



# Joint inspection of adult services

Integration and outcomes

South Ayrshire Health and Social Care Partnership

Draft Report

February 2023

## Contents

PART 1 – About Our Inspections.....	3
PART 2 – A Summary of Our Inspection.....	6
PART 3 – What We Found During Our Inspection.....	10
Key Area 1 - Key performance outcomes.....	10
Key Area 2 - Experience of people and carers.....	15
Key Area 5 - Delivery of key processes.....	20
Key Area 6 – Strategic planning, policy, quality and improvement.....	25
Key Area 9 – Leadership and direction.....	28
Conclusions .....	32
Appendix 1.....	33
Appendix 2.....	36
Appendix 3.....	41
Appendix 4.....	43

DRAFT

## **PART 1 – About Our Inspections**

### **Background**

The Care Inspectorate and Healthcare Improvement Scotland share a common aim that the people of Scotland should experience the best quality health and social care. We work together to deliver programmes of scrutiny and assurance activity that look at the quality of integrated health and social care services and how well those services are delivered. We provide assurance that gives people confidence in services. Where we find that improvement is needed, we support services to make positive changes.

### **Legislative context**

The Public Services Reform (Scotland) Act 2010 places a duty on a range of scrutiny bodies to cooperate and coordinate their activities, and to work together to improve the efficiency, effectiveness and economy of their scrutiny of public services in Scotland. Healthcare Improvement Scotland and the Care Inspectorate have been working in partnership under the direction of Scottish Ministers to deliver joint inspections of services for adults since 2013.

The Public Bodies (Joint Working) (Scotland) Act 2014 sets the legislative framework for integrating adult health and social care. The aim of integration is to ensure that people and carers have access to good quality health and care services that are delivered seamlessly and contribute to good outcomes. This is particularly important for the increasing numbers of people with multiple, complex and long-term conditions. The Care Inspectorate and Healthcare Improvement Scotland have joint statutory responsibility to inspect and support improvement in the strategic planning and delivery of health and social care services by integration authorities under Sections 54 and 55 of the Act.

### **Ministerial Strategic Group Report**

In February 2019, following a review of progress with integration, the Ministerial Strategic Group (MSG) for Health and Community Care made proposals for improvement. In relation to scrutiny activity, the MSG proposed that joint inspections should better reflect integration, and specifically, that the Care Inspectorate and Healthcare Improvement Scotland should ensure that:

- Strategic inspections are fundamentally focused on what integrated arrangements are achieving in terms of outcomes for people.
- Joint strategic inspections examine the performance of the whole partnership – the health board, local authority and integration joint board (IJB), and the contribution of non-statutory partners to integrated arrangements, individually and as a partnership.

## Inspection focus

In response to the MSG recommendations, the Care Inspectorate and Healthcare Improvement Scotland have redeveloped our approach to joint inspections. Our inspections seek to address the following question:

---

“How effectively is the partnership working together, strategically and operationally, to deliver seamless services that achieve good health and wellbeing outcomes for adults?”

---

In order to address the question over the broad spectrum of adult health and social care services, we are conducting a rolling programme of themed inspections. These look at how integration of services positively supports people’s experiences and outcomes. These thematic inspections do not consider the quality of specialist care for the specific care group. They are simply a means of identifying groups of people with similar or shared experiences through which to understand if health and social care integration arrangements are resulting in good outcomes. We will examine integration through the lens of different care groups which, taken together, will allow us to build a picture of what is happening more broadly in health and social care integration and how this supports good experiences and outcomes for people.

## Covid-19

At the time of our joint inspection of South Ayrshire health and social care partnership, partnerships across the country were continuing to experience a range of significant pressures related to the Covid-19 pandemic. The impact of the pandemic on service delivery and staffing across health and care services has been extreme and unprecedented. At the beginning of the pandemic, emergency measures changed the way care, support and treatment was provided. This impacted on the ability to visit people at home during lockdown. The Care Inspectorate and Healthcare Improvement Scotland recognise that all health and social care partnerships are currently in transition from emergency response to recovery. Our inspections are not focused on examining partnerships’ responses to the pandemic, but we will make every effort to understand and account for its impact on partnerships, providers, people and carers.

## National issues and context

Some of the issues and challenges highlighted for the South Ayrshire partnership in this report are national issues that are being faced by many other partnerships.

Audit Scotland produced a social care briefing in January 2022. This highlighted that across the country:

- increasing demand has led to tighter eligibility criteria being applied for accessing care and increasing levels of need, and

- the social care sector faces ongoing challenges with recruitment and retention. This puts the capacity, sustainability and quality of care services at considerable risk.

Developing systems which support staff to work in a more integrated way is another area where there is a national challenge. This includes sharing information across and between agencies. It has been highlighted and addressed in Scotland's digital health care strategy which was produced by the Scottish Government and COSLA in October 2021.

### Explanation of term used in this report

When we refer to **people**, we mean adults between 18 and 64 years old who have physical disabilities and complex needs.

When we refer to **carers**, we mean the friends and family members who provide care for people and are not paid for providing that care.

When we refer to **the health and social care partnership**, or **the partnership**, or **the South Ayrshire partnership**, we mean South Ayrshire Health and Social Care Partnership who are responsible for planning and delivering health and social care services to adults who live in South Ayrshire.

When we refer to **staff** or **workers**, we mean the people who are employed in health and social care services in South Ayrshire, who may work for the council, the health board, or for third sector or independent sector organisations.

When we refer to **leaders**, or **the leadership team**, we mean the most senior managers who are ultimately responsible for the operation of the health and social care partnership.

There is an explanation of other terms used in this report at appendix two.

## **PART 2 – A Summary of Our Inspection**

### **The partnership area**

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). There are 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 73.6 years compared to 80 years in Troon. Public Health Scotland's South Ayrshire HSCP Needs Assessment provides a comprehensive overview of the local 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. The partnership had produced Locality Profiles for each of its six 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 South Ayrshire HSCP is in contact with citizens at all stages of life. Services delegated by South Ayrshire Council and NHS Ayrshire & Arran 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). Of people under the age of 65, 16% have at least one 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 under 65 receiving care had a complex physical disability as their primary condition.

### **Summary of our inspection findings**

The announced inspection of South Ayrshire health and social care partnership took place between September 2022 and January 2023.

In our discussions with people and carers, we received 62 completed surveys, spoke to 31 people, 13 carers and undertook three focus groups.

In our discussions with staff for the health and social care partnership, we received 250 completed staff surveys, spoke to 96 members of staff and undertook four partnership meetings with the leadership team.

We reviewed evidence provided by the partnership to understand their vision, aims, strategic planning and improvement activities.

### **Key strengths**

Most people in South Ayrshire experienced positive outcomes from the delivery of health and care services. Generally, people had a positive experience of health and social care. This was especially the case when it came to engagement with staff.

Services worked well together. This was true where there were formal integrated teams as well as teams that were not formally integrated. There were particular strengths in the approaches to early intervention and prevention. This activity was captured in robust strategic planning that set out to achieve clear and relevant goals.

We witnessed, and staff spoke of a genuine commitment of leadership for change and improvement in South Ayrshire. There were good, trusting relationships at a senior level and there was clarity of purpose for individual leaders and senior managers.

DRAFT

## Priority areas for improvement

The partnership and the people it supported were emerging from an extremely challenging period as a consequence of the pandemic. Building on learning from the pandemic was recognised as critical in ensuring people felt supported and services continued to be relevant. The partnership needed to continue making the most of the learning opportunity offered by the experience of the last few years.

The partnership had made progress in areas such as self-directed support and anticipatory care planning. However, it needed to continue building on this. We were confident that the partnership's intentions would achieve this if plans were seen through.

Key Area	Priority for improvement
1 - Key performance outcomes	<ul style="list-style-type: none"> <li>The partnership should continue to improve the capture of qualitative data as a performance measure.</li> </ul>
2 - Experience of people who use our services	<ul style="list-style-type: none"> <li>The partnership should better capture the impact of its early intervention and prevention activity on people's experiences.</li> </ul>
5 - Delivery of key processes	<ul style="list-style-type: none"> <li>The partnership should continue to focus on increasing the amount of anticipatory care plans to ensure every person has had access to one.</li> <li>The partnership should continue their monitoring and improvement of self-directed support processes.</li> </ul>
6 - Strategic planning, policy, quality and improvement	<ul style="list-style-type: none"> <li>The partnership should be responsive to provider feedback, fully reinstating provider forums.</li> </ul>
9 - Leadership and direction	<ul style="list-style-type: none"> <li>The partnership should improve processes for gathering qualitative data, ensuring it is readily available for leaders and senior managers to further inform their decision-making.</li> </ul>



**Evaluations. The following evaluations have been applied to the key areas inspected. Further information on the six-point scale used to evaluate the key areas can be found in Appendix 3. Key Quality Indicators Inspected**

<b>Key Area</b>	<b>Quality Indicator</b>	<b>Evaluation</b>
1 - Key performance outcomes	1.2 People and carers have good health and wellbeing outcomes	<b>Good</b>
2 - Experience of people who use our services	2.1 People and carers have good experiences of integrated and person-centred health and social care	<b>Good</b>
	2.2 People's and carers' experience of prevention and early intervention	
	2.3 People's and carers' experience of information and decision-making in health and social care services	
5 - Delivery of key processes	5.1 Processes are in place to support early intervention and prevention	<b>Good</b>
	5.2 Processes are in place for integrated assessment, planning and delivering health and care	
	5.4 Involvement of people and carers in making decisions about their health and social care support	
6 - Strategic planning, policy, quality and improvement	6.5 Commissioning arrangements	<b>Good</b>
9 - Leadership and direction	9.3 Leadership of people across the partnership	<b>Good</b>
	9.4 Leadership of change and improvement	

## **PART 3 – What We Found During Our Inspection**

### **Key Area 1 - Key performance outcomes**

**What key outcomes have integrated services achieved for people and carers who use services in South Ayrshire?**

#### **Key messages**

- South Ayrshire partnership was delivering positive health and wellbeing outcomes for people with physical disabilities and complex care needs.
- The Integration Joint Board (IJB) actively reviewed performance and there was an appetite for continuous improvement.
- Measured against nationally used indicators, the partnership's performance was broadly in line with Scotland as whole. In some areas it was performing better than the national average.
- Key challenges, particularly the limited availability of some services meant that some people had not experienced positive outcomes. This was partly a consequence of the Covid-19 pandemic and also challenges around the availability of social care provision.
- The third and independent sectors in South Ayrshire were contributing to positive outcomes for people experiencing care.
- Outcomes for carers were positive but more needed to be done to ensure that they were supported to look after their own health and wellbeing.

#### **People and carers supported by integrated health and social care have good health and wellbeing outcomes**

The IJB recognised the usefulness of data in establishing progress on personal outcomes and it was evident in its discussions that there was an appetite for data and its analysis. The partnership reported on local progress against the Scottish Government's National Health and Wellbeing Outcomes in its annual report. The Public Health Scotland annual core suite of integration performance indicators evidences that health and social care services in South Ayrshire were supporting most people to look after their own health and wellbeing and live more independently. The partnership was outperforming the rest of Scotland in seven out of nine of these indicators however, there were very few statistically significant differences.

**National Health and Wellbeing Outcomes:**

National health and wellbeing outcome	Inspection Finding
1	<ul style="list-style-type: none"> <li>Most people were supported to look after their health and wellbeing as much as possible.</li> </ul>
2	<ul style="list-style-type: none"> <li>Almost all people were supported to live as independently as possible.</li> </ul>
3	<ul style="list-style-type: none"> <li>Almost all people experiencing care felt they were treated with dignity and respect</li> </ul>
4	<ul style="list-style-type: none"> <li>Most people had a better quality of life because of the health and social care services they received.</li> </ul>
6	<ul style="list-style-type: none"> <li>Outcomes relating to supporting carers to continue in their caring role and to look after their own health were less consistent than outcomes for people.</li> </ul>
7	<ul style="list-style-type: none"> <li>Most people with physical disabilities were kept safe from harm</li> </ul>

**Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer.**

As part of the inspection, we engaged with people with physical disabilities who use health and social care services, and their unpaid carers. We also reviewed their health and social care records. We found that most people in South Ayrshire were supported to look after and improve their health and wellbeing.

**Outcome 2: People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.**

In almost all records we reviewed, people experiencing health and social care in South Ayrshire were supported to live independently. This was evident when we spoke to people who shared their positive experiences and to staff engaging with them. The third sector in South Ayrshire had a significant role in supporting people in the community. This resulted in positive outcomes. The partnership supported people to live more independently at home or a homely setting. This was primarily through supporting people with aids and adaptations and promoting self-management strategies.

There were challenges in recruitment and retention, primarily in the social care workforce. These were issues that were present nationally but that the partnership was addressing in relation to how it affected people's experience in South Ayrshire. The partnership was clearly sighted on this and there were different strands of work, including links to colleges, to 'grow' the workforce. This was important as gaps in

social care provision could lead to professionals having to carry out work that was necessary but not part of their core duties. This had the potential to affect people's experience of care negatively.

**Outcome 3: People who use health and social care services have positive experiences of those services, and have their dignity respected.**

People experiencing care reported positive experiences about the care and support they received from health and social care services. Care and support received from independent and third sector providers was particularly positive. This included support to be as independent as possible and to build more self-care skills. In line with the national indicators, almost all people experiencing care felt that staff from health and social care services treated them with dignity and respect. This was also reflected in the records we reviewed and the Scottish health and care experience survey. For these people, the support provided allowed them to live their lives meaningfully. They were also supported to share their views about what mattered to them.

**Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.**

The partnership was committed to delivering person-centred health and social care services and was using self-directed support across all services. This was evident in almost all the records of the people who were experiencing care that we reviewed. People experiencing care who were in receipt of self-directed support reported positive outcomes due to having choice and control about their care. However, there were a few people whose experience of health and social care services had not been as positive. They did not feel that interventions from health and social care services had improved their health and wellbeing. Their concerns related to delays in getting the appropriate support and limited information about services and support available to them.

**Outcome 6: People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.**

Outcomes related to supporting carers to continue in their caring role and to look after their own health were less positive across all indicators. This was consistent with the national indicators. Positively however, almost all the carers with whom we engaged felt that staff from health and social care services treated them with dignity and respect. From our review of the records of people experiencing care, just over half of carers were mostly or completely supported to look after their own health. Ensuring carers support plans were consistently offered would help the partnership to further understand what was important to carers. It would also ensure that they were provided with meaningful support that was right for them.

**Outcome 5: Health and social care services contribute to reducing health inequalities.**

From our review of records, services in South Ayrshire were contributing to reducing health inequalities in almost all cases. There was a range of initiatives that were targeted towards those in most need. There had been a particular focus in getting integrated services working well in the more deprived areas within South Ayrshire. However, the lack of providers across areas was a concern for the partnership. The partnership was working with the third and independent sector to strengthen provision through micro-enterprises and further education opportunities.

**Outcome 7: People who use health and social care services are safe from harm.**

From our sample of records, most people with physical disabilities were kept safe from harm. The partnership had developed a plan in response to a recent joint inspection of adult support and protection. This had led to progress in implementing the inspection recommendations.

The partnership was keen to develop its methods for collating qualitative data and there had been some notable developments. The My Life My Outcomes tool was useful for identifying what was important to the person experiencing care, although was completed by a social services worker not the person. The partnership was also gathering useful insights on how well health and social services were delivering positive outcomes through Care Opinion. This was an open-access website that encouraged people to share their stories and experiences about care. However, the partnership wished to further improve its performance reporting using qualitative data. This was important in ensuring a comprehensive understanding of performance. While senior leaders had access to good quantitative data to inform service planning and improvement, capturing qualitative data on outcomes was more challenging.

The partnership recognised that there were opportunities to build on existing frameworks in order to ensure that outcomes data was captured effectively and used meaningfully to inform service improvement. Providers reported that outcomes monitoring was built into their contracts and was also prominent in their care planning tools. However, some of the electronic recording systems required upgrading to ensure that they were effectively capturing outcomes data.

**Impact of the Covid-19 pandemic**

Comparison of the health and care experience survey results for 2022 with the results of the previous survey in 2020 shows nationally that positive responses to all questions were lower. This was broadly similar to South Ayrshire, though in a few cases responses were slightly more positive or had remained the same. In general, this indicated that levels of satisfaction with health and social care in South Ayrshire and across Scotland as a whole declined during the pandemic. In many responses, South Ayrshire was performing better than the national average, and in some cases to a statistically important level.

In South Ayrshire, the differences between the two surveys were relatively small given the scale of the pandemic's impact. This is consistent with the huge effort made by staff to maintain outcomes for most people, despite all the challenges they faced.

The impact on outcomes at key points of the pandemic was significant, either because of disruption to the level and availability of support and because lockdown also restricted activities and groups within communities that were beneficial. This meant that not only did the pandemic exacerbate many of the factors which were undermining good outcomes for some people, but it also led to increasing demand for partnership services at the same time. In the partnership, as in the rest of Scotland, the pandemic caused considerable volatility in measuring and reporting accurately on performance. The partnership successfully implemented changes and monitored their effectiveness during this period to maintain performance. The partnership's responses to support their staff during the pandemic were effective in mitigating some of the negative impacts on outcomes for people and carers. For example, some staff commented that working online led to improved communication.

### **Evaluation**

- Good

## Key Area 2 - Experience of people and carers

What impact have integrated service approaches had on the lives of people who use services and on other stakeholders in South Ayrshire?

### Key messages

- Most people in South Ayrshire had a positive experience of health and social care.
- People had particularly high regard for the way services showed respect and value and upheld the dignity and rights of people experiencing care.
- People experienced positive early intervention and prevention as a result of partnership activity,
- Most people felt they were able to access good information and advice and were supported in exercising choice and control.
- People felt that their support was seamless, even when it was primarily delivered by a single agency or was not a formally integrated arrangement.
- In areas such as transition from children's services to adult services, people had experienced very positive outcomes from services working together around the person.

Most people experiencing care described it as positive, integrated, and person led. As one carer described, there was a

---

“...strong desire from everyone involved...to make things as good as they could get.”

---

People often described different staff as having established and trusting relationships. While this was the case for a lot of people, some spoke of feeling they co-ordinated how different professionals worked around them. The partnership had well-established integrated teams for learning disability and mental health. This had led to smooth working practices, which they were building on for other services. This was important because these integrated teams were considered to be strong on proactive, rather than reactive approaches. Replicating this work elsewhere had the potential to improve people's experiences more widely.

Most people described support as having improved their quality of life. This was higher than the national average. In particular, people with experience of the transition from children's services to adult services were almost entirely positive. This was especially in relation to how services, across social work, health and the third sector, had worked together to support positive outcomes. The success of transitions work had been recognised by those involved as a good model to be promoted. Some people felt that using self-directed support to increase their level of choice and control had improved their quality of life.

People talked about support and how it enabled them to continue living at home. Generally, services were set up and in place when people needed them. Aids and

adaptations were usually put in place when people required them, or when, for example, they were moving home or were being discharged from hospital. A small number of people described having to wait however. These delays were sometimes because of demands on occupational therapy services exceeding the capacity to immediately respond. Other areas of support, such as dietetics were quick and comprehensive in their response to need.

People and carers told us they were routinely encouraged to consider and build on their own assets and strengths. Staff we spoke to echoed this and the care planning tools in use encouraged this. Physiotherapy in particular was highlighted as an area where people were encouraged towards self-management. This also provided long-term benefits for people as a preventative support. Not everyone we spoke to felt they had written guidance to support them in self-management but knew where to go to, to resolve this.

Carers were encouraged and supported to continue caring, if that was what they wished. Many carers said that they were happy with the support and care they and their cared for person received. Although some carers did not have an adult carer support plan in place, they did feel involved in and part of the team that was supporting their cared for person. Some carers also said that they had been involved at all levels including service reviews and that staff understood their role as a carer. Generally, carer experience was positive and helped them to continue given the demands of the caring role. For some carers their cared for person did not always have consistency of care staff. This was not ideal and viewed negatively. Some carers also said that respite was not always available or sufficient to meet their needs.

There were various established ways for people experiencing care to give feedback. This was built into the My Life My Outcomes tool, used for assessment and care planning. Care providers routinely encouraged feedback in line with their requirements as a registered and contracted service. The partnership had implemented audits of carer experience prior to the pandemic. These had now restarted properly and sought feedback in a very personalised manner. Overall, the partnership had a number of routes open to people to give feedback, which it publicised. Critically, the partnership understood that to get full feedback and engagement relied on them being proactive. This meant ensuring there were meaningful routes for all people to give feedback.

Almost all the people we spoke to described how they felt listened to and treated with dignity and respect. It was commonplace in our conversations with people to hear the words 'kind' and 'respectful' being used to describe staff. The partnership had also received some of this feedback at Carers' Day events and through other engagement activities.

People experiencing care were generally positive about how services supported them to continue to live at home and participate in their community. Some people did not require ongoing support to continue living at home, after effective timely, initial interventions. People we spoke to in care homes or supported living also spoke positively about their support. They described how it was delivered to encourage them to remain independent, and also to promote choice and control.



## **People's and carers' experience of prevention and early intervention**

Many people experiencing care felt that early intervention had played an important part in maintaining or improving their quality of life. Some of this had been directly from health and social care services. People experiencing care also highlighted the role that wider community resources played, and how all these supports linked to each other. A number of successful initiatives had focused on proactively tackling physical frailty and ill-health, including the Ahead of the Curve initiative and a well-established Canadian model for occupational therapy early intervention.

People told us of activities supported by third sector organisations. These were easy to access and had minimal eligibility criteria. These typically involved monitoring of a long-term condition or engaging in physical activity, relaxation and activity groups and classes. People said these groups were helping them keep well and active. One person said they felt 'fitter, more calm and better about themselves' as a result.

Some people had also received early intervention and prevention services directly from partnership staff. This included help to manage their finances, advocacy, and counselling for mental health and wellbeing. The role of assistive equipment and housing adaptations, information from GPs and general advice was also cited. For example, one person said they had had three episodes of early intervention in one year - these had prevented their condition from deteriorating.

Many people told us of being supported to develop self-management skills as a means of prevention. This was important as it enabled people to maintain or improve their wellbeing, before services were involved.

It was routine for the partnership to promote independent living, for people with physical disabilities, through early intervention and prevention. Different therapeutic supports, such as occupational therapy and physiotherapy were commonly in place to support people moving house or being discharged from hospital. Similar services were provided at the Douglas Grant Rehabilitation Centre, where there was scope to test out and assess different forms of equipment with professionals on hand.

## **People's and carers' experience of information and decision-making in health and social care services**

The partnership had made a significant commitment to providing information through its web and phone directory South Ayrshire Lifeline. This was an easy-to-use resource that offered a range of information for people experiencing care. This had been accessed over 100,000 times in the twelve months prior to the inspection. In general people experiencing care said they were able to find information that was helpful to them. Some people and carers said they had good information and advice about the cared for persons' health and care needs. This included broader advice about how to support people as a carer, such as advice on benefits or adaptations. The partnership recognised a need to ensure information and advice was continuously reviewed and refreshed to ensure accuracy. This was important as the pandemic had led to significant changes to many aspects of people's lives and also to services. A few people and carers said that they did not find the information that they wanted or needed easily but this was a small minority.

Some people enjoyed the choice and control available from self-directed support. This was not the case for everybody. Others found it difficult to understand and navigate self-directed support. The partnership had also taken a very positive step in agreeing to implement the draft national standards for self-directed support. A major element of these standards relates to the experience of people engaging with self-directed support. This was positive as it offered the opportunity to empower people in exercising choice and control.

Overall, most people experiencing care said that they were supported to make meaningful decisions about the care and support they received. Staff across agencies consistently listened to, understood and respected the opinions and views of people and their carers. Some people commented that care providers went 'above and beyond' to ensure that people they support were able to make meaningful decisions about their care and support. Reviews were taking place regularly for most people, either six-monthly or annually. People and their carers felt able to express their views at these and so exercise choice and control over their care arrangements.

Most people experiencing care said that their informed choices were always respected by the staff supporting them. The partnership was keen that this was the case for all. The use of the My Life My Outcomes tool contributed to capturing what was important to people. Although relatively new at the time of inspection, it was effective in supporting personal outcomes.

### **Good Practice Example**

'Ahead of the Curve' work was an initiative that supported people over 18 at earlier and moderate stages of frailty. It encouraged self-referrals locally through GP practices. It used goal setting, self-management and other methods to provide support that complements formal partnership services. The partnership ensured services were brought closer to people by siting them in local GP surgeries. These included a wide range of disciplines and therapies. Through this the partnership has established effective multi-disciplinary working. Doing this proactively identified who may require but was not yet accessing support. As a result of this work people had already experienced and demonstrated improvements in a validated functional measure

### **Impact of the Covid-19 pandemic**

The pandemic had had a significant impact on service delivery. Despite this, most people were keen to talk about how they experienced services in the here and now. Services had been stretched during the pandemic and some were still in recovery. People consistently talked of feeling well-treated by services. There was not the same consistency yet when it came to exercising choice and control or accessing information.

**Evaluation**

- Good

DRAFT

## Key Area 5 - Delivery of key processes

### How far is the delivery of key processes in the South Ayrshire partnership integrated and effective?

#### Key Messages

- Early intervention and prevention approaches were well-developed and supported by good-quality, accessible public information. There were multi-agency initiatives to promote this agenda.
- Staff were confident and clear about using asset-based approaches.
- Key Information Summaries (KIS) were widely embedded in health records and supported services to work in a seamless way with people.
- Staff worked in an integrated way despite some being frustrated at working across different IT systems.
- People were involved in decision-making; Staff demonstrated an empowering attitude committed to shifting choice and control.
- Self-directed support was embedded as an approach. This enabled people to enhance the quality of their care.
- Challenge around recruitment and retention had a negative impact on delivery of services, particularly in relation to social care and the full range of self-directed support options. Positive steps had been taken to address this.
- Where adult carer support plans were in place these were of high quality

#### Processes to support early intervention and prevention

The partnership had a very positive approach to early intervention and prevention. It recognised it as integral in achieving the strategic objectives set out in its strategic plan. Early intervention and prevention were at the heart of its Wellbeing Pledge to the people of South Ayrshire. This was demonstrated in a number of initiatives and services. For example, the Ahead of the Curve programme supported early intervention and self-management. It encouraged self-referrals so that people had conversations with professional staff. These conversations identified what the person could do in order to maximise and maintain independence. Dedicated staff were based in localities and undertook outreach work to promote self-referral. These staff also worked with GP practices to educate them about services available to people for rehabilitation and encourage self-management.

Frontline staff told us they were increasingly having better conversations with people awaiting assessments. This meant people experiencing care were discussing early intervention and prevention, to improve, maintain or reduce deterioration in health and wellbeing. The partnership's enablement team had been using an improvement framework to be more proactive in supporting positive outcomes for people. This approach was multi-disciplinary and fostered good relationships across services, especially the link between hospitals and community-based care.

The partnership had carried out a great deal of work to ensure Key Information Summaries were robust and useful. It was seeking to do similarly with anticipatory care plans, building on current good practice to ensure these were all of a high level

of quality. The number of anticipatory care plans had increased in the last couple of years. There was however still some work to ensure everyone who was entitled to one had been offered one. This work was being carried out through a model of whole-system intervention, where an intensive, integrated approach was used for improvement.

The partnership had a trained practitioner who was able to advise staff from different sectors on Trauma Informed Practice. This was positive in furthering staff knowledge and understanding of the potential and different impacts of trauma. This enabled it to offer more appropriate forms of early intervention and prevention.

The Healthy Active Rehabilitation Programme (HARP) was an integrated service, led by health staff. This has a four-tier model, dependent on people's level of wellbeing. The programme had a focus on enabling people to improve their wellbeing and self-manage long-term conditions. People were able to move between the tiers, depending on needs and wishes. At one end of the spectrum there was general health advice for example about how to eat more healthily. This extended to how people could more fully self-manage long-term conditions such as diabetes. Importantly, people could join the programme without the need for a professional referral. People were then directed to the appropriate tier or group. The partnership had undertaken evaluation work on the programme which generated positive feedback from people. This model had been published in clinical journals. It was also 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.

These services had robust indicators in place to measure their impact on people's lives. The partnership had identified that it was difficult to measure the impact of not having these services in place. This was something they wished to address and were actively considering how to do so. Partnership leaders highlighted the potential for learning from other areas as well as a more qualitative or academic research approach.

### **Processes are in place for integrated assessment, planning and delivering health and care**

Health and social care integration in Scotland means that services feel integrated from the point of view of people experiencing care. People and carers should experience services that are as seamless as possible. The delivery of integrated services partly depends on effective coordination of a range of the partnership's processes. These include access to and assessment, planning and delivery of health and social care across different systems and processes. For example:

- Community health services delivered by NHS staff
- Social work and occupational therapy delivered by local authority staff
- Social care provision delivered by staff working in the statutory, third or independent sector

The My Life, My Outcomes tool was designed to promote an asset-based approach and focus on personal outcomes, as well as considering risk enablement. This supported staff in working in an outcome-focused fashion. This process was seen as positive in involving people and carers to identify what was important to them. As this was a general social care assessment tool, it sat alongside more episodic recording tools used by health colleagues. Partnership managers and staff spoke about the frustration from not having one single IT system. At the same time, they pointed out that one system would potentially be unwieldy. They also highlighted as a positive that different systems increased the amount of direct contact they had with other professionals. Staff told us this led to effective communication. This demonstrated the importance of sound culture and practice in delivering the goals of integration.

The partnership had an integrated sharing information policy in place, which was clearly robust and effective. It had also appointed a digital transformation manager just before the inspection. Their role was intended to oversee improvement in service systems, process and delivery for the partnership.

The partnership was enhancing the delivery of integrated services at a local level. At the time of inspection, it was recruiting to three new locality manager posts. These posts represented a significant investment and were aimed to ensure integrated work supported positive outcomes for people. The focus on improvements to local service delivery had been driven by senior managers. They had brought together multi-disciplinary staff groups and third sector organisations to identify improvement. Fully integrated, co-located working was already taking place in the Girvan and Maybole localities. This involved multi-disciplinary meetings and planning for specific individuals and their care and support. Feedback from senior managers, managers and staff was that this was significantly improving their capacity to deliver timely, integrated care.

In our review of records and in talking to people identified workforce challenges, particularly in social care capacity. The partnership was addressing this in a number of ways. There was a lot of emphasis on community partnership, in particular the further education system, as one part of the solution. The partnership was also supporting the development of micro-enterprises to create positive opportunities for working in the care sector.

Adult carer support plans (ACSP) were being carried out and had markedly increased in number over the last few years. The partnership was keen to ensure this growth continued. Staff told us they felt that the original ACSP format was not outcome-focused enough. They had fed this back to managers. As a consequence, the Carer Strategy Implementation Group was reviewing and improving the ACSP format. The ACSPs we read were all of good quality.

Reviews were taking place in almost all of the cases we saw. These were usually led by a single agency with collaboration between the providers, health and social care to share appropriate information. The review meetings we read about were led by a single agency just under half of the time (46%). Review meetings that were co-ordinated and shared, or fully integrated, also made up just under half of what we read (40%). People and carers were able to contribute to the review process and

any changes arising. In almost all cases we evaluated integrated reviews had not missed any opportunities to improve people's outcomes.

### **Involvement of people and carers in making decisions about their health and social care support**

People were involved in making meaningful decisions about the nature of their care and support. Often this meant involving other people who had legal powers to speak for them. In other examples it involved the use of communication devices and technology. These requirements were clearly set out, understood by staff and supported people and carers to be heard.

Staff were confident in talking about risk. Risk assessments were carried out with people on a regular basis although these were often single agency. This was often the case where there was a particular task or programme of tasks being carried out as part of rehabilitation. Provider service risk assessments were shared and used at reviews to inform how to continue to meet outcomes. This contributed to an integrated approach to risk management.

Health and social care staff were confident and clear about using asset-based approaches. We found examples of this when we reviewed records and when we talked to frontline practitioners. We were confident that this was an area the partnership demonstrated real commitment to.

People in South Ayrshire were able to access all the self-directed support options. Self-directed support makes four options available to people experiencing care:

- Option 1 is where the person receive money to pay for support themselves (also known as direct payments).
- Option 2 is where the person directs the support.
- Option 3 is where the local council arranges the support.
- Option 4 is a mix of the previous three options.

While option 3 remained very popular, there had been growth in the use of other options. Most staff understood their role in facilitating this, although some were less confident, due to unfamiliarity with the process. The partnership was committed to ensuring self-directed support was at the heart of how services were offered. The resource allocation process had been adjusted a few months before inspection to ensure different options were treated consistently. It was not particularly the case that the process was transparent to people experiencing care. This was an important area to consider, as transparency engenders trust and confidence. This was supported by some of the staff we spoke to. They also said that the resource allocation system could be time consuming and bureaucratic and not always transparent. However most staff said that they found these processes straightforward and just prior to inspection the partnership had streamlined its processes around allocating resources following assessment. There were some challenges around full implementation however. These particularly related to the recruitment of personal assistants, especially in the more rural and remote areas of South Ayrshire. Steps to address this formed part of the broader work at addressing workforce recruitment and retention.

With regard to carers, staff we spoke to felt they had a clear and shared understanding of carer needs. Importantly they were able to talk about how the needs of carers and cared-for people interacted often in a complex fashion. This was important in ensuring services met their duties under carer legislation.

### Evaluation

- Good

DRAFT



## Key Area 6 – Strategic planning, policy, quality and improvement

### How good are commissioning arrangements in the South Ayrshire partnership?

#### Key messages

- The IJB had published a comprehensive strategic plan which actions to improve outcomes for people and a focus on early intervention, prevention and tackling inequalities.
- The plan described a continuing dialogue with the community and partners. Providers were positive about their relationship with the partnership but highlighted the full reintroduction of forums as a desired improvement.
- Some providers had also highlighted concerns about funding levels for services, when set against different funding levels in other parts of the country.
- The commissioning intentions contained within the plan demonstrated that the IJB had an integrated approach to strategic planning and commissioning.
- The partnership did not have a specific commissioning plan in relation to physical disability but all their other plans covered elements of this.

#### Commissioning arrangements

The IJB had developed a ten-year Strategic Plan 2021-2031. This set out a comprehensive agenda to improve outcomes for people across health and social care. The plan described 86 actions to support achievement of strategic objectives. The IJB had also developed a Strategic Plan, running until the end of 2022. This acted as a bridge and reflected changes and learning within health and care services resulting from the pandemic.

The Strategic Plan had a clear focus on early intervention and prevention. It included strengths-based approaches to reablement and self-management across the whole system. Overall, the Strategic Plan also outlined a significant range of community-based services and approaches to support health and wellbeing. The commissioning intentions of the plan applied to a wide range of health and social care functions, activities and services. These fitted comfortably with the partnership's vision and strategic objectives. This demonstrated that the IJB had an integrated approach to strategic planning and commissioning.

Within its Strategic Plan the IJB wanted to continue to improve its approach to commissioning by building on trust and collaboration with its providers. Doing this was important as it enhanced the quality of care and generated best value from contracts. The partnership had sought to revise its community engagement strategy for people and communities. This had been delayed by the pandemic. These were supported by a flexible Framework Agreement for care and support provision. This, in turn, was underpinned by a Quality Assurance Framework.

The IJB had developed a specific strategy for carers 2019-2024. The strategy had been developed in collaboration with carers and the organisations that support them. The partnership had used several methods to engage with both carers and wider

stakeholders. These included an engagement event to identify priorities, an online survey, and consultation with managers and staff across all sectors. A Carers Reference Group had also contributed to formulating the strategy. An implementation plan for the strategy was in place, although the pandemic had an ongoing effect on priorities and goals. A number of priorities and goals had been achieved prior to Covid-19 and were subject to annual review to ensure there was no slippage. Priorities which had been delayed were now being addressed.

A Quality Assurance Framework for the delivery of care and support was in place. This had made a positive impact in terms of identifying issues. Almost all commissioned services had an initial quality assurance review. A RAG rating was used to ensure that any providers requiring additional improvement were supported and monitored. Contractual arrangements were structured around providers meeting outcomes and delivering high quality services in line with the national Health and Social Care Standards. Almost all registered services were performing at a level of adequate or above. A number of key services we met were performing at a level of good or very good. Care Inspectorate regulatory staff highlighted that the partnership was supportive to providers who were experiencing difficulties with service provision.

The recording of Quality Assurance visits was important to ensure consistency and accurately reflect actions and recommendations. Managers were working to maintain and improve the quality of recording of these visits. The partnership had also identified an opportunity to promote self-evaluation of performance and quality by its providers. This was important as validated self-evaluation encouraged shared accountability and better collaborative working.

The partnership had made a commitment to working collaboratively with providers in both the management of contracts and the development of future commissioning. The partnership had a contracts and commissioning team responsible for developing the operational protocols. These protocols allowed for effective coordination and management of contracts in accordance with national procurement legislation. Commissioning officers had their own caseload of providers which allowed positive working relationships to be developed. The partnership had recently invested in new posts to increase capacity. This included additional business support officers to support the quality assurance framework. Some providers had expressed concerns about the sustainability of funding levels, specifically hourly rates paid for care and support services. Providers working across more than one partnership area spoke of their other services effectively subsidising their work in South Ayrshire. This was a source of pressure for the partnership. It had recently absorbed a significant amount of service provision from external agencies. While this guaranteed service delivery for people experiencing care, it had created significant and unplanned financial costs for the partnership.

Facilitated providers' forums had existed prior to the pandemic. These had been paused and had not fully restarted at the time of inspection. Providers spoke positively about their relationship with the partnership but felt the forums had provided a useful and helpful means of sharing experiences and giving collective feedback. They were keen that the forums were re-established. A particular positive

however was the trust and collaboration that had built up from 1:1 engagement during the pandemic. Providers did express concerns about the development of a National Care Service and the implications for them and the partnership. Senior managers in the partnership were aware of these concerns and the importance of ensuring good relationships continued, based on trust and collaboration.

### Evaluation

- Good

DRAFT

## Key Area 9 – Leadership and direction

### How has leadership in the South Ayrshire partnership contributed to good outcomes for people and their carers?

#### Key messages

- The partnership had a clear leadership structure, working to deliver a concise vision, supported by relevant principles and values.
- This clear leadership structure supported the partnership in meeting its strategic objectives, as outlined in its strategic plans.
- There were robust links between these objectives and day-to-day operational activity, with sound governance built in.
- There was very strong evidence of a commitment to improvement activity and collective ownership of change.
- There were good examples of the partnership's approach to self-evaluation and self-assessment. This gave a solid foundation for ensuring this was consistent, maintained and used for improvement across all services.

#### Leadership of people across the partnership

The partnership had a clear and concise vision, underpinned by relevant values and principles. This clearly informed the strategic objectives of the partnership. Operational and improvement work within the partnership connected neatly to this framework. This made it straightforward to understand the direction of the partnership.

This approach was laid out in the partnership's strategic plan and associated documents which provided more detail about how the vision would inform service delivery and service development. Leaders had taken care to ensure that their approach was built on talking and listening to people who wished to contribute to the discussion and planning around what services looked like. This had included directly contacting people in localities to seek out their views. This supplemented more traditional forms of engagement such as surveys and public forums. It was also clear that leaders saw service delivery and service improvement as being an integrated approach.

The partnership was effectively managing its finances. It was projected to perform within its 2022-23 budget, while maintaining reserves of around 10%. The partnership had consequently allocated some additional monies from 2022-23 towards a number of preventative and early intervention measures. Specifically, this included investment in multi-disciplinary services that should reduce readmissions and facilitate safe hospital discharge across all age groups. This included 15 intermediate care places and recruitment of dedicated additional social work staff

It was also evident that the partnership valued the importance of professional and clinical leadership. There were robust approaches to reinforce the connection between the various disciplines and the overall direction of the partnership. The partnership had a health and care governance group, involving key professional leads and senior managers. This brought clinical and care leadership and

governance issues to one forum. This was helpful in identifying cross-cutting governance and professional leadership themes. It also strengthened senior officers' understanding of the work of their peers.

The impact of the Covid-19 pandemic had brought about significant challenges in leading health and social care. This included developing working protocols across all services to minimise the spread of the pandemic. Further problems included the capacity to maintain essential services in the face of increased staff absence due to Covid-19 and shielding. There had also been challenge in the work of leading the partnership out of the pandemic, into a different environment from the one that existed pre-pandemic. This impacted on the leadership team as a whole. The commitment of leadership to delivering change for improvement meant they were well-placed to manage the impact of the pandemic.

There was widely shared positive regard for the leadership team. People experiencing care who engaged in networks or forums, spoke about the visibility and accessibility of leaders. Similarly, staff spoke positively about the visibility and approachability of leaders, while acknowledging that there were limitations on their availability. Of note was how the leadership team ensured visibility with staff working in remote locations, working from home or hybrid working. Many staff told us they appreciated the video blog, set up and used by one senior manager to share information and developments with the workforce.

The partnership had robust arrangements in place for workforce planning. A three-year plan had been prepared and submitted for 2022-25 in line with Scottish Government guidance. The partnership plan was linked to NHS Ayrshire and Arran, and South Ayrshire Council's workforce planning. The plan provided a comprehensive analysis of the current workforce and projected demand. It identified detailed actions to be taken over a three-year period as well as actions to be taken by the end of 2022-23. Some of the longer-term actions had yet to be allocated and this was acknowledged in the plan, with the partnership actively engaged in addressing this.

The partnership had undertaken a training needs analysis for staff and identified areas for development. Its particular focus was ensuring staff were and felt equipped for their role. Where relevant, training was delivered on an integrated basis, inclusive of third and independent sector providers. Evaluation was routinely carried out to see if training outcomes had been met and where improvements could be made. Improvements had also been made to the partnership's arrangements for professional support and supervision of staff. This made it more meaningful and linked to quality assurance. Audits and action plan reporting were routinely carried out to evaluate the quality and frequency of professional support.

Care and support providers highlighted the improvements in the clarity of message from the leadership team over the last few years. They spoke very positively about the flexibility and collaborative mindset shown by the partnership during the pandemic. This was demonstrated in ensuring there were clear channels of communication and a pragmatic and practical mindset around service delivery.

Partnership senior managers were clear and compelling when they spoke of the value of third and independent sector supports for people.

The leadership team's engagement with the IJB was robust and effective. IJB voting members expressed confidence in the officers reporting to them and there appeared to be good working relationships present. At the same time, it was clear that the IJB voting members took their role seriously in holding the work of the partnership to account. This was demonstrated by robust interrogation of performance data, service feedback and service planning and delivery.

### **Leadership of change and improvement**

There was a very pronounced focus on improvement planning and activity within the partnership. This was evident at all levels.

The IJB and its Performance and Audit Committee were particularly sighted on change for improvement, and what they could do to encourage this. Both bodies received regular briefings and updates from officers outlining progress and subjected them to robust scrutiny. There was significant attention paid to how the improvement work supported the strategic objectives of the partnership. While this felt thorough, there was acknowledgement that the partnership could develop its scrutiny of this work further, by looking to make more use of qualitative data.

The partnership had also carried out an adult social work learning review and was addressing its findings. This included promoting the role of social work within integrated services. This was important in ensuring that people felt different services fitted around them, rather than them having to fit into services. It also included work to better-publicise its complaints system. The partnership had made a major commitment to developing and implementing a framework for quality improvement that made improvement work a core element for all staff, tailored to their level. This reflected a visible commitment from leaders to ensure continuous improvement and ensure the partnership was equipped to rise to the challenges it was facing currently and may face in the future.

Implementing this framework was an ambitious step. Not all training had been completed at the time of inspection, but genuine and meaningful progress had been made. We were made aware of examples of how the framework had already been used in different service settings to successfully drive improvement. This included using the framework to put in place a model of practice between hospital and community physiotherapy and social care. This was to support work to reduce avoidable readmissions. Another example was the implementation of an enablement approach involving occupational therapy and social care staff. This was designed to improve self-management and reduce people's overall need for care. Importantly, the staff we spoke with were very positive about working within this improvement framework. They understood the framework's purpose and their role in ensuring improvement and were enthusiastic about it.

The partnership also sought to find improvement through other means. It had employed tools such as 'Whole Systems Improvement' to drive change in some

service settings where there was complexity and interdependencies for example in acute hospital settings.

This reflected a theme in the work of the partnership, where it was not wedded to one approach or system. Instead, it employed different tools as required, albeit all within the framework of its vision and strategic objectives. This was apparent in the work of the Driving Change group. This was a monthly forum, that sought to share experience and practice across the range of improvement activity. Doing this allowed the partnership to see whether there was scope for different pieces of work to benefit others. This group was also able to capture the various elements of change taking place. What bound them together was their natural fit, within the vision and objectives of the partnership, to support positive outcomes. This was important because it ensured that partnership activity met integration principles.

This meant there was a structured approach to improvement, working to ensure a number of specific goals were achieved before moving onto another set of specific goals. These changes and improvements were derived from the priorities of the Strategic Plan. The Strategic Plan had been developed by the partnership to reflect other higher-level and related plans. These included the Community Planning Partnership's Local Outcomes Improvement Plan, NHS Caring for Ayrshire Strategy and South Ayrshire's Council Plan. Ensuring the right changes were implemented at the right time was crucial. For example, the partnership had created and was recruiting to new locality manager posts. Having officers in these posts, with clear delegated authority, would allow them to implement and drive future change.

The pandemic had undoubtedly had an impact on how the partnership worked to deliver change and improvement it. It was noticeable however that there was an appetite to take learning from what had worked well. This was important as it gave the opportunity for the partnership to evaluate what could also be effective post-pandemic.

### Good Practice Example

The Driving Change Group met monthly, with its meetings chaired by the Head of Community Health and Social Care. Its purpose was to draw together all of integrated improvement activity. It also identified potential opportunities of cross-fertilisation of ideas. The Driving Change Group reported to the IJB and partnership senior management team. It was described by those involved as having an integral role in capturing the range of 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.

## Evaluation

- Good

## Conclusions

The South Ayrshire health and social care partnership had faced significant demands in recent years. It managed high levels of deprivation alongside an already high and growing population of older people. The impact of Covid-19 pandemic in conjunction with these existing pressures had given the partnership major challenges to address.

We found that South Ayrshire was performing well on key outcomes. On many indicators they were better than the national average, and in a few of these there was a statistically significant positive difference. This showed to us that despite the challenges faced, they were performing well. People experiencing care spoke very positively about the regard they were held in by staff working for the partnership and the third and independent sectors. Most people experiencing care had positive experiences of accessing support and using services. Some people had experienced positive outcomes in this regard and addressing this was important for the partnership to continue improving.

In delivering its processes we found good examples of integrated working, but this approach was not fully realised. Nevertheless, this had not stopped the partnership from supporting positive outcomes for people. The partnership was sighted on where integrated systems were working and how that could successfully be replicated elsewhere. Overall, it was clear that professionals saw themselves as working towards common aims, regardless of the organisation that employed them. This was all informed by a clearly articulated vision and sense of purpose and values. These spoke to all health and social care services and informed strategic objectives. There were clear links between operational planning and delivery, and overarching strategy. A number of partnership managers and staff spoke about this as being a 'golden thread'.

Leadership of health and social care had significantly evolved since integration legislation was implemented. A number of newer leaders and senior managers were in place and had established their clear vision for services. At the heart of this was a determined focus and commitment to continuous improvement. This recognised that change had been required and would continue to be required to address current and future challenges. We had confidence in the approach the leadership team were taking to manage a complex and evolving landscape.



## Appendix 1

### Inspection Methodology

The inspection methodology included the key stages of:

- Information gathering
- Scoping
- Scrutiny
- Reporting

During these stages, key information was collected and analysed through:

- Discussions with service users and their carers
- Staff survey
- Submitted evidence from partnership
- Case file reading
- Discussions with frontline staff and managers
- Professional discussions with partnership

The underpinning Quality Improvement Framework was updated to reflect the shift in focus from strategic planning and commissioning to include more of a focus on peoples' experiences and outcomes.

### Quality Improvement Framework and Engagement Framework

Our quality improvement framework describes the Care Inspectorate and Healthcare Improvement Scotland's expectations of the quality of integrated services. The framework is built on the following:

- The National Health and Wellbeing Outcomes Framework. These outcomes are specified by the Public Bodies (Joint Working) Scotland Act 2014 to describe what integrated health and social care should achieve. They aim to improve the quality and consistency of outcomes across Scotland and to enable service users and carers to have a clear understanding of what they can expect.
- The Integration Planning and Delivery Principles. These are also specified by the Public Bodies (Joint Working) Scotland Act 2014 to describe how integrated services should be planned and delivered.
- Health and Social Care Standards. These seek to improve services by ensuring that the people who use them are treated with respect and dignity and that their human rights are respected and promoted. They apply to all health and social care services whether they are delivered by the NHS, Councils or third and independent sector organisations.

The quality improvement framework also takes account of the MSG's proposals in relation to collaborative leadership, working with the third and independent sector, strategic planning and commissioning, clinical governance and engaging people, carers and the wider public.

## Quality Indicators

We have selected a set number of quality indicators from our full quality improvement framework. The indicators relating to people and carer's outcomes and experiences are central to the framework. Other indicators consider the outcomes and experiences that integrated health and social care achieve.

The framework sets out key factors for each indicator and describes how they can be demonstrated. It also provides quality illustrations of good and weak performance. The indicators that will be inspected against are:

1.2	People and carers have good health and wellbeing outcomes
2.1	People and carers have good experiences of integrated and person-centred health and social care
2.2	People's and carer's experience of prevention and early intervention
2.3	People's and carer's experience of information and decision-making in health and social care services
5.1	Processes are in place to support early intervention and prevention
5.2	Processes are in place for integrated assessment, planning and delivering health and care
5.4	Involvement of people and carers in making decisions about their health and social care support
6.5	Commissioning arrangements
9.3	Leadership of people across the partnership
9.4	Leadership of change and improvement

Our engagement framework underpins how the Care Inspectorate and Healthcare Improvement Scotland will undertake and report on engagement with people using services and their carers.

The framework consists of 12 personal "I" statements, which focus on the experience and outcomes of people using services and their carers.

The 12 statements are:

1. From the point of first needing support from health and social care services, I have been given the right information at the right time, in a format I can understand.
2. I am supported to share my views, about what I need and what matters to me, and my views are always valued and respected.
3. People working with me focus on what I can do for myself, and on the things I

- can or could do to improve my own life and wellbeing.
4. I am always fully involved in planning and reviewing my health and social care and support in a way that makes me feel that my views are important.
  5. Professionals support me to make my own decisions about my health and social care and support, and always respect the decisions that I make.
  6. I get the advice, support, treatment and care that I need, when I need it, which helps me to become and stay as well as possible for as long as possible.
  7. The health and social care and support that I receive, help me to connect or remain connected with my local community and other social networks.
  8. Health and social care staff understand and acknowledge the role of my family and friends in providing me with care and support. Services work together to ensure that as far as possible, my family and friends are able to provide support at a level that feels right for them.
  9. People working with me always treat me with dignity, respect my rights and show me care and kindness.
  10. My carers and I can easily and meaningfully be involved in how health and care services are planned and delivered in our area, including a chance to say what is and is not working, and how things could be better.
  11. I am confident that all the people supporting me work with me as a team. We all know what the plan is and work together to get the best outcomes for me.
  12. The health and social care and support I receive makes life better for me.

## Appendix 2

Term	Meaning
Adult carer support plan	Under the Carers (Scotland) Act, every carer has a right to a personal plan that identifies what is important to them and how they can be supported to continue caring and look after their own health. This is called an adult carer support plan.
Agile working	Being ready to change the way people work by allowing them greater flexibility in their working hours and where they work, using technology. It also can include changing how people work together or their role.
Aids and adaptations	This means equipment and changes to people's homes which help with everyday tasks so that they can live independently. Examples include grab rails, bath and shower seats, wheelchairs, special mattresses and communication aids.
Anticipatory care plan	Unique and personal plans that people prepare together with their doctor, nurse, social worker or care worker about what matters most to them about their future care.
Capacity	Capacity is the maximum amount of care, support or treatment that day service or individual member of staff can provide.
Care and clinical governance	The process that health and social care services follow to make sure they are providing good quality and safe care, support and treatment.
Carers' centre	Carers' centres are independent charities that provide information and practical support to unpaid carers. These are people who, without payment, provide help and support to a relative, friend or neighbour who cannot manage without that help. Carers' centres are sometimes funded by health and social care partnerships to provide support.
Commissioning	Commissioning is the process by which health and social care services are planned, put in place, paid for and monitored to ensure they are delivering what they are expected to.
Complex needs	People have complex needs if they require a high level of support with many aspects of their daily lives and rely on a range of health and social care services.

Contract Management	Contract management is the process that local councils and the NHS use to ensure that services they purchase from other organisations are of a good standard and are delivering at the expected level.
Coordination	Organising different practitioners or services to work together effectively to meet all of a person's needs.
Core Suite of integration indicators	These are indicators, published by Public Health Scotland to measure what health and social care integration is delivering.
Day services	Care and support services offered within a building such as a care home or day centre or in the community. They help people who need care and support, company or friendship. They can also offer the opportunity to participate in a range of activities.
Direct payments	Payments from health and social care partnerships to people who have been assessed as needing social care, who would like to arrange and pay for their own care and support services.
Digital transformation	Digital transformation is a process of using digital technologies like computers and the internet to create new ways of doing things to meet people's needs.
Early intervention	Early intervention is about doing something that aims to stop the development of a problem or difficulty that is beginning to emerge before it gets worse.
EFQM	The European Foundation for Quality Management is an organisation which has developed an approach to quality improvement that can help organisations to improve.
Eligibility criteria	Eligibility criteria are used by social work to determine whether a person has needs that require a social care service to be provided.
Emergency planning	These are plans that set out what will be done to maintain the health and wellbeing of people who need support when their normal support cannot be provided because of some kind of emergency, for example if an unpaid carer falls ill.
External providers	Independent organisations from which the health and social care partnership purchases care to meet the needs of people who need support.

Future planning	Adult carer support plans are required to include plans for how the cared for person's needs will be met in the future, including when the carer is no longer able to provide support.
Health and Social Care Integration	Health and social care integration is the Scottish Government's approach to improving care and support for people by making health and social care services work together so that they are seamless from the point of view of the people who use them.
Health and Social Care Partnership	Health and social care partnerships are set up to deliver the integration of health and social care in Scotland. They are made up of integration authorities, local councils, local NHS boards and third and independent sector organisations.
Health Promotion	The process of enabling people to improve and increase control over their own health.
Hospital at Home	Services that treat patients in their own home rather than occupying a hospital bed. They are managed by a dedicated team with of health professionals who are responsible for the person's care and treatment.
iMatter	A tool to improve the experience of staff who work for NHS Scotland.
Independent sector	Non statutory organisations providing services that may or may not be for profit.
Integrated services	Services that work together in a joined-up way, resulting in a seamless experience for people who use them.
Integration Joint Board (IJB)	A statutory body made up of members of the health board and local authority, along with other designated members. It is responsible for the planning and delivery of health and social care services.
Localities	Agreed sub-areas within a health and social care partnership area. The partnership should make sure it understands and responds to the different needs of people in different localities.
Low threshold services	Easy access services that people do not have to meet set standards or criteria to access, for example drop-in centres or conversation cafes. Low threshold services are often seen as a way of stopping people's health and wellbeing getting worse.

Microsoft Teams	An IT platform that allows people to meet and work together on the internet.
National health and wellbeing outcomes	Standards set out in Scottish legislation that explain what people should expect to get from health and social care integration.
National Performance Indicators	Measures that are used to evaluate how well organisations are doing in relation to a particular target or objective. For example, the Scottish Government uses national performance indicators to understand how well health and social care partnerships are achieving good health and wellbeing outcomes for people.
Organisational development	A way of using strategies, structures and processes to improve how an organisation performs.
Outcomes	The difference that is made in the end by an activity or action. In health and social care terms, the difference that a service or activity makes to someone's life.
Personal assistant	Somebody who is employed by a person with health and social care needs to help them live the best lives they can. People who need care can ask a health and social care partnership for a direct payment so that they can employ a personal assistant.
Person-centred	This means putting the person at the centre of a situation so that their circumstances and wishes are what determines how they are helped.
Prevention	In health and social care services, prevention is about activities that help to stop people becoming ill or disabled, or to prevent illness or disability becoming worse.
Procurement	The process that health and social care partnerships use to enter into contracts with services to provide care or support to people.
Public Health Scotland	A national organisation with responsibility for protecting and improving the health of the people of Scotland.
Quality indicators	Measures that are used to evaluate how good a process is – how efficient and effective a process is in achieving the results that it should.
Rehabilitation	The process of helping a person to return to good health, or to the best health that they can achieve.

Residential care	Care homes – places where people live and receive 24-hour care.
Respite care	Temporary care that is provided for someone with health and social care needs, usually to provide a break for the person or their carer. Respite care is often provided in a residential setting but can also be provided via short breaks for the person and/or their unpaid carers.
Scoping	The process of examining information or evidence to understand what it means.
Scrutiny	The process of carefully examining something (for example a process or policy or service) to gather information about it.
Seamless services	Services that are smooth, consistent and streamlined, without gaps or delays.
Self-directed support	A way of providing social care that allows the person to make choices about how they will receive support to meet their desired outcomes.
Service providers	Organisations that provide services, such as residential care, care at home, day services or activities.
Short breaks	Opportunities for disabled people and/or their unpaid carers to have a break. Its main purpose is to give the unpaid carer a rest from the routine of caring.
Strategic needs assessment	A process to assess the current and future health, care and wellbeing needs of the community in order to inform planning and decision making.
Supported living	Housing with attached support or care services. Supported living is designed to help people to remain living as independently as possible in the community.
Third sector	Organisations providing services that are not private or statutory. The term is often used to refer to voluntary organisations but can also refer to community organisations or social enterprise organisations.
Workforce plan	A plan that sets out the current and future needs for staff in the organisation, and how those needs will be met.



## Appendix 3

### Six-Point evaluation scale

The six-point scale is used when evaluating the quality of performance across quality indicators.

Excellent	Outstanding or sector leading
Very Good	Major strengths
Good	Important strengths, with some areas for improvement
Adequate	Strengths just outweigh weaknesses
Weak	Important weaknesses – priority action required
Unsatisfactory	Major weaknesses – urgent remedial action required

An evaluation of **excellent** describes performance which is sector leading and supports experiences and outcomes for people which are of outstandingly high quality. There is a demonstrable track record of innovative, effective practice and/or very high-quality performance across a wide range of its activities and from which others could learn. We can be confident that excellent performance is sustainable and that it will be maintained.

An evaluation of **very good** will apply to performance that demonstrates major strengths in supporting positive outcomes for people. There are very few areas for improvement. Those that do exist will have minimal adverse impact on people's experiences and outcomes. While opportunities are taken to strive for excellence within a culture of continuous improvement, performance evaluated as very good does not require significant adjustment.

An evaluation of **good** applies to performance where there is a number of important strengths which, taken together, clearly outweigh areas for improvement. The strengths will have a significant positive impact on people's experiences and outcomes. However, improvements are required to maximise wellbeing and ensure that people consistently have experiences and outcomes which are as positive as possible.

An evaluation of **adequate** applies where there are some strengths, but these just outweigh weaknesses. Strengths may still have a positive impact but the likelihood of achieving positive experiences and outcomes for people is reduced significantly because key areas of performance need to improve. Performance, which is evaluated as adequate, may be tolerable in particular circumstances, such as where a service or partnership is not yet fully established, or in the midst of major transition. However, continued performance at adequate level is not acceptable. Improvements

must be made by building on strengths while addressing those elements that are not contributing to positive experiences and outcomes for people.

An evaluation of **weak** will apply to performance in which strengths can be identified but these are outweighed or compromised by significant weaknesses. The weaknesses, either individually or when added together, substantially affect peoples' experiences or outcomes. Without improvement as a matter of priority, the welfare or safety of people may be compromised, or their critical needs not met. Weak performance requires action in the form of structured and planned improvement by the provider or partnership with a mechanism to demonstrate clearly that sustainable improvements have been made.

An evaluation of **unsatisfactory** will apply when there are major weaknesses in critical aspects of performance which require immediate remedial action to improve experiences and outcomes for people. It is likely that people's welfare or safety will be compromised by risks which cannot be tolerated. Those accountable for carrying out the necessary actions for improvement must do so as a matter of urgency, to ensure that people are protected, and their wellbeing improves without delay.

## Appendix 4

### The National Health and Wellbeing Outcomes

- **Outcome 1:** People are able to look after and improve their own health and wellbeing and live in good health for longer.
- **Outcome 2:** People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
- **Outcome 3.** People who use health and social care services have positive experiences of those services, and have their dignity respected.
- **Outcome 4.** Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
- **Outcome 5.** Health and social care services contribute to reducing health inequalities.
- **Outcome 6.** People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.
- **Outcome 7.** People using health and social care services are safe from harm.
- **Outcome 8.** People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
- **Outcome 9.** Resources are used effectively and efficiently in the provision of health and social care services.