

JOINT INSPECTION (ADULTS)

The effectiveness of strategic planning
in the **North Lanarkshire Partnership**

FEBRUARY 2018

JOINT INSPECTION (ADULTS)

The effectiveness of strategic planning
in the **North Lanarkshire Partnership**

FEBRUARY 2018

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

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

© Care Inspectorate and Healthcare Improvement Scotland 2018

We can also provide this report:

- by email
- in large print
- on audio tape or CD
- in Braille (English only)
- in languages spoken by minority ethnic groups.

Contents

	Page
1. About this inspection	2
2. The North Lanarkshire context	4
3. Our inspection of the partnership's strategic planning	5
4. Summary	22
5. Conclusion	24
 Appendix 1 – Quality Improvement Framework	
Appendix 2 – Methodology	

1. About this inspection

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

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

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

Integration is bringing 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 this inspection we did not set out to evaluate people’s experience of services in their area. Our aim was to assess the extent to which the health and social care partnership was 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 the country.

We inspected the North Lanarkshire Partnership. It comprises mainly of North Lanarkshire council and NHS Lanarkshire and is referred to as the partnership throughout this report. The inspection took place between May and August 2017 and is the first to focus on the effectiveness of strategic planning and commissioning.

The findings within this report were in evidence during the period of our joint inspection.

So that our joint inspections remain relevant and add value, we may refine our scrutiny methods and tools as we learn from each inspection. The quality indicators and illustrations used to support the joint inspection of the North Lanarkshire Partnership are set out in Appendix 1. There is a summary of the methodology in Appendix 2.

2. The North Lanarkshire context

North Lanarkshire is the fourth largest local authority area in Scotland by population and covers a geographical region of over 180 square miles within Scotland's central belt. The area includes a variety of communities ranging from rural settlements to larger towns such as Airdrie, Motherwell and Wishaw.

The structure of the North Lanarkshire economy has undergone major transformation in the last twenty years. North Lanarkshire's economy has been most affected by the loss of its heavy industry, particularly during the 1980s and early 90s, and more recent significant reduction in its manufacturing sector which has suffered a decline of almost 30% over the period from 2004 to 2013 (representing a loss of some 5,500 jobs).

Life expectancy is still below national levels; both males and females in Lanarkshire as a whole live on average a year less than others in Scotland. The number of people being admitted to hospital for alcohol related reasons in North Lanarkshire (525 per 100,000) has risen over the last few years exceeding the Scotland average (460). The unemployment rate in North Lanarkshire is higher (7.3%) than that of Scotland (5.9%) and of the rest of the UK (5.7%). It is estimated that two-thirds of the population in North Lanarkshire are either overweight or obese. Eighty-four per cent of the bed days used in 2014/15 were related to unplanned care. Over the last five years the number of people staying in hospital has risen, though the time that they stay in hospital for planned procedures has dropped. The number of people in residential care is around 1500, around 9% lower than in 2011. The number of homeless applications has fallen from 4,000 in 2004/05 to just under 2,000 in 2014/15. Presentations at A&E from North Lanarkshire have remained constant over the last three years, though demand fluctuates.

(This text has been taken from the North Lanarkshire Strategic Needs Assessment and Strategic Plan. If you want to know more, these documents are available from the North Lanarkshire partnership at www.nhslanarkshire.org.uk).

3. Our inspection of the partnership's strategic planning

Strategic plans and needs analysis

The Scottish Government required health and social care partnerships to produce joint commissioning strategies for all delegated functions by April 2016 and their impact to be monitored by scrutiny bodies from April 2017. National progress with strategic planning and commissioning by integration authorities is generally at an early stage.

The North Lanarkshire partnership was beginning to lay down strong foundations to support the integration of health and social care. It had developed a range of strategies to inform service planning and was working towards operational structures intended to deliver a proportionate, localised and seamless response to those who present with health and social care needs. Structural arrangements in place to support the planning process included the strategic planning group; care-group partnership boards with a focus on mental health, learning disability, addictions, and frailty and long-term conditions; and locality planning groups. The partnership acknowledged that these arrangements were evolving and would mature over time.

A thorough piece of work had been carried out by the partnership to produce a strategic needs analysis. This provided detail about the current and longer-term needs of the whole of the Lanarkshire population, with some information specific to North Lanarkshire. It included comprehensive data around key areas of need and service demand, including poverty, co-morbidities, homelessness, alcohol and drugs, obesity and demographic pressures.

The North Lanarkshire strategic plan Safer, Healthier, Independent Lives (2016-26) is a wide-ranging document that sets out the partnership's strategic vision and overarching ambition to deliver health and social care in line with the national health and wellbeing outcomes. The key strategic priorities for adult services are appropriate in the context of the national outcomes and local challenges. The priorities are: changing services to focus on those in greatest need; supporting people to live at home independently; reducing inequalities; closer working with communities to build on local knowledge; and developing existing community assets to tailor services to improve equity of access and deliver positive outcomes for people.

The overall strategic direction for the integration of health and social care in North Lanarkshire had been set out in three key documents: the commissioning plan Achieving Integration – March 2017; NHS Lanarkshire's plan Achieving Excellence; and North Lanarkshire council's business plan. Achieving Excellence is a Lanarkshire-wide health plan aligned to national policy, with specific goals for each partnership. The actions outlined in the council's business plan reflect the focus on community capacity building and further investment in early intervention and

prevention. There are distinct connections across these plans; one of the common principles is to improve the relationships partners have with communities and the third sector to support communities to be more resilient. The emphasis on community capacity building was clearly evident in how the locality structures had developed and were functioning, and in the partnership's investment in its relationship with the third sector interface and the third sector consortium.

The commissioning plan links into the strategic plan and is an extensive document that details the commissioning intentions to be taken forward. Its overall aim is to enhance or commission support services that are fit for the future, sustainable and developed in partnership with stakeholders. The 10 commissioning intentions within the plan were developed following engagement activities with key stakeholders. Eight relate specifically to adult care and include expanding multi-disciplinary locality teams in communities, reconfiguring the home support service, strengthening rehabilitation within a community setting and bed remodelling.

The whole system approach within these intentions was clear, with the bed modelling plan setting out the future volume and mix of community beds required across both health and social care, plus the service models within. To facilitate its move into the locality teams within communities as part of the new rehabilitation model, the acute sector stopped recruitment to some physiotherapy and occupational therapy posts. Whilst work was underway to progress these intentions, this was at a very early stage and we were unable to draw any firm conclusions in respect of impact and improved outcomes.

The Housing Contribution Statement (2016) is a detailed report with an action plan that sets out the role of housing in achieving the outcomes within the strategic plan. Though there are no timescales set against the actions, there was evidence of some having been progressed. For example, there had been significant investment made to tackle fuel poverty and maximise income. Community resource flats were being used for step down from hospital in four locations across North Lanarkshire. A tower block in Wishaw had been redesignated as a sheltered housing complex with a 24-hour concierge service and an assigned sheltered housing officer. Two other towers had been identified for redesignation. One of the housing partners, Trust Housing told us about a proposal to pilot a housing and care model, linking into localities to identify people who may benefit from moving into this type of care and support model, though there was no implementation date for this pilot.

Progress towards joint strategic commissioning

While our scrutiny highlighted areas of operational performance that needed improvement, for example managing hospital discharge and unscheduled care, it was evident that the partnership was strongly committed to implementing the integration of health and social care and improving personal outcomes with a focus on local need and priorities. It had made significant progress in developing the

building blocks, such as strategic plans and establishing operational structures to support integrated working. Services were already being commissioned and contractual agreements monitored, however the joint planning work and tests of change currently underway had yet to influence future investment and disinvestment. Strategic planning will take time to move from intentions to commissioning decisions and service redesign. This is a major step change, which will require a shared approach to managing risk, informing expectations and agreeing shared priorities for investment.

Locality structures

Partnership working at a locality level is historically embedded in North Lanarkshire and had been enhanced to enable more integrated working and a strategic focus. For example, using locality planning groups to support strategic service development in response to locally-identified needs. There are six localities across North Lanarkshire, each with its own priorities, which are comprehensively detailed within the locality profiles. Commendably, these profiles have been developed in consultation with local people, carers, service providers and professionals who work in the locality areas.

The locality profiling tool had enabled each locality to use local data to identify and prioritise local need for service design and delivery. For example, in Airdrie a multi-agency approach to smoking cessation had targeted local communities based on need and known barriers to attending centralised resources. Overall, the locality profiling tool, which had helped prioritise need in local communities, was an innovative use of data. However, as there was no plan in place to capture the impact of the tool on better targeting of need, we would suggest that this is an area for further work by the partnership.

Locality planning groups were initially set up for case discussion to manage the most complex cases in the community. The partnership was working to maximise the scope and impact of the locality structures. The development of integrated teams had resulted in the locality planning groups developing from a solely operational remit into strategic service development groups with a focus on all adults from March 2017. There were also six consortia, led by the third sector, that met regularly and included membership from social work, health and community groups. Each had a delegated budget of £30,000 (this had initially been set at £15,000) to distribute over three years as a micro fund. This provided opportunity for co-production and community empowerment within each locality, linking into the needs identified within the locality profiles. We consider this to be an example of good practice.

Work was progressing to ensure that people using services, carers and third sector organisations were consistently represented across all localities, as this was not always the case. The partnership still had work to do to map local resources and to

provide locality planning groups with access to performance data. This will be fundamental in informing service planning and delivery at a locality level.

Integrated working, early intervention and prevention

The partnership had adopted a whole-system approach in managing their response to demand. This meant they considered the needs of the whole person, not merely the presenting problem or the immediate cause of ill-health. They assessed how these needs could be met appropriately across relevant agencies by sharing responsibility and accountability for improving outcomes. Mental health, learning disability and addictions services in North Lanarkshire have a long history of working across agencies, supported by co-located offices. One positive example of this, which had improved people's access to support, was the development of the integrated addictions service (to be renamed the addiction recovery team) where two separate services had been brought together under a single management structure. This service targeted people across North Lanarkshire who were at increased risk of adverse health outcomes and whom services had previously found hard to reach. The Outcome Star assessment tool used by this team gathered feedback from people who had used the service. This data was collected monthly and reported through the local alcohol and drugs partnership.

The partnership's focus on preventative activity was evident. Performance data indicated improvement in the uptake of preventative screening projects and alcohol interventions being delivered. Cancer screening and smoking cessation are particularly relevant, as chronic obstructive pulmonary disease and cancer account for a high level of premature deaths in North Lanarkshire. However, the uptake of only a small number of available screening projects was being monitored. The scope should be extended to include all available cancer screenings.

Responses to our staff survey indicated a positive perception of services preventing admission to hospital. More than two-thirds (71%) of respondents agreed or strongly agreed that services work well together to successfully prevent avoidable hospital admissions. Hospital at Home was a pilot project funded from the Integrated Care Fund, which extended from Monklands Hospital into the Wishaw General Hospital site in May 2017. It was established to prevent unscheduled admissions to hospital by providing medically-led interventions at home. It was based in acute sites and the team included allied health professionals, nurses and medical staff. It operated seven days a week, mainly during working hours, with the aim of getting people who present to accident and emergency home quicker. However, we noted communication difficulties between the acute-based Hospital at Home and community staff who were not always advised of involvement and clinical decisions. There was a lack of clarity about who was clinically responsible for patients when they were in the community but cared for by the acute-based Hospital at Home. There was also a lack of robust, ongoing evaluation of the outcomes delivered. The Hospital at Home performance report up to August 2016 showed an increase in the

number of people being seen by this service. The evidence provided of the number of bed days saved was less positive, with an inconsistent trajectory and a decline in the number of people being supported at home. When developing and expanding the service, a comprehensive understanding of the target groups and desired outcomes will be essential in reducing the partnership's high rates of unscheduled care.

At the time of inspection, the partnership was two standard deviations above the mean for all adults in respect of the rate of emergency beds used. Updated information subsequently provided indicates that the rate of emergency beds used for those under 65 years is significantly above the national average, but lower than the national average for those over 65 years. Positively, the latter is on a decreasing trend. The use of bed days for multiple emergency admissions was significantly above the national average. The partnership was keenly aware of its performance in these areas and recognised the need to address these pressures. For example, senior staff acknowledged the need to get better at proactively identifying individuals at risk of homelessness earlier. Individuals in this high risk group tend to present at a point of crisis and this inevitably creates unplanned pressure, particularly on acute services.

Staff consistently referred to the GP link worker initiative as a positive innovation. This initiative was provided by the third sector, was accessible to all adults and primarily offered a signposting service to support people in accessing the right support at the right time. Initially, a small test of change was undertaken, during which a link worker was based in one GP practice. This had been undertaken with no additional financial resources. The partnership subsequently provided funding for this project from the Primary Care Transformation Fund and the Mental Health Innovation Fund and the initiative was extended to six link workers. The GPs and localities had worked together to identify the number of hours each link worker should spend in each surgery, based on local need. In excess of 100 referrals had been received over two months, including a high number for males aged between 35 and 54 years. This is very encouraging, since it is the target range for suicide prevention. The referral process aimed to more effectively support individuals experiencing stress caused by factors such as having caring responsibilities, poor housing, bereavement, domestic abuse, isolation and mental health difficulties. An evaluation was to be completed, which would be essential in capturing the impact of the project and ensuring that future provision meets local need.

Staff we met during our inspection felt positive about the locality approach in terms of the response it provided to falls and acute illness to support the prevention of hospital admission. However, it was reported that only small numbers of people had accessed this.

Resourcing early intervention and prevention initiatives is challenging when there are savings targets and limited resources. It was evident that the development of community initiatives in North Lanarkshire were at an early stage and longer-term commissioning decisions were yet to evolve out of the planning work and tests of change that were underway. There were a number of initiatives in place however, we considered there was a need for more investment to reduce crisis interventions.

Stakeholder engagement

There was compelling evidence that the partnership was committed to developing a culture that promotes meaningful engagement with stakeholders. This approach is explicit within its participation and engagement strategy for 2017-2020, in which one of the key principles is that services are developed in partnership and planned in a way which engages with the community and local professionals.

A genuine partnership had been established with the third-sector interface Voluntary Action North Lanarkshire (VANL) which indicated it felt centrally involved in shaping strategy. An effective and robust relationship is critically important if the partnership is to successfully deliver on the principles contained within the strategic plans and to develop community capacity and resilience. The third-sector organisations that made up the North Lanarkshire consortium indicated strongly that they felt like equal partners and were very positive about their contribution to building capacity in the community, the work of VANL and their links into the locality planning groups. They also told us that allocation of funding for projects is decided using a collaborative approach involving third-sector organisations, social work and NHS representatives, carers and service users. There was a coherent link between funding decisions and local needs assessments. Priorities for funding were identified within each locality development plan, which was informed by the locality profile.

In line with the partnership's whole-system approach, we saw evidence of close working between housing, social work and health. For example, the homelessness action plan was a joint piece of work being undertaken with health. Housing was represented on the integration joint board (IJB) and the strategic planning group. Registered social landlords were represented on the strategic planning group and they fed into the registered social landlords' forum. Housing was also represented on the locality planning groups. Registered social landlords indicated they had very good working relationships with North Lanarkshire council officers and were represented on working groups.

The partnership had also engaged positively with carers and carer representatives in planning for the implementation of the Carers Act in 2018. Both the commissioning plan and the participation and engagement strategy refer to a range of engagement activities with key stakeholders including locality events, meeting with existing groups and forums as well as a conference that was scheduled for September 2017.

Despite a clear commitment to involving stakeholders in policy development, there were some areas that could be strengthened. Focus groups to help identify gaps in service provision were held in localities to canvas the views of people using care at home services and locality support. However, these were limited to those already accessing support services. The quality assurance team needed to engage more routinely with localities in respect of their monitoring work. More needed to be done to engage with care home providers in respect of service planning and the longer-term management of the care home contract. Carers themselves, and not simply people representing carers' interests, should be involved routinely on locality planning groups with due account taken of the developing cultural and ethnic diversity of the community in North Lanarkshire. Responses to our staff survey indicated that the partnership had some work to do to ensure that staff working at all levels are fully engaged in service planning, with fewer than half (41%) agreeing or strongly agreeing that the views of staff are taken into account fully when planning services at a strategic level, and more than a third (38%) disagreeing or strongly disagreeing.

The integration joint board (IJB) raised some concerns with us that carers and carer issues did not have a high-enough profile on the board. The IJB had been working to strengthen participation at a strategic level of carers and those who use services. The carer strategy implementation group appeared to offer a critical stage in evaluating and deciding on carer issues, which would then inform the thinking of the IJB. The IJB also told us it no longer had representation from the independent sector, though the sector was represented in a number of other groups. When planning for the longer term, it will be essential for the partnership to consider how they can best engage with the independent sector to develop services and enhance capacity in response to demand and reshaping care.

Strategic planning

The partnership was making good progress in identifying and developing strategies to respond to challenges and develop service planning. We consider the establishment of the integrated service review board (ISRB) in March 2017 to be an example of good practice and an innovative approach to addressing local challenges. The work of the ISRB is intrinsic to progression of the intentions detailed within the commissioning plan. The IJB gave members of the ISRB the task of carrying out a whole-system review of current service provision, linking this into the needs analysis within the locality profiles. The ISRB would then develop a report for the IJB, setting out:

- how to invest and disinvest from current service provision to maximise outcomes
- a proposal for structural opportunities to maximise the impact of integration
- a proposal for a transformational programme of service model redesign
- the baseline commissioning position for 2018/19

- a proposal for budget use for the remainder of the commissioning cycle.

An interim draft report was issued by the integrated service review board (ISRB) in July 2017, with a final report expected in September 2017. The main proposal within the draft surrounded the development of a single locality health and social work team with three sub-teams to provide integrated community services in all six localities. The September report was intended to provide an implementation plan on this proposal for the IJB to consider. Though they had been given a challenging agenda, the ISRB members appeared enthusiastic about the potential for structural change intended to enable a greater locality focus and more effective use of existing resources in response to growing demand and financial constraints. There was also a shared sense of ownership in respect of enabling change and supporting improvement. The work of the ISRB was expected to complement the work done on locality profiling to inform future use of resources by the partnership. We were advised by the IJB that this would likely lead to disinvestment in some areas to allow new or additional investment in others. There would be scope for the partnership to articulate how it would deliver on any recommendations made by the ISRB, critically if there was disagreement or conflict in relation to decisions about disinvestment either amongst voting members or between voting members and officers. This chimed with other evidence we heard about there still being work required to help inform people and carers' expectations of what services would, could or should be delivered, particularly if there was the potential for some existing services to change, or new ones to emerge.

Home care

In common with other partnerships, one of the biggest commissioning challenges faced by North Lanarkshire is home care, referred to as 'home support' by the partnership. The limited capacity in response to demand was largely a symptom of difficulties with staff recruitment and retention and sustainability of service provision across a mixed economy of care.

For older adults living in the partnership area, the proportion of home support provision in-house was 80%, with 20% provided by the independent sector. In-house home support provided by North Lanarkshire was not always able to offer equity of access, continuity, capacity or a personalised approach. This had contributed to the reasons for delayed hospital discharges and restricted the partnership's ability to deliver end-of-life care at home. Statistical data showed that from the autumn of 2015 there had been a significant increase in the number of people whose discharge had been delayed and in the number of occupied bed days. Positively, the partnership had taken a number of steps to address this.

- Initiatives had been taken to maximise the current capacity of home support and to support service improvement. For example, prescribing practices were being reviewed in collaboration with local GPs, the aim being to free up home

support capacity where possible. In practice, this meant reassessing whether medication could feasibly be prescribed on a less frequent basis, perhaps by changing the drug prescribed, and therefore reducing the number of visits required by home support staff to support the administration of medication.

- The partnership had recently tendered for and implemented a new home support framework, which is a type of contractual arrangement, resulting in an increase in the number of external providers from six to fourteen. This had created more choice for those needing to access home support.
- Recognising that there continued to be significant pressures on home support provision, the partnership had made an explicit commitment to reviewing home support and had set up a cross-party working group in August 2017 for this purpose. The key aspirations were to maximise personalisation, increase the capacity of re-ablement and develop a more mixed economy of care. The findings arising out of this group were intended to inform the IJB's decision making around the future shape and configuration of home support.

The IJB was using shared resources and expertise to scope the issues and look for collective solutions; this is a valuable and productive way forward. The recommendations arising from the cross-party working group and the subsequent decisions by the IJB will be vital in informing the commissioning of sustainable home support provision.

The partnership was aware of the importance of opening up the market in order to provide greater choice and equity of access and indicated that it planned to produce and submit a market facilitation plan to the IJB by March 2018. While there is no legislative requirement for this to be in place, Scottish Government guidance suggests that partnerships should develop market shaping plans as part of the overall suite of strategic planning documents. This would be a valuable addition to the strategic plans already in place, as the partnership does need to set out how it intends to stimulate and sustain a mixed economy of care.

Hosted services

Some health services continued to be delivered across Lanarkshire but were hosted by either the north or south health and social care partnerships. Physiotherapy, occupational therapy, primary care and dental care were all hosted services and the challenge going forward is how these will fit into the locality structure. A positive development was that the hosted services group had been set up to review planning, performance, significant incidents and risks of all hosted services. Senior managers suggested that the integrated service review board may make some recommendations in respect of hosted services and they indicated that there needed to be change to effectively manage finance and governance. We are keen to see

how this develops and whether the partnership can evidence any improvements in performance and outcomes as a result.

Contracts and quality assurance

The contracts team had recently evolved and matured as a direct result of personnel changes as well as a desire on the part of managers to move from a compliance model to one of supporting improvement in the quality of service provision. The contract management framework approach is referred to as the 'service improvement process' (SIP). A more integrated approach had been adopted, with the social work service now linking into the corporate performance team. This should enable better information sharing about service performance in order to target resources to achieve maximum impact. The quality assurance team had responsibility for more than 100 contracted services. These included joint contracts with NHS Lanarkshire, for example with advocacy and carers services, and some tripartite services funded by North Lanarkshire, South Lanarkshire and NHS Lanarkshire. Positively, all tendering exercises included a stakeholder day involving locality staff, care groups and quality assurance. There was a commitment to involving people who use services and carers where possible in commissioning activity. Service user involvement was an integral part of the advocacy tender evaluation and work was underway to extend this approach to the forthcoming carer tender by taking account of carers' views, from the development of the specification through to the evaluation. The service specification for home support showed a distinct focus on the outcomes to be delivered, which were used to inform routine evaluation. There was a clear system in place to support effective monitoring of the performance of providers of home support within the framework against the specified outcomes, including information from locality managers. This was the responsibility of the quality assurance team.

The partnership had deliberately shifted its approach to quality assurance, from one of compliance to one that supported and enabled improvement. They communicated and met regularly with the Care Inspectorate as part of their approach to sharing information and intelligence. Care home providers spoke positively about their contact with the quality assurance team. They described a recent development of one care home undertaking a test of change initiated by the quality assurance team to pilot advocacy services.

At 31 March 2017, there was a total of 143 registered adult services in North Lanarkshire, the majority of which were provided by the third sector. Overall, the number of services had reduced over the previous three years. Enforcement activity carried out by the Care Inspectorate in a small number of independent sector care homes for older people had increased incrementally over the previous three years. This was because the Care Inspectorate had found a decline in the standard of care in the course of their inspections of these individual care services. Care home providers were positive about the level of support they received from the quality

assurance team when experiencing performance issues highlighted by inspection. This support had resulted in improved quality evidenced by these services achieving higher quality grades following further inspection.

Performance

Our scrutiny during this inspection focused mainly on strategic planning. The evidence we considered suggests that the partnership was making good progress in developing integrated structures and planning service responses. Its work so far was supporting the development of an integrated approach to managing performance across the whole system. It was also developing preventative and longer-term interventions to support improvement in personal and organisational outcomes. As this was at an early stage, it was not yet influencing improvement in all areas of operational performance such as supporting sustained reduction of unscheduled care admissions.

It was positive to note that the partnership had developed a comprehensive 'dashboard' system for performance data. This was a co-ordinated system with shared common sources and targets. The data gathered on the dashboard had clear links to the national outcome indicators and the local delivery plan. Performance data was gathered regularly and clear lines of accountability had been developed. The chief accountable officer and the chief executives of both North Lanarkshire council and NHS Lanarkshire reviewed the performance regularly. The IJB saw the performance data and IJB members were represented on each of the performance subcommittees. Feedback was given to senior staff responsible for achieving targets and improvements throughout the year, ranging from weekly to quarterly. Performance was benchmarked against other partnerships, including those with a similar profile.

However, from the evidence given to us during the inspection, we noted that some unmet targets did not have action plans that were being monitored to ensure enhanced performance. For those that did, the action plans were not robustly implemented or evaluated. The delayed discharge action plan 2017/18 – 2018/19 had an associated driver diagram. We were advised that this plan was at an early stage of implementation and that the driver diagram had been altered to reflect the fact that the initial trajectory for reducing occupied bed days was too ambitious. This was in part due to home-care accessibility, community capacity and the challenges of accessing packages of care quickly. While the action plan contained clearly stated targets, there was a lack of evidence to demonstrate that specific actions taken towards meeting these targets were being monitored and evaluated. Integration joint board members also indicated that their main concern was how to interpret and use performance data to inform the priorities for future investment in new and existing provision.

The partnership had changed the funding formula for self-directed support from an hourly basis to a 12-month budget. This had enabled a more individualised approach to the delivery of personal care. In 2016, 200 people living in North Lanarkshire received self-directed support, which was a 33% increase from 2015. Over the same period, there was an increase of 17% across Scotland as a whole. Of these 200 clients, 40% (80 people) were aged 65 years or over. This was higher than the national figure of 38%. However, during 2015/16 the partnership had lower provision of self-directed support option 2 than the Scotland average. There had been no change in the total value of self-directed support in North Lanarkshire over the last year, while nationally, the figure had increased by 10%. Acknowledging that there had been some success in providing self-directed support options to younger adults and those with complex needs, senior staff did recognise the need to invest more in extending self-directed support options to older people. This was not without its challenges given that the majority of home support provision for people aged 65 years or over is provided in-house. Work was needed to further extend individual budgets to older adults and to develop the capacity within home support provision.

The partnership had made some positive progress over a number of years in respect of shifting the balance of care away from long-stay institutional care to enabling people to stay at home. The rates of population aged over 65 years receiving home care and intensive home support were both higher than the Scotland average. The rates of population aged between 18 and 64 years receiving home support and intensive home support were less than the Scotland average, with more provision being delivered by independent sector providers for younger adults through the self-directed support route.

There were fewer people aged 65 years and over being accommodated in care homes in North Lanarkshire in comparison with the rest of Scotland. The average length of stay for all adult care home residents aged over 18 years was 3.1 years in comparison with the Scotland average of 3.4 years. The partnership had 21 beds in both Monklands House and Muirpark care homes (owned and operated by the council) which were used for the purposes of intermediate care, rehabilitation and recovery. It was a positive indication of the impact of intermediate care that the average length of stay in both facilities was 44.5 days, with 79% of people returning to live at home. Off-site NHS beds accommodating people who were not acutely unwell but needed ongoing nursing and rehabilitation also had some success in getting people home again. This clear emphasis on supporting people to remain in the community was reflected in the responses to our staff survey, in which 85% of respondents agreed or strongly agreed that their service does everything possible to keep adults at home and in their local communities.

Despite falls assessment training having been rolled out and there being an increase in the number of falls assessments recorded, information about falls assessments was not adequately being shared with partners working across acute and community

to effectively manage risk. Work with the Scottish Ambulance Service had initially delivered some positive results but this had been challenging to maintain within existing resources. There was no evidence of an evaluation of the impact of the Right Call for a Fall initiative and there was confusion about the pathway for falls and the referral process.

The partnership appreciated the benefit of anticipatory care plans (ACPs) for people with long-term conditions and there was a desire in the acute sector to have these in place and accessible. However, implementation across the partnership was still at an early stage. Some important pillars for improvement had been put in place including a well-attended ACP steering group and an ACP co-ordinator. Tests of change had been taking place with the acute sector, aimed at increasing knowledge of the accessibility and use of ACPs during unscheduled care. However, the main focus to date had been on end-of-life care and care planning within care homes. The numbers of people who were able to spend their last six months at home was consistent with the national average, a position which may have been better had the partnership promoted anticipatory care planning more proactively. There was no agreed system of quality control that would reliably ensure information was kept up to date, accurately reflected individuals' needs and was shared with the appropriate people at critical times. Anticipatory care plans were seen as belonging to the individual and as such, it was their responsibility to share this information with emergency staff. This approach could potentially instigate a service response that goes against a person's wishes.

Though there was widespread use of ACPs in care homes and the practice of routinely recording ACPs on the electronic key information summary tool (eKIS), there was no measure in place to ensure quality control or review of the individual's wishes. When ACPs were completed, they were not shared across agencies and often not accessible when required. GPs recognised the benefits, but did not feel that systems and processes were in place to facilitate meaningful anticipatory care planning. The partnership should take steps to improve anticipatory care planning for all adults living in North Lanarkshire.

The implementation of the National Dementia Strategy and the provision of timely post diagnostic support for people with dementia was a challenge for the partnership. The length of time that elapsed between diagnosis and the provision of support services impacted on staff effectiveness because they often missed the optimum time to help with symptom management, planning and decision making and maintaining community links. Staff had developed a number of alternatives to reduce the negative consequences of lengthy waits including phone contact and training for social work staff to deliver post diagnostic support. The partnership should evaluate the impact of these approaches.

A lack of effective communication across a range of service areas, including between acute and community services, was a key concern of staff responding to our survey. Effective and enabling communication systems are vital to future success and effective information sharing that manages risk. In the event that funding is made available, improved IT systems could support the partnership's overall vision of more integrated working and increase responsiveness across all areas.

Leadership - vision, values and culture

There was evidence of a shared and explicit commitment to integrating services and locality working within North Lanarkshire. We found positive and valuing relationships between and across voting members and chief officers, with a shared undertaking to work together to achieve desired outcomes. This included an agreement between councillors of different political parties to collaborate in a cross-party arrangement to support the work of the IJB.

Voting members of the IJB spoke of having confidence in the chief officers. They acknowledged that the last 18 months had seen two different cultures adapting to each other. This was generally described in positive terms, recognising that the two organisations were still adapting to markedly different decision-making approaches from each other.

The partnership was able to present a vision that was clear, concise and easy to understand and that informed its strategic planning. We found that the vision was recognised by staff in various settings, as well as in groups that represented the third sector, people and carers. Of the respondents to our staff survey, more than half (53%) felt they recognised and understood the vision. The single largest group of staff who responded to the staff survey were employed in posts where they delivered direct care. We would not expect that all of these staff would yet have experienced the impact of integration on their specific roles and responsibilities and we realise they may be later than more senior staff in understanding and adopting the vision.

The partnership issued the NHS iMatter survey across health and social care teams in the partnership from April 2017 and received responses from 4,047 people. Two-thirds of respondents felt that senior managers were visible. However, we noted that overall, staff had mixed views about the pace of change and visibility of the senior leadership team.

The development programme, Leading Integration, had been rolled out for senior managers across primary, secondary and social care, with an initial focus on the strategic commissioning plan. The chief accountable officer saw this as successful and it had been expanded to involve more managers from secondary care settings. Development sessions had been arranged and delivered for IJB voting members.

These were important due to the turnover of representatives from the local authority following elections.

While progress had been made with developing strategic plans and structural arrangements, it was evident that there continued to be challenges in the relationship between acute and community services. More work was needed to further develop the whole-system approach, share responsibility, shift expectations and review the integrated approach to, and management of, risk. There was still work to do to help inform expectations of future service access and delivery. Elected members have a role and responsibility in reshaping expectations and supporting change.

The process of aligning differing strategies produced by NHS Lanarkshire, the North Lanarkshire IJB, North Lanarkshire council and South Lanarkshire council was described as a challenge, in no small measure due to uncertainties about financial settlements. Staff at a senior level told us that this challenge had been met, though staff operating at less senior levels expressed some concern about potential conflict between the differing strategies. There was potential for local priorities to be subsumed by Lanarkshire-wide issues, which may be perceived to carry greater weight and link more closely with national targets for performance. There would be scope to ensure that staff fully understand the implications of the strategies, when they are renewed, and how they align or support each other.

Finance

The financial plan had been agreed but not finalised. Overall, we could see that it would be very challenging for the partnership to deliver the services required as needs and expectations rise and with the resources available. Senior finance officers indicated that the funding provided through the Integrated Care Fund was positive but limited, which hindered opportunities to progress with preventative work streams. A financial framework was in place and this was regularly monitored. Current projections indicated a £4m overspend, though we were advised by senior finance officers that steps were being taken to address this. The Financial Overview of Local Government in Scotland report published by Audit Scotland in November 2016 reflects this position, one of the key messages being that significant financial challenges within local government generally will continue to prevail.

There were continuing challenges in respect of differing reporting cycles for North Lanarkshire council and NHS Lanarkshire. The fact that the NHS budget is held centrally and released in phases throughout the financial year created challenges for IJB planning, in addition to the significant constraints of an annual local government settlement. Similar to the NHS and local authorities, annual financial planning presents a huge challenge to third-sector services, which are constrained in providing enough job security to staff to develop and maintain sustainable services. One of the risks highlighted by the Audit Scotland Annual Audit Plan for the North

Lanarkshire IJB 2016/17 is that procedures for agreeing the year-end balances are not fully embedded, resulting in financial statements not being delivered to the agreed timescale and in the required format.

Sustainability of third-sector funding had a significant impact on forward planning across a wide range of services commissioned by the partnership. Third-sector services were spending a significant proportion of time applying for funding as opposed to direct service delivery. Voluntary Action North Lanarkshire (VANL) indicated that they were in discussion with the partnership about a five- to ten-year strategic plan, which would need an investment and disinvestment plan to sit alongside it.

To some degree, budgets had been devolved to localities with the intention of expanding on this as structures and governance arrangements mature with the progress of integration. However, this was still at a very early stage. Senior staff indicated there was scope for further harmonisation of health and social care budgets. They also indicated that there was still some inflexibility when it came to transferring resources, particularly at locality level. At the time of inspection, the partnership was managing to operate within its financial means however, expenditure must be closely monitored, particularly as recommendations begin to emerge from the integrated service review board and the cross-party working group on home support.

Governance

The structure for joint care and clinical governance was still developing and will need to take account of locality work at some point. Before this structure was established, single-agency arrangements were in place for clinical and care governance. The remit of the support, care and clinical governance committee includes clinical and care governance, child, adult and public protection, and feedback and learning from complaints, claims, comments and suggestions. This multi-agency group was established in September 2016 to integrate governance arrangements. The committee indicated that the collation of performance data had been challenging. Much of the data they had received related to the acute sector. Work on a joint framework for responding to complaints was progressing but there was not yet a single framework for complaints reporting. However, the support, care and clinical governance committee felt they were beginning to work in a more integrated way, were aware of the main challenges for services and committed to quality improvement and providing assurance to the IJB.

Workforce development

The draft integrated workforce plan dated November 2016 was a detailed piece of work looking at the current workforce across the partnership. It noted the challenges for the future in terms of increasing need and in respect of the increasing age of trained staff. Similar to other partnerships, recruitment was reported to be a

challenge across all areas of provision. The plan included a number of actions with identified leads and clear time scales by which proposals needed to be worked on. In response to the demands arising from integration, some health and social care staff had benefited from various training programmes on strategic commissioning. This had included a five-day course provided by Birmingham University, tailored to the Scottish perspective.

A number of new posts to support integration had been developed, including advanced nurse practitioners and GP link workers. Senior managers acknowledged the importance of building skills and resilience to support community capacity building, targeting people coming out of hospital. The partnership was planning to pilot the role of an integrated support worker in the Motherwell area. The intention was to have 20 posts that would also link into off-site beds used for intermediate care with a view to reducing the length of stay. Detailed information about this pilot was limited at the time of our inspection, though we are keen to understand the impact of this investment as it develops. An evaluation will be vital to inform longer-term decisions about integrated working and workforce development.

4. Summary

Quality indicator 1: Key performance outcomes

1.1 improvements in partnership performance in both healthcare and social care

Adequate

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

6.1 strategic planning and 6.5 commissioning arrangements

Good

Quality indicator 9: Leadership and direction that promotes partnership

9.1 vision, values and culture across the partnership and 9.2 leadership of strategy and direction

Not subject to evaluation against the six-point scale

The progress of strategic planning and commissioning within the partnership is at an early but productive stage, with sound partnership working in evidence. We are confident that officers in senior leadership posts have made significant investment and good progress driving towards a culture of shared responsibility and accountability, with building blocks in place to support improvement in outcomes. There are comprehensive strategies in place and structural arrangements being developed to support the integration of health and social care, with the ultimate aim of delivering personalised outcomes and using finite resources to best effect.

The integration joint board (IJB) and senior leadership team have set a clear vision with a shared and explicit commitment to integrating services and locality working, taking a whole-system approach to support the delivery of better outcomes in an integrated way. The overall vision, which aligns with national priorities and outcomes, is to transform, redesign and enable improvements in respect of people, localities, systems and culture. There is a robust and inclusive approach to marrying national and partnership outcomes to those at locality level.

There are strong working relationships between and among voting members and senior officers. The senior leadership team has a representative from the third sector as a full member of the team and we saw evidence of their active participation in the leadership team meeting. Housing is also represented on the IJB and the strategic planning group. There is evidence of learning from other partnerships and of work taking place to develop robust joint governance arrangements for the delivery of care.

The partnership is keen to develop a more streamlined locality response which makes best use of existing resources and which focuses more on the community and less on acute services. Locality structures are historically embedded and are being revisited to enhance integrated working and streamline decision making. This

position was reflected in our staff survey responses, which indicated that 82% of staff agreed or strongly agreed that joint working is supported and encouraged by managers.

There is a shared commitment to increasing the availability and sustainability of preventative and early intervention supports and community capacity building however, there is evidence that this needs to be enhanced and developed. For example, improved communication and further investment will be required to maximise the effectiveness of Hospital at Home, with robust evaluation to ensure the service meets the needs of those most vulnerable to unscheduled care and to monitor admissions which occur soon after Hospital at Home withdraw.

The partnership has demonstrated a willingness to look for common solutions to support a more efficient approach to improving personal and organisational outcomes. It is expected that the integrated service review board report to the IJB in September 2017 and the recommendations flowing from the cross-party working group on home support, will inform the process of delivering proposals for decision making in respect of plans for disinvestment and reinvestment in service redesign. Delayed discharges and unscheduled care are continuing to put pressure on acute services. Planning and performance processes are evolving and the partnership needs to closely scrutinise the proactive use of performance data to effect change and improvement. This is necessary in order to ensure that accountability for performance is effectively managed and action plans are regularly reviewed and evaluated. The risk of not taking such an approach is that operational performance fails to improve and pressures on acute services promote a reactive and short-term response.

The principle aim within the partnership is to support people to remain at home and in their communities for as long as possible. Pressure on home support capacity is evident. There is not enough capacity in reablement and home support to respond to assessed need, choice and increasing demand. This is reflected in the responses we received to our staff survey, which indicate that some staff feel people are waiting too long in hospital for access to home support. While there is significant evidence to demonstrate progress with strategic planning, this is at an early stage and not yet impacting on the partnership's performance in managing hospital discharge and unscheduled care. The partnership is clear in its intention that there will be a step change in how services are delivered. Strategies have been developed. Structures are in place and evolving to support the delivery of this change. We acknowledge that this will take time and will develop incrementally. At the time of our inspection, the partnership had set out its commissioning intentions. We expect that decisions concerning disinvestment and investment will be made by the IJB, flowing from the work of the ISRB.

5. Conclusion

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

This can be evidenced by the areas of strength outlined below.

1. A range of detailed and comprehensive strategies have been developed to support the integration agenda with a strong locality focus.
2. There is a shared vision and collective commitment to the development of the integration of health and social care in North Lanarkshire with the aim of supporting community capacity building and improvement in personal outcomes.
3. Well-embedded locality structures have been enhanced to support more integrated working and a strategic approach to service planning and development.
4. A strong partnership is in evidence with the third-sector interface and third-sector service providers.
5. Partners are willing to think about doing things differently and seek shared solutions to improving personal and organisational outcomes.
6. There is a clear commitment to stakeholder engagement and to developing a mixed economy of care to enable choice and enhance capacity.

The Care Inspectorate and Healthcare Improvement Scotland recommend that the partnership continually monitors and evaluates progress of the planning processes currently underway, the impact these are having on operational performance and that it takes appropriate action in the event of progress being slower than planned or not delivering expected improvements. To enable this approach, the key areas for improvement detailed within the body of this report are set out below. The data and evidence collated from this self-evaluation activity will inform discussions with the link inspector for the partnership and the nature and timing of future scrutiny activity.

Areas for improvement are as follows.

1. The partnership should ensure that SMART action plans are in place to support internal challenge and to evaluate and improve performance, in particular those areas that are off-target. These should be reviewed regularly to maintain a focus on improvement and to support informed decisions in respect of planning and commissioning.
2. The partnership should produce a plan to develop a mixed economy of care. This should clearly indicate how the partnership intends to engage with all stakeholders to continue to shift the balance of care. It should ensure that there is sustainable and sufficient service availability to respond to need, offering choice, control and equity of access across all localities with the aim of reducing the need for intervention at a point of crisis, irrespective of age or care group. This should be informed by the recommendations and actions flowing from the integrated service review board and the cross-party working group on home support services.
3. The partnership should develop or enhance current communication strategies to ensure stakeholders understand how the partnership will address issues such as aligning strategies, dealing with disinvestment decisions and progressing locality budgeting in the future.
4. The partnership should consider how to raise the profile of some stakeholders in planning activity, specifically carers and independent sector providers.

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	6.3 Quality assurance, self evaluation and improvement	7.3 Training, development and support	9.3 Leadership of people across the partnership
2.1 Experience of individuals and carers of improved health, wellbeing, care and support	5.2 Assessing need, planning for individuals and delivering care and support	6.4 Involving individuals who use services, carers and other stakeholders	8. Partnership working	9.4 Leadership of change and improvement
2.2 Prevention, early identification and intervention at the right time	5.3 Shared approach to protecting individuals who are at risk of harm, assessing risk and managing and mitigating risks	We assessed 6.5 Commissioning arrangements	8.1 Management of resources	10. Capacity for improvement
2.3 Access to information about support options including self directed support	5.4 Involvement of individuals and carers in directing their own support		8.2 Information systems	10.1 Judgement based on an evaluation of performance against the quality indicators
3. Impact on staff			8.3 Partnership arrangements	
3.1 Staff motivation and support				

Appendix 1 – Quality Improvement Framework

The areas we assessed in this joint inspection are highlighted below.

Appendix 2 - Methodology

Our inspection of the North Lanarkshire HSCP was carried out over three phases:

Phase 1 – Planning and information gathering

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

Phase 2 – Staff survey and fieldwork

We issued a survey to 7,092 staff. Of those, 1,831 responded and 1,193 completed the full survey. We also carried out fieldwork over seven and a half days during which we interviewed a number of people who hold a range of responsibilities across the partnership.

Phase 3 – Reporting

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

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



care inspectorate

To find out more about our inspections go to www.careinspectorate.com and www.healthcareimprovementscotland.org

Contact us:

Telephone: 0345 600 9527

Email: enquiries@careinspectorate.com

Write: The Care Inspectorate, Compass House, 11 Riverside Drive, Dundee, DDI 4NY.

We can provide this publication in alternative formats and languages on request.



Edinburgh Office
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB
Phone: 0131 623 4300

Glasgow Office
Delta House
50 West Nile Street
Glasgow
G1 2NP
Phone: 0141 225 6999

www.healthcareimprovementscotland.org

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.