Joint Inspection of Adult Services (Integration and Outcomes)
Position Statement

Partnership Name: South Ayrshire Health and Social Care Partnership

A. Local Information and Context

Local demographics and contextual background information	
Max 500 Words	Evidence Ref:
South Ayrshire Health and Social Care Partnership's (SAHSCP) Strategic Plan 2021-31 provides a range of high-level contextual information on South Ayrshire including our geography (page 10) and locality planning arrangements (pages 10-14). South Ayrshire has a unique demography: there are high levels of deprivation alongside one of the most elderly populations in Scotland. The high and growing proportion of older people (26% aged over 65 compared to 19% nationally) sits alongside one of the highest dependency ratios in Scotland (71% in 2020 projected to be almost 90% by 2040). We have areas of significant deprivation (17.1% of the population live in the 20% most deprived data zones), particularly in Ayr North where life expectancy is 73.6yrs compared to 80yrs in Troon. Public Health Scotland's SAHSCP Needs Assessment provides a comprehensive overview of our demography including trends and projections. The majority of the population live in the more urban areas of Ayr, Prestwick and Troon in the North of the County with a more rural and dispersed population inhabiting the South. We have produced Locality Profiles for each of our 6 locality areas to support the assessment of need and decision making at a more local level. The Partnership delivers and commissions a broad range of services, meaning SAHSCP is in contact with citizens at all stages of life. Services delegated by South Ayrshire Council and the NHS cover Adult Community Health and Care Services, Allied Health Professions, Children, Family and Justice Services, Planning, Performance and Commissioning, Business Support and Administration and Professional Oversight. Comprehensive arrangements are in place to ensure appropriate multi-agency strategic oversight of strategic objectives. Operational oversight is also provided through a range of multi-professional, multi-agency groups. Strategic Change for adult services is directed through the HSCP's Driving Change Group which meets monthly. In 2019/20, 27% of the total population had at least one physical long-term condition (LTC). 1.6 in 10 people under the age of 65 have at least 1 LTC. Of those with a LTC, 23% of those under the age of 65 have more than one LTC, compared to 56% of those aged over 65. Approximately 180 of those receiving care have a complex physical disability as their primary complaint.	1: SAHSCP IJB Strategic Plan 2021-31 50a: Performance and Audit Committee Agenda 300622 (Item 5) 2: PHS South HSCP Needs Assessment 2022 3a-f: Locality Profiles 2021 – Ayr South & Coylton; Ayr North & Former Coalfield Communities; Girvan & South Carrick Villages; Maybole and North Carrick Communities; Prestwick; and Troon. 4a: SA Governance Structure October 2022 4b: SAHSCP Organisational Structure October 2022

B. Overview/ Summary

Please use this section to provide an overview or summary of the key points you wish to highlight from your position statement.
SAHSCP has been through a period of significant improvement over the last four years. Since 2018, and in response to some very challenging circumstances, we have: • Invested in leadership capacity and capability at all levels. • Strengthened our approach to financial management moving from a significant overspend, to a balanced budget; and then utilising resources freed up from downstream to invest in upstream activity. • Strengthened strategic relationships with key partners through the Community Planning Partnership, 3-way Meeting, other strategic fora and shared projects. • Worked with partners and communities to develop strategic and service level plans that shift our attention and spend towards prevention and earlier intervention. • Invested in front line capacity, capability and team work to deliver on the objectives set out in those plans.

- Improved our systems and governance arrangements to enable more effective oversight and decision making.
- Strengthened the involvement of partners, communities, and people in all that we do.
- Committed to a culture of continuous learning and improvement through our Quality Management and Quality Improvement approaches.

Having a clear sense of purpose and direction, we have been able to navigate some of the most challenging years experienced in Health and Social Care, providing excellent support to our partners and service users during the Pandemic and maintaining momentum across a range of improvement activity.

Despite these significant developments we continue to strive to improve and deliver better outcomes for our citizens by strengthening our team around the locality approach by:

- Working with partners to plan modern buildings that enable better collaborative working.
- Working with partners to improve workforce recruitment and retention across our services.
- Investing in management and leadership to further improve our professional support and governance, and collaboration.
- Strengthening our person-centred approach to assessment and support through better use of Self-Directed Support and Community Led Support.
- Further shifting our improvement and investment activity towards prevention and early intervention.
- Continuing to improve our performance information systems and use of quantitative and qualitative data to drive improvement.
- Building on our work to engage and get feedback from those who use and deliver our services, putting them at the heart of all our planning and improvement activity.
- Celebrating and sharing our learning and successes locally, nationally, and internationally and learning from others in order to adopt best practice and drive improvement.

We are committed to meeting the needs of those who use our services within a culture of openness, transparency and integrity that nurtures learning and improvement at every level of the organisation. By listening to and involving people we strive to, “empower our communities to start well, live well and age well”.

C. Quality Indicator Framework for Adults and Carers

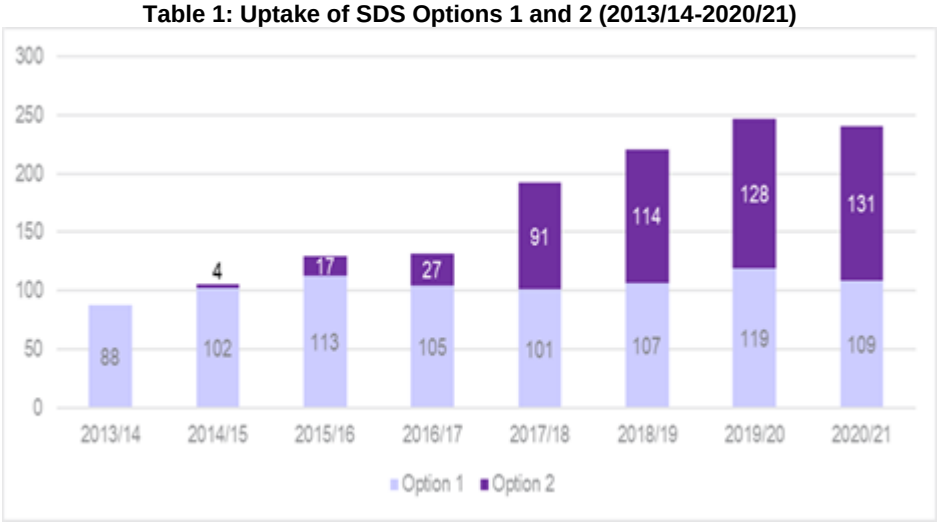
C.1 Key area 1: Performance outcomes

Quality Indicator 1.2: People and carers supported by integrated health and social care have good health and wellbeing outcomes	
	Evidence Ref:

A range of national and local data is available to evidence that we support people to look after their own health, living more independently at home for longer. The Partnership's Annual Report provides detail on our local progress against the Scottish Government's National Health and Wellbeing Outcomes. The Public Health Scotland Core Suite of Integration Indicators (20/09/22 Release) evidences in South Ayrshire: • A decrease from 94% in 2019/20 to 91.7% in 2021/22 of adults able to look after their own health very well or quite well. (National average = 90.9%) • A decrease from 82.3% in 2019/20 to 76.5% in 2021/22 of adults supported at home agree that they are supported to live as independently as possible (National average = 78.8%). • A small increase from 74.9% in 2019/20 to 75.8% in 2021/22 of South Ayrshire adults supported agree that they have had a say in how their help, care or support was provided (National average = 70.6%). • A decrease from 81.2% in 2019/20 to 71.9% in 2021/22 of adults supported at home agreed that their services and support had an impact in improving or maintaining their quality of life. (National average = 78.1%) • A decrease from 80.8% in 2019/20 to 76.5% in 2021/22 of adults who receive any help, care or support services rated them as excellent or good (National average = 75.3%). • A decrease from 72.4% in 2019/20 to 61.3% in 2021/22 of adults supported at home that agree that their health and care services are well coordinated. (National average = 66.4%) The general deterioration in some indicators mirrors a deterioration across Scotland and it is acknowledged that the pandemic is likely to have been a significant contributory factor (see 'Section E – Impact of COVID' for further detail). Consequently, there are a range of improvements, as outlined in Section B, that we have applied and continue to implement that aim to improve these scores, however challenges with workforce, information sharing, and premises continue to negatively impact on some of these outcomes. Work is underway to improve our integrated leadership and management arrangements following a learning review of adult social work and community nursing which concluded in April 2022. As a result of this work, the Community Health and Care Service is being restructured to improve both access to, and delivery of, social work through a new multi-disciplinary team locality 'front door' providing a single point of access to both community-based and more formal services. Our Team Around the Locality work is a priority within our Service Improvement Plans. Initial multi-professional workshops on multi-disciplinary working were held in summer 2022 and follow-up workshops will include the wider wellbeing team (third, independent and other public sector partners). The Public Health Scotland Core Suite of Integration Indicators (20/09/22 Release) also evidences that in 2021 in South Ayrshire 73.3% of adults with intensive care needs received personal care or direct payments for care at home, against a national average of 64.9%. Choice and control are core to the delivery, of person-centred health and social care and we utilise Self-Directed Support (SDS) to deliver this across all our services. Staff carry out their statutory role to offer SDS at each assessment and review (as evidenced by our audit of support plans) and information on SDS is available on our website. The uptake of SDS options 1 and 2 has increased by 71% from 192 in 2017/18 to 328 in 2021/22. Option 1 uptake increased by 40% from 101 to 142, and Option 2 increased by 104% from 91 in 2017/18 to 186 in 2021/22. Although we have seen a steady increase in SDS uptake, through benchmarking, we are aware that other partnerships perform better in this area. We are continuing to focus our improvement efforts on SDS	6: SAHSCP Annual Report 2021/22 7a: PHS Core Suite of Integration Indicators 20/09/22 Release 8: Adult Social Work Learning Review Final Report 31/03/22 36b. IJB Agenda 140922 (Item 7) 45: Community Nursing Review 5a: Community Health and Care Adult and Older People Service Improvement Plan 5b: South Ayrshire Adult Learning Disability Strategy 2022-2027 5c: South Ayrshire Adult Community Mental Health Strategy 2017-22 9a: SDS Policy 2022-23

in 2022/23 - this priority piece of work is being monitored through the Community Health and Care Driving Change Group.

Table 1: Uptake of SDS Options 1 and 2 (2013/14-2020/21)



The Public Health Scotland Core Suite of Integration Indicators (20/09/22 Release) also evidences that in 2021 in South Ayrshire 88% of people's last 6 months of life were spent in a community setting in South Ayrshire, this is against the national average of 89.8%.

The Public Health Scotland Core Suite of Integration Indicators (20/09/22 Release) evidences that for people with caring responsibilities in South Ayrshire in 2021/22, 33.8% of carers feel supported to continue caring (national average = 29.7%).

The Health and Care Experience Survey 2022 evidences that in South Ayrshire:

- 65% of people with caring responsibilities feel they have a good balance between caring and other things in their life. (National average = 63%)
- 52% of people with caring responsibilities feel they have a say in services provided to those they have caring responsibilities for. (National average = 39%)
- 32% of people with caring responsibilities feel local services are well coordinated for those they have caring responsibilities for. (National average = 29%)

7b: PHS Health and Care Experience Survey 2021-22

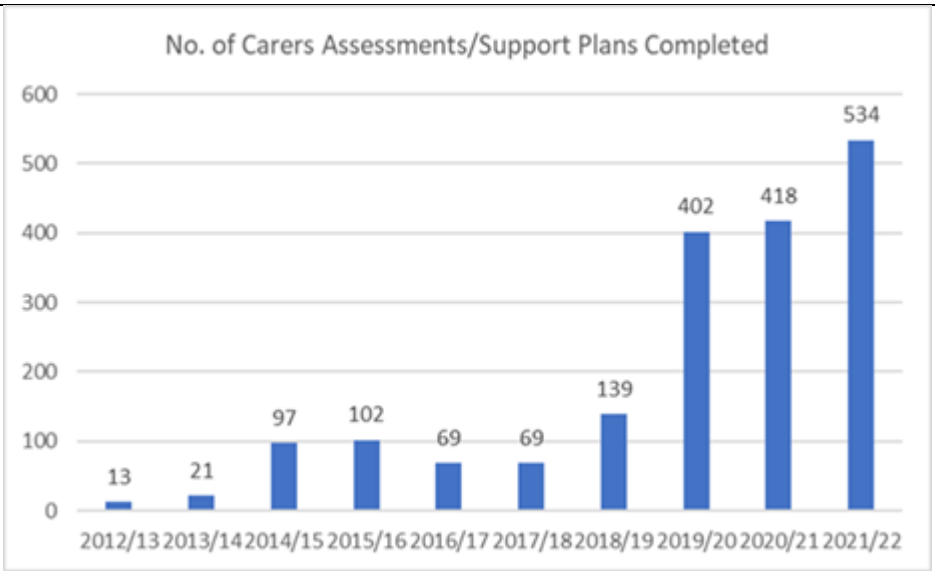
Improving communication with carers and raising awareness of available support has been a key focus throughout the COVID-19 pandemic and over the past year. A Carers Policy Implementation Officer post was created to improve support available to carers. South Ayrshire Carers Centre is commissioned to provide a range of supports to carers including 1:1 and group support (virtual or via telephone), financial support, signposting and access to funding. There is a referral pathway in place for independent advocacy for carers and South Ayrshire Carers Centre also continue to deliver advocacy and support to carers. The Adult Carers Strategic Group will be carrying out a review on advocacy support going forward. Work has begun on a new Carers pathway with CAMHS to identify and support families at point of referral to the service. A pan-Ayrshire working group has been established that contains carers with lived experience as leads from South, North and East Ayrshire to provide input and shape the new pathway.

11a: SAHSCP Adult Carers Strategy 2019-24
11b: PAC Report - Implementation of Adult Carers Strategy
12b-d: Quality Assurance Report Examples

An audit of the current Adult Carer Support Plan (ACSP) documentation focused on the quality of completed plans and how they evidenced an improvement in the quality of life for carers. Despite the challenges of the pandemic, there has been a 28% increase in the number of Carer's Support Plans/ Assessments completed in 2021/22 compared with those completed in 2020/21. 418 in 2020/21 rising to 534 in 2021/22.

22c: Adult Carers Support Plan Audit 2022

Table 2: Number of Carers Assessments/ Support Plans Completed (2012/13-2021/22)



The results of the recent audit were also positive with regards to the quality of the completed plans with improvement measures being taken forward through the Adult Carers Strategic Group. There is work planned to refresh ACSP documentation in consultation with Carers, SAHSCP and the Carers Centre.

We have recently introduced a case recording quality assurance policy along with a scrutiny tool and qualitative feedback statement across all our teams. There is a specific focus on how outcomes are set out in the care planning process and the direct feedback we receive from individuals/ carers around the impact of the support they receive. Although this work is at an early stage, we are beginning to identify areas that will inform our on-going improvement planning processes.

We are reliant on a combination of local and national data to help us understand how our services impact on outcomes for people. We continue to build on these existing sources of data to triangulate data we currently have, with the voice of service users and carers to better understand the impact our services are having.

Key Area 1 – Key Performance Outcomes: Areas for Improvement

- Build practice knowledge and competence around SDS leading to empowerment for those who use our services.
- Continued development with the third sector on the use of micro enterprises to support the social care landscape to increase choice.
- Improve our focus on, measurement and use of outcome information.

13. Carers Strategic Group Papers August 2022

14a: Case Recording Quality Assurance Policy
14b: Case File Audit Assessment Tool
14c: Audit Evaluation and Learning Summary Template
50a. Performance and Audit Committee Agenda 300622 (Item 10)

C.2 Key Area 2. Experience of people who use our services

Quality Indicator 2.1: People and carers have good experiences of integrated and person-centred health and social care	
	Evidence Ref:

Data from the Local Government Benchmarking Framework for 2019/20 indicate that 74.9% of adults supported at home, felt they had a say in how help, care or support was provided to them. (National average 75.4%)

The Public Health Scotland Core Suite of Integration Indicators (20/09/22 Release) indicates that in South Ayrshire:

- A small increase from 74.9% in 2019/20 to 75.8% in 2021/22 of adults supported that agree that they have had a say in how their help, care or support was provided (National average = 70.6%).
- A decrease from 72.4% in 2019/20 to 61.3% in 2021/22 of adults supported at home that agree that their health and care services are well coordinated. (National average = 66.4%).

The Health and Care Experience Survey 2022 highlights that 32% of people with caring responsibilities in South Ayrshire, feel local services are well coordinated for those they have caring responsibilities for. (National average = 29%).

The Scottish Government Framework for Community Health and Social Care Integrated Services informs our approach to service delivery directing us towards greater locality focused working to deliver seamless coordinated integrated care.

In April 2022 we published our Adult Social Work Learning Review that will establish multi-disciplinary teams within localities and aligns work with Primary Care and GP Practice. This will support earlier intervention and prevention work and provide a more coordinated, localised and tailored response to people and their carers who require services.

Our approach to assessment of individuals and carers is person-centred and underpinned by the Talking Points outcome framework. A strength-based person / carer centred throughout informs our practice and planning. We gather feedback through reviews on experience measures to evaluate our performance**.** Over the last 12 months (August 2021 to August 2022), 1957 individual support plans have been completed, and during a review of these plans the experience measures demonstrated very positive feedback:

Table 3: Audit of Support Plan Responses (August 2021-22)

Support Plan Experience Question	**YES**	**NO**	**NOT KNOWN**	**TOTAL**
I feel more confident about managing my health and wellbeing	81%	4%	15%	100%
I have been fully informed about how the Self-Directed Support Options can be accessed to meet my Outcomes	90%	2%	8%	100%
I have been provided with information and advice about a range of community-based services	86%	7%	7%	100%
I have had a say in how my care and support will be provided	92%	1%	7%	100%

As a result of our multiagency assessment, planning and support 81% of respondents identified that they feel more confident about managing their health and wellbeing.

Our lived experience League of Champions Group have contributed heavily to the development and delivery of our Learning Disability Strategy while establishing a model of peer and group support. This is a good example of engaging service users and carers in planning services and engaging them in the development of our services for them and by them. Taking the learning from this model, we are developing similar groups for those with mental health needs and our older adults in addition to strengthening local representation within our Locality Planning Partnerships and locality team development.

15: Local Government Benchmarking Framework

7a: PHS Core Suite of Integration Indicators 20/09/22 Release

7b: PHS Health and Care Experience Survey 2021-22

1: SAHSCP IJB Strategic Plan 2021-31
5a: Community Health and Care Adult and Older People Service Improvement Plan
8: ASWL Review Final Report 31/03/22
48. Video: Barns Medical

16a. My Life My Outcomes Assessment Tool
16b. My Life My Outcomes Review Tool
16c. My Life My Outcomes Support Plan
16d. My Life My Outcomes Guidance

18. Adult LD Strategy Engagement Report

19: SPAG Report-Participatory

We have also used participatory budgeting to engage groups to develop localised support for issues including loneliness and isolation, transport, physical activity, dementia, mental health, and family support. We are continuing to implement our SDS improvement plan which aims to increase the knowledge and confidence of workers to advance options that enabling greater choice and control. Supporting carers is core to our working practice and despite the impact of COVID we have continued to increase the uptake of Adult Carer Support Plans (ACSP). Our Carers Strategic Group comprises of staff across all sectors and monitors the implementation of the Adult Carers Strategy A recent audit of ACSP to consider both the quality and consistency of our practice. This audit demonstrated we are delivering positive engagement for carers but also highlights some areas for improvement: • 85% of carers consulted knew who the manager/ social worker was for the person they had caring responsibilities for; • 98% of carers were clear what their assessed needs are; • 76% of carers believed that the 4 SDS options had been discussed with the person they provide care for; • 54% of carers were of the view that the person they provided care for were offered alternatives to a traditional care package; • 64% of carers were offered a carers assessment/ support plan in their own right; • 39% of carers were offered a copy of their carers assessment/ support plan; • 46% of carers would like a copy of their assessment; • 59% of carers have requested respite support; • 44% of carers have been offered respite support. Improvement actions arising from this audit are being taken forward through implementation of the Adult Carers Strategy. We have also focused on support for young carers within our communities - increasing knowledge to support identification of young carers, offering young carers statements and action planning through Team Around the Child to ensure that they have the support and care they require. • We have increased the number of Young Carers known to services and registered for support with the Carers Centre • We have commenced a programme of knowledge and awareness sessions visiting 46 local schools as well as local teams and resources to date and creating 26 young carer champions. • We have formed our Young Carers Voice group to assist us in future service development. • We have increased the completion of Young Carers Statements. We have launched an adult carers survey to gather the views of unpaid carers that will assist us with our partners to design and commission services that will make the most impact and deliver positive outcomes. In 2022, we enhanced promotion of Care Opinion to gather the view of people and carers who use our services, and because of this work we have seen an increase in the amount of people using the portal during 2022. The stories speak positively of the support that we have provided for those in need of support and some examples can be accessed here: • A huge asset to South Ayrshire! | Care Opinion • Amazing care at home | Care Opinion • I feel very lucky | Care Opinion	Budgeting Locality Evaluations 20: Locality Development Sessions Summary Report 9b: SDS Improvement Plan 2022-23 31: Carers Experience Audit Report 2021 11b: PAC Report - Implementation of Adult Carers Strategy 22c: Adult Carers Support Plan Audit 2022 22a. Adult Carers Support Plan Guidance 22b. Adult Carer Support Plan Template

We will continue to actively encourage people who use our services to engage with this feedback platform by: • Discussing the opportunity to provide feedback at every review home visit; • Leaving written material for service users; • Promoting Care Opinion on corporate letter heads; • Rolling out to all service areas during 2022-23. We celebrate these positive stories with staff through our communications and individually. We ensure appropriate follow-up should any concerns arise from this feedback. <u>Key Area 2 – Experience of People Who Use Services: Areas for Improvement</u> • Improve performance management dashboard and develop methods to collect qualitative data (service user and carer survey, provider survey, roll out Care Opinion). • Continue to invest in locally tailored, prevention and early intervention initiatives through Participatory Budgets.	

Quality Indicator 2.2: People's and carers' experience of prevention and early intervention	
	Evidence Ref:
Our primary driver to enable people to look after and improve their own health and wellbeing is our Wellbeing Pledge. This is a core part of the Strategic Plan and seeks to work in partnership with local people to achieve better outcomes. This has required a new relationship between SAHSCP, our communities and the third sector. We aim to collaborate and coproduce services that are integrated and meaningful to those we serve. The Pledge forms the paradigm that runs throughout our work from early intervention to complex care and support packages.	1: SAHSCP IJB Strategic Plan 2021-31
Our multi-agency working and collaboration with primary care, local groups and our third sector interface forms the mainstay of our preventative supports and access to services. This work aims to ensure people and carers experience timely support by providing a single 'front door' to access to both community-based and more formal services. We aim to build on this approach by implementing the recommendations from the Adult Social Work Learning Review creating physical and digital local front doors for people to access information and support. This continues to be driven forward through our Team Around the Locality work overseen by Driving Change Group and our adult services management re-structure.	8: Adult Social Work Learning Review Final Report 31/03/22
'Ahead of the Curve' work is one example that supports people at earlier and moderate stages of frailty using goal setting, self-management and other methods to provide support as well as formal SAHSCP services. We bring services 'in situ' to the GP setting including Community Treatment and Care, Pharmacotherapy, Mental Health Practitioner, Community Link Practitioner, MSK Physiotherapist and Occupational Therapy. Through this we have also established effective multi-disciplinary working. This includes self-referral at earlier stages and the use of the Frailty Tool at GP level to proactively identify who may require but are not yet accessing support. As a result of this work people have already demonstrated improvements in a validated functional measure.	56a-c: Ahead of the Curve Summary and Stats
Another example is Our Healthy and Active Rehabilitation Programme (HARP). A tiered rehabilitation programme for people affected by cancer, stroke, cardiac or pulmonary conditions, diabetes, or an elevated risk of falls, and at least one other condition. Evaluation of the first 3 years highlights that it supported people to make positive changes across lifestyle risk factors and help them take control of their health and wellbeing. Outcome measures demonstrated a positive impact on cardiovascular risk factors and fewer emergency bed days. Service users perceived improvements in their quality of life, fatigue, fitness levels, physical function and weight management, with many appreciating the positive impact of peer support on their confidence, motivation, and socialisation.	41a. HARP Evaluation 2017-18 41b. HARP Evaluation 2015-18

The Partnership has seen a decrease in the fall rate from 25.81% in the period between June 2021 and June 2022 with hip fracture rate decreasing 18.75% for the reporting period. While it is difficult to draw direct correlation from one area of intervention to the falls rate data, it is reasonable to conclude that the re-start of HARP and Invigorate programmes contributed to this. Referring to our MDT Primary Care Team and Community Link Workers programme we have received positive feedback from people who use our services:  Additionally, our Primary Care Community Link Practitioners work from GP practices and support a strength-based conversation that promotes self-management and community engagement. We are continuing to develop opportunities within GP practices and Community Pharmacies to provide more flexible support for local people. We have appointed a new Clinical Director who is part of our DMT to codesign, collaborate and advance these. Another example of our preventative work is the Living Well programme. This is a free six-week programme aimed at people with long term health conditions which has been specifically designed to help participants develop skills to better manage their health conditions. The programme assists participants to set goals and identifies and engages them with opportunities to improve their health, experience less social isolation and offer peer support. Participant's feedback of the programme generated the following qualitative statements: • "I really enjoyed meeting other people who are having similar experiences to me" • "It has helped my mental health and motivated me to re-join activities again" "It has helped me focus on helping myself" • "I feel less isolated now" The examples above and the methodology adopted in relation to our Learning Disability Strategy has set the blueprint for further work to develop preventative and early intervention resources for those who use our services. Key to this is the expertise of those with lived experience to identify across the spectrum the range of supports that they require. SAHSCP have committed to invest an additional £100k to stimulate and grow the range of preventative and early intervention initiatives at grass roots level.	38a: Falls Specialist Assessment Pathway 38b: Falls and Hip Fractures Dashboard 38c. Falls and Hip Fractures Maps 24: CPP Webinar Series Event 18. Adult LD Strategy Engagement Report

Quality Indicator 2.3: People's and carers' experience of information and decision-making in health and social care services	
	Evidence Ref:
Working with our third sector partners, we have introduced South Ayrshire Lifeline. This web and phone-based directory of local community support groups alongside advice and guidance on general health and wellbeing aims to enable choice and engagement. During the last 12 months (since October 2021) the website has received over 100,000 views. A webinar exploring what South Ayrshire Lifeline can offer people within our communities is planned as part of a series of events promoting examples of work taking place and opportunities by partners who are 'working together to make lives better.' The HSCP has strengthened our organisational structure to provide both a Communications Officer and a Digital Programme Manager with a view to developing	49: South Ayrshire Life Website Stats 24: CPP Webinar Series Event 4b: SAHSCP Organisational

our messaging and engagement through social media, our website and other channels; and our digital service offer/ access arrangements. 86% of respondents in our review of Adult Support Plans identified that they had received good information and advice relating to a range of community-based services that they could access. SAHSCP actively uses data and feedback we from people who use our services and their carers to drive service improvement. An analysis of complaint and service requests from our management systems LAGAN / GOSS do not highlight a concern in relation to the provision of information and advice to assist people who use our services and their carers to experience increased choice and control in managing their health and wellbeing. We receive a small number of formal complaints – only 5 formal social work complaints recorded between January and June 2022. Where issues are raised about service provision we respond to these informally where appropriate to do so, and timeously, as close to the point of service delivery as possible. We work collaboratively with people who use our services and carers to make improvements based on feedback received. An example of this is feedback that we received about our SDS processes that have been experienced as bureaucratic. This feedback led to a recent review of this area of practice. Out with formal complaints processes, and surveys, we receive positive feedback via email, Care Opinion and cards of appreciation from carers and service users that speak of the person centred and high quality of care received. Section 2.1 has further information on this. Analysis of the balance of SDS which demonstrates a heavy weighting towards Option 3 services selected and arranged by SAHSCP may point to a confidence and trust of our practice and professionalism. (See Section 1.2 for more detail). The Local Government Benchmarking Framework evidences that we have a lower uptake of Option 1 and Option 2 in South Ayrshire with only 3% of social funding allocated using direct payments or personalised managed budgets versus a national average of 8%. Similar local authority areas range from 2.5% to 8%. Work to improve knowledge and competence around the area of SDS is encapsulated within our SDS Improvement Plan. We aim to promote awareness the provision of SDS through Option 1 and Option 2 that may offer people more independence and franchise by engaging services of their choosing. Despite this feedback and need for improvement, analysis of our Adult Carers Support Plans highlight that 90% of respondents agreed that they have been fully informed about how the Self-Directed Support Options can be accessed to meet their outcomes. The Partnership is good at ensuring that people and carers are routinely supported to make meaningful decisions about their health and social care and feel that they exercise choice and control over the care services they receive. Local data from a review of individual support plans demonstrates that 92% of people had a say in how their care and support will be provided. National data from Public Health Scotland indicates a lower proportion (76%) of South Ayrshire adults supported agree that they have had a say in how their help, care or support was provided but this remains a high proportion and higher than the National average (71%). This evidences our commitment to our Wellbeing Pledge to listen to those who use our services and empower and enable them to take control of their own care. In some instances, people may lack capacity to be fully involved in decisions about their care. Where this is the case, our teams liaise with their proxies and aim to fully involve them in making choices about their care and support. Where these powers are not present, we work with family members to enable them to assume these powers. In	Structure October 2022 10. SW Complaints Report 15a: Local Government Benchmarking Framework 15b: Service and Performance Panel Agenda 220622 (Item 3) 9b: SDS Improvement Plan 2022-23 22c: Adult Carers Support Plan Audit 2022 7a: PHS Core Suite of Integration Indicators 20/09/22 Release

some cases, these powers are delegated to Social Workers by the Chief Social Work Officer. We utilise our Adults with Incapacity Procedures and the Team Around the Person Model to consider the views and wishes of the individual and those who care for them. Key to this is the provision of advocacy to allow family members to be informed of their rights and support them to assert their views, to identify a family members or relevant person. Circles Network have been commissioned by the Partnership to advocate for people who use our services. In the 2-year period between April 2020 and March 2022, Circles received 812 referrals for advocacy, with 10% of these referrals for clients with a Physical Disability. The HSCP commenced the first stages of development of a Strategic Advocacy Plan in 2018. The strategy is informed by information from the Scottish Independent Advocacy Alliance alongside views from the community, service users, third sector organisations and the three advocacy organisations commissioned by the partnership. The strategy will cover all vulnerable groups who have a legal right to be supported by advocacy. Whilst the draft version of the strategy was started in 2018, the process was paused due to COVID with a revised target completion of June 2023. Once complete, the advocacy contract will be re-tendered. <u>Key Area 2 – Experience of People Who Use Services: Areas for Improvement</u> • Development and provision of easy-to-understand information and service directories to help people to self-manage and find the support they need. • Improve/ promote processes for gathering data and service user/ carer feedback for improvement. • Embed team around the locality approach within each of the six localities to Improve access for people and their carers for early intervention, assessment and support using learning from new initiatives to reshape our approach. • Promote and support the early identification of Power of Attorney to ensure those who cannot offer their views have a voice through their appointed person. • Development of advocacy strategy.	21. Circles Advocacy Stats 2020-22

C.3 Key area 5: Delivery of key processes

Quality Indicator 5.1: Processes are in place to support early intervention and prevention	
	Evidence Ref:
Prevention and early intervention are at the heart of our Strategic Plan and our service plans. Our Wellbeing Pledge within the Plan sets out our shared responsibilities and expectations for teams, partners, people and their carers. The unique nature of our partnership sees the integration of Health, Childrens Services and Adult Services. This promotes early intervention and prevention approaches across the life cycle through the GIRFEC (Getting It Right For Every Child) National Practice Model and My Life My Outcomes to ensure that people Start Well, Live Well and Age Well. Additionally, we have adopted a Community Led Support approach at our 'front doors' providing a single point of access to both community-based and more formal services. Using a strengths-based approach we aim to engage people who use our services and their carers to supports within their communities. We have partnered with Voluntary Action South Ayrshire (VASA) who run South Ayrshire Lifeline. They are a key partner in offering guidance and support to promote engagement with local supports with the overall aim of building community and personal resilience. Practitioners across services work closely with Council partners in Leisure, third sector partners through VASA, and Community Link Practitioners to signpost individuals to options in the community that may benefit their health and wellbeing. Processes are in	1: SAHSCP IJB Strategic Plan 2021-31 50a: Performance and Audit Committee Agenda 300622 (Items 5, 7) 49: South Ayrshire Life Website Stats

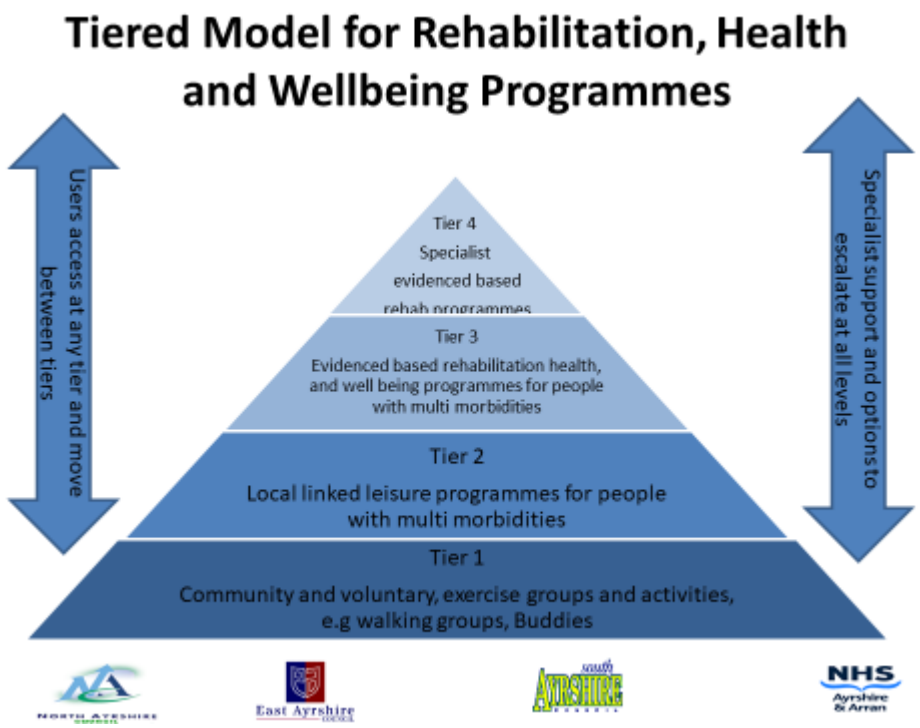
place to allow easy referral between partners underpinned by good relationships and a culture of value and mutual support.

We have developed a range of services and pathways to support early intervention:

HARP

Healthy Active Rehabilitation Programme (HARP) was implemented in 2015 to provide a tiered multi-agency approach to rehabilitation and education for people with multiple conditions (Cardiac, Respiratory, Falls, Cancer Stroke and Diabetes) to improve health and wellbeing and help people to anticipate own needs and build on own strengths to address these. This tailored, option-based programme was developed and delivered in partnership with leisure services and third sector partners with a focus on strengthening links into community activities and enabling people to move between Tiers according to needs and wishes.

41a. HARP Evaluation 2017-18
41b. HARP Evaluation 2015-18



This pioneering model has been fully evaluated and published in clinical journals. It has attracted attention from across the UK and is cited within recommendation 6 of the national rehab framework Rehabilitation and Recovery: A Once for Scotland Person-Centred Approach to Rehabilitation in a post-COVID Era as an example of a model that could be rolled out locally and nationally.

Ahead of the Curve: Frailty Early Intervention Service

This new service aims to engage with people during the mild to moderate stages of frailty to support people and their carers to stay happier and more independent for longer. The service proactively seeks referrals via a range of community/ third sector services at the earliest stages of frailty (e.g., as people seek personal footcare) rather than waiting for people to seek formal services. Use of the Frailty tool at GP level identifies those with moderate frailty and proactive contact is made to support people with self-management and connect them with community activities. Early data from the first 100 participants demonstrates some improvement in the validated functional measure.

56a-c: Ahead of the Curve Summary and Stats

MDT Primary Care Team and Community Link Workers

The development of the wider multidisciplinary team within primary care including pharmacists and pharmacy technicians, MSK advanced physiotherapy practitioners, mental health practitioners, occupational therapists and community link practitioners increase capacity within primary care to provide opportunities for earlier intervention

and prevention and collaborative working with local and health and care teams and community wellbeing teams for anyone who is struggling with any aspect of their daily life regardless of condition. The team provide early assessment, intervention and self-management advice and support for people whose mental or physical wellbeing is impacting on their function or quality of life. The use of Technology provides alternative approaches to self-management and face to face support, resulting in improved access for some who otherwise did not engage with services. <u>Falls Prevention</u> We have a multi-agency approach to the prevention and early intervention of falls across acute and community, in house and commissioned services (including sheltered Housing). Community teams and leisure services promote the falls prevention awareness using local "positive steps" resources, and national resources such as "up and about" leaflet and "super 6". Our well established, Invigor8 programme offers falls prevention exercise classes within local communities and links with other community options and is a notable example of integrated working. <u>Weigh to Go</u> Weigh to go is a lifestyle programme to support weight management delivered by partners in leisure within communities, and Health Care Support Workers within HARP, supported by dieticians. Individuals can self-refer onto the programme or be referred by health and care teams. <u>Early Intervention for Care Homes</u> Our pan-Ayrshire Multidisciplinary Professional Liaison Team consisting of nursing staff, an Occupational Therapist and a Dietician work with our care home colleagues to provide education and advice to improve standards of care and the health and wellbeing of our care home residents. Additional guidance and support is available from other AHP and Mental Health staff as required. The team support the homes with training and link with GPs (who are aligned to the home) and Hospital at Home to provide specialist interventions and provide alternatives to admission. There have been good outcomes related to increasing physical activity, reducing falls, preventing pressure sores and reducing urinary tract infections.	38a: Falls Specialist Assessment Pathway 38b: Falls and Hip Fractures Dashboard 38c. Falls and Hip Fractures Maps 52a-c: Diabetes Prevention Programme EIA's
Processes to support early intervention and prevention specifically for people with physical disabilities and their carers: The unique nature of our partnership enables us to support people and families at the earliest stages of their lives through the GIRFEC practice model. Our Childrens Services and Health work with our partners in Early Years and Education to ensure that South Ayrshire is the best place to grow up. Support from multi-agency meetings (such as Team Around the Young Person) ensure that all key individuals such as health and education, are part of the planning process and that the young person and family/ community members own their plan, build and are key in driving forward the supports. Our Adult Learning Disability Team worked with Children and Families Disability Team to develop the "Moving On" document that targets best practice in transitions between these services and can also be used for transitions between any child and adult service. This, in partnership with the Young People in Transition Policy 2022-26, identifies young people with physical disabilities who would benefit from continuing support throughout their lifespan. The family and community networks of the young person are engaged during the initial conversation to understand their assets and identify any gaps. The Self-Directed Support (SDS) Policy options are then considered to plan creative supports to address those gaps. Conversation around transitions with families is used to prepare for this time and joined up working with adult teams build relationships and confidence. Transition meetings	46: Planning for Moving

ensure that families are identified for transition to adult services and preparation work is undertaken to support families in this change. The use of the Young People in Transition Policy ensures that families are supported through their whole life planning and is specific to those with a learning and/or physical disability. The use of Self-directed Support is an innovative and crucial support for families who require social care. The use of all options can be considered for community support and agency delivered support such as Short Breaks and any other interventions or supports that help people achieve their goals. Resource Allocation Groups (RAG) are used to assess the need for packages of structured care within children's services and adult services. The transition policies prepare and support families through what is a significant change. Working together ensures that practitioners get a good sense of family and individual strengths. Transition from the Signs of Safety format to My Life My Outcome assessment and planning formats therefore should evidence strength based and person-centred supports. For people requiring our services, our 'front doors' (points of access) offers timely advice and guidance to individuals and their carers as referrals can be made by staff at any time or individuals can self-refer. During duty home visits our staff provide individuals and their carers with information and leaflets. South Ayrshire Life also promotes local services and provides a directory of resources and contacts. Teams work in partnership with specialist services from Douglas Grant Rehabilitation Centre, Biggart Community Hospital and third sector organisations e.g. MS Society, MND Scotland, Headway, Chest Heart and Stroke and Parkinsons Disease society to provide early intervention and self-management advice to individuals with physical disabilities, their families and their carers. Individuals are offered post diagnostic support and education and can self-refer to specialist services as required. Individuals and carers are supported to access peer support groups and leisure activities within their communities and are signposted to a range of resources both online and printed that assist individuals to be well informed and make choices that are right for them.	37: Short Breaks Statement 16a. My Life My Outcomes Assessment Tool 16b. My Life My Outcomes Review Tool 16c. My Life My Outcomes Support Plan 16d. My Life My Outcomes Guidance 22a. Adult Carers Support Plan Guidance 22b. Adult Carer Support Plan Template

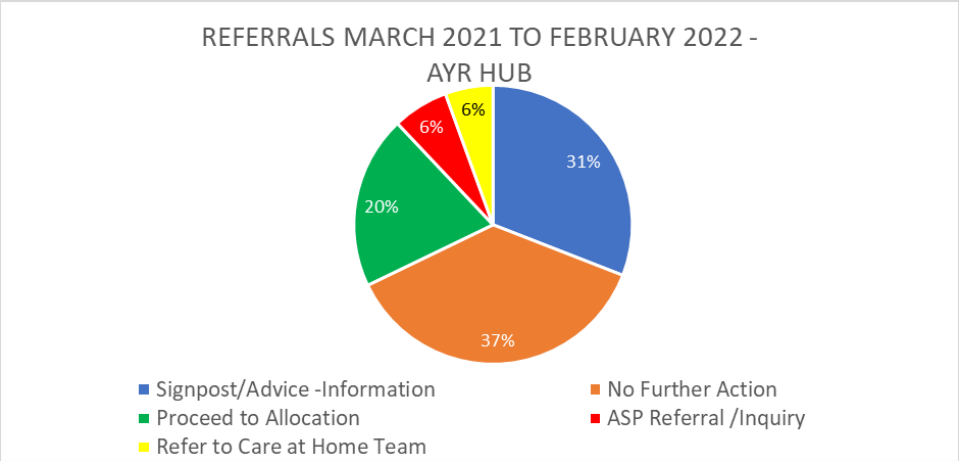
Quality Indicator and 5.2: Processes are in place for integrated assessment, planning and delivering health and care	
	Evidence Ref:
A data sharing protocol is in place across NHS Ayrshire & Arran and South Ayrshire Council that enables the sharing of information to support integrated working. Integration of digital systems across health and care remains a challenge for the HSCP and we continue to work with our parent organisations to find a way forward that will improve efficiency and experience of staff and service users. Role defined systems access requests are used to allow community health staff access to EMIS Web and additional health systems in Acute and Mental Health to assist clinicians in gaining a holistic picture of an individual's health needs and professionals involved. Some health administration staff and clinicians, depending on their specific role (e.g. Intermediate Care Team and Occupational Therapists), can access the Community Care System to view who and what care/ supports are in place to facilitate joint planning and improve service user experience by avoiding duplication. Mental Health Officers (MHO), employed by South Ayrshire Council can have 'read only' access to Care Partner (NHS case record system) of individuals that they are MHO for. Service managers who manage health and care staff have access to both health and local authority systems.	25. Information Sharing Agreement 16a. My Life My Outcomes Assessment Tool

Across adult services we have adopted the My Life My Outcomes (MLMO) framework which aims to make a positive difference to the lives of individuals and their carers and build capacity within our communities. This framework is person-centred and has a clear focus on what matters to the individual and how we can support them to live independently within the community. Social Work are the lead agency in the assessment process but also involve any key professionals involved with the individual to contribute to the assessment. Alongside this, we also have the Carers Support Plan which is offered to all carers and is supported by our Short Breaks Statement Guidance. This Guidance highlights how we are committed to focussing on the health and well-being of our carers and the importance of supporting them in their caring role. Examples of joined up working that avoid duplication and delay ensuring that people receive the right support by the right person at the right time: • Within Intermediate Care, Community Rehabilitation and Community AHP services a single point of contact (health and social care) screens referrals to ensure that the referral goes to the right team. • The use of EMIS (health system) and Carefirst (social work system) enables information sharing to identify who has been involved in an individual's care. • Weekly meetings between Intermediate Care, Community Rehabilitation and Reablement take place to discuss complex cases across teams and facilitate an integrated approach to assessment and meeting health and care needs. The teams work closely with primary care, locality and acute based teams to smooth transition into the community and prevent admission. • District Nursing keep their paper records in individual's homes where the individual, their families, carers and other health care professionals can access them. The team are in the process of moving to digital only records. • The Ayrshire Urgent Care Service (AUCS) provides an integrated pan-Ayrshire Hub delivering an out of hours response for community services including primary care, social work, district nursing and mental health services supported by local urgent care centres and NHS 24. Processes are in place to share information in timely manner with appropriate local teams following out of hours intervention or to plan out of hours support. Our Frailty Pathway work also supports an MDT approach to assessment and care planning using the electronic-frailty index to identify patients at risk and working with them and their carers to mitigate the effects of frailty in anticipatory ways. The MDT meetings around Practices (or at locality level in Girvan) allow for joined up supports to be in place. For many years most GP Practices have been aligned to Care Homes and this allows better integrated care from Primary Care and HSCP staff (such as dementia liaison, AHPs, DNs, etc). This allows strong relationships to be developed underpinning the approach to care and care planning. Our Learning Disability Social Work, Nursing and AHP teams share an open plan office and are in the process of developing a single point of contact for specialist Learning Disability services. This has improved integrated working, reducing duplication and improving information sharing. At a locality level, clinicians are aligned to localities and GP practices wherever possible. There are good examples in Girvan and Maybole where teams are co-located and meet regularly to coordinate care in an anticipatory approach. Referrals are received, discussed and allocated by the multi-disciplinary teams. Other localities are at different stages of implementation with inadequate premises and barriers to information sharing being the main challenges. Our specialist teams (Learning Disabilities, Mental Health, Addictions, Intermediate Care, Community Rehabilitation Team) also receive referrals to a single point of contact and allocate work through regular multi-disciplinary meetings. For those who are in hospital, referrals are made	16b. My Life My Outcomes Review Tool 16c. My Life My Outcomes Support Plan 16d. My Life My Outcomes Guidance 22a. Adult Carers Support Plan Guidance 22b. Adult Carer Support Plan Template 37: Short Breaks Statement 53. Project Charter - Community Response Team

through Trak (digital referral system) and triaged to be assessed by either Reablement/ Care at Home (simple referrals) or Social Work (more complex referrals). Where inequalities are identified we have taken a proactive approach with partners to address these. Wallacetown is one of the most deprived communities in Scotland and has challenges relating to mental health, addictions and correspondingly low life expectancy. People generally do not engage with services unless in crisis with associated high levels of hospital admissions. The Partnership have worked closely with education, housing, community planning, police, fire, third sector and other partners to provide an innovative and proactive approach. Services have worked together to make access to services easier and to address the causes of health inequalities such as crime, poor housing, poor environment and employment. The Partnership has provided a dedicated link worker who has a presence at the school and other community venues to help people to access the help they need. Equality impact assessments were completed for our Diabetes prevention programmes - 'Weigh to Go' Tier 2 Adult Weight Management Programme; Total Diet Replacement Project; and Diabetes Prevention Projects. The Locality Dietetic team will monitor and feedback to the project team, examples where mitigations can be improved. Our overall approach to self-evaluation, quality improvement and health and care governance supports regular review of our processes and opportunities for improvement. Reablement and Care at Home Processes have been reviewed and updated to improve efficiency in receiving and processing referrals, and reviewing care needs, to maximise reablement and care at home capacity and improve experience for individuals. Clinicians from the Intermediate Care and Frailty teams are undertaking their practitioner level Quality Improvement training and are reviewing their processes as part of their quality improvement projects. In addition, managers from across health and care meet regularly to review performance data, delays, waiting times, adverse events, and discuss concerns around access or experience e.g. Community Oversight Group, Adverse Event Group. Trends and inequalities of access, outcomes, experience are identified and targeted solutions agreed and progressed. **How have these processes supported good outcomes and experiences?** The MLMO framework promotes that a 'good conversation' is undertaken with individuals to understand the outcomes that matter to them. The assessment process consists of key questions that gather the views of the individual separate to the assessor's views. These outcomes are recorded and reviewed. For the past two years we have consistently completed over 90% of our reviews within the annual target timescale. Our support planning process clearly captures the individual's outcomes that they are working towards. At the end of the support planning process we have a feedback section which seeks to capture how well we have supported the individual through our assessment process. Within this section we ask questions based on the national experience measures and to date we have consistently scored high in these areas (further detail can be found within Section 2.1). Young people and their families are included in planning and support and are encouraged to be the driver in the plan. This empowers families and respects them as experts in their own lives. Refining processes and joint working across Intermediate Care, Community Rehabilitation, and Reablement through the Community Rehabilitation Improvement project has resulted in people being seen by the right person first through improved	42: CPP Agenda 221022 (Item 5b5 and 6) 52a-c: Diabetes Prevention Programme EIA's 33a-j: Care at Home and Reablement Referral Pathways

triage, greater understanding of roles and skills, and weekly case review. Waiting times continue to be high due to impacts of COVID and workforce pressures but there is greater confidence through peer discussion that individuals who need to be seen quickly are seen quickly. Challenges with workforce capacity across our health and care system mean that demand regularly outstrips capacity with a range of key services including Social Work and Care at Home. This results in delays in people accessing assessment, review and care support. Benchmarking shows that despite challenges being particularly significant in South Ayrshire due to geography and demography we are in line with others in Scotland when it comes to assessment and review but a significant outlier when it comes to delays in accessing care. This is despite significant service efforts to address the issues. Where people do receive care their supports are personalised as much as possible and people generally have a good care experience (see Section 2). <u>Key Area 5 – Delivery of Key Processes: Areas for Improvement</u> • Greater system-wide use of the electronic Key Information Summary (eKIS) that allows key parts of Anticipatory Care Planning to be made accessible to a range of staff at all times and places to reduce unnecessary admissions. • Recruitment and retention of staff across the health and care system.	39. APC Report: Community risks and Mitigations

Quality Indicator 5.4: Involvement of individuals and carers in making decisions about their health and social care support	
	Evidence Ref:
The principles of choice, self-determination and autonomy are set out in our ethics of care framework and the principles of early intervention and self-management in our Wellbeing Pledge. These strong, underpinning values are implicit within our Service Level Plans. The processes employed, as described in Sections 5.2 and 5.3, aim to deliver on these principles, ensuring that young people, adults, their families and carers are fully involved in the assessment and decision-making process throughout. The My Life, My Outcomes, Self-Directed Support and Transitions processes give a structure to a personalised and tailored approach to care planning. The Community Led Support approach encourages an asset based, community response in the first instance that encourages early intervention and self-management so that those who do not meet the critical criteria set for access to formal services will still receive support to meet their outcomes. Advocacy is offered where appropriate to strengthen the voice of the person and their carer during our assessment and review processes. Carer support groups can also be helpful for individuals to seek a community of support and understand their caring responsibility and impact on daily life. Advice and information is provided throughout the engagement/ assessment and review process - linked to the provision of SDS leaflets, websites and any other available leaflets/ literature. Further evidence regarding SDS is set out in Section 2. Community Led Support has been embedded throughout the Partnership. This has included training for frontline staff around 'good conversations.' With our My Life My Outcomes assessment framework we have continued to work with individuals from initial engagement through to assessment, review and support planning. Our approach is underpinned by a strength based and risk enabling approach as set out in our practitioner guidance with the aim of achieving positive outcomes for individuals. Our approach to signposting individuals toward accessible community resources is evidenced through the data we gather at our social work front doors providing a single point of access to both community-based and more formal services. On average we have good conversations and provide advice and guidance including access to alternative community resources to around 35% of the contacts we receive. **Table 4: Signposting of Ayr Hub Referrals March 2021-February 2022**	40: Ethics of Care Framework 5a: Community Health and Care Adult and Older People Service Improvement Plan 5b: South Ayrshire Adult Learning Disability Strategy 2022-2027 5c: South Ayrshire Adult Community Mental Health Strategy 2017-22 16a. My Life My Outcomes Assessment Tool 16b. My Life My Outcomes Review Tool 16c. My Life My Outcomes Support Plan 16d. My Life My Outcomes Guidance 9a: SDS Policy 2022-23 46: Planning for Moving 22c: Adult Carers Support Plan Audit 2022 13: Carers Strategic Group Papers August 2022



SAHSCP is committed to funding local grass roots organisations through small grants and participatory budgeting as a priority within our Older People Service Plan mechanisms to support them to develop supports for issues such as loneliness and isolation, transport, physical activity, dementia, mental health, family support, etc.

Utilising the cycle of assessment driven by the My Life My Outcomes and Signs of Safety approaches, we aim to identify the strengths and needs of people and their carers who use our services; and, working in a Team Around the Person, codesign support plans to meet their needs.

Our cycle of review places their voice and views at the centre. The review is crucial to ensure that we can provide the adjustments to the enable people to Grow Well, Live Well and Age Well. We promote the use self-directed support to achieve our goal of ensuring that people can assume the level of control they wish helping themselves to improve or maintain their health and wellbeing for as long as possible.

19. SPAG Report- Participatory Budgeting Locality Evaluations

These processes are universal and apply to those with a physical disability.

<u>Key Area 5 – Delivery of Key Processes: Areas for Improvement</u>

- Premises to support collaborative working within localities.
- Use of Self-Directed Support options 1 and 2 building on the good work in Learning Disability Services.
- Digital systems that help teams share information and better coordinate care.
- Improve access to assessment for people and their carers.
- Continue to develop flexible care and support services within local communities that people can easily access when needed
- Further engage carers in developing our approaches to supporting them in their role.

C.4 Key Area 6: Commissioning arrangements

Quality Indicator 6.5: Commissioning arrangements	
	Evidence Ref:
Our commissioning plans for adult services have been developed and are delivered in accordance with the National Outcomes for adults and older people as set out in Regulation as part of the provisions of Public Bodies (Joint Working) (Scotland) Act 2014. Commissioning frameworks are in place for Care at Home, Mental Health and Learning Disability. Following publication of the IJB Strategic Plan in 2021, the commissioning framework for Care at Home was updated earlier this year to reflect the HSCP's strategic objectives and outcomes as well as the South Ayrshire Wellbeing Pledge. The Learning Disability and Mental Health Commissioning Plans, originally produced in 2018, will also be refreshed over the coming months in line with the HSCP's Strategic Plan. They will be further informed by the new Learning Disability Strategy 2022-2027 which was published in 2022; and a new Mental Health Strategy which is planned for	35a-c: Commissioning Frameworks – MH, LD and Care at Home 16a. My Life My Outcomes Assessment Tool

publication in 2023. While we do not have a framework in place specifically for people with physical disabilities and their carers, each of the commissioning frameworks in place cover physical and/ or other disabilities. The Partnership's use of My Life, My Outcomes, Self-Directed Support and Transitions processes give a structure to a personalised and tailored approach to care planning and this is echoed in our commissioning arrangements to ensure providers are commissioned who can be flexible to meet all of the options offered within our self-directed support approach and individual need. We are committed to working collaboratively with all our commissioned services and providers to ensure that we continue to develop and grow a range of supports to meet the changing needs of those who use our services. To achieve this goal, we meet regularly and as necessary and we have received excellent feedback about the support we have provided to providers during the Pandemic. We will continue to build on our established working relationships with all our commissioned providers with the shared objective of delivering high-quality care and support services. We also encourage service user representation however further work is required to strengthen this. An integral part of our commissioning process involves collaborative working with private and third sector partners to ensure a focus on a preventative approach; and to take into account individuals whose needs and/ or the need of their carers require more intensive support. Within each commissioning plan financial framework, Providers are contractually obliged to pay the agreed minimum hourly rate for those staff where the Scottish Government has stipulated a minimum. Commissioned spend is regularly analysed as part of the HSCP's budget monitoring arrangements. Reports are prepared by Finance and issued to Budget Holders, with high level spend on social care routinely reviewed by the HSCP's Chief Financial Officer. The HSCP's commissioning cycle and Flexible Framework Agreement for Care and Support across Mental Health, Learning Disability and Care at Home complies with the National Health and Social Care Standards - My Support, My Life[1] and links to our own Quality Assurance Framework for Commissioned Services which was introduced in August 2021. This Quality framework sets out both the framework and the intelligence-based approach we have in place to provide assurance that our commissioned services are providing high quality care and support to those who use our services and their carers on a consistent basis; and is further supported by our Procurement Contract Supply Management (CSM) process. The majority of our providers have had an initial quality assurance review and a plan is in place to further implement the Framework across all providers. In line with the Framework, external providers are managed using a 'RAG (Red, Amber, Green) status to ensure that any providers requiring additional improvement are monitored and supported appropriately. Our quality statement of intent is, 'We consider the delivery of high-quality social care and support as a shared objective that can be best achieved by all stakeholders working together. Stakeholders include people who access services, relatives, carers, social care providers, staff delivering the service, social work staff, health colleagues, safeguarding professionals and regulatory bodies including the Care Inspectorate. Our approach will be transparent and focussed on delivering consistently high standards of care and support. We are commitment to collaborative practice and engagement with all our commissioned services, rebuilding our provider forum and having a whole system focus on continuous improvement.' Central to our approach to quality assurance is direct feedback from individuals in receipt of services. At every assessment and review we gather feedback from individuals, their families and carers around services they receive. We will also build in quality assurance visits to be carried out by our own experienced social care staff to	16b. My Life My Outcomes Review Tool 16c. My Life My Outcomes Support Plan 16d. My Life My Outcomes Guidance 9a: SDS Policy 2022-23 46. Planning for Moving On 44. Service Provider Forum Action Notes 51a-b: Confidential: Budget Monitoring Reports Mental Health, LD and SI 12a: Quality Assurance Framework for Commissioned Services 12b-d: Quality Assurance Report Examples

the residence of individuals in receipt of commissioned services. These visits will focus on the quality of care being provided, documentation and records and gather direct feedback. Any concerns noted through these visits can then be reviewed with the service provider to ensure they are meeting their contractual agreement in the delivery of the service making it safer for the service user. Collaborative working takes place as part of the Wellbeing Pledge to ensure all required agencies are aware of any concerns and can support as part of an action plan. The above Commissioning and Quality Assurance Frameworks, aim to support good outcomes and experiences for people in receipt of a service. Service users are in charge of their own care and support needs and are supported to remain at home or in a setting of their choice, safely and for as long as possible, allowing them to maintain close links to communities and people they are close to. Commissioning Officers within the Partnership have allocated portfolios allowing positive working relationships to be developed with each provider. As outlined in Section E, relationships were proven and strengthened during the Pandemic when the care sector required high levels of support to ensure the ongoing high standard of care and safety of service users under very difficult circumstances. Providers have regularly fed back how much they have valued this close collaboration and support, the benefits of which remain today. The establishment of our Community Services Oversight Group and associated Quality Assurance Framework was one of our early responses to COVID and we were one of the first partnerships in Scotland to include Care at Home and in-house services as part of these multi-professional, multi-agency oversight arrangements. The Care Home Support Team, formed to support care homes through the pandemic, continues to provide a multi-disciplinary approach to driving improvement and maintaining quality within Care Homes. As detailed in Section 2.3, the HSCP commenced the first stages of development of a Strategic Advocacy Plan in 2018. The strategy is informed by information from the Scottish Independent Advocacy Alliance (SIAA), guidance from Independent Advocacy Guide for Commissioners from the Scottish Government (2013), alongside views from the community, service users, third sector organisations, including the three advocacy organisations commissioned to provide advocacy to children, young people and adults, within South Ayrshire and HSCP staff. The strategy covers all vulnerable groups who have a legal right to be supported by advocacy. Whilst the draft version of the strategy was started late in 2018, the process was paused due to COVID with a revised target completion of June 2023. Once complete, the advocacy contract will be re-tendered. <u>Key Area 6 – Strategic Planning, Policy, Quality and Improvement: Areas for Improvement</u> • Develop a specific policy for support to people with physical disabilities to inform commissioning arrangements. • Continue to implement quality assurance monitoring arrangements with providers. • Record and evidence improvements achieved because of monitoring arrangements to identify good practice and opportunities for learning. • Improve service user representation and engagement to inform commissioning. • With providers, review contracted outcomes to improve outcome data captured.	43. CSOG BRAG Minutes

C.5 Key Area 9: Leadership and Direction

Quality Indicator 9.3: Leadership of people across the partnership	
	Evidence Ref:
A collaborative culture and shared values are promoted through our IJB Strategic plan which assimilates ambitions set out in our Community Planning Partnership's Local	1: SAHSCP IJB Strategic Plan 2021-31

Outcomes Improvement Plan, NHS Caring for Ayrshire Strategy and South Ayrshire's Council Plan. Throughout 2020-21, the IJB co-created our vision and strategy with users, carers, staff, third sector, private sector and other partners, "*to empower our communities to grow well, live well and age well"*. Our Strategic Plan 2021-31 clearly outlines how we aim to deliver on this vision to provide person-centred outcomes for those in need of support and those who care for them. Oversight of our strategic plan is provided by the IJB, Strategic Planning Advisory Group and Wellbeing Pledge Board. Leaders are committed to long term objectives as set out in our planning and performance frameworks. These ensure clarity around our planning hierarchy and improve the 'golden thread' linking our vision and strategic objectives to service level, team and even individual plans. These long-term plans are taken into account when responding to short term pressures at every level of leadership allowing creative and timely responses. Both the Adult and Older People and Learning Disability plans were revised in 2022 and work will begin on revision of the Adult Community Mental Health Strategy later this year. The Quality Management Framework Team Planning and Self-Evaluation Guidance outlines the way in which staff can contribute to the delivery of our objectives. Taking a learning, no blame approach is key to our culture. In response to some significant challenges in 2018-19 (Significant Case Review SG, Review of Kyle Day Service, Budget overspend) we have reviewed and strengthened our governance arrangements and introduced new fora where partners can collaborate to address shared challenges and ensure clear decision making (3way meeting, Budget Working Group). External audit and scrutiny identified the progress that we have made in our leadership. We have strengthened our organisational structure to provide effective clinical and professional leadership and practice development in several key areas to support our services managers team leaders and workers to embrace and identify their role and contribution to our long-term vision: - We were the first Partnership to appoint a standalone Chief Social Work Officer adding to our existing professional leadership team including Associate Nursing Director, Clinical Director and AHP Lead. These roles provide independent professional advice and leadership capacity that complement the work of the general management team. - New Practice Development Service Manager and Training and Development Coordinator posts. - Additional quality assurance capacity within the CSWO, commissioning and care at home teams. - A standalone Chief Finance Officer post. We have commissioned and implemented a number of significant service reviews including Reablement, Responder Service, Care at Home and Mental Health Officer arrangements. During 2021 there were in depth reviews of Adult Social Work and District Nursing which involved high levels of staff engagement and are in the process of being implemented and will have a major impact on the future delivery of integrated services with a focus on multi-professional, multi-agency locality-based working. A review of administration has also recently been commissioned and will conclude in 2023.	42: CPP LOIP Annual Report Oct 2022 50a: Performance and Audit Committee Agenda 300622 (Items 5, 7, 8) 50b: Performance and Audit Committee - 26 August 2022 - Health and Social Care Partnership (south-ayrshire.gov.uk) (Item 7) 5a: Community Health and Care Adult and Older People Service Improvement Plan 5b: South Ayrshire Adult Learning Disability Strategy 2022-2027 5c: South Ayrshire Adult Community Mental Health Strategy 2017-22 23a: QM Framework Team Self-Evaluation and Planning Guidance 23b. Example of Team Plan 4a: SA Governance Structure October 2022 4b: SAHSCP Organisational Structure October 2022 8: ASWL Review Report 31/03/22 45: Community Nursing Review 17: COG Report: MJ Action Plan Review 47: APC Report – LSA Rozelle Action Plan 26: OP Weekly Management Report

We respond to significant events by taking every opportunity to learn and improve. A good recent example of this has been the MJ Significant Case Review MJ and the Large-Scale Investigation related to Rozelle Care Home. Our open and transparent approach supports our integrated teams to reflect, learn and improve together. We regularly review data at team, service and partnership level; both quantitative and qualitative to celebrate success and identify areas where we need to improve. Senior Leaders within the Directorate Management Team (including Head of Community Health and Care Services) are trained in Quality Improvement to lead level and together drive a culture of improvement. Our culture of continuous learning and improvement are further informed by external scrutiny, compliments/ complaints, staff survey/ meetings feedback, case file audit etc. A good recent example of feedback being used to help drive improvement has been the Mental Welfare Commission Self-assessment and Adult Support and Protection Inspection and associated action plans. Operational oversight is provided by a range of multi-professional, multi-agency groups who work collaboratively and creatively to deliver on the changes set out in the Strategic Plan and deliver day to day quality services. We highly value the contribution of our Third Sector partners and work collaboratively with them through involvement with the Carers' Network, Locality Planning Partnership, Third Sector Forum, Independent Providers Forum and Interface with Voluntary Action South Ayrshire (VASA). The Quality Improvement Framework is part of a collection of documents which describes our arrangements for governance, planning and performance. It sets out our plan to "empower our workforce to deliver quality services supported by a culture of continuous improvement". It outlines our intention to increase leadership capacity and capability, to support delivery of our strategic objectives and our commitment to deliver high quality health and care services. To deliver on this, we have developed a new Leadership Programme for our current and aspiring leaders. We have also worked with NES to provide online improvement training modules for all of our people and our intention is to roll this out to third and independent sector partners. We are also working to establish a bespoke programme to develop quality improvement coaches and mentors. In addition to this, we are developing and engaging our leaders through regular team lead and service manager development sessions, a new induction programme and a bespoke collaborative leadership programme. Our vision and approach are reinforced through regular leadership and engagement and communications (DMT meet several times per week who in turn meet with their own teams several times per week; and SMT meet monthly), and we have increased our use of social media to share our vision, celebrate our successes and to highlight opportunities for all to engage and to seek support to improve the quality of their lives. For staff, we have introduced weekly vlogs, a 'Director's Spotlight' news feature, regular '7-minute briefing' notes, annual face to face visits etc. The 2022 iMatter staff survey report evidences that 88% of staff are very clear in their roles and responsibilities and that 85% understand how their role contributes to the Partnership's goals.	36a: Integration Joint Board Agenda 121022 (Item 5) 27: ASP Improvement Plan 55a-b: MWC Reports – ARBD/ Discharge 28: Quality Improvement Framework 29: Corporate Induction Presentation Slides 30: iMatter Directorate Survey Results

Quality Indicator 9.4: Leadership of change and improvement	
	Evidence Ref:
Change is dynamic and in the context of an extremely volatile period over the last three years, the need to provide strong, compassionate leadership has been greater than ever. Our clear vision for improvement, good structures to support it, and leaders who	1: SAHSCP IJB Strategic Plan 2021-31

are seeking to embed and enable a culture of continuous improvement have enabled us to maintain momentum around our improvement priorities. The IJB Strategic Plan takes account of national and local context and sets out the priorities for the partnership. These priorities act as way markers, enabling an agile response to emerging pressures whilst remaining focussed on our long-term goals. Within the partnership there are key approaches to leading change and improvement that align all improvement work to our strategic plan and these are set out in our Quality Management Framework: • Large scale, strategic, multi-team improvement projects are identified through our Service Level Improvement Plans and are overseen by Senior Managers which for Adult Services is coordinated and reported through the Driving Change Group to the Directorate Management Team (DMT) and IJB Performance and Audit Committee. Our approach to developing our Learning Disability Strategy and Older People Service Improvement Plan have been and celebrated locally and nationally. Both plans skilfully align to national work whilst engaging and involving local people in their development and delivery. • New projects may be progressed where sources of funding are identified or in a response to emergent risks or pressures. These projects are reported through the CHCS Finance, DMT Finance and IJB Budget Working Groups. • Smaller scale team level improvements are identified through annual team level self-evaluation. Teams review a range of information and align a small number of improvement actions to the relevant Service Level Plan. All team members should then agree personal objectives that enable everyone to contribute to the team plan. This improvement activity is reported through CHCS Governance and the IJB Health and Care Governance Groups. • Improvement action plans in response to inspection, internal or external audit and learning reviews (Case Reviews, Large Scale Investigations) have their own action plans so that they can be tracked, reported and closed against a specific report. These are reported through CHCS Governance and IJB Health and Care Governance Groups; and where appropriate, Adult Protection Committee and Chief Officers Group. Achieving good outcomes for our carers is central to our vision, and our Adult Carers Strategy outlines how we aim to deliver on our strategic priorities for carers. We have established a reference group of people who use our service to collaborate and offer feedback that enables us to provide services informed by them to meet their needs. We intend to develop this model further. As part of our re-commissioning of carers services we have developed a survey for all carers and young carers known to the HSCP to identify what they value most about services. A range of workforce development programmes have been developed to support teams and individuals engage in, contribute to and support delivery of our strategic objectives: • Our Quality Improvement Framework is in the first year of delivery and will ultimately see 15-20 people undertake lead mentor/ coach level training, 180 people undertake practitioner level training and 1500 people undertake foundation level training over a 3-year period. • A commissioned Leadership Programme for those existing and aspiring leaders and managers brings people together across the partnership to explore the personal impact of being a leader and manager. The programme has been over-subscribed with 108 people (36 existing leaders/ managers and 72 aspiring leaders/ managers) attending in 2022-23 and has been reviewed extremely favourably by attendees. Further cohorts have been commissioned for 2023-24 with spaces assigned to third and independent sector partners at each course. • Service Manager and Team Leader Development Sessions bring leaders together from across Adult Services with Strategic Leaders (IJB Chair), third sector and private sector partners and partners from other departments within the NHS and Council to focus on particular topics or areas for development.	23a: QM Framework Team Self-Evaluation and Planning Guidance 5a: Community Health and Care Adult and Older People Service Improvement Plan 5b: South Ayrshire Adult Learning Disability Strategy 2022-2027 5c: South Ayrshire Adult Community Mental Health Strategy 2017-22 34: Driving Change Agenda/ Papers Example 36a: Integration Joint Board Agenda 121022 (Item 5) 23b: Example of Team Plan 17: COG Report: MJ Action Plan Review 27: ASP Improvement Plan 54. Health and Care Governance Agenda 11a: SAHSCP Adult Carers Strategy 2019-24 28: Quality Improvement Framework 8: ASWL Review Final Report 31/03/22 45: Community Nursing Review

• Adult Social Work Review and District Nursing review had representatives from across Social Work and District Nursing within and out with the Partnership and used an evidence-based approach to make recommendations about how we do our work and £0.5m of investment in professional leadership with a focus on integrated locality working which are in the process of being implemented. • Leaders learn from research, service redesign, scrutiny reports, recommendations from external independent reports and consider how this learning can be used to deliver seamless services with good and improving outcomes for people and carers. Workforce development is a prominent and shared strategic priority and as a result staff are well placed to support the delivery of existing and developing services by maximising their skills and learning. Partners have identified opportunities to develop their workforces jointly • Strategic, service and team plans align individual objectives to the Strategic Plan ensuring that everyone contributes to the future of our services. We use data and engagement of people to identify priority areas and evidence-based approaches such as our recent use of the principles set out in Life Curve alongside our demographic projections that informed our investment in a range of services including reablement (£1m), responder service (£0.4m), Hospital at Home (£0.3m) and Ahead of the Curve early intervention programme (£0.34m). We make a strong contribution to the Community Planning Partnership in particular in the work around Wallacetown and Craigie Campus which aim to take a more proactive and preventative approach to addressing health inequalities. We are currently working with the Community Planning Partnership to agree the scope of an Aging Well Strategy for South Ayrshire. A recent report by internal auditors to the Performance and Audit Committee recognised our strong integrated leadership and robust and transparent governance arrangements, though it did acknowledge that further work is required to progress with implementing delegated hospital budgets and set aside requirements. The report also noted the specific focus on transformational change in setting budgets. Key Area 9 – Leadership and Development: Areas for Improvement • Workforce recruitment, retention and development to address the backlog of those awaiting care and to enhance our integrated response. • Management restructure to increase professional leadership capacity and our focus on integrated locality focussed work. • Consolidate improvement action plans and reporting to ensure a whole system approach when identifying and resourcing change priorities. • Further improve visibility of Partnership improvement work within the NHS and Council, building on current work to celebrate success locally, nationally and internally.	40: Ethics of Care Framework 42: CPP LOIP Annual Report Oct 2022 50b: Performance and Audit Committee - 26 August 2022 - Health and Social Care Partnership (south-ayrshire.gov.uk) (Item 8)

D: Physical Disability Practice Examples to Illustrate Impact of QI 1,2,5,6 and 9

Practice Example 1
Mr A (Mental Health)
Summary of Case Mr A is a gentleman who lives with his wife and son. His daughter lives nearby. He was diagnosed as having Huntington's disease in early 2019 and was the first person in his family to receive this diagnosis. His main carer is his wife and he is also supported by the Community Mental Health Team (CMHT) Huntington's Disease (HD) Clinic and a Specialist HD Nurse. He has received input from Speech and Language Therapists and Dieticians and has a support package delivered by Turning Point. **How our Processes Helped** Mr A has been supported throughout his journey and there is regular liaison between people involved in the delivery of his care. His wife is his main carer and also experiences mental health issues. She is also supported by the Social Work Mental Health Team, the CMHT and the HD nurse. During review of his wife's

situation, it was identified that their son who lived in the property was regularly aggressive and threatening to Mrs A. This was having a significant impact on both Mr and Mrs A and as a result a number of Adult Support and Protection (ASP) meetings took place. All services were involved in the ASP planning process which concluded with the application for a banning order to remove the son from the home. Throughout these discussions everyone was aware of not only the impact of the son's behaviour on Mr and Mrs A but there was also recognition that these behaviours may potentially be symptoms of a possible HD diagnosis. As such, great care was taken to ensure that support was equally in place for the son as well as Mr and Mrs A.

How our Approach to Commissioning Helped
Mr A is supported by Turning Point using SDS Option 2. This provider delivers support to a number of people locally who have been diagnosed with HD and our experience is that they are extremely creative in developing strategies and supports for people with HD. In addition, South Ayrshire HSCP commission Scottish Huntington's Association jointly with East and North Ayrshire HSCPs to deliver this specialist service. The support offered by the HD specialist nurse has been invaluable to the family as a whole as well as to each individually.

How our Approach to Leadership Helped
The Mental Health teams each have a team plan detailing a range of service improvements and an associated work plan. From a SW perspective this has included creating capacity to focus on case management and statutory processes e.g. ASP. These changes were possible following the creation of the new Mental Health Officer (MHO) team (following a formal review of our MHO arrangements during 2021) which has enabled separation of the workforce and allocation of work to provide greater focus on specific tasks.

What was the Impact on the People and their Carers Experience?
Tensions within the family home have significantly reduced and both Mr and Mrs A have reported an improved relationship with their son. They are able to meet up socially in a way that manages tension and ensures boundaries for acceptable behaviour are maintained.

What was the Impact on the People and their Carers Outcomes?
Due to the issues within the family home Mr A had offered to move into residential care to defuse tensions and this was avoided. Their son also acknowledged that he would never have moved out or changed his behaviours. He is now living in his own tenancy with support from SW. He is also being supported by the HD nurse to explore the benefits and costs to seeking genetic testing for HD at this time.

Good Practice Example 2

Mrs X (Older People)

Summary of Case
Mrs X attended the Emergency Department (ED) following a fall which resulted in a fractured humerus and dislocation of her shoulder. There was no medical need for admission and Mrs X wanted to return home. She was initially assessed in ED as requiring four daily care visits each day to support her at home. ED contacted the Intermediate Care Team (ICT) for advice. ICT liaised with the Reablement Team who assessed Mrs X in ED, identified her care needs and established that Mrs X did have good rehabilitation potential. ICT arranged twice daily care visits to commence that evening and set up iCare meals to start the following day, allowing Mrs X to be discharged home, avoiding hospital admission and meeting the wishes of Mrs X.

Mrs X was seen at home the following day by a Physiotherapist. A Comprehensive Geriatric Assessment (CGA) was completed and goals set. The ICT worker liaised with a family member regarding concerns around medication and as a result, her daughter agreed to fill a weekly dosette box as Pharmacy had no capacity to provide a blister pack. Her daughter was also provided with contact details for assistance in applying for benefits/ income maximisation and blue badge application which were also processed and put in place. Mrs X received input from Physiotherapy, Occupational Therapy and Pharmacy as well as a technical instructor to help her regain independence, increase confidence and return to her previous level of function. She was provided with aids and given a home exercise plan. The care was reduced to once daily after 6 days and stopped completely after 13 days.

This case highlights integrated working with various services linking up to ensure Mrs X was able to access the right service timeously, avoiding a hospital admission and a lengthy wait for a package of care. The team worked with the individual and her family members providing them with information to allow them to

self-manage and access other agencies. The home exercise and education programme, and aids and advice were provided to minimise her risk of further falls, promote independence and improve her confidence demonstrating early intervention and prevention.

How our Processes Helped
In line with the Quality Strategy to ensure safe, effective and person-centred care across partnerships, the focus was on treating Mrs X at home rather than in hospital. Partnership working between NHS and Social Work allowed access to a package of care short term to support Mrs X to be at home. Timeous input resulted in a reduction to, and then removal of care that was no longer needed - without the input of the team, care may have been required for a longer period of time. The Service Plan highlights organisational efficiency and an integrated approach in relation to service, quality and safety.

How our Approach to Commissioning Helped
ICT commissioned the care as Reablement were unable to provide care within ED meaning the patient would have had to be transferred to the Combined Assessment Unit resulting in a minimum overnight stay in hospital. The family were signposted to services that could assist with benefits, foot care needs etc – again adhering to the vision focusing on home and communities with people being supported by families. This also allowed for an integrated and seamless transition from hospital to home.

How our Approach to Leadership Helped
South Ayrshire Health and Social Care Partnership have clear objectives to ensure people can access the right care, at the right time, and in the right place. Integrated working is in place across acute and community teams to ensure timeous assessment, access to services and resources despite capacity challenges within other teams (Reablement in this instance); taking ownership of the needs of Mrs X and the impact on the whole system.

What was the Impact on the People and their Carers Experience?
Mrs X wishes were met – she wanted to be at home rather than hospital and with minimum input from services. Her family were able to support her with right care in the right place. The patient's goals were identified and achieved in a short period of time.

What was the Impact on the People and their Carers Outcomes?
Goals were set and met in partnership with Mrs X and her family. The family were able to maintain level of support to continue to meet Mrs X's needs. There was an improved outcome for Mrs X who regained her independence and function and was provided with the knowledge and skills to manage within her community with increased confidence, with access to resources if required in future.

Good Practice Example 3

AB (Transitions)

Summary of Case
AB is a young person who has complex physical disabilities due to having cerebral palsy. They have been in receipt of services from a range of health professionals since their early years to provide support, equipment and therapy in relation to their disability. Despite having a disability, AB and their parents have strived to overcome many challenges. AB became known to social work in 2007 when a moderate care package was put in place as AB was very well supported by his family. The focus of this was to provide some respite for the parents and begin to support AB to be more independent.

How our Processes Helped
In 2020 it was agreed that AB's case would transfer to our adult care team. The Service Manager from adult care led on the transition and referred to the transition policy that was already working well in Learning Disability to support the approach. This approach was agreed with the family and social workers from both teams who worked alongside each other for 6 months to support the transition and the completion of the 'My Life My Outcomes' assessment. AB fully engaged in this process and alongside this a carer's assessment was also completed for his mother. Following assessment, it was agreed that the level of care and support would be maintained at the level already in place however at AB's review in 2022 they clearly stated that they wanted to be more independent of their parents and were therefore seeking additional support which was understandable given AB's age and stage

. The adult care social worker took time to build up a positive relationship with AB and his family and used the assessment process to fully explore what mattered to AB. AB had completed their secondary education in 2019 before going to university and then employment. AB also participates in Race Running and won a gold medal for this in 2018 at the World Para-Athletic Championships.

How our Approach to Commissioning Helped
It was evident that AB led a fulfilling life and had been well supported by their family however now that they were expressing that they wanted to be more independent, additional support was agreed. AB was very keen to employ a PA and use the supports flexibly to allow them to participate within the wider community without being dependent on their parents. Our SDS policy promotes individuals having choice and control over their care and AB embraced this. AB and their mother received support from Ayrshire Independent Living Network who we commission to support individuals to employ their own PA's. This has been remarkably successful and AB and their mother can already see the benefits with AB planning trips on their own away from the family using their care and support in a flexible way.

How our Approach to Leadership Helped
The Service Manager overseen the joint working of both adult and child teams to support a positive transition for the family. The Service manager supported an introductory meeting and explained the process which was adopted from the Learning Disability Transitions Policy. The case exemplifies our ambition for people to grow well, live well and age well as set out in our strategic plan; being as independent and fulfilled as possible and being empowered to make their best contribution to society.

What was the Impact on the People and their Carers Experience?
The transition was well supported from the outset with a meeting being held with both teams and AB and his mother outlining and agreeing the approach to the transition and the adult assessment of need. AB and his mother had a very positive experience and AB has been able to fully participate in drawing up their support. AB's parents were keen for AB to receive more formal supports to enable him to be more independent and have a life without their input. As informal carers, AB's parents were beginning to feel the strain mentally and physically, they are delighted to see AB become employed and succeed in life despite their disability and they find it reassuring to know they can have a life outwith their support. As parents, they are thinking ahead, in the future when they are no longer here. This budget secured through Self-Directed Support Option 1 has been a huge step forward for the whole family.

What was the Impact on the People and their Carers Outcomes?
AB has begun to take more control of his life and utilise support flexibly to promote their independence and lead a fulfilling life outside the parental home, having used some support to recently go away on a work trip. AB's parents have advised throughout AB's life that they have never had much time as a couple as they always had to be there for AB. They are feeling reassured that this support will enable them to have a holiday together which is something they would never have considered before. The following is a quote from an email received by AB's mother, "*We would like to thank you, NH and JB for enabling AB to have the support which will allow them to live independently - at work, in study and leisure."*

Good Practice Example 4

Mr R (Learning Disabilities)

Summary of Case
Mr R has cerebral palsy, flexion contractures of the lower limbs and a moderate learning disability. He uses a stand aid for all transfers, can weight bear using handrails and is wheelchair dependent. He uses a turning circle to get in/ out his mobility car. Mr R mobilises independently around the home using his wheelchair but requires staff support outwith the home. Having worked on his upper body strength Mr R can now transfer independently from his chair to his bed using handrails.

After assessments by Occupational Therapy, South Ayrshire Council made many adaptations to Mr R's home, to allow him to be more independent. This included a wet floor shower room, lowered kitchen worktops, wider doors, and a back door ramp to allow him to access his garden and car park. Risk assessments and 6 monthly reviews of Mr R's care package concluded that Mr R no longer required his initial care package.

Mr R had moved into his current South Ayrshire Council tenancy in 2009 with 24-hour support provided by Partners for Inclusion. He required sleepover support however with appropriate assistive technology and response in place Mr R's care package was reduced to 70 hours per week in 2013. Mr R said he likes his

current home which is suited to his needs, but he would like to live in Ayr to be nearer his friends and family. He would also like to continue to be supported by Partners for Inclusion as they have supported him for 13 years and know him really well. Mr R feels in Ayr town centre he could access some resources, shops and possibly voluntary employment independent of staff support. Collaborative work with the Housing Association, Occupational Therapy, Care Provider, Care Manager and Mr R will support Mr R to achieve his outcomes in life. Through this collaborative working, a suitable property has been identified with access to the Core and Cluster housing development's events and activities.

How our Processes Helped
As recommended in the Keys to Life Policy we aim to enhance Mr R's Health, Choice and Control, Independence and Active Citizenship. This move for Mr R will enhance his mental health as he experiences a development in his confidence and independence. As resources are easily accessible, Mr R will be able to utilise activities independently of staff support and he will have more choice and control of his daily living as he will be able to manage more independently. Mr R enjoys representing people and relaying their views so it is almost certain he will be an asset to this new development and other tenants.

How our Approach to Commissioning Helped
All 4 options under SDS are offered and discussed with service users and carers. Mr R has chosen option 3 to fund his support.

How our Approach to Leadership Helped
Our Team Plan recommends that service users are fully involved in their own assessment/ reviews, how this is done is dependent on the individual person and their communication needs. This can be done on their own, with a person who knows them well (this could be family, parent, support worker) and depends on who the person feels most comfortable with. Circles Advocacy referrals can also be made, where appropriate, to ensure that the service users views are heard and recorded. Good conversations are encouraged to identify service user's needs are being met.

As recommended by the Learning Disability Strategy we aim to enhance Mr R's Health, Choice and Control, Independence and Active Citizenship. During consultations with service users, friends and family were identified as the most important thing to most people. Mr R states that this move means everything to him. He feels it would allow him to see more of his friend who lives a short distance away from the new development.

What was the Impact on the People and their Carers Experience?
The impact on Mr R's experiences will be enormous. He will be able to access local resources independent of staff support. He will have a wider range of activities to participate in with or without support. Mr R will have more opportunities for voluntary work experience. He will not always need staff to run him in his Motability car to venues or to his friend's home.

What was the Impact on the People and their Carers Outcomes?
The opportunities and experiences that the move will allow Mr R will support him to achieve his outcomes in life in areas of developing confidence, independence, good mental health and social inclusion.

E: Overall Impact of COVID

Overall Impact of COVID	
	Evidence Ref:
Overall Impact of COVID COVID had a major impact on our ability to deliver services and support people in planned ways but also required the development of new services and interventions. Despite this, and in retrospect, significant progress was made in a number of areas and in some areas the impact led to creative and flexible ways of supporting people that continues to affect longer term service planning. The following is a snapshot of key areas of impact: • Leadership In the period prior to the covid pandemic the partnership experienced a number of pressures as a result of a challenging financial position and changes in leadership. The pandemic response together with the establishment of a more confident	32a: IJB Report COVID19 Mobilisation

leadership team enabled a greater degree of partnership working. This has significantly strengthened relationships and enabled the HSCP to make a much more significant contribution to a range of partnership initiatives, Community Planning, for example.

During the early stages of the pandemic the Directorate Management Team (DMT) met frequently, with clear roles identified for each team member. The DMT continue to meet three times per week.

HSCP Senior Leaders and Managers led community-based mobilisation particularly aimed at those in most need and at most risk.

HSCP leaders worked closely with the Council, Community Planning and third/ community sector leaders to offer comprehensive supports including those that targeted people in most need (for example phone-based befriending, shielding support, access to digital supports and technology, medicine delivery, low level rehabilitation and access to information and advice). There was a very significant mobilisation of community organisations; partnership working with Council and third sector (including leadership from Voluntary Support South Ayrshire (VASA)) and the growth of new services such as Telephone Befriending, Connecting Scotland (digital support), Up and About, Living Well and lockdown related services such as medicines delivery

Strong HSCP leadership resulted in flexible and bespoke responses to those whose services were limited from house visits, garden visits, on-line supports (for example, for carers) and neighbourhood-based supports. South Ayrshire was one of the only partnerships in Scotland who increased the level of care delivered during the early stages of the pandemic. This was achieved through effective partnership working with the third and independent sector.

Despite the huge disruption of COVID, very significant progress was made in relation to longer term strategic developments such as production of a new Strategic Plan (involving a range of staff and community engagement), a Learning Disability Strategy, Sensory Impairment Strategy and Adult and Older People Service Improvement Plan. The DMT have endeavoured to take short term decisions that also support our longer-term goals although this has not always been possible and the pace of change has been adversely affected with key meetings having been postponed (a significant example being our Team around the Locality workshops which were planned for May 2020 and only took place during August 2022.)

- Access to front-line services

  Whilst core HSCP services such as Social Care, Nursing and AHPs remained in place, other services, such as Day Services became constrained and more flexible supports were put in place.

  South Ayrshire were one of the first partnerships to adapt and re-establish Day Services and day supports for those who were most vulnerable.

  Some rehabilitation services were significantly affected and different ways of offering support and advice were developed.

  New services were initiated and consolidated such as reablement, frailty related, and primary care services (such as Community Treatment and Care, Pharmacotherapy Mental Health, Community Link, Physiotherapy and OT services) and those linked to specific population groups such as Learning Disability including the development of housing options and other support.

and Response 250620
32b: CHC Learning from COVID Report

32c: VASA COVID Report

42: CPP LOIP Annual Report Oct 2022

1: SAHSCP IJB Strategic Plan 2021-31
50a: Performance and Audit Committee Agenda 300622 (Items 5, 7)
5a: Community Health and Care Adult and Older People Service Improvement Plan
5b: South Ayrshire Adult Learning Disability Strategy 2022-2027

Telephone and near me consultations and online support worked well for some service users and will continue to be used as an option to offer more choice to service users and improve access.

A range of community-based supports were developed for the shielded population including befriending services, low level community-based rehabilitation, self-management skills development and technology-based supports.

In relation to carers, reduced options for respite and day activity support has had a big impact on their lives. During COVID an on-line Carers summit tried to provide a context for senior leaders to listen and to respond to carers directly. A range of flexible supports were developed but the lack of in situ options for some groups remains a challenge, for example in dementia care.

- <u>Commissioning</u>
  There were particular challenges for commissioned services (care homes, care at home and others) and the weekly external provider forums that took place during the pandemic ensured good information flow between the HSCP and providers including ensuring Scottish Government messaging and instruction was clear and intelligible. Providers have regularly fed back how much they have valued this close collaboration and support, the benefits of which remain today.

  The establishment of our Community Services Oversight Group and associated Quality Assurance Framework was one of our early responses to COVID and we were one of the first partnerships in Scotland to include Care at Home and in-house services as part of these multi-professional, multi-agency oversight arrangements. The Care Home Support Team, formed to support care homes through the pandemic, continues to provide a multi-disciplinary approach to driving improvement and maintaining quality within Care Homes.

- <u>Communication</u>
  Underpinning all of the above was focus on communication both internal and public facing. Weekly briefings were delivered with external communication delivered through a variety of platforms including much greater social media activity. The new HSCP lead officer for communication has built upon the learnings from COVID to ensure comprehensive multi-faceted communication for a diverse set of stakeholders and audiences.

- <u>Staff wellbeing</u>
  COVID has had a very significant impact on HSCP and partner staffing both directly and indirectly. Staff have been affected by the episodes of their own (or family) COVID experience, by post-COVID issues (such as long COVID), by the impact of the lockdowns, and by general burn out and fatigue.

Whilst a range of mitigations have been put in place to support staff (helplines, wellbeing hubs, counselling, access to alternative therapies, etc) this still remains a large issue with high levels of vacancies (20-30% in some areas) and sickness absence (up to 12%). This has contributed to growing levels of unmet need with delays to accessing assessment and care for those in the community and in hospital.

44. Service Provider Forum Action Notes

43. CSOG BRAG Minutes

39: APC Report: Community risks and Mitigations

F GLOSSARY

ACRONYM	DESCRIPTION
AAIFS	Ayrshire and Arran Improvement Foundation Skills
ACSP	Adult Carer Support Plan
AHP	Allied Health Practitioner
ASWLR	Adult Social Work Learning Review
AUCS	Ayrshire Urgent Care Service
CFDT	Children and Families Disability Team
CHCS	South Ayrshire Health and Social Care Partnership's Community Health and Care Service

COG	Chief Officer's Group
CPP	Community Planning Partnership
CSOG	South Ayrshire Health and Social Care Partnership's Community Services Oversight Group
CSWO	Chief Social Work Officer
DMT	South Ayrshire Health and Social Care Partnership's Directorate Management Team
DN	District Nursing
eKIS	Electronic Key Information Summary
HARP	Healthy Active Rehabilitation Programme
HCES	Health and Care Experience Survey (2021/22 – Published May 2022)
HSCP	Health and Social Care Partnership
IJB	Integration Joint Board
LTC	Long Term Conditions
MDT	Multi-Disciplinary Team
MLMO	My Life My Outcome Assessment
NES	NHS Education for Scotland
NHS A&A	NHS Ayrshire & Arran
PAC	South Ayrshire IJB's Performance and Audit Committee
PHS	Public Health Scotland
QA	Quality Assurance
RAG	Resource Allocation Groups
SAC	South Ayrshire Council
SAHSCP	South Ayrshire Health and Social Care Partnership
SCR	Significant Case Review
SDS	Self-Directed Support
SPAG	Strategic Planning Advisory Group
VASA	Voluntary Action South Ayrshire