Joint inspection of adult services

Integration and outcomes – focus on people living with mental illness.

Clackmannanshire and Stirling Health and Social Care Partnership

November 2024

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PART 1 – About Our Inspection

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 set out our planned 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.

The inspection in the Clackmannanshire and Stirling Health and Social Care Partnership was the fifth in the series of inspections, and the second to consider the inspection question through the lens of people living with mental illness. We are using the definition of mental illness from the National Mental Health and Wellbeing Strategy, 2023:

"Mental illness is a health condition that affects emotions, thinking and behaviour, which substantially interferes with or limits our life. If left untreated, mental illnesses can significantly impact daily living, including our ability to work, care for family, and relate and interact with others.

Mental illness is a term used to cover several conditions (e.g. depression, post-traumatic stress disorder, schizophrenia) with different symptoms and impacts for varying lengths of time for each person. Mental illnesses can range from mild through to severe illnesses that can be lifelong."

National issues and context

During the pandemic, there were extreme and unprecedented impacts on service delivery and staffing across health and care services. The Care Inspectorate and Healthcare Improvement Scotland recognise that all health and social care partnerships still face significant challenges. Our inspections are not focused on examining partnerships' responses to or recovery from the pandemic, but we will make every effort to understand and account for its impact on partnerships, providers, people, and carers.

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

Several reports[1,2,3,4,5] and our own recent inspections have highlighted that across the country:

- Demand for health and social care is increasing.
- The health and social care sector face ongoing challenges with recruitment and retention. This places considerable pressure on the capacity, sustainability, and quality of care services.

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, an issue that has been highlighted and addressed in Scotland's digital health care strategy produced by the Scottish Government and COSLA in October 2021.

Explanation of terms used in this report.

When we refer to **people**, we mean adults between 18 and 64 years old who are living with mental illness.

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 Clackmannanshire and Stirling partnership**, we mean Clackmannanshire and Stirling Health and Social Care Partnership who are responsible for planning and delivering health and social care services to adults who live in Clackmannanshire and Stirling.

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

[1] Audit Scotland, Social Care Briefing, January 2022 (https://www.audit-scotland.gov.uk/publications/social-care-briefing)
[2] Audit Scotland, NHS in Scotland 2023, February 2024 (https://audit.scot/publications/nhs-in-scotland-2023)
[3] Audit Scotland, Integration Joint Boards' Finance and performance 2024 (https://audit.scot/publications/integration-joint-boards-finance-and-performance-2024)
[4] Social Care Benchmarking Report 2022. July 2023. University of Strathclyde, CCPS, HR Voluntary Sector Forum (https://www.ccpscotland.org/ccps-news/media-release-report-reveals-reality-of-staffing-crisis-in-social-care-with-more-than-half-of-those-moving-jobs-last-year-leaving-the-sector-2/
[5] Health, Social Care and Sport Committee's scrutiny of the NHS at 75 – what are some of the key issues in 2023? June 2023, The Scottish Parliament (https://spice-spotlight.scot/2023/06/29/health-social-care-and-sport-committees-scrutiny-of-the-nhs-at-75-what-are-some-of-the-key-issues-in-2023/)

When we refer to **senior 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

The Clackmannanshire and Stirling partnership is between Clackmannanshire Council, NHS Forth Valley, and Stirling Council. It is the only HSCP in Scotland covering two local authority areas. Clackmannanshire and Stirling Councils had a shared service agreement for social work services which reverted to social work departments in the two respective councils in September 2015. The Senior Leadership Team (SLT) for the partnership manages a budget of £257.384m managed by three SLT members with support from the Chief Finance Officer (CFO).

The Integration Authority, and the governing Integration Joint Board became responsible for oversight of delivery of community-based health and social care services to adults over 18 years of age on 1 April 2016. This includes strategic planning and commissioning of provision by direction to deliver the strategic plan. The HSCP took on operational management of Clackmannanshire Council social care services in June 2017 and Stirling Council social care services in September 2018.

The HSCP is served by one acute hospital, Forth Valley Royal Hospital, Larbert (FVRH). The HSCP also manages the community hospital in Clackmannanshire and some services at the Health and Care Village in Stirling, where there is a minor injuries unit on the site. The Acute Mental Health in-patient unit is within FVRH. The community mental health teams are based in the Livilands resource Centre, Stirling, and in the Mental Health Resource Centre at Clackmannanshire Community Healthcare Centre (CCHC). There are also in-patient mental health services in Bellsdyke Hospital, Larbert, and community-based mental health services provided from a range of community locations across Forth Valley. Clackmannanshire and Stirling is a HSCP of approximately 145,730 people across three localities covering a large rural area in Stirling, which covers 2,187 square kilometres in total. Over half of Clackmannanshire residents live in the 20% most deprived data zones in Scotland with a lower job density rate than Stirling and Scotland.

The partnership has a range of community assets and services, such as The Bellfield Centre at Stirling Health and Care Village; district nursing; mobile emergency care service and technology enabled care and care at home providers to support the citizens of the communities they serve. The age profile of the population is similar to that of Scotland as a whole - with growing numbers of older people.

Figure A – Map of Clackmannanshire & Stirling

The associated needs of the populations within the three localities are different and some challenges are noted from the Strategic Needs Assessment (SNA), SNA focussed update and Locality Profiles:

- The overall population of Clackmannanshire is set to fall between now and 2039 by around 3%, while the proportion of older people will rise. During this period, the number of people of working age is expected to fall. This will present some specific challenges in terms of both meeting growing levels of health and care needs and the availability of a skilled local work force to deliver services.
- Clackmannanshire has some of the most deprived areas in Scotland with associated challenges resulting from inequalities.

- Stirling covers 2,187 square kilometres, with one of the smallest populations per kilometre in Scotland presenting both opportunity and challenge for delivery of services.
- Stirling has areas of marked contrast in terms of inequalities with some of the least deprived areas in Scotland sitting alongside some of the most deprived, for example, Kings Park and Raploch.
- Both Clackmannanshire and Stirling have an ageing population. By 2041, the number of people of pensionable age and over is expected to increase by 27.5% in Clackmannanshire and 29.3% in Stirling. In addition, the population of people aged 75 and over is expected to increase by 99.5%. This will impact significantly on demand in the years ahead.
- In line with the national picture, it is projected that more people living in Clackmannanshire and Stirling will have long term health conditions, multiple conditions, and complex needs. Developing new care pathways and guidelines away from current disease specific models towards a greater focus on the holistic needs of people will be needed. Early intervention and community-based services will help to ease the growing pressure on acute unscheduled care services.
- To help keep people living independently in the community for longer there will be an increasing need for unpaid carers, therefore supporting unpaid carers is a priority.
- Reducing risky behaviours such as smoking, consuming alcohol, drugs and poor diet remain public health priorities and are of relevance in some areas of the HSCP.

Summary of our Inspection Findings

The joint inspection of Clackmannanshire and Stirling health and social care partnership took place between April 2024 and September 2024.

In our discussions with people and carers, we spoke to 35 people and six carers through conversation and focus groups.

In our engagement with staff from the health and social care partnership, we received 175 completed staff surveys, spoke to 86 members of staff, and undertook four professional discussions sessions with the leadership team.

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

Key Strengths

- Staff across the partnership were working hard to support people living with mental illness in Clackmannanshire and Stirling. Their care and compassion contributed to good outcomes for some people and improved their quality of life.

- The introduction of community link workers and primary care mental health nurses had strengthened early intervention and prevention support for people living with a mental illness. People who had accessed these services reported positive experiences.

- The partnership was developing an innovative collaborative approach to implementing its commissioning priorities through commissioning consortia that involved people, carers and third and independent sector providers. It planned to use this approach to progress improvements in mental health provision in the future.

Priority areas for improvement

1. The partnership should develop processes for capturing robust data on outcomes for people using mental health services and their unpaid carers to inform service planning and ongoing improvement.
2. The partnership should support staff across all mental health services to identify and respond to the needs of unpaid carers of people living with mental illness.
3. The partnership should improve its integrated processes for assessment, care planning and treatment to support more effective collaboration between health and social care staff.
4. The partnership should develop a more proactive approach to emergency and future care planning.
5. The partnership should provide people living with mental illness and their unpaid carers meaningful and accessible opportunities to share their views and contribute to plans for the services they use.
6. The partnership should progress plans to implement its new Self-Directed Support (SDS) policy and improve outcome-focused assessments. All options should be offered to people, with the necessary support systems in place, to allow them to exercise their rights.
7. The partnership should review the assessment templates in use across NHS services for people living with mental illness to support a greater focus on outcomes.
8. The partnership should strengthen its professional governance and assurance framework for social work functions and statutory duties.
9. Senior leaders should continue to develop their approach to managing change across the partnership. Frontline staff should be fully involved in designing and implementing improvements identified from self-evaluation activities.
10. The partnership should review the existing evidence and its wider approach to strategic planning at the earliest opportunity. Leaders should ensure that any initiatives that could rapidly improve outcomes for people living with mental illness and their unpaid carers are identified and implemented.

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		
Key Area	**Quality Indicator**	**Evaluation**
1 - Key performance outcomes	1.2 People and carers have good health and wellbeing outcomes	**Adequate**
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	**Adequate**
	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	**Weak**
	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	**Adequate**
9 - Leadership and direction	9.3 Leadership of people across the partnership	**Weak**
	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 Clackmannanshire and Stirling?

Key Messages

- The partnership was delivering positive health and wellbeing outcomes for people experiencing mental illness in most cases.
- Unpaid carers of people living with mental illness were not routinely supported to look after their own health and wellbeing or to manage their caring role.
- Performance and outcomes data were not being routinely collated and analysed to understand what was important to people and unpaid carers and to inform service planning.

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

Public Health Scotland publishes an annual core suite of integration performance indicators for every health and social care partnership in Scotland. The indicators describe what people can expect from integrated health and social care. They measure progress around the national health and wellbeing outcomes set out in legislation. Overall, Clackmannanshire and Stirling health and social care partnership's performance against the most recent core integration performance indicators was broadly in line with the national averages. People's positive experiences of care provided by general practice was higher than the Scotland average. The partnership had also improved on its own performance in this area compared to the last Public Health Scotland indicators report from 2022.

The partnership was generally delivering positive outcomes for people against the national health and wellbeing outcomes. However, weaknesses in the partnership's integrated processes meant that opportunities to deliver better outcomes were missed. In addition, there was no systematic approach in place to identify carers and understand their needs. This meant that unpaid carers of people living with mental illness were not routinely supported to look after their own health and wellbeing or to manage their caring role.

The partnership's information systems did not support routine collection and collation of performance data. This meant that there was limited information about outcomes for people living with mental illness and unpaid carers available to inform service planning or improvement. This had been identified as a risk. The partnership intended to develop a more efficient system that would provide a better understanding of what was important to people. As this was work in progress it was too early to evaluate the impact of the approach during the inspection.

From conversations with people and carers engaged with mental health services, and from reviewing their records, we found that:

National Health and Wellbeing Outcomes:

National health and wellbeing outcome	Inspection Finding
1	Most people were supported to look after their health and wellbeing as much as possible.
2	Just over half of people were supported to live as independently as possible.
3	Just over half of people experiencing care felt they were treated with dignity and respect.
4	Most people had a better quality of life because of the health and social care services they received.
6	Most carers did not feel supported to continue caring and look after their own health and wellbeing.
7	Most people experiencing mental illness were kept safe from harm.

* Outcome 5 not evaluated due to lack of national data to benchmark against.

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

Most people were supported to look after their health and wellbeing as much as possible. Staff across the partnership worked well within their respective roles to support people living with mental illness and deliver positive outcomes. Community and third sector services had a positive impact on people in supporting them to look after their health and wellbeing. However, care, treatment and support were often delivered as single agency inputs rather than through integrated working. This meant that people were not always supported to receive the right level of help at the right time in the right setting.

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.

Just over half of people living with mental illness felt the support they received helped them to connect or remain connected with the local community and wider social networks. Some people reported positive experiences for example, being supported to take up volunteering and other social activities within their communities. However, a few people felt lonely and isolated due to services not supporting them to stay connected to their local community. The partnership's performance against the core integration performance indicator for people feeling they were supported to live as independently as possible was below the Scottish average.

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

Just over half of people felt that health and social care staff respected their rights and treated them with dignity. People were positive about the care and support provided by general practice. Clackmannanshire and Stirling's integration indicator for people with positive experiences of the care provided by their general practice was higher than the Scottish average. Feedback relating to community link workers and third sector services was particularly positive. However, some people who could have benefited from accessing those services had not been supported to do so. Additionally, people's experiences of using services across the partnership's mental health system were more mixed. For some people opportunities to experience more positive outcomes were missed. Greater collaboration between health and social care services could have enhanced people's experiences of those services.

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.

Clackmannanshire and Stirling's integration indicator for people agreeing that services had an impact on maintaining or improving their quality of life was in line with the Scottish average. In most cases, health and social care services supported an improved quality of life for people living with mental illness. However, delays in accessing some services impacted on the quality of life for a few people. From our engagement activities, some people expressed difficulties accessing the neurodevelopmental care pathway and psychological services. Long waits for support and treatment had a negative impact on their health and wellbeing.

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.

Clackmannanshire and Stirling's integration indicator for carers feeling supported to continue in their caring role was just above the Scottish average. Outcomes for unpaid carers of people living with mental illness were less positive. Most unpaid carers did not feel that health and social care staff understood and acknowledged the role of family and friends in providing care. They did not feel that staff supported them to share their views about what mattered to them.

Most unpaid carers spoke positively about the support they received from the Carers' Centres. However, not all carers who may have benefitted from this service had been supported to access it. Adult carer support plans (ACSPs) were not routinely offered or completed. Some carers could have experienced improved outcomes through the timely offer and completion of an ACSP and provision of appropriate supports.

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

Clackmannanshire and Stirling's integration indicator for people supported at home feeling safe was below the Scottish average. However, amongst people living with mental illness, most felt safer in their home and in the community due to the health and care support they received.

Evaluation

Adequate

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 Clackmannanshire and Stirling

Key Messages

- Most people felt that services working with them supported them to be independent and focused on things they could improve on their own.
- People had mixed experiences of being able to share their views and make decisions regarding their care treatment and support.
- Unpaid carers were often not identified. Most people and their unpaid carers did not receive complete information about self-directed support and the options available to them.
- A few people and some unpaid carers felt that they could have benefited from earlier support and treatment.
- Independent advocacy services were not widely used to provide the appropriate support for some people and unpaid carers.

People and carers have good experiences of integrated and person-centred health and social care.

Most people living with mental illness were involved in discussions concerning their care, treatment and support on a day-to-day basis. However, people's experiences of planning and reviewing their health and social care supports to address more long-term needs were less positive.

Just over half of the people living with mental illness felt staff treated them with dignity and respect. They felt that professionals who worked with them valued their views and respected their decisions. Significantly, not all people and unpaid carers shared this positive experience, and some were unsure.

The introduction of community link workers and primary care mental health nurses in general practices across the partnership was positive. People living with mental illness who had accessed these services reported good experiences.

> One person commented “I feel very strongly that the link worker works as part of a team and is a key resource in making things happen in a joined-up way.”

Approaches to deliver integrated care, treatment and support were inconsistent across the partnership. This meant that people’s overall experiences of integrated health and social care services were mixed. Across the partnership’s two local

authorities, exactly half of the people living with mental illness reported positive experiences of health and social care services. Significantly, half of the people and almost all carers we engaged with expressed a negative experience of services.

Just under half of the people were confident that the staff supporting them worked as a team. Some people said that they often had to repeat information about their lives to the professionals from different agencies who were involved in their care. Sometimes this was the case even when staff were based in the same building.

> A person told us: "services do not work together as a team" and that this had adversely impacted on their health, home environment, ability to parent to the best of their ability and to participate in the community.

Just over half of people did not feel they had been involved with reviewing their health and social care supports. Opportunities to understand what was important to people and capitalise on the strengths of different care partners to respond to their needs were missed. A more coordinated approach that included people and unpaid carers at the centre would have provided consistency and resulted in more positive experiences of care and treatment reviews.

A few unpaid carers who had accessed the Carers' Centres spoke positively about the support they received. However, experiences of unpaid carers accessing support across the partnership's health and social care services were less positive. Almost all carers expressed negative experiences of the support they had received. In addition, only half of the people who were supported by services felt that their unpaid carers were included as part of the team providing their support. Most unpaid carers did not feel that their rights as partners in care were always recognised. They reported difficulty accessing services at the right time, delays in self-directed support (SDS) payments and lack of respite opportunities as particularly challenging. Only half of unpaid carers were offered an adult carer support plan, and none had an emergency carer support plan in place.

Good practice example

A partnership between psychological therapies and lived experience of recovery in substance use services

Psychological services, within the alcohol and drugs partnership, worked with Recovery Scotland to develop a service to support people to build social networks. The service was developed in line with Medication Assisted Treatment (MAT) standard 6.

The two recovery development workers had lived experience of both trauma and substance use and were employed by NHS Forth Valley Substance Use Psychology Team on a part time basis. These workers had training and experience in motivational interviewing and basic cognitive behavioural therapy (CBT) informed psycho-social interventions. Their role was to support people who received psychological therapy to practice their new skills in the community, and to achieve their psychological goals. The recovery workers supported the implementation of a shared care plan informed by psychological assessment, formulation, and goal planning. The approach aimed to maximise improved outcomes by applying both psychological and lived experience support. Supervision and support were provided to the lived experience recovery workers by the psychologist.

A comprehensive evaluation of the service was carried out. It evidenced improved outcomes for people. It demonstrated the benefits of the involvement of the lived experience recovery workers in enhancing the experience and outcomes for people. This was an excellent example of the added value of integrated working to improve outcomes for people.

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

Staff demonstrated care and compassion towards people living with mental illness. Most people felt that services working with them focussed on what they could do for themselves and on what they could improve on their own. Just over half of people told us the support they received helped them to connect or remain connected with their local community and wider social network.

> 'Staff help me stay in contact with my brother in America through zoom.'
>
> 'I have a busy social life and go to cafes and a group in Alloa. I have the choice of a member of staff going with me if I want.'

People did not feel that that they had experienced any form of early intervention or prevention activities. A few people felt they would have benefited from earlier support and treatment. In addition, almost all carers felt they had not received the advice and support that they needed to keep well. However, there was evidence of early intervention and prevention activities for people living with mental illness in just over half of the records we reviewed. Activities identified included physical health checks from health maintenance clinics, harm reduction work and group support therapies. It may be that these interventions were not recognised as early intervention and prevention by the people using services.

People were not routinely supported to consider their future care needs and plan for any changes in circumstances. A few unpaid carers expressed concern about what would happen to the person they cared for if something happened to them or if there was a crisis. A more proactive approach to emergency and future care planning might have provided some reassurance.

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

People and carers had mixed experiences of receiving timely, relevant, and accessible information about their health and social care support options. Most people and their unpaid carers were positive that they could ask their health and care workers questions and would receive the information they needed. There were positive examples where people felt that care staff had effectively supported them to understand their illness and medication management. However, for some people information was not always provided in an accessible way. This was particularly the case for individuals who were newly diagnosed with a neurodevelopmental condition or a hoarding disorder. They found being signposted to online resources difficult and overwhelming.

There was limited evidence about how people were supported to make decisions and choices about their own lives. Most people and carers had not received complete information about self-directed support (SDS) and the options available to them. This meant people and carers were not always fully informed of their statutory rights in relation to their care and support. Almost all people living with mental illness were supported using SDS option 3 and there was little evidence that other options had been fully explored. Some carers had been offered an adult carer support plan. However, not all people who identified as carers were recognised by services as fulfilling this role. None of the carers we met were receiving SDS. The partnership recognised this as an area for improvement and steps were being taken to develop a more consistent approach.

People's experiences of being able to share their views about their care and support were mixed. Some people felt that they were fully involved in planning and reviewing their health and social care in a way that made them feel their views were important. On a few occasions, people were fully involved in major decisions relating to their care, for example, changing support providers and accommodation options. However, this was not everyone's experience.

Some people and carers found multi-disciplinary reviews intimidating. They found it difficult to articulate their views in a room full of professionals and some chose not to participate. The use of advocacy may have been a positive addition to care and support in these instances, but this was not always facilitated by staff. From our review of records, advocacy services were used more consistently when adults were subject to mental health legislation.

Similarly, where adults were subject to mental health legislation the care programme approach (CPA) was used effectively to plan and manage their care in most cases. However, for people living with mental illness who were not subject to statutory measures the approach to reviews was inconsistent. Most reviews were done by third sector organisations on a single agency basis. This was not usually viewed as an omission by the people receiving services. However, opportunities to enhance the experiences of people living with mental illness were missed. An integrated approach to care planning and reviews that capitalised on the skills of all multi-agency staff who were involved in their care would have enhanced people's experiences.

Evaluation

Adequate

Key Area 5 - Delivery of Key Processes

How far is the delivery of key processes in the Clackmannanshire and Stirling partnership integrated and effective?

Key Messages

- The partnership had two Integrated community mental health teams. Multi-disciplinary staff in these teams had largely positive relationships with the people they supported.
- Integrated Community Mental Health Teams (ICMHT) were proactively supporting people with self-management, health advice and support through the health maintenance clinics and day units.
- Co-location and shared access to the care partner recording system supported joint working amongst ICMHT staff. However, NHS and social work staff did not work in an integrated way and information sharing with staff in the locality teams was inconsistent.
- Staff who worked in secondary care and inpatient services had limited awareness of the resources available to people living with mental illness in their communities. This limited their ability to link people to the appropriate supports in the communities where they lived.
- Processes for assessment, care management and reviews were inconsistent. There was little evidence of proactive planning, so support tended to be day-to-day rather than working toward longer term agreed outcomes.
- There were limited processes or systems in place to support people and unpaid carers to provide feedback on the services they used. Very few people and no carers had experience of involvement in planning and contributing to the development of services in their area.

Processes to support early intervention and prevention

The partnership had a range of services that were supporting the delivery of positive mental health outcomes. Across primary care services, community link workers were involved in mapping local initiatives that could support positive mental health for people in their communities. Within secondary care, day units in the two Integrated Community Mental Health Teams (ICMHTs) in Clackmannanshire and Stirling helped people develop skills to manage their mental health. The ICMHTs hosted health maintenance clinics which provided annual health checks, screening, and health promotion activities. Staff from the ICMHT and third sector providers were proactive in supporting people to attend the clinics. This was a targeted approach to tackling health inequalities that helped people to maintain good health and wellbeing.

The day units in both ICMHTs were well used and there was a 16-week waiting list for groups. However, links to third sector and other community-based services were underdeveloped. Staff in secondary care services had limited awareness of community-based resources. This meant opportunities to signpost people to the appropriate supports in their own communities were missed.

There was not a systematic, integrated approach to early intervention and prevention supported by clear processes. This meant that service delivery was inconsistent across the partnership. This created an inequality of access to services and resources. There was useful information available to people on the HSCP and NHS Forth Valley websites. However, the quality and availability of online self-management resources across the two local authority websites was variable.

The Clackmannanshire ICMHT had a community access team which supported people who had been acutely ill to rebuild social and activity networks. This was a positive addition to the team. It had the added advantage of providing information about community resources to staff within the wider ICMHT. Clackmannanshire Council had also commissioned counselling services to support positive mental health in its communities. The Stirling ICMHT hosted a Mental Health Money and Benefits Advice Project, provided by the Citizens Advice Bureau. This was a targeted service for people with long term mental health problems. It aimed to reduce the effect of financial stressors and promote financial inclusion. Evaluation of this service showed a valuable impact on outcomes for people and reducing demand.

There was some evidence of staff completing safety plans with people they were supporting. Where these were in place, they helped people to manage their wellbeing and could provide early indications of deteriorating mental health. However, there was no process in place to support a consistent and proactive approach to emergency and future care planning.

NHS Forth Valley was working on developing Early Intervention in Psychosis and Distress Brief Intervention (DBI) services. Delivering DBI across two partnerships was reported to have been challenging which had caused some delay. This was a missed opportunity to intervene early to support people's mental health and wellbeing. Arrangements to begin implementation across NHS Forth Valley were put in place during the inspection, but progress was slow.

The partnership had recently developed a new carers' information pack and implemented 'Mobilise,' an online resource for carers. These initiatives had the potential to provide early support for people living with mental illness and their unpaid carers, but it was too early to identify their impact. There were no processes in place to support staff to consistently identify people who provided unpaid care for people living with mental illness. This meant some unpaid carers were not signposted to the appropriate resources. This was important because people did not always identify as unpaid carers and needed support from staff to help them consider this. This meant in some cases, carers' wellbeing and their ability to continue caring was at risk.

Good Practice Example

The Mental Health Money and Benefits Advice Project was established in 2022. It was jointly funded by the HSCP and The Robertson Trust and delivered through the Citizens Advice Bureau. The Citizens Advice Bureau worked in partnership with Action in Mind and NHS Forth Valley to provide this essential service for people who use mental health services. It provided targeted advice and ongoing support to vulnerable people experiencing long term mental illness. It was based in the Stirling ICMHT, Action in Mind in the Stirling area and in Adult Mental Health Inpatient services across Forth Valley.

The project has evidenced significant impact against its outcomes of improving access, reducing the demand on mental health services, and improving outcomes for people engaged in treatment for long term or episodic mental illness. An evaluation of the project found that between April 2023 to January 2024, it assisted 221 people who were engaged in treatment for long term mental health problems and provided significant financial gain for those using the service. This project was a proactive and targeted intervention to tackle health inequalities and improve outcomes for people with mental illness.

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

There was a coherent NHS system for supporting people living with mental illness. This incorporated primary and secondary care mental health services, in-patient provision and community emergency and out of hours support through the Mental Health Acute Assessment and Treatment Service (MHAATS).

The two integrated community mental health teams (ICMHTs) had the same standard operating procedures and shared a recently implemented protocol for joint working with substance use services. They incorporated nursing, occupational therapy, medical and social work staff who were based in the same building. Nursing staff across both services were managed by a single manager and there was a single service manager who had oversight of both health and social work functions across the two sites. However, the two teams operated separately and apart from the psychiatrists managing their capacity across both ICMHTs, there were limited examples of resources being shared.

There was a single pathway for referrals to the ICMHTs from GPs, primary care mental health nurses, or MHAATS. Positively, services had successfully delivered assessments against the target timescale of 12 weeks. However, once people were discharged from the ICMHT, the partnership did not have a process in place for direct re-referral to the ICMHT and specialist mental health support. If a person became unwell again, they had to be re-referred via their GP. This caused delays

which sometimes resulted in crisis and poor outcomes for people and their unpaid carers. Also, third sector and housing providers were left managing people who were becoming acutely unwell, without recourse to specialist mental health support.

The partnership had not yet taken the opportunity to establish clear integrated processes and procedures that supported health and social care staff to deliver seamless support. Collaborative working depended more on informal relationships and communication than clear integrated processes. Systems and processes for identifying and responding to people living with mental illness and their unpaid carers were largely single agency. While many people were supported effectively on a day-to-day basis, services did not work together to develop coordinated plans for care treatment and support. As a result, services had not made the best use of available resources to support people to achieve what was important to them. More integrated processes and consistent collaborative practice had potential to support improved outcomes.

Multi-disciplinary team meetings in ICMHTs were used to discuss referrals, allocations, reviews, ongoing cases and overall caseload management. However, social work and occupational therapist attendance was sporadic. Therefore, they did not consistently benefit from the full range of professional perspectives. For people on statutory orders and people with complex support needs the Care Programme Approach (CPA) was the key framework for providing integrated and coordinated care. Use of CPA meant all services participated in regular shared assessment, planning and review meetings. However, CPA was not available for everyone who needed their care co-ordinated. There were few examples of alternative integrated processes when CPA was not in place. There was no CPA co-ordinator in post at the time of the inspection and the lack of administrative support for the approach limited its use.

Across all services, approaches to assessment, care planning and reviews were inconsistent. Recording templates were brief or incomplete and failed to capture the person's perspective. Although both health and social care staff were trained in "good conversations," there was limited evidence that staff spoke with people about the outcomes they wanted. Apart from CPA, there were often no formal reviews recorded beyond individual notes on single agency systems following a multi-disciplinary team meeting (MDT) or professional meeting.

Across the partnership, staff were working across different business systems. There were two different social work case recording systems which were old and inefficient. This was identified as a risk by the partnership and improvements were being considered along with a review of NHS Forth Valley's reporting and recording systems to ensure they were fit for purpose.

The social work teams in both ICMHTs had similar staff complements which comprised mental health officers (MHOs) and social workers. The Stirling ICMHT had an additional social work assistant. Social workers were not included in the assessment rotas for new clients, nor did they fulfil the key worker role. Mental health officers undertook care management for people subject to statutory measures in addition to their statutory responsibilities. Across both services, capacity was

stretched. The waiting time for some areas of work such as private guardianships was four to six months. For people not subject to statutory measures, locality social workers mainly undertook care management. The absence of shared recording systems and the benefits provided by services being co-located created barriers to effective communication between the ICMHT and locality teams.

The partnership's strategic commissioning plan identified significant health inequalities in some communities. The partnership had taken positive steps to implement a new protocol to support effective mental health care and treatment for people with co-existing substance use issues. The money advice project in Stirling ICMHT had had some impact in addressing financial exclusion. However, processes to enhance access to mental health services in areas of higher deprivation had not been developed. Additionally, there was no evidence of targeted support for people with higher risk of poor outcomes, for example, people living with learning disabilities or people experiencing homelessness.

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

There was limited evidence that targeted information was routinely provided to support people with decision-making. Relatives were not always provided with information they needed about mental health legislation, guardianship and power of attorney. In addition, independent advocacy was not widely used.

Some tools and processes that could help to ensure people's full involvement in decisions and plans were not used to their best effect. Relevant assessments and reports were not always shared with all the professionals who were involved with the person. This meant that decisions about treatment and care were not always made based on a full understanding of people's circumstances. Health and social care reviews did not always involve people and their unpaid carers which meant some key decisions were made without consultation with the person. There was some evidence of people being referred to advocacy, but no information about the outcomes of referrals.

Some people had named persons and advance statements, but there was limited evidence that these were routinely discussed with people as a way of ensuring that their voice was heard in decision-making processes. Letters were routinely sent out asking people if they wanted to make an advance statement. This process was ineffective, especially without more direct support and discussion with the person. There was no evidence of future care plans in place, even where people's current living circumstances were uncertain, for example, people who were receiving substantial care from aging parents.

Staff identified that there were fewer resources available to support people in their local communities than before the Covid-19 pandemic. Forums that used to support people living with mental illness to share their views had lapsed to a significant extent. Klacksun and the Stirling Mental Health Users Network were no longer operating in a meaningful way. NHS Forth Valley attempts to set up a mental health and learning disability patients' participation group were ineffective. Care Opinion

was used in the partnership, but this was not always an appropriate option for people living with mental illness. To ensure that people living with mental illness and their unpaid carers were able to provide meaningful feedback and contribute to plans for the services they use. Managers recognised that there was a need to review the systems and processes in place at the time of inspection.

Evaluation

Weak

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

How good are commissioning arrangements in the Clackmannanshire and Stirling partnership?

Key Messages

- The health and social care partnership was in the process of re-establishing an integrated approach to strategic commissioning. Mental health was a strategic priority for the partnership.
- The partnership had agreed to lead the development of a Forth Valley wide mental health strategy, due to be finalised in March 2025 but progress to improve mental health services was slow.
- The partnership had successfully established an integrated planning and commissioning team. This was a good example of the partnership investing in an integrated approach.
- Outcome focused commissioning for people living with mental illness was still to be developed.

Commissioning arrangements

The Integration Joint Board (IJB) had clearly set out wide-ranging commissioning priorities, including priorities for mental health, in its strategic commissioning plan 2023 - 2033. These focused on how high-quality services would deliver positive outcomes for people in a way that is consistent with the national Health and Social Care Standards.

The Covid-19 pandemic significantly disrupted strategic commissioning activities and locality planning until the current strategic plan began to be developed in 2022. Development of the strategic plan represented a positive effort to begin to re-establish an integrated approach. The plan was based on a robust and detailed up-to-date strategic needs assessment and engagement with a range of stakeholders including people and their unpaid carers. Locality planning groups in each of the partnership's three localities were redeveloped and a locality plan was developed for each.

There was little evidence that the partnership had a track record of successfully implementing its strategic priorities. Mental health was also a priority in the partnership's previous commissioning plan 2016 – 2019. The partnership's annual performance report 2022/2023 highlighted successful developments, including expansion of the primary care mental health nursing team, development of rural homecare, and support for carers. However, these actions were more driven by Scottish Government policy or immediate operational pressures rather than effective strategic planning and commissioning.

The commissioning intentions in the current strategic plan were integrated and applied to the health and social care functions that the IJB had responsibility for. The plan highlighted that a range of more detailed plans would support the delivery of each of the broad commissioning priorities. These included plans related to groups such as people living with mental health difficulties, learning disabilities and

plans for supporting more activities such as health improvement, transforming care, finance and workforce.

The partnership had agreed timescales for a mental health strategy to be completed by March 2025. The strategy would cover all of NHS Forth Valley area. Unfortunately, this meant that it would be more than two years after the adoption of the strategic commissioning plan before actions to improve outcomes for people living with mental illness would begin to be implemented.

A range of services and initiatives focused on early intervention and prevention had been developed. These included the Mental Health Group, the Family Well-Being Partnership and Family Support Collaborative. It was not clear that these were part of a developed strategic approach, seeking to maximise outcomes across the whole partnership. Some developments had been commissioned in Clackmannanshire in response to local need but without being integrated into the partnership's wider commissioning discussions or processes. These included Safeguarding Through Rapid Intervention (STRIVE) which provided a multi-agency approach to alleviating poverty, and Kooth and Qwell for mental health and wellbeing support. As a result, there was a risk that the partnership was missing opportunities to ensure a consistent response to needs.

The partnership had taken positive steps to improve its implementation of the priorities in its current strategic commissioning plan 2023 – 2033 by developing a commissioning consortium approach. This was based on an agreement with the third sector and represented an innovative and collaborative approach to strategic commissioning. It included open commissioning consortium meetings with supported people and their representatives and current and future providers. The partnership had successfully initiated commissioning consortia in relation to its alcohol and drugs partnership, carers support and dementia. There were plans to develop further consortia for mental health services, learning disability and palliative and end-of-life care.

The conclusions of the partnership's evaluation of commissioning consortia highlighted that feedback from people, carers and providers was positive. It also suggested that the approach was resource intensive, required collaborative leadership through the strategic planning group and a slower pace to commissioning. Senior leaders recognised that combining effective collaboration with a faster pace of change presented a further challenge that required consideration.

The partnership had successfully put in place an integrated planning and commissioning team delivering a wide range of commissioning activities from developing the strategic commissioning plan, to contributing to commissioning consortia and commissioning social care services from the third and independent sector. This team was a good example of the partnership investing in an integrated approach.

For the most part, the team had positive relationships with third and independent sector providers. However, commissioning of support for people living with mental illness was previously undertaken directly by services. This meant work to progress

outcome focused commissioning approaches for people living with mental illness was still developing. The absence of a collaborative culture between the mental health services delivered by NHS and social work and third and independent sector providers, also limited the team's effectiveness.

Both NHS and social work staff identified that there were fewer resources available to support people in their local communities than before the Covid-19 pandemic. Many felt that the pandemic continued to have a significant impact on the availability of support. However, without a detailed analysis and strategy it was difficult to be certain if this perception was accurate or reflected a gap in awareness and integrated working.

Overall Clackmannanshire and Stirling's commissioning arrangements were in a period of transition. This involved moving from a minimal approach to integration to a clearer focus on improving outcomes through collaboration with people and carers and the third and independent sector. This transition was still to extend to people living with mental illness. Learning from the other areas where the partnership has already begun implementing this approach suggests that progress in improving outcomes for people may take considerable time.

Evaluation

Adequate

Key Area 9 – Leadership and direction

How has leadership in the Clackmannanshire and Stirling partnership contributed to good outcomes for people and their carers?

Key findings

- Specialist mental health services were only delegated to the health and social care partnership in January 2023. This facilitated the commencement of whole systems planning across the partnership's mental health services.

- The partnership had made progress in addressing workforce challenges and developed a comprehensive workforce plan which supported an integrated approach to workforce management.

- The partnership's senior leadership team had increased focus in the past year to develop a more collaborative culture across health and social care services.

- Integration arrangements prior to 2024 meant that the Integration Joint Board (IJB) was limited in its ability to fulfil its responsibilities for the effective delivery of services.

- The pace of developing integrated mental health services that were seamless from the point of view of the people who used them was slow.

- The development of the Integrated Clinical and Professional Governance Group was a positive step, but the professional governance of social work functions needed to be strengthened.

Leadership of people across the partnership

The partnership's vision for the effective delivery of health and social care services and its priorities for mental health were clearly laid out in the 10-year strategic plan. Most staff felt that this vision was clear, and their line managers encouraged them to work collaboratively. They were confident that they had the appropriate knowledge and experience to provide care, treatment and support for people living with mental illness.

Within the last two years the partnership had faced significant challenges. NHS Forth Valley was receiving senior external support and monitoring to address weaknesses in governance, leadership, and culture. This had an impact on the functioning and performance of integration arrangements across the health and social care partnership. Alongside this, historical challenges in the integration arrangements between the NHS board and the two local authorities meant that integration had not progressed adequately. Lack of pace in the delegation of operational management of services meant that the integration joint board was limited in its ability to fulfil its responsibilities for the effective delivery of services.

The partnership faced significant challenges with recruitment and retention of staff at all levels and across all sectors. There had been significant changes in the senior leadership team since the inception of the health and social care partnership.

Progress had been made to address recruitment challenges. Key appointments to executive leadership positions within the NHS board and both councils had been made. Alongside this, recruitments to senior manager posts across adult mental health services were beginning to bring some stability to the workforce. The partnership had invested in dedicated lead roles to support improvement coordination and implementation in specific priority areas. This included self-directed support, carers and health improvement. A new housing policy officer was recruited to support greater collaboration with that sector. In some cases, these developments were beginning to have a positive impact.

There was a clear sentiment amongst all staff that mental health services in Clackmannanshire and Stirling were not yet operating in a fully integrated way. Staff acknowledged that there was an increased focus in the past year to foster a more collaborative culture. Senior leaders recognised that empowering staff at all levels was crucial if they were to achieve their vision for integrated services. The interim chief officer prioritised staff development to support better integration.

The partnership developed a comprehensive workforce plan that included all staff, including those from the third and independent sectors. Leaders recognised third and independent sector staff as integral members of the partnership's workforce. There were several examples of promoting integration with staff from these groups and involving them in service planning at a strategic level. However, we identified important gaps and missed opportunities to capitalise on cross-sector relationships and promote greater collaboration amongst staff who worked in frontline services.

Commitment to the partnership's current make-up of two local authorities being integrated with one NHS board was uncertain. As late as December 2023 senior leaders in both Council's elected member groups were still considering exploring alternative partnership arrangements. This had the potential to further derail progress and impact on service delivery.

Leadership of change and improvement

A new senior leadership team structure had been implemented across mental health and learning disability services. The partnership had also recently developed an Integrated Clinical and Professional Governance Group (ICPGG). The role of the ICPGG was to provide assurance to the IJB, agree governance priorities, give direction and monitor progress of change.

Specialist mental health services were only delegated to the health and social care partnership in January 2023. The delay in delegating these functions meant that the partnership was limited in its ability to develop a whole systems approach to planning and delivering its mental health services. Overall progress toward delivering integrated mental health services that were seamless from the point of view of the people who used them was slow.

Most improvement focused on collaborative leadership, integrated finances, strategic planning, governance, and engagement. At the time of our inspection, staff did not feel that senior leaders were visible. Leaders were working to address this across all

sectors. Current efforts were focused on building foundations to support greater collaboration. There were a few examples where integrated teams and single management structures had been successfully implemented. However, there were still differing approaches to service delivery and implementation of change across Clackmannanshire and Stirling.

The partnership faced further challenge to address areas of improvement in the context of current significant pressure on public sector finances. Over the past year, the partnership had completed the expansion of its primary care mental health service. This was beginning to have a positive impact on reducing pressure on general practices. A dedicated Transformation and Savings Progress Group had been established to drive forward transformation and health and social care modernisation across the partnership's delegated services and monitor progress. There was limited evidence of impact at the time of our inspection.

The partnership revised its directions policy in March 2024 to make the process more efficient. Senior managers were currently progressing work to implement a new self-directed support policy across Clackmannanshire and Stirling. This was signed off by the IJB in June 2024. Alongside this, a direction was issued to both councils to require and support their staff to implement the self-directed support legislation in full. The policy aimed to address the improvements identified following an independent audit of the delivery of self-directed support in Stirling Council. This was positive and it demonstrated the partnership's commitment to a "once for Clackmannanshire and Stirling" approach to the delivery of services.

The partnership's overall approach to managing change required further development. Systems for capturing performance information were underdeveloped. This meant that senior leaders had limited reliable data available to support them to identify priorities and evaluate plans to improve outcomes effectively. Frontline staff and team leaders had limited awareness of improvement developments. Most local authority staff did not have confidence that senior leaders managed change effectively. Senior managers and other staff described the partnership's previous approaches as singular and involving minimal integration which minimised their impact on existing services and organisations.

The new senior leadership team had the potential to more effectively coordinate and direct clinical and social care governance within the partnership and drive forward improvement. The new arrangements aligned with established NHS Forth Valley wide clinical governance groups and there were clear lines of reporting in place to provide assurance to the IJB. However, there was still a gap in social work governance across both local authorities. The partnership was in the process of developing a new framework to address this but in the interim a lack of oversight over professional social work functions presented a risk that required monitoring.

Evaluation

Weak

Conclusions

Clackmannanshire and Stirling health and social care partnership is the only partnership in Scotland where two local authorities were integrated with an NHS board. This arrangement presented unique challenges that affected the quality of support that the partnership could deliver for people living with mental illness and their unpaid carers. Integration had not progressed at the same pace as other partnerships in Scotland and most services were delivered on a single agency basis.

Staff across the partnership were working hard to deliver positive outcomes for people that were broadly in line with other partnerships across Scotland. People living with mental illness had mixed experiences of the support that they received from health and social care services. They felt that staff valued their views and respected their decisions. Unpaid carers of people living with mental illness had negative experiences of the support they received from services. Unpaid carers did not feel that their role was recognised, and it was difficult for them to access services at the right time.

Multi-disciplinary staff across the two integrated community mental health teams (ICMHT) had positive relationships with the people they supported. Co-location and shared access to the care partner recording system supported joint working amongst ICMHT staff. However, there was a lack of integrated processes. This limited collaboration between staff within the ICMHTs as well as staff across the partnership's wider mental health system. There was no systematic approach to providing care, treatment, and support. This meant that staff were not able to capitalise on the strengths of integration partners to deliver services that were seamless from the point of view of people who used them.

Over the past year, there had been an increased focus to develop a more collaborative culture across all sectors in the health and social care partnership. The partnership had successfully established an integrated planning and commissioning team and revised its integration arrangements to ensure that they were more aligned with the principles of the Public Bodies (Joint Working) (Scotland) Act 2014.

Progress had been made to strengthen the workforce and clinical and care governance. However, these improvements were developing from a low base and overall progress to improve mental health services was slow. The new senior leadership team had the potential to build on the momentum built over the past year to address immediate areas of improvement. Success will require strengthening the partnership's outcome-focused commissioning approaches for people living with mental illness. This should be considered in the partnerships ongoing work to develop a Forth Valley wide mental health strategy, due to be finalised in March 2025.

We met with the partnership on 6 November 2024 to discuss strengths and areas for improvement. We requested a joint improvement plan that clearly details how the partnership will address the key improvement areas identified by the inspection. Progress on implementing this plan and improvement achieved will be monitored in the short term through established link inspector arrangements. We will also arrange a formal follow up review at an appropriate stage beyond the next 12 months.

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 the 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

Engagement framework

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. 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.
Advance statement	This is a written statement, drawn up and signed when the person is well, which sets out how they would prefer to be treated (or not treated) if they were to become ill in the future. It must be witnessed and dated.
Advocacy (services)	Advocacy services support people to express their views and wishes and help them to stand up for their rights. Someone who helps in this way is called an advocate.
Anticipatory care plan	See Future Care Plan.
Capacity	Capacity is the maximum amount of care, support or treatment that a day service or individual member of staff can provide.
Care Programme Approach	A process that enables effective multi-disciplinary working to support people living with mental illness and associated complex health and social care needs to receive on-going care support and supervision throughout their detention in hospital and rehabilitation into the community.
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.
Cognitive behavioural therapy	Cognitive behavioural therapy (CBT) is a talking therapy that can help you manage your problems by changing the way you think and behave.

Collaborative commissioning consortium	A commissioning consortium enables a partnership approach to health and social care delivery. All strategic partners (including third and independent sector), partner authorities and citizens, particularly those with lived experience, work together to develop improved services based on need and resources. It offers a robust framework with clear roles, responsibilities, and processes.
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.
Community link workers	An early intervention service which offers support to people who attend their GP and sometimes require support with social or other issues. It supports people to improve their health and wellbeing and enable people to self-manage health conditions by providing information, support, and signposting to appropriate services.
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.
Core Suite of integration performance indicators	These are indicators, published by Public Health Scotland to measure what health and social care integration is delivering.
Distress brief intervention	This programme is being rolled out to improve the response to people in distress. It is a non-clinical intervention enabling first response personnel to have a compassionate and connected approach. Followed by the opportunity for onward referrals for continued to support from local services to develop community-based solutions, wellness and distress management planning.
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.
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 well-being 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.

Future 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. This was previously called an anticipatory care plan.
Good conversations	This training supports staff to develop skills in adopting a personal outcomes approach with service users. It enables staff to improve assessment and planning of care support and rehabilitation by supporting a focus on wellbeing, prevention, anticipatory care and self-management.
Governance	The process that health and social care services follow to make sure they are providing good quality and safe care, support and treatment.
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.
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.
Kooth and Qwell	Digital mental health platforms which provide free and anonymous online counselling and mental health support.
Localities	Agreed sub-areas within a health and social care partnership area. The partnership should make sure it understands and responds to the diverse needs of people in different localities.

Medication Assisted Treatment Standards: access choice support	Evidence based standards to enable the consistent delivery of safe, accessible, high-quality drug treatment across Scotland. **Standard 6: Psychological Support:** This standard focuses on the key role that positive relationships and social connection play in people's recovery. Services recognise that for many people, substances have been used to cope with difficult emotions and issues from the past. Services will aim to support people to develop positive relationships and new ways of coping.
Mental Health (Care and Treatment) (Scotland) Act (2003)	Legislation that applies to people who have a "mental disorder" - this is defined under the Act and includes any mental illness, personality disorder or learning disability.
Mental Health Acute Assessment and Treatment Service	A 24-hour a day service offering emergency mental health assessment, liaison psychiatry, supported discharge, intensive home treatment and crisis intervention.
Named person	Someone who can look after your interests if you are cared for or treated under mental health legislation.
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.
NHS Scotland support and intervention framework	Scottish Government framework for monitoring performance and managing risk across the NHS in Scotland. The framework provides five stages of a ‘ladder of escalation’ that provides a model for support and intervention by the Scottish Government. Stage four means senior external support and monitoring. The onus remains on the NHS board to deliver the required improvements

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.
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.
Public Health Scotland	A national organisation with responsibility for protecting and improving the health of the people of Scotland.
Providers	Organisations from which the health and social care partnership purchases care to meet the needs of people who need support. Services, such as residential care, care at home, day services or activities.
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.
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, 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.
Statutory orders	Powers applied under legislation. This may be restrictions on liberty or decision making under the Mental Health (Care and Treatment) (Scotland) Act (2003).

Strategic needs assessment	A process to assess the current and future health, care and wellbeing needs of the community to inform planning and decision making.
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. Whilst 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 whilst 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 & 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.

Headquarters
Care Inspectorate
Compass House
11 Riverside Drive
Dundee
DD1 4NY
Tel: 01382 207100
Fax: 01382 207289

Website: www.careinspectorate.com
Email: enquiries@careinspectorate.gov.scot
Care Inspectorate Enquiries: 0345 600 9527

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