was the absence of a market position statement to facilitate and encourage providers to develop their services on the basis of shared understanding of local markets and the needs and characteristics of the population.

The partnership had begun to identify information to develop market facilitation only with care home providers. This limited the partnership's ability to offer choice to older adults requiring care at home, the lack of a commissioning strategy for community supports also reduced choice for all adults.

Self-evaluation and quality assurance

The partnership had undertaken a range of self-evaluation activities from appreciative enquiry to specific evaluations of service developments. These activities varied considerably in terms of the scale, detail and comprehensiveness of the evaluation. There was limited evidence to demonstrate that these self-evaluation activities were consistently informing strategic plans through application of the findings and recommendations. Examples within learning disability services included evaluation of tests of change in respite provision and the care at home/tele-care pilot in learning disability services. This evaluation of tele-care demonstrated a reduction in the need for sleepovers and was reported to have been effective in empowering service users. There was ongoing evaluation being facilitated through assignment of a project manager.

It was positive that outcomes for addiction services linked back into the strategic plan and that the performance data was supplied to a central group which screened the data and provided feedback on the quality. We noted some concern from third sector representatives about the allocation of monies from the Integrated Care Fund and, in particular, the rationale behind the decision to cease projects and move services in-house. There had been representation in this process and representatives of the third sector service providers from the third sector interface (TACT) were positive about being involved.

There was evidence of a lack of comprehensive self-evaluation of services for older people. The information provided on the evaluation of step up/step down provision in a care home had a limited scope and lacked content. There was no information on the costs of running the service and minimal qualitative data on outcomes. While the evaluation indicated that the views of some staff were that the project had been successful in providing temporary residential accommodation for people who would benefit from reablement, the majority of people using the service were admitted to the care home on a permanent basis. As the partnership intends to use this evaluation to inform discussions that have just begun with care home providers to develop new models of provision, there needs to be greater clarity about the key

success measures of such projects as well as the costs and expected efficiency savings.

There were a number of feedback and consultation mechanisms being used by the partnership. This included information from complaints, the Care Opinion website, adverse events monitoring and contract monitoring.

Governance arrangements for managing performance and risk

The IJB performance and audit sub-committee was chaired by an elected member who also sits on the IJB. The partnership was subject to audits by the council, the NHS board and external audit. An annual audit programme had been identified with the internal auditor for North Ayrshire Council and the IJB. The Head of Finance and Transformation was involved in this process. Performance of commissioned services provided by the third and independent sectors was being reported to the governance committee. While this is positive, as noted above, different performance management arrangements for in-house and external provision limited the extent that performance and risk are managed from a whole system perspective for some functions that rely on a mix of in-house and external provision, for example care at home.

There were some examples of the partnership successfully developing processes to manage risk. These included the strategic risk register (SRR) which is a comprehensive document linked to the delivery of the strategic plan. Reports are provided to the IJB on a six-monthly basis and monitored on a more frequent basis by the senior management team. The financial position of the partnership is entered as a risk on the SSR, signalling its priority. The partnership acknowledged that an integrated approach to risk management was still being developed.

The IJB was receiving budget monitoring reports on a monthly basis together with a RAG⁷ status and active discussion was taking place on areas of concern.

The IJB received reports on operational performance but these did not drill down to provide information on personal outcomes. The partnership was beginning to work towards processes to achieve this with assistance from ISD analysts.

Financial governance was being supported by the implementation of a budget holder's charter. The partnership had carried out a budget holder's audit and held development sessions with teams in support of their responsibilities for managing the budget.

The effectiveness of the partnership's risk management was limited in some areas. Improvements were needed to make sure that the strategic commissioning plan was informed by a whole system approach that describes all of the commissioning intentions the partnership is delivering. It should also be aligned with the

⁷ The **RAG** system is a popular project management method of rating for issues or status reports, based on Red, Amber (yellow) and Green colours used in a traffic light rating system.

partnership's financial planning as this limits the effectiveness of risk management in some areas. For example, performance information from contract monitoring of external providers was not reported to the IJB and information on external services and internal provision was not combined or compared to give an effective overview of service areas such as care at home. Failure to include strategies such as the operation of waiting lists to manage budgets and aligning strategic commissioning intentions with financial plans means that any risks to individual or whole system outcomes arising from these actions had not been identified, monitored and actions taken to mitigate them.

Performance information provided to the IJB was not detailed enough to show why there were delays for people who had been assessed as having "critical and substantial" levels of need but who had not received a service in response to this assessment because they were on a waiting list for a care home. The partnership's risk register presented to the IJB in May 2018 described this risk in terms of lack of funding leading to service users' assessed needs being not met and classified it as high risk. However, the mitigation and control measures it described relied on professional judgement.

Mitigation and control measures had not included processes to collect data systematically on outcomes from which the overall risk management strategy can be evaluated. As part of this inspection we requested data on waiting lists. The information provided by the partnership gave no detail on outcomes for those waiting. Instead, it provided quantitative data only which showed that at the end of August 2018, 78 people were waiting for a care home placement, 36 of whom were waiting in hospital. There was no information provided on the length of wait, or the circumstances of those people waiting for care. In the same month, 20 people were waiting on a package of care in the community. Consideration of strategic risks to the sustainability of provision and whole system impacts such as increased levels of delayed discharge were not identified.

Senior staff acknowledged that, overall, a more integrated approach to performance monitoring needed to be developed. It was positive that discussions had started with the aim of supporting the SPG to monitor the performance of the strategic plan.

Involvement of stakeholders

The partnership was committed to stakeholder involvement and had made significant efforts to make sure that it engaged with a range of stakeholders and used their views to influence and inform its strategic commissioning activities. It continued to seek opportunities to develop and improve how it engaged with service users, carers and the wider public. "Doing what matters together" is the partnership's participation and engagement strategy for 2018-2021. Whilst the partnership acknowledged that they still had work to do to fully implement this strategy and maximise the contribution of LPFs, it was commendable that they had set up the Engagement and

Development Group in 2017 to support the review of the processes and structures for participation and engagement with a view to improving their approach.

We noted that there was an ongoing investment in improving approaches to engagement. The partnership had learned from previous engagement events and acknowledged that there was a need to provide engagement that is best suited to the needs of different audiences. There was a genuine commitment to listening to communities, but at the same time an acknowledgement by the partnership that it was developing its approaches going forward. An example of an approach where the views of stakeholders had influenced strategic commissioning was in the redesign of NADARS. This resulted in an agreement to make sure that the employment of people with a lived experience would be part of the specification for services that will be commissioned for people with an addiction.

The partnership had a range of systems and processes for quality assurance, self-evaluation and improvement. One of these “You said, we did and we didn’t”, was a record of suggestions and comments received from the consultation process undertaken on the new strategic plan (2018–2021). The consultation phase took place during January and February 2018. It was positive that the partnership was making the investment to provide feedback from a consultation exercise in this way. Carer representatives indicated that the partnership had historically consulted carers about issues of service improvement and this positive relationship was continuing to develop.

Overall, the evidence gathered during our inspection about the relationship between the partnership and service providers was mixed. The third sector interface told us that planning forums exist at an operational level, with the sector conveying a sense of positive relationships up to senior management level. The third and independent sectors had a well-established seat on the IJB and SPG and there was evidence of a good level of challenge from and debate with representatives from the sectors. The independent sector indicated that they had been involved at the highest level within the partnership prior to the IJB being formed.

The provider forum was a robust, self-managed group which provided opportunities for joint working across sectors. Third sector representatives reported that quality and procurement issues as well as the strategic plan were discussed at the provider’s forum. However, some providers were less positive about the frequency and value of these forums. Some indicated that they had lost trust in the partnership over recent years and did not feel valued or fully and meaningfully engaged. Not all third sector providers were invited to provider forums, with some expressing criticism of the level of communication afforded to them by the partnership and how this was impacting on their working relationship and their engagement in discussions about service planning. Some independent sector providers shared a similar view and voiced concern that the challenging financial position for the partnership had impacted on their working relationship with the partnership.

We learned from some independent sector representatives that the care home providers forum was rarely held, with attendance at this having decreased. Similarly, the care at home providers forum had been suspended whilst tendering was undertaken and meetings had not been reinstated.

The partnership had begun dialogue with independent sector care home providers about the re-modelling of care home provision. However, there was no evidence provided by the partnership of a strategy or financial plan having been developed to inform or support these discussions. Neither was there a proposal in place, as we were advised by senior staff that a process of data collection was under way to inform the longer term strategy, and that a report is planned to be submitted to the IJB early in 2019.

We noted from our staff survey, which was issued to staff across the partnership, that not all staff felt engaged in strategic planning. Responses showed that 48% of staff disagreed or strongly disagreed that their views are fully taken into account when services are being planned at a strategic level. The partnership had already developed its second strategic plan and had made a firm commitment to engagement and consultation in this plan.

It was positive to hear from those who represented the voice of mental health service users that there had been meaningful engagement with them by the partnership, including discussion about the development of the strategic plan and service changes. Feedback had been used to inform change, which was a positive reflection of engagement. Communication from the partnership to the community about the changes to mental health services was not perceived as successful by some stakeholders.

Integrated team working was most evident in addiction services. The intermediate care team was a further example of integrated working, having been developed to support avoidance of unnecessary hospital admissions. The partnership was also taking action to enable the mental health team to be co-located, with the aim of having a central point of contact for people who may need to access support. Plans for the co-location of some learning disability services had also lost momentum and the co-location of justice services had not been as positive as originally anticipated. These plans to integrate and co-locate teams were reflected as positive by staff, however there were concerns expressed that progress was slower than anticipated.

'Public Health' is part of the partnership's senior management team and a member of the team attends regular meetings to provide input to the health and care governance group. They also contribute to emergency planning and resilience, including winter planning. Their membership of the SPG was positive and enabled ongoing communication and information sharing, although there was little detailed evidence on how Public Health had informed the development of the strategic plan, beyond the production of elements of the strategic needs assessment.

We have indicated in this report that where North Ayrshire has lead responsibility across the whole of Ayrshire for a specific care group, we have seen evidence of an approach to strategic planning and service delivery which has a clear focus on improving personal outcomes. We considered that the development at Trindlemoss in Irvine was a good example of a planned and collaborative approach to service change.

Trindlemoss was designed to support adults with complex mental health issues and learning disabilities and was being developed from a site vacated in 2015 by a third sector provider. The model includes supported accommodation, day support, rehabilitation and long stay care. The ethos is to promote community inclusion and independent living, in part by ensuring that individuals will be able to be supported as close as possible to their home area and out with a hospital environment.

5. Leadership and direction

Vision and values

The partnership's vision, "All people who live in North Ayrshire are able to have a safe, healthy and active life", was outlined within the strategic plan 2016–2018. It was evident that the aims of the partnership were consistent, shared and well understood. We surveyed the staff in the partnership and 86% of those responding were aware of the partnership's vision. During the inspection, we found that tackling inequalities and improving mental health and wellbeing were the elements most evident and consistently described. Positively there was evidence of collaboration on developments which reinforced the vision. The SPG reflected that there was "a continuing journey with a shared vision and passion, trying to reduce inequalities."

The collaborative leadership of the partnership demonstrated a clear vision and intent for delivery of services in North Ayrshire which was evident and understood across a range of stakeholders.

Culture and standards

There was a culture of collaboration and continued strengthening of integrated working to improve standards evident across the partnership. This culture was well supported by managers, professional leads, elected and Board members. The positive support for integration within the partnership was reflected by the results in our staff survey and during our inspection from a range of staff groups.

The partnership's iMatter survey in 2017 and 2018 reported that some staff did not know who senior managers were. In our survey of staff, 47% disagreed/strongly disagreed that senior managers communicate well with frontline staff and 45% disagreed/strongly disagreed that 'Leaders are visible'. Efforts to improve communication were evident. Senior managers and elected members told us of an ongoing commitment to connect with staff. This was done through walk rounds, team events, site visits, service visits and iMatter events. The weekly email update sent by the HSCP Director was popular across a range of staff. It was evident that the partnership has a system of capturing staff opinion, and we would expect to see improvement in staff satisfaction with communication from senior managers.

Collaboration

At a senior level there was evidence of collaborative leadership across the partnership and involvement in decision making at a pan-Ayrshire level. This was evident through the Senior Partnership Operational Group (SPOG).

Where agreement was reached at SPOG, decision and approval was then sought from the SPG and IJB. Examples of this process included plans for the continuation of a police and crisis service collaboration for winter planning and people attending A&E with mental health concerns. Sharing work across the other Ayrshire HSCPs was another benefit of this collaborative senior forum.

An example of sharing good practice was the contribution of the partnership's change team in supporting the other Ayrshire partnership areas to address pressure on care homes and care at home teams after this had been identified at SPOG.

The partnership's management structure was supporting collaborative leadership in North Ayrshire and pan-Ayrshire. The ability to deliver services and work collectively were described positively and supported by senior managers and by the IJB. One advantage was the ability to share and resolve similar issues across the three partnerships which were discussed then shared with the respective IJBs.

IJB members worked well together, with members actively questioning and seeking additional detail to make sure they had a full understanding of the issues being discussed. They were actively and fully engaged in the integration agenda and supportive of progressing integration. This was evident for financial reporting and management of budgets and, through minutes and directions, the expectations of North Ayrshire Council and NHS Ayrshire & Arran were clear.

The partnership's senior managers who were involved in decisions at a pan Ayrshire level were clear how work was progressing. Confidence and understanding of developments for services where the partnership has a lead role, for example mental health and learning disability, were demonstrated during our inspection. Clarity across all stakeholders in relation to services for older adult services was not evident. Some staff told us that there were limited options available to older people receiving services in the partnership and were unclear about the progress of developments. Senior managers expressed confidence that the work streams associated with older people's services were making progress. There was acknowledgement that there were several work streams associated with older adult services in development, and communication on progress could be strengthened.

Good examples that demonstrated the strength in collaborative decision making and resource allocation were evident. These include the joint purchase and funding of Trindlemoss and development of the intermediate care and rehabilitation service with additional funding from NHS Ayrshire & Arran. Senior managers expressed confidence in the strength of collaborative working and the ability at HSCP Director level to develop and deliver services both for pan-Ayrshire and North Ayrshire.

Integration had brought changes which included the co-location of senior management from health and social care across two sites. This was a change that required adjustment but this move to co-location had brought benefits. These were described as an increased understanding of roles of others, better communication and an enhanced team identity which has supported the delivery of strategic objectives. This is further described in the section on workforce.

At a senior management level, co-location had enabled improved networking and an increased sense of a partnership approach. The introduction and implementation of an integrated supervision policy had been regarded as a success. As in other

integration authorities, the lack of integrated IT systems was an ongoing challenge. There was an acknowledgement that the integration of teams required further development and support.

Priorities

The intention to reduce inequalities was clearly evidenced during our inspection as being integral to improving the quality of life for everyone. This was recognised by senior management and was shared and supported by staff working across the partnership. Senior managers sought the assistance of NHS Health Scotland in completing the strategic needs assessment to inform the 2018–2021 strategic plan. The valued role of NHS Health Scotland to advise and provide evidence strengthened this work and supported the partnership staff in understanding the issues and factors which contribute to inequalities. This work was positively perceived across the partnership.

The partnership had developed five strategic priorities for their first strategic plan 2015–2018:

- tackling inequalities
- engaging communities
- bringing services together
- prevention and early intervention, and
- improved mental health and wellbeing.

The decision to retain these five strategic priorities in the 2018–2021 strategic plan had been based on extensive consultation with stakeholders. This consultation had resulted in a consensus that these remained the right priorities and were agreed by the SPG and supported by senior managers as being integral to realising the partnership's vision.

Locality priorities

There was evidence of value being placed on identifying need at locality level. This was demonstrated through a revision of the original locality profiles being undertaken. This work was supported by ISD in providing an analysis of performance against the Ministerial Strategy Group (MSG) indicators⁸. This detailed analysis was a positive move that provided profiles to inform all stakeholders and support decision making around planning locality priorities and the strategic objectives of the partnership.

⁸ The Ministerial Strategy Group for Health and Community Care (MSG) monitor a suite of indicators to measure the impact of integration. The MSG was established in 2008 to provide a forum in which leaders from health and social care could meet to discuss matters of mutual interest and to provide leadership, direction and support in working across organisational and structural boundaries. It assumed overall responsibility for policy matters that crossed the local government/NHSScotland interface and is a key forum for taking forward COSLA and the Scottish Government's joint political leadership of health and social care integration. <http://www.cosla.gov.uk>

Work to identify and determine local needs had begun to be developed through the locality forums. The level of confidence expressed in the effectiveness of the LPFs was found to be mixed across staff groups. Changes to support the structure and functions of LPFs had been identified and there was support at senior level for the development of these forums within localities.

These changes comprised of revising the Terms of Reference to include regular updates on reports on achievements, performance and progress made against priorities at local level and inclusion of third sector representation across all forums. The experience of representatives of TACT and other areas of third and independent sector in locality planning was described as mixed.

A process for raising questions with the IJB was demonstrated. For example, a question had been raised about the use of funds from the Carers Act monies to support respite. We saw that carers groups across the localities were valued and we evidenced a request for views on types and need for respite from carers to be gathered and fed back to the IJB. These routes for questions and the highlighting of issues were both positive and demonstrated good communication between the IJB and carers forums.

New roles had been created for Locality Engagement Champions and Locality Communication Champions. These had been designed to extend engagement at locality level and are planned to be introduced through a pilot in Kilwinning, commencing October 2018, followed by the North Coast in November 2018.

A public engagement pilot for LPFs had been planned from November 2018 to April 2020 and was seen as “an important step forward.” The timescales for the introduction of these pilots were over an 18-month period across six localities. As a result of this time commitment, evaluation and evidence of any benefit will not be measurable in the short term to inform planning. Sharing of learning and communication of progress will be required to inform stakeholders across North Ayrshire of the work of the LPFs. These measures demonstrated a commitment by the partnership to improve engagement and communication and sharing of performance information to inform the effectiveness of planning at a locality level.

These developments demonstrated a positive effort on the part of the partnership to improve and support the function and the engagement and effectiveness of the LPFs. The value placed on support for developing LPFs and carers groups was a strength for the partnership.

Workforce

A key issue facing all IJBs was workforce planning. The IJB was in the draft stages of workforce planning. It had not prioritised the development of a comprehensive approach to workforce planning in the past.

The partnership's requirement for a workforce able to meet the demands of the service to deliver the strategic plan was reflected in the draft Joint Workforce Development Strategy. The plan is still under development and the intention is to take it to the Staff Partnership Forum in March 2019 and IJB in April 2019. The plan acknowledges the different terms and conditions that exist and that this position would be unchanged over the period of the plan.

We heard from staff who thought the variation in terms and conditions between NHS and council staff was a barrier to integration. There was a historical issue of separate roles and responsibilities for local authority and NHS occupational therapists and, despite integration, this had not been resolved. There was evidence of a lack of an integrated approach for the recruitment of an occupational therapist responsible for assessment of individuals requiring aid and adaptations. Although there were efforts being made to recruit, this was a situation that was impacting on the delivery of this service. There was a positive example of an integrated workforce development by the recruitment of generic technical instructors in the intermediate care team, which was described as having a positive effect within this service. A decision had been taken to delegate the responsibilities of the allied health professional to the partnership, this was a change which offered the potential to create opportunities of integrated working for occupational therapists.

Positive changes in working and a greater understanding of roles were described as a benefit of integration across health and social care staff and this was reflected in the staff survey. Most staff indicated that they were supported and encouraged to "work collaboratively to support meaningful integrated working and good practice."

A profile of the partnership workforce was being developed and this work was at an early stage. The partnership recognised the need to have this information to support work to determine future staffing requirements, and inform recruitment requirements, training needs and projected costs.

There was no evidence of development for management roles within the partnership. We heard from some groups that this limited opportunities for progression. Where there were absences at a senior management level these were covered from within the team.

NADARS was the only fully integrated adult service within the partnership that had brought both staff together and improved access through a single point of referral. Integration of the mental health team was planned but had been delayed at the time of our inspection. Multidisciplinary team working was being piloted as part of the Primary Care Improvement Plan.

The commitment to integrated working was evident but while this was seen within some areas of service there was no clear link between individual areas of service or development and the partnership workforce plan evident at the time of our inspection.

Clinical and professional governance

Clinical and professional governance and leadership was in place and although it was robust, the structure in place for the partnership was supplemented by additional pan Ayrshire professional groups. There was continued support for these professional forums, including social work, allied health professions, learning disability services and mental health services. There was evidence of a review of the effectiveness of one of these groups which indicated meeting as professional groups was valued by participants. However, this review was limited and did not demonstrate any benefit to the partnership's workforce. Senior managers reflected that pan-Ayrshire approaches benefited all three HSCPs, for example dissemination of good practice and sharing learning from adverse events.

Increased links between health and social care had supported learning from adverse events and reduced the number of investigations. The partnership had invested in root cause analysis training⁹. This had enabled a wide staff group to apply this standardised approach to investigation. The benefits of this investment was not yet apparent. There was an increased representation of health and local authority at recent governance group meetings and work had been done to align processes. Over the last six months of 2018, recording of adverse events from NHS board and local authority systems had been captured. However, the recording systems are separate. This is an issue nationally.

There has been a review of the health and care governance group's Terms of Reference to improve its effectiveness. Undertaking this demonstrated the development of this group to meet the requirements of the Health and Social Care Governance Framework. These requirements were being met within the current structure for governance and provided assurance to the NHS board, council and IJB.

The partnership highlighted the example of the mental health adverse events review group as good practice. This was a pan Ayrshire weekly forum where all mental health-related incidents that meet an agreed criteria are reported. A second group was in place which is for North Ayrshire only. The purpose of this group was cited as providing the NHS board, council and IJB with assurance in respect of professional standards of those staff working in integrated teams, reviewing significant and adverse events, improving the quality of care and ensuring the views of people using services are sought. We considered it was positive that this reporting structure was in place.

A pan Ayrshire clinical and care governance framework had been in place since 2017 and an established governance framework for the North Ayrshire IJB had been in operation since 2015. Social work staff had access to the Chief Social Work Officer for any professional issues. Governance structures for health and social care integration were continuing to develop with service change. Senior staff voiced some concern in respect of the capacity of mental health officers to support out-of-hours

⁹ Root cause analysis (RCA) is a method of problem solving used for identifying the root causes of faults or problems.

services which were hosted out of East Ayrshire and run pan Ayrshire and that there was pressure in the form of increasing demand for guardianship and financial intervention. Work to address this included a new governance framework agreed by the senior management team to protect mental health officers' time to deliver statutory services. This will be considered further as part of a wider review of community care services.

6. Summary and conclusion

By taking appropriate action to further develop the plans and structures currently in place and ensuring a proactive approach to the management of operational performance, we are confident that North Ayrshire Partnership will continue to move forward with the integration of health and social care.

Our evaluation of quality indicators 1, 6 and 9

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

Quality indicator 1: Key performance outcomes

1.1 Improvements in partnership performance in both healthcare and social care

The partnership had developed its performance reporting framework to monitor performance of health and social care services in North Ayrshire. It demonstrated that extensive reporting structures to collate and analyse data from across the partnership had been developed. This was mapped against national and local indicators and aligned to the partnership's strategic priorities.

Review of national and local performance data in terms of key outcome areas for adults showed a number of performance measures that indicated a mixed performance compared to Scotland as a whole. A number of measures showed performance was worse than the Scotland average.

The partnership benchmarked its performance against its National Health and Wellbeing Indicators family group. The partnership's performance was worse than the comparison group on more than half of the comparative indicators. There was no demonstrable use of this information to improve performance.

Monitoring and reporting of performance had not impacted on continuous improvement. This had been recognised by the partnership which had enlisted ISD and LIST support to work on developing baseline measurements aimed at improving how the partnership translates national outcomes to delivering better outcomes for the people of North Ayrshire.

The delivery of care at home provision was a major factor in supporting the partnership's attempts to improve performance. Data showed that progress had been made towards shifting the balance of care to enabling more people to stay at home. Whilst North Ayrshire was performing well for those aged 18–64, the

partnership's performance for intensive homecare for those aged over 65 was lower than the Scotland average.

Overall, North Ayrshire had made progress in developing its performance framework and was clear on the outcomes required of services to deliver for the people of North Ayrshire. However, a systematic approach to utilising data was not demonstrated. Development in the use of performance data to drive improvement in key outcome areas needs to be progressed in order to clearly demonstrate how this information is contributing to positive experiences and outcomes for people.

Evaluation: Adequate

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

6.1 Operational and strategic planning arrangements

6.5 Commissioning arrangements

The partnership's operational and strategic planning arrangements had a number of strengths. There was clear evidence of an integrated approach to the planning, development and delivery of services, particularly in relation to mental health, learning disability and drug and alcohol services. They included a clear vision supported by a wide range of commissioning intentions to achieve strategic priorities across the range of service areas that it is responsible for and a commitment to involving stakeholders and using feedback from communities, service users and their carers to inform strategic planning. The partnership had been proactive in the development of localities, including consideration of current and future service performance, demand and resource usage to inform its strategic needs assessment and financial planning. Members of the IJB had developed very positive constructive working relationships with opportunities for respectful questioning and challenge. There was a clear commitment to managing budget pressures and regular reporting of financial performance. Self-evaluation was particularly strong in learning disability and addictions services and good progress had been made to develop processes to manage risk, including financial pressures.

The extent to which strategic plans were informed by a whole system approach and aligned to financial planning was less evident, as is the extent to which the plans can be monitored against SMART criteria. Planning for older adults was less robust than for other care groups. The partnership's approach to promoting a mixed economy of care in consultation with the third and independent sectors was not well defined. There was some evidence to indicate that the partnership needed to invest more time in developing stronger relationships with the third and independent sectors, with the aim of continuing to shift the balance of care, particularly for older adults.

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

A vision for services to meet the needs of the people of North Ayrshire that reflects strategic priorities to reduce inequalities was evident, widely understood and supported across the partnership.

The intention to reduce inequalities was clearly evidenced during our inspection as being integral to and recognised by the senior management of the partnership. This was shared and supported by staff working across the partnership.

At senior level, there was collaborative leadership across the partnership and involvement in decision making at a pan-Ayrshire level. It was evident that the discussion and agreement reached was shared, and approved, through the IJB and provided a strong basis for sharing approaches.

There had been a review of the health and care governance group's Terms of Reference to improve its effectiveness. Undertaking this demonstrated the development of this group to meet the requirements of the Health and Social Care Governance Framework. These requirements were being met within the current structure for governance and provided assurance to the NHS board, council and IJB.

Where North Ayrshire had a lead for pan Ayrshire mental health and learning disability services, there was evidence of a confidence and understanding of the developments for these services demonstrated during our inspection. However, for older adult services, staff and external stakeholders were unclear about the progress of developments and told us that there were limited options available to older people receiving services in the partnership. Senior managers expressed confidence that the work streams associated with older adult services were making progress. There was acknowledgement that there were several work streams associated with older adult services development and communication on progress could be strengthened.

A profile of the partnership workforce was being developed and this work was at an early stage. The partnership recognised the need to have this information to support work to determine future staffing requirements, inform recruitment requirements, training needs and projected costs.

There was no evidence of development for management roles within the partnership. We heard from some groups that this limited opportunities for progression.

Evaluation: Good

7. Areas for improvement

- 1 The partnership should evaluate how well ASPIRE is delivering its intended outcomes.
- 2 The partnership should improve its systems for measuring individual service user outcomes and the system of reporting to the IJB and other stakeholders to inform improvements in service delivery.
- 3 The partnership should proactively review each of its commissioning plans and intentions from a whole system perspective to identify and address impacts on other parts of the health and social care system. This review should make sure that financial plans and strategies are aligned with the strategic commissioning plan and progress investment or disinvestment needed to achieve strategic priorities. This includes reviewing existing commissioning intentions to make sure they are underpinned by robust financial planning.
- 4 The partnership should make sure its commissioning intentions work together to improve and sustain outcomes for people who use services in each service area and in each locality. Detailed information should be routinely presented to the IJB about outcomes for people who use services and include the impact of delays.
- 5 The partnership should further develop preventative services and self-directed support implementation to support its objective of moving to an asset based approach. All health and social care services delivered directly or by external providers should take account of the national health and social care standards. To support this approach, the partnership should take steps to engage more proactively with providers and staff.
- 6 The partnership should identify the workforce requirements to meet the delivery of services through linking all workforce developments to identify the recruitment, training and development needs for the partnership.
- 7 The partnership should ensure pan-Ayrshire planning and development of older adult services is communicated across staff and relevant stakeholders in the partnership.

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 6.1 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 – Methodology

Our inspection of the North Ayrshire 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 556 staff. Of those, 418 (75%) responded, with 360 (65%) of the total issued completed the full survey. We also carried out fieldwork activity over 9 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.

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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.