# Joint inspection of adult services

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

Highland Health and Social Care Partnership

August 2025

## Contents

# 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 proposed that joint inspections should better reflect integration, and specifically, that the Care Inspectorate and Healthcare Improvement Scotland should ensure:

- 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) or equivalent, 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 Highland health and social care partnership was the sixth in the series of inspections, and the third 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

The Scottish Government's priorities for improvement in mental health services are set out in the Mental Health Strategy 2017-27 and the Mental Health and Wellbeing Strategy 2023.

Health and social care partnerships across the country, including the Highland partnership, are currently facing a number of challenges. These challenges affect the planning and provision of the range of health and care services, including mental health services.

Covid-19 increased demand for health and social care services and led to challenges with recruitment and retention. This put the partnerships ability to maintain capacity, sustainability and quality of care services at considerable risk. Several other reports[1,2,3,4] have highlighted this across the country.

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

## Explanation of 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 Highland partnership**, we mean Highland Health and Social Care Partnership which is responsible for planning and delivering health and social care services to adults who live in Highland.

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

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

There is an explanation of other terms used in this report at **appendix two**. This includes our data descriptors, where we use the terms **almost all, most, some, few** or **just under** or **over half** to describe a volume of data.

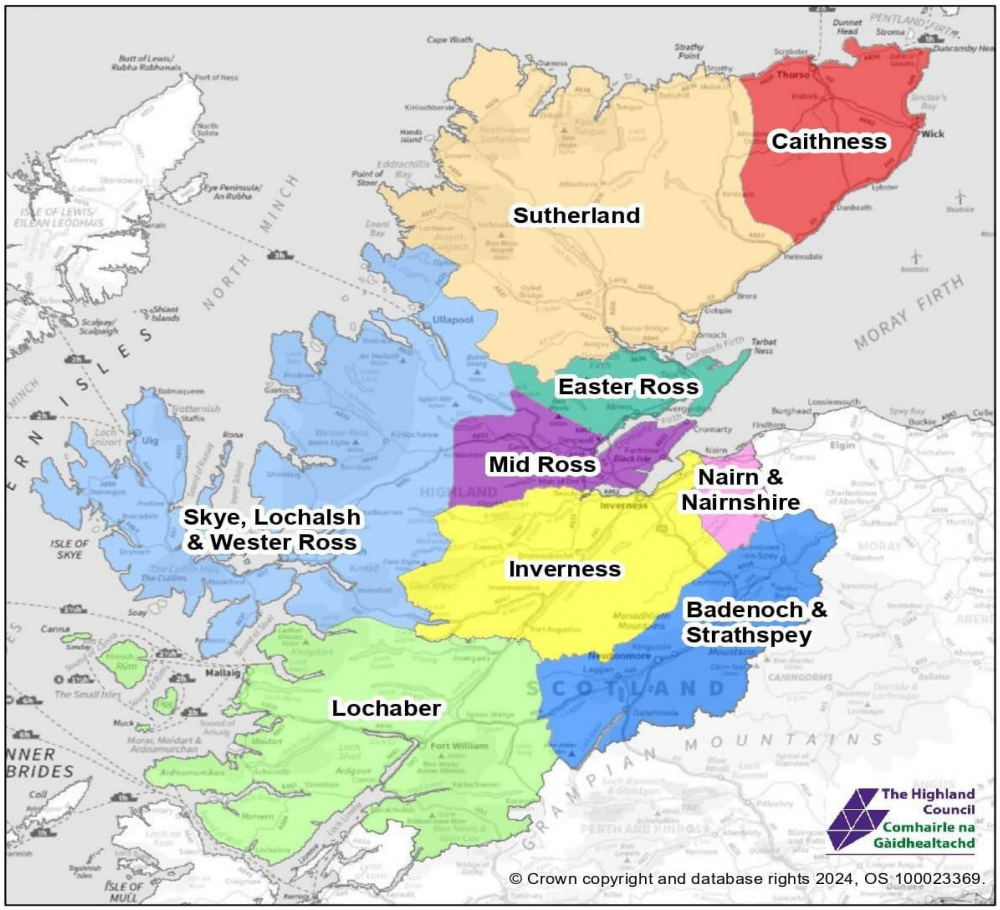
[1] Audit Scotland, Social Care Briefing, January 2022 (https://www.audit-scotland.gov.uk/publications/social-care-briefing )
[2] Audit Scotland, NHS in Scotland 2021, February 2022 (https://www.audit-scotland.gov.uk/publications/nhs-in-scotland-2021)
[3] Social Care Benchmarking Report 2022. July 2023. 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/ )
[4] 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/)

## PART 2 – A Summary of Our Inspection

### The Partnership Area

The Highland partnership area was co-terminus with The Highland Council (THC) area. Highland has a vast area, covering more than a third or 42% of Scotland's land mass. It is comprised of urban areas, small towns, rural and very rural areas, with Inverness City as the main centre. Figure 1 shows the nine community planning partnerships known as districts within the wider partnership area. Caithness in the very northeast includes the towns of Wick and Thurso which are affected by high levels of socioeconomic deprivation. Surrounding Inverness are Mid Ross, Nairn & Nairnshire and the district of Inverness itself. North of Mid Ross is East Ross which also has high levels of deprivation, with Alness town in its locality. Very rural areas include Badenoch & Strathspey, Lochaber, Skye Lochalsh & Wester Ross and Sutherland in the far northwest, adjacent to Caithness. In this report the term partnership refers to the health and social care partnership, with districts being used to describe community planning partnerships.

**Figure 1 – Community Planning Partnership area map for Highland Council**




**Source: Highland Community Planning Partnership, 2024**

Some areas of Highland are the most remote and sparse in the country. Across this geography, Highland has a population of 235,540 people, the seventh highest population of the 32 local authorities, although not densely populated. Between 2001-2023, Highland experienced a 13.1% increase in population, while Scotland's population saw an 8.4% increase. Its gender split was 51% female and 49% male. The most populous age range was 45-64 years, with the greatest growth being in people aged over 75 years.

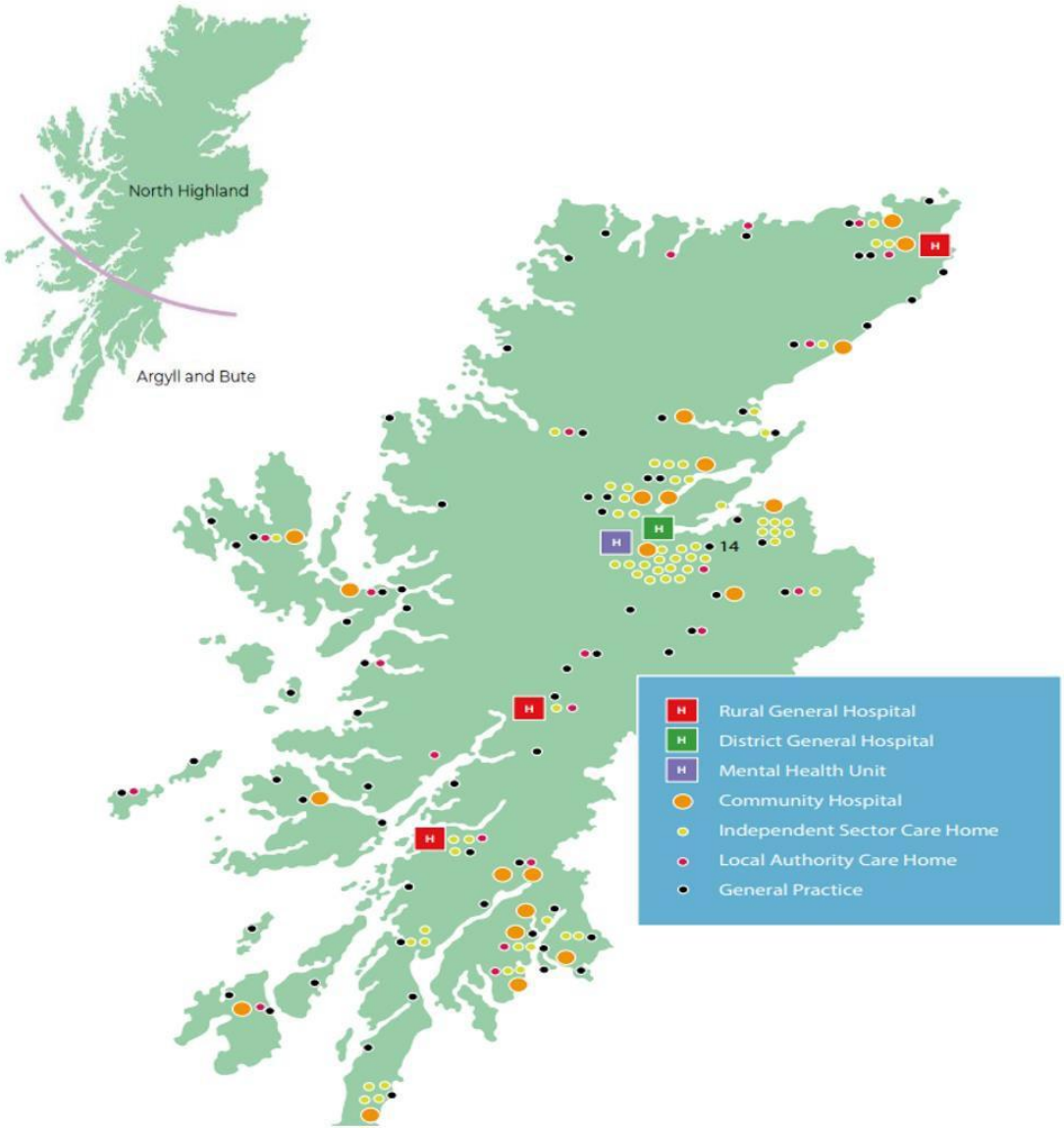
In 2022 the Highland population was almost all white Scottish or British (92.1%). The largest minority ethnic group was white Polish, forming 1.91% of its population. Within Highland 8.08% of people had one or a combination of Gaelic speaking, reading or writing skills.

Exploring health and determinants of health, women had a life expectancy of 81.8 years and men of 77.6 years. Almost a quarter (23.5%) of children aged under 16 years lived in households affected by poverty, and 9% of all people lived in socioeconomically deprived areas of Highland. In December 2023, a small proportion of adults (2.5%) aged at least 16 years were unemployed, with most working aged adults (76%) in Highland being employed. Highland performed better on average than Scotland for both employment and unemployment. These impact on mental health, with Highland suicide rates being the second highest in Scotland.

Highland partnership operated a lead agency model with NHS Highland being the lead agency for adults' health and social care. Highland Council (THC) were the lead for children's services. Instead of an integration joint board arrangement the Highland partnership had a Joint Monitoring Committee (JMC), which provided an alternative model of integration. The JMC oversaw governance, with several thematic working groups including representation from health, social work, third and independent sector, carers and people with lived experience of using health and care services. Significantly, in December 2024 the partnership made the decision to progress from the lead agency model to an alternative model of integration.

Locations of some key health and care services are shown in Figure 2. This shows a cluster around Inverness. These served the large city population and often the Highland wide area. Other services were predominantly scattered along the coastline and the Great Glen Fault.

**Figure 2 - Map of NHS Highland health and residential care services and the boundary line map (top left) between NHS Highland's two partnerships**




**Source NHS Highland Together We Care strategy 2023-28**

In 2023 there were 21,500 people living independently at home with a mental health condition and 11,000 people living with a mental illness who required support from mental health services in Highland partnership. The proportion of people reporting a mental illness in Highland rose from 3.7% in 2011 to 10% in 2022, a threefold increase in demand. The most prevalent mental health group by age was people aged 25-34 years, followed by 16-24 years and thirdly those aged 35-49 years.

The primary care and forensic mental health teams, psychology and the Mental Health Assessment Unit (MHAU) were managed centrally by NHS Highland. In-patient services were provided at New Craigs Hospital, Inverness. New Craigs was the specialist mental health hospital for the Highland area. There were nine integrated Community Mental Health Teams, one for each district. There were four mental health care homes, two in Inverness and one in Nairn and Alness. The recovery centre in Inverness provided by Centred provided step-down care and support to people coming from New Craigs Hospital and care at home. There was one residential rehabilitation provider locally which provided residential rehabilitation and supported accommodation for those seeking recovery and abstinence from drug and alcohol use. There were a range of housing support, day and care at home services across Highland.

## Summary of our Inspection Findings

The inspection of Highland health and social care partnership took place between January 2025 and June 2025.

- We received 19 completed surveys from people and unpaid carers and spoke to 93 people living with a mental illness and 31 carers. Our engagement with people and carers was conducted through 66 individual conversations and eight focus groups across all nine Highland districts.

- We reviewed the records of 33 people living with a mental illness, three of which the partnership identified as good examples of integrated working between health and social care. The review of records sample was based on the nine districts of Highland. Following this we met with 12 multi-disciplinary teams of 41 staff, and nine people and carers.

- We carried out a survey with staff, which was distributed by the partnership, and received 118 completed surveys from staff, managers and leaders from health, social work and the third and independent sector across the Highland partnership.

- In our discussions with staff, we spoke to 84 members of staff from health, social work, occupational therapy, third sector social care providers and

planners, commissioners and managers. We undertook six individual professional discussions with the Highland partnership's leadership team.

- We carried out two site visits involving mental health wards, the Mental Health Assessment Unit, the Forensic Mental Health Service and the Inverness Community Mental Health Team, all of which were based within New Craigs Hospital in Inverness.

- Across the inspection 151 people and carers and over 249 staff and leaders informed our inspection, in addition to those spoken to informally during site visits, meetings and whilst receiving training on the partnership's recording systems.

- We reviewed some 155 pieces of written evidence provided by the partnership and sourced online. This included a comprehensive position statement report on the partnership's work regarding mental health strategy and delivery.

## Key Strengths

- The partnership delivered positive outcomes for most people living with mental illness.

- Most people living with mental illness had a positive experience of the support they received to maintain and improve their health and wellbeing. Good care and support from health and social care services ensured this.

- The partnership worked closely with their NHS Highland's public health colleagues and offered a range of effective early intervention and prevention initiatives which people valued and was beneficial to them.

- The partnership engaged collaboratively with people and carers, and between staff teams and services, in designing and delivering operational processes and effective strategic planning for health and social care within mental health services.

- Partnership leaders demonstrated a clear strategic vision, strong values and modelled these to positively influence the Community Planning Partnership and local government councillors. This strengthened the overall commitment and prioritisation of mental health strategic work.

- The leadership team was focused on integration, and sought to deliver change, learn from others, and focus on improvement. They were a unified team that instilled confidence in their capacity to make the shift to a body

corporate model.

- Highland partnership was responsive and innovative in its approach. It introduced several pilot initiatives to reduce inequalities and consistently delivered health and care services to people across the partnership, with online and in-person options offered.

## Priority areas for improvement

- The partnership should develop an integrated outcomes framework that captures personal outcomes data for people living with mental illness and for their carers. Their feedback is essential for driving improvement.

- The partnership was innovative and was implementing change aimed at addressing gaps in remote and rural areas. Successful pilots needed accompanying delivery plans and scaled up if the partnership was to take full advantage of these measures and address equality issues.

- The partnership should provide an effective system to support staff in sourcing care and support options for people needing care and support. Information on health and care service options should be more accessible and in a suitable format for people and carers seeking mental health services.

- The partnership should develop a joint workforce strategy to support its clear commitment to staff development and progression.

- The partnership should develop a quality assurance system to monitor implementation of its valuable processes and procedures. Findings from this would inform workforce development planning at a strategic level.

## 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 | **Good** |
| 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 | **Good** |
| | 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 | **Good** |
| 9 - Leadership and direction | 9.3 Leadership of people across the partnership | **Good** |
| | 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 living with mental illness and their unpaid carers in Highland?

### Key Messages

- The partnership delivered positive outcomes for most people experiencing mental illness.
- People and carers outcomes data was not routinely collated and analysed. If addressed, the partnership would better understand how well services were supporting people and what service planning and improvement would be helpful.
- The Highland partnership effectively supported people to look after their health and wellbeing.

### 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. The Highland health and social care partnership's performance against the most recent core integration indicators was positive given the unique challenges in which the partnership operated.

Our inspection found the partnership delivered positive outcomes for most people. The partnership had a range of clinical outcome measures and tools used to gather information about people's outcomes, including a well-designed personal outcomes plan template that encompassed carer information. The partnership's adult carer support plan also effectively captured their outcomes.

While these useful outcome tools and templates were in place the partnership did not aggregate, analyse or use them to monitor people and carers' personal outcomes. This meant it did not accurately know the impact of health and care service contributions to people's health and wellbeing.

From conversations with people and carers engaged with mental health services, and from reviewing their records, we found the following.

## 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 | Most people were supported to live as independently as possible. |
| 3 | Most 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* | Outcomes relating to unpaid carers feeling supported to continue in their caring role and to look after their own health were less consistent than outcomes for people. |
| 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 living with mental illness experienced positive outcomes and were well supported to look after their mental health and wellbeing. Statutory and third-sector services worked together to achieve this. People were supported by health and social care staff working collaboratively to access a range of valuable community resources that helped them to maintain their positive mental health. Examples included volunteering opportunities at CrossReach's residential rehabilitation service, Beechwood House, where former residents were supported to share their ideas in designing a new residential service. These effectively supported people's self-esteem and wellness. Other people kept well by developing skills and interests such as horticulture, furniture making and animal care at the Cantraybridge Centre. Good support from care staff with daily living skills was also available to help people pay bills, cook and carry out housework. Positive outcomes from these interventions included returning to, or maintaining employment, and knowing where to go for support when needed.

**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.**

Most people living with mental illness were supported to live as independently as possible. This included those supported by services and community resources aimed at maintaining parental responsibilities, developing community interests, and sustaining positive relationships.

The partnership effectively promoted all self-directed support options to most people experiencing mental illness. This supported people to have more control over their care and support although geographical challenges made some options challenging to deliver.

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

Most people living with a mental illness in Highland were treated with dignity and respect. Health and care professionals showed people care and kindness whilst providing them with care and support. Most people positively rated the help, care and support they received from the partnership. They valued treatment interventions from psychologists, psychiatrists, community mental health nurses, social workers, occupational therapists and social care staff. They described health and social care professionals as helping them to better understand their world and life experiences. These positive working relationships helped people to complete their treatment, attend appointments, and improve their mental health and wellbeing. It increased confidence amongst people to live safely and contentedly in their communities supported by a network of family, friends, neighbours and health and social care professionals.

**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.**

Health and social care services supported an improved quality of life for most people living with mental illness. People experienced improved mental health, increased confidence and independence. They continued living at home, accessed local communities, developed skills, lived productive lives and sustained positive relationships. Overall, there was good evidence that relationships between staff and people were therapeutic and impactful.

**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.**

The partnership strove to support carers. They commissioned the Connecting Carers service and critically, those accessing this service had positive experiences and outcomes. This service provided flexible support, including short break funds, benefits rights advice, financial advice, access to grants and completion of an adult carer support plan (ACSP). Carers benefitted from peer and staff support through the carer service. This evidenced that where carers accessed support it was impactful and helped carers to maintain good health and wellbeing.

Despite this valuable service, not all carers were aware of ACSP options or offered support and carers' outcomes across Highland were more mixed. It was important for carers to look after their health and wellbeing to enable them to continue their caring role.

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

Most people living with mental illness felt safer in their home and in the community due to the health, care and support interventions they received. This enabled people to live in their communities for longer which was a desired outcome for most people. This was positive given the significant geography and limited resources available in Highland.

## Evaluation

- **Good**

## Key Area 2 - Experience of people and carers

### What impact have integrated service approaches had on the lives of people living with mental illness in Highland?

### Key Messages

- Most people were offered a range of early interventions to help them look after their own health and wellbeing and live better for longer.
- Most people maintained or improved their health and wellbeing for as long as possible because of the care and support they received from health and social care services.
- Most people were treated with dignity and respect and were shown care and kindness by staff in health and social care services.
- Most people felt that services and teams worked well together to support them in achieving improvements in their lives.
- Most people were supported to attend their reviews and were supported by staff to share their views.
- Most people were supported to make meaningful decisions about their care and treatment, though more use of advanced statements was needed.
- There were specific challenges for a few people in accessing services at the right time, with limited choice in remote and rural areas.
- Carer services were effective, though overall carers of people living with mental illness had more mixed experiences and outcomes from the support they received from health and social care services.
- People and carers had mixed experiences in accessing advice and information about where to get help.

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

From the records we read and the people we spoke to, most people experienced good outcomes through services and teams working well together. We saw good involvement of the third sector and independent sector. Most people living with a mental illness agreed that staff worked well as a team to help them improve their lives and most people had positive experiences of care and support in Highland.

Most people confirmed services communicated well between teams and the different staff who supported them. Staff collaborated well with one another, sharing information, assessments and care plans. This removed the burden from people needing to update their different staff on important changes in their lives. Some clearly experienced very good outcomes from different teams and professionals working together to help them achieve what they wanted in terms of housing, treatment, care and lifestyle. Yet this was not always the case. Some people were supported by different services working to different plans, holding separate reviews. Most carers felt that support could be improved if it was better joined up across health and care services.

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"If anything goes wrong staff will be on the phone to each other." (Person 1)

"I don't have to keep repeating myself and they do listen." (Person 2)

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People described positive experiences when services intervened in critical situations and when providing continuing support to manage their health and wellbeing. They viewed staff as thorough and empathetic throughout the spectrum of care provided. People experienced a quick response when they were in a mental health crisis, although they felt that access to a hospital bed was limited. Local police were particularly helpful during urgent and crisis situations, sometimes providing people with a place of safety when required although follow up care was inconsistently provided by health and care services.

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"The service I have received has been seamless. A crisis made me realise that I needed help. I saw my GP and the support kicked in immediately." (Person 1)

"I just needed people to care for me and that's what happened." (Person 2)

"There has never been a time when I have felt alone on my journey." (Person 3)

"The community police live in our communities, so they understand the issues. They gave me a safe place to sleep for the night." (Person 4)

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People described impactful learning through self-management techniques that improved their recovery and independence using integrated approaches and peer support. Most people experienced improved quality of life because they regained or

maintained their employment, lived independently, developed community connections/networks of support, and knew where to receive help. Carer views were more mixed with just under half feeling supported to look after their health and wellbeing and live better for longer.

> "I am still on a journey towards better mental health. The support I am getting is helping me to get there." (Person 1)
>
> "Tips and techniques to manage my breathing and thoughts have helped me manage my symptoms and not feel suicidal." (Person 2)

Carers had mixed views about the person-centeredness of some services. For example, people had to complete online courses such as 'decider skills' before they could receive cognitive behavioral therapy (CBT). These online courses were clearly not suitable or accessible to everyone which diluted their value and meant that care pathways did not adjust to people's needs. People were sometimes asked to participate in group therapy which could be distressing, rather than an offer of individual interventions. More positively, people felt able to discuss issues when required, and they were involved in meetings with professionals. Where a carer's plan was in place it led to more positive experiences, including getting additional leave at work for caring responsibilities.

A few people experienced difficulties accessing services at the right time due to the lack of equitable service provision across Highland. Access and choice was more limited in remote and rural areas due to the challenges of delivering services to these locations with limited resources.

> "My life doesn't feel like it matters. You feel worthless when they say there's no money." (Person)

Most people were treated with dignity and respect and shown care and kindness by health and social care professionals. People felt understood and respected by staff and that staff were aware of their mental health challenges and how this affected their lives. Staff were empathetic and would mediate for them with other people using services to enable both to continue attending, having resolved any conflicts or tensions which arose.

> "The staff know me well, they pick up when I am feeling down and spend extra time with me." (Person 1 from focus group in Centred in Invergordon)

> “All staff have always treated me with dignity and respect. I have never had any issues… I have been treated with kindness by everyone.” (Person 2 regarding staff at New Start social enterprise service)
>
> “They talk to me as a person, as an individual. It's a great thing!” (Person 3 regarding NHS, social work team and the Gateway homelessness service)

In a few instances staff were not as respectful to people as they could be. A few people described not being listened to, shown compassion or treated with dignity and respect. Sometimes staff didn’t recognise people’s presentation or behaviour was due to their distress and or poor mental health. At times people and carers in remote and rural areas felt pressured to make certain decisions about care options, due to the lack of availability of community services. They were told that they just had to ‘*take it or leave it’*. Some carers also felt that communication could be better. While we saw that carers were almost all part of the integrated team around the person, some did not feel listened to by services.

> “They asked me, ‘Are you really providing 12 hours of care for your son?” (Carer who was paid through direct payments)

Some carers felt that it was a challenge to balance their caring role and paid employment. They felt that being a carer trapped them in a poverty cycle which made life harder for them.

> “My life is not better due to services as it adds so many complications with inconsistency of carer [staff] and no social work allocation. I wish I could give up work to care for my mother...” (Carer)

### People’s and carers’ experience of prevention and early intervention

Most people were able to maintain or improve their own health and wellbeing for as long as possible because of the care and support they received from health and social care services. The partnership offered an effective range of therapeutic

interventions to support positive mental health and wellbeing. This included decider skills, ‘You Matter’, early intervention in psychosis, graded exposure therapy, dialectical behavioural therapy, and psychosocial interventions in psychosis. Community mental health nurses and social workers also directly referred people to

local non-statutory or third sector services which provided effective therapeutic support and social activities.

There were numerous good examples of prompt access to services, support through community initiatives, employability opportunities and peer led support. For example, people were supported with self-management techniques. If they were not feeling well, support staff would encourage people to see their GP pre-emptively to support good mental health. Mental health practitioners within GP practices were very supportive and signposted people to useful community supports to maintain social contact and keep busy. Carers benefitted from peer and staff support through the Connecting Carer's service.

Despite the positive array of services people and carer's experiences of early intervention and prevention were mixed. Some people felt that they did not get the support they needed at the right time or in the right place. People and carers were not routinely offered opportunities to discuss future health needs and plan for changes in their circumstances, for example through pre-emptive emergency care plans and advance statements.

> "They don't recognise I need scheduled support to be able to function in life." (Person 1)

In a few instances where people lived with their carers, they were assessed as 'homeless at home', making them a low priority, despite a statutory duty to offer temporary housing. Carers felt that this left them in an uncomfortable position where the only way to progress their housing application was to evict the person from their home, putting them at risk. Carers felt that there was a lack of supported housing available in Highland for people needing help to live independently.

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

We found most people and carers were involved in a range of care and treatment reviews. Most said they were supported to make meaningful decisions about their care and treatment. They felt supported to share their views about what mattered to them and that their views were always valued and respected. Some reviews were multi-agency, including the Care Programme Approach (CPA), and other reviews were single agency led.

> “I am fully supported by the staff to make my decisions…they [staff] offer suggestions, but I don’t have to take them.” (Person 1)
>
> “My psychiatrist always asks me how I am and what I think.” (Person 2)
>
> “When I was first admitted I was allocated a male key worker. I relate better to women. This was considered and a female key worker was allocated to me.” (Person 3)

People and carers had mixed experiences of being able to find the right information at the right time. Some people felt that they were given helpful information about their illness, which helped them to understand and prepare for their treatment journey. However, others found it difficult to find the right information and they felt that the information available online was not helpful.

> “I received good information about the service and the commitment and responsibility was very clearly explained to me.” (Person 1)
>
> “They could not have given me more information. The way they told me helped me understand what was going on.” (Person 2)
>
> “My GP diagnosed me with PTSD, but I received no information on the illness at that time. This made coping with the illness more difficult as information online was overwhelming.” (Person 3)

Carers who drew on the support of the Connecting Carers service and the Citizens Advice Bureau were well informed. However, outwith these services, carers received insufficient information and/or in a less helpful format on mental health services and community resources which could help the people they cared for. A few carers felt that their rights as carers were not always fully explained to them.

Some people and carers were supported by advocacy services. In these instances they felt that it was "*helpful in the big meetings*" and enabled them to receive appropriate care and support from health and social care services. People spoke positively about the Spirit Advocacy collective advocacy service which was commissioned by the partnership. They felt that this service gave them a voice which could help improve services and hold the partnership to account. People and carers generally did not provide feedback to statutory health and social care services, but third and independent sector services positively sought this.

Most people were well supported by staff to make meaningful decisions about how they wanted their care and support provided with overall good choice including the gender of staff. They could choose to attend many health and social care interventions in person or online. We saw evidence of initial or comprehensive self-directed support (SDS) discussions with most people. There were a few instances where people and carers' experiences were less positive. This related to occasions where people lacked awareness of SDS brokerage services and recruitment of staff. People and carers found the SDS landscape difficult to navigate without brokerage support.

### Evaluation

- **Adequate**

## Key Area 5 - Delivery of Key Processes

### How far is the delivery of integrated processes in the Highland partnership effective in supporting positive outcomes for people living with mental illness?

### Key Messages

- The partnership had effective early intervention and prevention systems and processes in place that supported people to achieve and maintain good mental health and wellbeing.

- The partnership commissioned a collective advocacy service to systematically involve the voices of people living with a mental illness in its strategy and delivery of mental health services. It was used effectively to inform the partnership on these areas.

- The partnership promoted a wide range of community services and initiatives that supported people living with mental illness to stay well and engage with their communities. It used in-person and remote options to reach people across the partnership.

- Highland had an effective carer service that provided good advice and promoted good outcomes for those accessing the service.

- The mental health officer (MHO) team was nationally recognised for its sustainability and good practice. Out of hours rurality provided challenges.

- Staff worked collaboratively across sectors but this was hampered by technology restrictions, occasional use of paper records and lack of information sharing agreements with third sector partners.

- While there was a range of helpful guidance on health and care processes and procedures health and social work staff were not always aware of some key procedures and guidance.

- The capacity assessment process lacked clarity and staff awareness.

### Processes to support early intervention and prevention

A good range of early intervention and prevention initiatives, activities and services were in place across Highland. Positive examples included arts and crafts, sporting and outdoor activities, peer support groups and volunteering and employability initiatives. These innovative services promoted and supported people to maintain

good mental health and wellbeing. Staff actively promoted this broad range of opportunities, there was better availability in South and mid-Highland.

GPs further supported the partnership's early intervention approach through the Primary Care Mental Health Team (PCMHT). It provided treatment for people with mild to moderate mental health needs. To support all areas equally, the PCMHT had two mental health professionals in each GP cluster area. Most people who completed treatment achieved good outcomes which indicated that treatment was impactful. Improved information and awareness about the service's referral criteria was needed to enhance access and attendance.

There was use of self-management techniques, crisis self-management plans, advance statements and prompt responses to people during a mental health emergency. Where these plans and statements were in place people had copies which promoted self-control and prevention principles. Wider promotion of their use by community mental health teams (CMHTs), in-patient and psychology services and sharing with partners would strengthen preventative approaches and any future crisis care.

To support ongoing recovery, prevent relapse and provide hope for other people's recovery journey, the partnership delivered a range of effective recovery and peer support interventions. This involved support and training opportunities for people living with and recovering from a mental illness and created avenues for people to achieve better health and wellbeing outcomes. People could access volunteering and employment opportunities to sustain their recovery, hope and improved prosperity in local areas. Skills academies offered training for people and carers to enhance their skills.

Carers provided good support for people living with mental illness across Highland which most staff recognised. The partnership commissioned the Connecting Carers service to provide dedicated support and advice. This valuable service had a mental health link worker for carers who facilitated weekly daytime support groups in Inverness. The group made a significant difference to carers' wellbeing, with some carers travelling long distances to attend. Carers were supported by the short breaks fund and other grants such as Support To Be breaks and Wee Treats. These improved carers' quality of life and helped them to continue caring. The partnership was aware of the challenges in providing consistent carer support and advice across Highland and was working to find solutions. A refreshed Carer's Strategy 2025-28 was co-produced with carers to provide improved responses for carers.

For people requiring urgent mental health support and treatment, responses varied across Highland's districts. The mental health assessment unit (MHAU) based in Inverness provided in-person or remote assessment 24/7 across all NHS Highland areas. It provided urgent mental health assessment and responses for new and existing patients. This helped to keep people safe and reduced the need for

emergency detention and hospitalisation. Direct referral by third and independent sector providers would provide direct access and strengthen this model. Feedback from people and partners from north and west Highland would support the exploration of alternative models to that which they had.

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

The community mental health teams (CMHT's) operated under two separate structures, with community management in north and west areas of Highland, and mental health and learning disability management in south and mid areas of Highland. Each of the Highland districts had its own identity. The partnership agreed a plan to create a single mental health led service structure bringing one management structure, more effective oversight and shared learning.

Different electronic recording systems and a reliance on paper-based recording in a few areas of practice hampered information sharing between teams and services. This posed a risk to the safe delivery of care and effective integrated working. The issue was most evident where staff worked with people subject to mental health or adults with incapacity legislation who did not always know if a mental health officer (MHO) was involved. NHS Highland was close to completing the introduction of a new patient information system across Highland. This supported stronger information sharing between health professionals. Access to this system for social work or third sector staff would enhance the effectiveness of this system.

Despite these specific challenges, we found staff from other services collaborated and shared information well. Examples included co-located services, use of the care programme approach (CPA) and across residential services. The CPA was used for people with complex mental health needs and linked well with other services involved, such as homelessness or drug and alcohol recovery services (DARS). This strengthened a multi-agency approach and shared understanding of the person's plan and desired outcomes. Regular integrated CPA reviews effectively oversaw the plan's progress and was managed by a care coordinator. This was further strengthened by good key worker involvement from relevant disciplines. Use of multi-disciplinary meetings facilitated good care coordination more generally.

Integration was further supported by Highland-wide daily huddles between all nine CMHTs, police, unscheduled care teams and distress and brief intervention (DBI) staff to ensure all referrals were appropriately considered. This was a well deployed approach, with concern reports which any service could submit to alert community mental health teams of a person at mental health risk. South and mid-Highland CMHTs had co-located professional groups, with the Inverness CMHT additionally co-located within New Craigs Hospital enabling enhanced joint working with ward

staff. New Craigs Hospital had rehabilitation beds and step-down care through the Centred Recovery Centre. Residential mental health services often displayed good communication between providers and statutory services.

The personal outcomes plan (POP) template was a well-designed tool used by services to access social care services for people, record reviews and outcomes. This led to supported information sharing and integrated practice. Social work staff used this tool more routinely. More consistent recording in the POP and increased use by health professionals would strengthen comprehensive implementation of this tool.

Partner agencies regularly contributed to meetings and reviews. Some arrangements shared assessments, for example between CMHT and DARS. Highland was one of the high performing areas for medication assisted treatment (MAT) standard 9, supporting people with substance use and another mental illness to access prompt mental health treatment. This was a longstanding improvement area across Scotland that they were actively addressing. While positive areas of practice were noted, more was needed to support the consistent spread of enhanced joint working and strong outcomes for people.

A single point of access (SPOA) was available for integrated community services. Thereafter, social workers worked hard to ensure people identified and received the most suitable self-directed support (SDS) options and waiting lists were effectively monitored to reduce long waits. Despite this there was a high level of unmet need experienced by people in Highland. Staff were not supported with an online system to efficiently source appropriate available support for people assessed to need help. This caused considerable duplication of effort for busy social work staff.

The partnership succeeded in making some improvements to the quality of people's experiences of emergency mental health responses in remote areas. A new escort policy was used to facilitate people's transport to hospital when they were acutely unwell. This used cars rather than ambulances and people could be accompanied by someone they knew. In remote areas, the police were often welcome first responders and the partnership used local community hospitals for assessments. GPs were often authorised emergency detentions of people to hospital out of hours.

Accessing more general mental health in-patient care and treatment in Highland was difficult, due to geography, bed availability and timing. Highland had approximately 59 mental health inpatient beds for adults under 65 years, which was low for its population size. Occupancy was consistently at 100%. Before each weekend, hospital staff were under pressure to create bed capacity due to anticipated increased demand, leading to people being sent home on temporary pass and others being admitted to chairs for several hours rather than beds. This impacted on the quality of people's care. The partnership was aware of this resource issue. They were in the process of reconfiguring hospital beds to prioritise acute care and

drawing on the nearby Centred Recovery Centre for rehabilitation beds with new terms and conditions.

New Craigs hospital had effective multi-agency discharge planning arrangements in place including digital applications. Greater awareness amongst staff would enhance the impact of this process. In addition to technology for recording systems, the large geography was an obstacle for district staff in maintaining relationships with people through visits due to the lengthy travel time required. Not all third sector partners were invited to multi-disciplinary discharge meetings. This led to a communication gap at discharge which negatively impacted on people.

There were long waiting lists for psychological services and psychiatry, and for Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder (ASD) assessments. People with ASD and borderline learning disability struggled alone with poor mental health and came to the attention of services when they experienced a mental health crisis. Programmes were offered by Community Mental Health Teams (CMHTs) to provide interim support to people waiting for psychology services. While the partnership had reduced the psychology waiting list, not all people removed from the list had received treatment. Check-ins with people while waiting would have enabled oversight of risk and changing prioritisation and kept people informed. The use of risk assessments was less consistent for people living with a mental illness who were supported by statutory services.

The CMHTs had a growing caseload due to pressure on services but they prioritised people. Responsibly and through regular reviews, where people were stable and had support, safe discharge occurred. People with more complex needs remained on CMHT caseloads for periodic psychiatric review or annual review, keeping people safe. Good collaborative working supported people with complex needs, such as through DARS and justice, preventing exclusion and risk. Other minority groups required a more considered response and where people were discharged to adult social work teams, these teams would have benefitted from more training to provide support for complex needs.

While the partnership's adult carer support plan (ACSP) template usefully incorporated a Carer's Star tool to measure their outcomes, information on carers was also captured within people's personal outcomes plan. This was not commonly completed but would enable staff to be informed on carer's needs and circumstances. Staff fulfilled people's wishes regarding sharing their information with carers and their involvement in the planning, delivery and review of treatment and care services.

Highland Council had a good mental health officer (MHO) staff ratio for the population of Highland. The team was fully staffed, performed at a high level and had no waiting list. Most MHOs travelled to locality bases when required, often over significant distances. To help address the geographical challenges in Highland, a

blend of online and in-person MHO service options was offered to help during crises incidents. The Highland emergency social work service was staffed with social workers 24/7 who were dual qualified as MHOs and could respond with mental health expertise. While the service had definite strengths, there were challenges in MHO availability out of hours in remote and rural areas.

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

The partnership provided a broad range of information about mental health and services via websites and leaflets, and a network of local community-based organisations and hubs. This was primarily designed for professionals and was publicly available. Adapting this information for people and carers as a distinct audience would have been beneficial.

Practitioners were confident in engaging people in meaningful conversations. Assessments, care and treatment plans, case notes and reviews demonstrated that people were listened to and assisted by staff to understand their rights and be involved in planning and reviewing their care needs. Where people's level of care and support was reduced the partnership had an effective appeal system in place. This enabled more evidence to be considered and for people to retain their existing level of care and support where required.

Most people's circumstances were appropriately considered during short term detention through social circumstances reports completed by mental health officers. There were lower rates of emergency and short term detention in Highland than the Scottish average.

Advice on self-directed support was provided by services such as the Community Connections and brokerage services such as Highland Brokers, provided payroll services that effectively supported most people to manage direct payment packages. Commendably the partnership was piloting more flexible payments to friends and families for delivering care.

Advocacy services were available to people but needed to be used more effectively. More positively, the partnership supported a collective advocacy project which strengthened the voice of people to inform strategy and delivery of services in Highland.

We found that some staff were unclear about the process for requesting a capacity assessment where there were concerns about a person's ability to understand information or make decisions. This caused lengthy delays for people who needed legal protection. Training for staff on this process would have been helpful for people and improved staff's confidence.

### Good Practice Example

Spirit Advocacy was a collective advocacy organisation operating across Highland and funded by NHS Highland for people living with mental illness or a learning disability. The partnership valued the contribution of collective advocacy: "It continuously reminds us of patient experience when we fall into our corporate mindset."

Spirit Advocacy's purpose was "to establish a culture of acceptance, inclusivity, and empowerment in collective advocacy by amplifying the voices of lived experience, leading to increased awareness, improved support services, and driving positive change, recovery and independent living within communities."

People involved with Spirit Advocacy told us that it made a difference to their lives because it:

- connected them to people with similar experiences who understood them
- allowed them to share their stories and feel heard
- could hold the partnership to account
- provided information about rights, services and support with access.

Examples of Spirit Advocacy's influence on mental health policy and improvement.

- Supporting the review of CMHT guidance, with significant input in developing the patient information leaflet.
- Participating in the induction of new mental health nursing staff, with a focus on the voice of lived experience, which was '*powerful*' for participants.
- Exploring the impact on people's engagement with locum psychiatry, in Highland and nationally, which led to national research by Vox Scotland.
- Supporting the review of the mental health assessment template.
- Participating in the mental health clinical and care governance group.

The partnership and Spirit Advocacy worked hard to establish and maintain a positive working relationship of mutual benefit, through honesty and respect, while recognising natural tensions which would arise.

## Evaluation

- **Good**

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

### How effectively do commissioning arrangements in the Highland partnership support positive outcomes for people living with mental illness?

### Key Messages

- The partnership had a strong awareness of the challenges it faced. The adult services strategic plan was informed by a comprehensive joint strategic needs assessment and annual performance reports. It clearly set out the partnership's commissioning intentions and was well aligned to mental health strategies.

- The partnership worked collaboratively to implement its strategic plan, aligning it with the Community Planning Partnership and effectively utilising its District Planning Groups.

- The partnership was progressive in its approach. Pilots were in place, including self-directed support, aimed at addressing regional inequalities but needed scaled up where found to be impactful.

- There was a growing ethical and collaborative commissioning approach in place. There was a stronger partnership culture of openness and transparency with partners including the third and independent sector, people and carers.

- The partnership was both responsive to critical emerging locality needs and strategic priorities. Commissioning occurring outwith the strategic plan needed to be more closely aligned to the aims of the strategic plan.

### Commissioning arrangements

The partnership had an adult services strategic plan 2024-27. The strategic plan was a high level three-year plan with clear overarching strategic aims focused on transformation. These were co-production and co-design, person-centred care, local care and valuing the workforce. The strategic plan clearly outlined actions necessary to meet these aims, which included commissioning services in a way that supported a diverse market and reduced the administrative burden. Commendably, the strategic plan was devised following extensive engagement with statutory, third and independent sector and with people who used services. The partnership demonstrated that they listened to people and subsequently adopted a strong focus on mental health.

The partnership collaborated with the Highland community planning partnership to ensure the strategic plan closely aligned with locality improvement plans from its nine community partnerships or districts. There was a strong emphasis throughout the strategic plan on Highland's planned local care model and placed-based care,

which was reflected in other relevant planning and strategy documents. The strategic plan was well linked to Highland's nine emerging district planning groups and the Community Planning Partnership.

A robust joint strategic needs assessment was developed by the partnership to support its strategy. This assessment provided comprehensive health and social care data and outlined challenges for the partnership. It encompassed mental as well as physical health and reported on national outcome indicators.

The strategic planning group (SPG) oversaw the work of the adult strategic commissioning group. The identified priorities from the district plans included care at home and care home provision, suicide prevention, workforce challenges, and mental health and drug and alcohol recovery capacity. Once completed there was an agreement for the plans to be collated by the strategic planning group which led the delivery of Highland's health, social work and social care service priorities. The group's remit included commissioning, workforce and market facilitation, and procurement and implementation. While the partnership had a sound strategic planning and delivery foundation in place, its collaborative approach meant that progress was at a slower pace. However this meant that there was local ownership of the plan and a greater likelihood of effective implementation across Highland.

There was a specific mental health and learning disabilities strategy 2024-27 called 'Together Stronger', which effectively outlined the complexity of service provision across Highland. This aligned well to the overarching strategic plan. The strategy identified a range of important priority actions including early intervention and tailored support for individuals. It aimed to build and enhance care, providing support and housing options for people with complex needs to allow people to continue living in their local communities which was important to people. Together Stronger was developed collaboratively with the third and independent sector, carers and people living with a mental illness. The partnership clearly valued the third and independent sector and was conscious of its need to increase the frequency of its meetings with this group.

NHS Highland had a valuable, Together We Care Strategy, which was board-wide and consisted of the board's strategic vision, mission, and objectives for the next five years for all health and care. An annual delivery plan (ADP) captured the progress of the strategy, including for mental health.

The partnership's governing group, the joint monitoring committee, had good oversight of annual performance reporting. Its focus was on integration and outcomes within the context of health and care interventions. It achieved this through monitoring performance against the national health and wellbeing outcomes. The partnership was in the process of agreeing a revised performance framework, which would reflect an increased focus on outcomes through an outcomes measurement framework to strengthen strategic commissioning.

Commissioning was encompassed within the partnership's well set out strategic plan. While this was in place, the partnership was also able to be responsive to pressing need and could be flexible in working with the third sector proactively.

While this was positive and opportunistic with providers suggesting solutions to local challenges, there was also a need to balance this with progressing the strategic plan utilising detailed delivery plans and ownership of tasks. This would provide market stability and meet the needs of people living with a mental illness and carers across Highland.

Providers described a positive relationship with mental health service leads who were committed to people with a mental illness and aimed for high quality services. New leaders worked hard to address challenges and successfully developed positive relationships with the third and independent sector partners. This furthered the partnership's culture of openness and transparency.

Early Intervention and prevention work was effectively overseen by partners from mental health and public health services. The Community Wellbeing Fund and Distress and Brief Interventions (DBI) were positive examples of preventative interventions along with the primary care mental health service for early intervention. The community wellbeing fund was distributed through the local third sector interface and aligned to the partnership's strategic aims. These early intervention and prevention interventions were helpful and could be strengthened through growth and sustainability planning.

The new self-directed support (SDS) strategy in Highland was an innovative response to a previous low uptake of options 1 and 2. The partnership aimed to use financial balances accrued from unused option 1 allocations to encourage more locally available support. This intended to provide a catalyst for more care being available in local areas, as part of the place-based approach. Lochaber, Sutherland and Caithness were successful pilot areas which received specific resources to generate a more diverse market of support. The partnership was awaiting confirmation of agreement to extend this pilot.

The partnership was addressing social inequalities in remote and more socioeconomically deprived areas focused on recruitment challenges for people hiring personal assistants. The partnership agreed incremental hourly rates for care staff being recruited across urban, rural and remote areas, with remote having the highest rate. This made travel to more remote areas less costly and potentially more attractive to staff, addressing recruitment gaps in these areas.

### Evaluation

- **Good**

## Key Area 9 – Leadership and direction

### How has leadership in the Highland partnership contributed to good outcomes for people living with mental illness and their unpaid carers?

### Key Messages

- Partnership leaders demonstrated good leadership of people. Their strategic vision and values prioritised people living with a mental illness in their improvement plans and developing positive relationships with staff and partners.
- Leaders were committed to a body corporate model of health and social care integration to align with other partnerships across Scotland. They recognised this will improve benchmarking, driving change and learning from other partnerships.
- Partnership leaders effectively oversaw performance in relation to health and social care delivery. A focus on personal outcomes of people and carers would strengthen oversight and improvement.
- Leaders successfully prioritised improvements at New Craigs Hospital, despite limited resources. This improved the ward environment and bed capacity.
- The partnership was creating a single structure for community mental health teams (CMHTs). This promoted better information sharing, and consistent delivery of community mental health teams responses across Highland.
- The partnership was innovative and driven to deliver improvement but this was not supported by detailed delivery and improvement plans which hampered effective delivery. Evidence of positive outcomes from pilots needed scaled up to address inequalities prevalent in some rural districts.
- The partnership was committed to promoting a learning culture but lacked a strategic approach provided through a workforce development strategy, and supporting competency framework.
- The partnership did not have equitable representation from across agencies and sectors in its governance structure making reaching decisions and communication more difficult.

### Leadership of people across the partnership

Highland partnership leaders shared a strong strategic vision and values. These underpinned their integrated working wider strategies. These valued people with a lived experience of mental illness, their carers and the contribution of all partners. The NHS Highland strategy, Together We Care, commendably placed mental health on an equal footing with physical health demonstrating it was a high priority improvement programme. While this was strongly understood amongst leaders staff

were less clear. Leaders acknowledged that due to their recent significant decision to move to a body corporate model, discretion was required until they were in a position to make a public announcement in December 2024. Since then there has been regular communication with staff about this change and what it will mean for staff.

The leadership team were unified and displayed a strong commitment to improve community services for people and carers. There was a focus on people, place and prosperity in the partnership's refreshed January 2025 Highland Outcome Improvement Plan (HOIP). The place-based approach informed commissioning, and prioritised recruitment, self-directed support (SDS), peer recovery interventions and volunteering opportunities. These were aimed at improving people's economic status built on compassionate values, putting vulnerable people first, and seeking to improve their lives through a more equal delivery of health and care services across the Highland HSCP. Leaders were available across the partnership area to connect and build relationships with their staff and providers. Almost all staff agreed that joint working was encouraged between teams and across agencies.

Partnership leaders valued their staff and prioritised improvement and developing them professionally. For example, Highland Council was recognised nationally for its mental health officer (MHO) practice award, recruitment and stable staff team. This was externally validated by the Scottish Association of Social Work as sector leading. There were other similarly positive initiatives in place to build all areas of the social work and care workforce including national recognition on work to implement a pilot self-assessment site for the national Mental Health Quality Standards 2023 in partnership with Healthcare Improvement Scotland and the Scottish Government. Part of this included the Community Mental Health Team (CMHT) staff developing guidelines to support delivery of the Core Mental Health Standards and enable services to measure the quality of their care.

There were also career development opportunities for nursing staff, recognised as good practice by the Mental Welfare Commission (MWC). The partnership utilised lived experience through Spirit Advocacy which provided training to new mental health hospital staff, in addition to its main collective advocacy role. While there were many useful learning opportunities available, staff knowledge on carer's rights and quality assurance of partnership processes and procedures needed strengthened.

In response to Mental Welfare Commission reports identifying safety concerns the partnership had listened and delivered enhanced safety, privacy and quality of life for some people living with a mental illness in hospital settings, with further improvements imminent. At New Craigs hospital renovations had been completed in one ward and another ward was in progress. A reconfigured bed model effectively redistributed resources towards beds for acutely unwell people. A new service

specification had been developed with the Centred Recovery Centre in Inverness to improve patient flow between the hospital and community, with no additional cost.

While the partnership was clearly committed to promoting a learning culture it lacked a strategic approach. There was no workforce development strategy to enable leaders to have oversight and help ensure staff had the necessary training for their role. This would benefit specialist mental health and wider health and care staff, including the third and independent sector and be focused on the needs of people living with a mental illness and their carers.

Leadership outwith the lead agency model, across wider services, was less well connected, meaning mental health and social work, including mental health officer services, were underrepresented in some parts of the partnership's governance structure. This was being remedied through the proposed shift to an integrated model of health and social care partnership.

### Leadership of change and improvement

During the inspection the Highland partnership was at a critical stage of re-configuring its health and social care integration arrangements and was reviewing the current integration model with proposed establishment of an alternative body corporate model. Once implemented this will align them with every other partnership in Scotland. Leaders demonstrated a positive commitment to remain working closely together throughout this change. Crucially, this involved third and independent sector partners, people living with a mental illness and carers.

While leaders expressed confidence, staff had mixed views about integration within the partnership. This change brought uncertainty regarding employment and salary arrangements for staff employed by the NHS Highland or the Highland Council. Most staff identified integration as both a partnership strength and an improvement area, specifically in joint working, collaboration and co-location. Social workers were less confident in supporting complex mental health than those in community mental health teams, and they felt detached from Council employed mental health officers. Partnership leaders were critical of aspects of the lead agency model. They were confident that the change to a body corporate model would bring an improved governance structure, smoother decision-making processes, and strengthen the leadership of social work and social care services. Enabling benchmarking with other Integration Joint Boards (IJB) across Scotland was seen as an opportunity to promote learning and positively impact future joint models of care, support and policies.

To support the transition towards a body corporate integrated model, partnership leaders established a models of integration steering group which met regularly, with external consultancy support. Leaders regularly communicated with staff with the

involvement of trade unions. The partnership was positively addressing this complex challenge and was determined to introduce change positively.

Most strategies, including for mental health, had a clear rationale and focus including finance, staffing, reducing deaths by suicide and people prescribed anti-depressants and improving outcomes for people and carers. The partnership drove positive improvement through staff training, use of improvement champions and approving innovative tests of change carried out by staff. A draft delivery plan had been developed to support the draft Together Stronger strategy, which outlined the partnership's intentions to people. This was recently added to translate the policy into practice for people, carers and communities and to take forward the recommendations.

There was good leadership oversight of performance relating to capacity and staffing challenges, with subsequent improvement initiatives. This included increased numbers of people on self-directed support taking forward option 1. There was a positive recovery of respite care breaks for carers following the pandemic, with increased numbers accessing breaks. During 2022-24 Highland lost 204 care home beds due to temporary and permanent service closures. NHS Highland had managed to save three care homes by bringing these into the NHS. The partnership had developed sound plans for centralised care home provision in the Inverness area with accommodation for staff, and two other care homes following the same model anticipated. This would bring an additional 78 beds to Highland communities. This new provision was designed to support recovery in bed capacity. The care home developments utilised economies of scale with efficient financial planning, more attractive jobs for staff with accommodation and less travel, ensuring safe staffing levels and more effective management of demand for care home provision. In 2024 the partnership appointed a two-year careers and attraction officer post to support recruitment to social care. The partnership prioritised people amidst a climate of downward spiralling budgets. It kept people safe, delivered services and sought to manage its finances through a service transformation plan, including a single mental health management structure for Highland.

While all the core elements of change and improvement were evident, oversight of delivery and improvement were areas for development. Monitoring of adult mental health required improvement to support leadership and strategic management oversight, and to successfully identify and address operational challenges. Leaders identified that performance reporting was predominantly focused on health data. For example, for mental health there was reporting on NHS Health, Efficiency, Access, and Treatment (HEAT) waiting times for psychological therapies, but critically not community mental health team (CMHT) waiting times performance. While CMHTs were an NHS service, delivery was integrated for both health and social work. To improve the pace of change, leadership plans would have benefitted from being more detailed, identifying who was responsible for each change, timescales, information on progress and how successful change would be extended and

embedded across the partnership. Positive improvement examples were viewed by the inspection team which were recently introduced, short term or pilot initiatives and would benefit from being embedded long term.

The partnership tried different innovative approaches to support remote and rural areas and reduce inequalities. For example, its self-directed support pilot and increased payments for staff in more remote and rural areas such as Lochaber, Sutherland and Caithness provided greater flexibility in providing care and greater employment opportunities. Where people struggled to recruit care staff, partnership leaders said that services would step in to provide help, however we saw examples where people were left without care for lengthy periods. Fully developed delivery plans and self-evaluation of improvement initiatives were less visible in Highland. These would support the partnership to implement its valuable strategies and scale up successful innovation.

Most rationale for change evidence was focused on improving outcomes for people and carers, however there were occasions where this appeared solely financially driven. For example, there had been a significant reduction in secondary care beds for mental illness over the past 25 years for all adults. Meanwhile there were access issues for inpatient provision, expanding caseloads in CMHTs and no increased capacity in care homes or supported housing specifically for people with a mental illness, which also experienced long waits. While beds were being reconfigured, past decisions to reduce beds had not helped people experiencing a mental health crisis in Highland. In the current financial climate, Highland struggled to address this issue.

### Evaluation

- Good

## Conclusions

The Highland partnership performed well on health and wellbeing outcomes across its population and for people living with a mental illness whose records we read and with whom we spoke. To ensure confidence in this, the partnership should routinely collect and aggregate people and carers' outcomes. This will drive informed improvement and promote more effective services and outcomes for people and carers across Highland. Commendably Highland implemented an individual personal outcomes plan tool that gathered outcomes information. The partnership should use the results from this in its outcomes-based performance framework to support planning, commissioning and leadership oversight.

Most people maintained or improved their own health and wellbeing for as long as possible because of the effective support they received from health and social care services to make decisions. They felt listened to and involved in decision making about their care and support. People achieved good outcomes in Highland through integrated joint working approaches. The partnership offered a good range of early intervention initiatives, and through public health, prevention interventions were made available to people. Most people were supported to look after their own health and live in their communities and homes for longer. While this was positive, there were challenges for a few people, predominantly those living in remote and rural areas, there was less availability of services and staff, and with access to New Craigs Hospital. Improved oversight of these people was needed to ensure that people were safe and to identify any change to their prioritisation. Most had good experiences of health and care services' integrated working in Highland and importantly staff treated people with dignity and respect. More than half of people felt that their staff worked collaboratively to create a seamless approach which improved their quality of life. Highland utilised both in-person and remote online support to care for people living with a mental illness across the large partnership and with limited resources.

Carers felt under pressure due to the poor mental health of the people they cared for and lack of balance this created in their lives. When people needed help, people and carers had mixed views about the clarity and ease of access to information and advice available. In these circumstances carers were less able to have breaks and worried about the person being unwell and not receiving timely help. Adult Carer Support Plans were inconsistently used to support carer needs. However, Highland had commissioned a carer service, Connecting Carers, which improved outcomes for most carers who accessed the service.

There was a range of helpful processes and procedures available to staff, with information about routes into services for people and carers. That said, not all staff were aware of this. The partnership would benefit from quality assurance systems targeted at addressing this. There was good collaboration between staff, involving people, carers and providers. Tailored information on services would have been

helpful to people and carers. Districts had their unique identities and individual approaches to local delivery and there was a twin approach to managing community mental health across Highland. The partnership identified that consistent delivery could enhance this approach, and to this end, they agreed to manage community mental health services centrally.

Given the partnership's good leadership and demonstrable commitment to improvement we have a good level of confidence in its capacity to deliver the significant change envisioned in Highland, which has a set aside transformation fund to support implementation. The collaborative leadership team was open, supportive, focussed and driven to make ambitious changes, such as a new integration model and to reflect on national learning. They were a cohesive team and prioritised people living with a mental illness and their carers. They worked collaboratively with them at a strategic level and progressively supported and involved collective advocacy. The partnership faced significant challenges, including finance, staffing and the vast geography of Highland. In response, it actively supported improvement across its staff, and through trialling new models of care and support. While encouraging, a more strategic approach was needed to extend and embed these encouraging innovations, based on successful evaluation. Closer oversight of partnership delivery and improvement plans was needed for more successful and timely delivery. To achieve this, these plans would benefit from being SMART (Specific, Measurable, Assignable, Realistic and Time-related).

# Appendix 1

## Inspection Methodology

The inspection methodology included the key stages of:

- Information gathering
- Scoping
- Scrutiny
- Reporting

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

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

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

## Quality Improvement Framework and Engagement Framework

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

- The National Health and Wellbeing Outcomes Framework. These outcomes are specified by the Public Bodies (Joint Working) Scotland Act 2014 to describe what integrated health and social care should achieve. They aim to improve the quality and consistency of outcomes across Scotland and to enable service users and carers to have a clear understanding of what they can expect.

- The Integration Planning and Delivery Principles. These are also specified by the Public Bodies (Joint Working) Scotland Act 2014 to describe how integrated services should be planned and delivered.

- Health and Social Care Standards. These seek to improve services by ensuring that the people who use them are treated with respect and dignity and that their human rights are respected and promoted. They apply to all health and social care services whether they are delivered by the NHS, Councils or third and independent sector organisations.

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

## Quality Indicators

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

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

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| 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:

| No. | People | Carers |
|---|---|---|
| 1 | From the point of first seeking support from health and social care services, things have been explained clearly to me and I have been given the right information at the right time. | From when I first asked for help from health and social care services, things were explained clearly to me and the person I care for. We were given the right information, at the right time and in an understandable format. |
| 2 | The advice, support, treatment and care that I receive, help me to stay as well as possible for as long as possible. | The person I care for receives the advice, support, treatment and care that they need, when they need it. This helps them to become and stay as well as possible, for as long as possible. |
| 3 | I am fully involved in planning and reviewing my social care and support and in making meaningful decisions about my healthcare, in a way that makes me feel that my views are important. | I and the person I care for are always fully involved in plans and reviews of the help they receive in a way that makes us feel that our views are important. |
| 4 | Professionals support me to make my own decisions about my health and social care, and respect the decisions that I make. | Staff support the person I care for to make their own decisions about their health and social care, and always respect the decisions that they make. |
| 5 | My views, about what I need and what matters to me, are valued and respected. | I and, the person I care for, are supported to share our views, about what we need and what matters to us, and our views are always valued and respected. |
| 6 | People working with me treat me with dignity and respect and show me care and kindness. | People from health and care services working with me and the person I care for treat us with dignity, respect our rights, and show us care and kindness. |
| 7 | People working with me focus on what I can do for myself, and | Staff focus on what the person you care for can do for themselves and |

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| | the things I can do to improve my own life and wellbeing. | the things they can or could do to improve their own life and wellbeing. |
| 8 | The health and social care and support I receive, help me to remain in and be part of my community. | The health and social care support the person I care for receives helps them to connect or remain connected with their local community or other social networks. |
| 9 | 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. | Health and social care staff understand and acknowledge my role as a carer. Staff work together to ensure, that as far as possible, I am able to provide support at a level that feels right for me. |
| 10 | My unpaid carers and I can be involved in how health and care services are planned and delivered in our area, including a chance to say what is and isn't working, and how things could be better. | I and the person I care for can easily and meaningfully be involved in how health and care services are planned and delivered in their area. This includes a chance to say what is and isn't working, and how things could be better. |
| 11 | I'm confident that all the people supporting me work as a team. We all know what the plan is and work together to get the best outcomes for me. | I'm confident that all the people supporting the person I care for work as a team. We all know what the plan is and work together to get the best outcomes for the person I care for us. |
| 12 | The health and social care and support I receive has made life better for me. | The health and social care support that the person I support receives makes life better for us. |

## 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. (The equivalent for a young carer is called a young carer's statement).<br><br>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. |
| Anticipatory care plan | See Future Care Plan. |
| Alcohol and Drug Recovery Service (ADRS) | The ADRS is a joint health and social work team that offers support to people with alcohol or drug problems. The service includes addiction workers and addiction nurses who are supported by other professionals including doctors, psychology, and occupational therapists. |
| Capacity | Capacity is the maximum amount of care, support or treatment that day service or individual member of staff can provide. |
| Care and clinical governance | The process that health and social care services follow to make sure they are providing safe, effective and person-centred care, support and treatment. |
| Care opinion | A UK-wide online platform that allows people to share their experiences of health and social care services. It also allows services to respond to people's posts. |
| Care programme approach | A multi-agency approach to providing effective co-ordinated care to people with severe and enduring mental illness or learning disability, who have complex health and social care needs. |
| 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 |

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| | relative, friend or neighbour who can't manage without that help. Carers' centres are sometimes funded by health and social care partnerships to provide support. |
| Commissioning | Commissioning is the process by which health and social care services are planned, put in place, paid for and monitored to ensure they are delivering what they are expected to. |
| Community Mental Health Team (CMHT) | The CMHT is a community-based mental health service. The service includes a range of mental health experts who work together to provide assessment and treatment for people with suspected or diagnosed moderate to severe mental illness/ mental disorder. |
| 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. |
| Compulsory Treatment Orders (CTOs) | Under the Mental Health (Care and Treatment) (Scotland) Act 2003. A compulsory treatment order (CTO) allows for a person to be treated for their mental illness.<br><br>The CTO may set out a number of conditions that the person will need to comply with. These conditions will depend on whether the person has to stay in hospital or in the community. |
| Contract Management | Contract management is the process that local councils and the NHS use to ensure that services they purchase from other organisations are of a good standard and are delivering at the expected level. |
| Coordination | Organising different practitioners or services to work together effectively to meet all of a person's needs. |
| Core suite of integration indicators | These are indicators, published by Public Health Scotland to measure what health and social care integration is delivering. |
| Crisis response Team (CRT) | Community mental health service providing emergency mental health support. |
| Community link workers | Community Link Workers are practitioners who work within GP practices providing non-medical support with personal, social, emotional and financial issues. |
| Day services | Care and support services offered within a building such as a care home or day centre or in the community. They help |

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| | people who need care and support, company or friendship. They can also offer the opportunity to participate in a range of activities. |
| Direct payments | Payments from health and social care partnerships to people who have been assessed as needing social care, who would like to arrange and pay for their own care and support services. |
| 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 wellbeing of people who need support when their normal support cannot be provided because of some kind of emergency, for example if an unpaid carer falls ill. |
| External providers | Independent organisations from which the health and social care partnership purchases care to meet the needs of people who need support. |
| Future 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. |
| 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. |
| Hosted services | An arrangement whereby one health and social care partnership in a health board area takes responsibility for the |

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| | planning and delivery of a particular aspect of health care for all the partnerships in the health board area. |
| iMatter | A tool to improve the experience of staff who work for NHS Scotland and in health and social care partnerships. |
| Independent sector | Non statutory organisations providing services that may or may not be for profit. |
| Integrated services | Services that work together in a joined-up way, resulting in a seamless experience for people who use them. |
| Integration Joint Board (IJB) | A statutory body made up of members of the health board and local authority, along with other designated members. It is responsible for the planning and delivery of health and social care services. |
| Localities | Agreed sub-areas within a health and social care partnership area. The partnership should make sure it understands and responds to the different needs of people in different localities. Each partnership is required to have at least two localities. |
| Low threshold services | Easy access services that people do not have to meet set standards or criteria to access, for example drop-in centres or conversation cafes. Low threshold services are often seen as a way of stopping people's health and wellbeing getting worse. |
| Mental Health Assessment Unit (MHAU) | Mental Health Assessment Units provide emergency mental health assessments in response to people who may be experiencing a mental health crisis. |
| Mental Health Officer | A Mental health officer (MHO) is a social worker who has the training, education, experience and skills to work with people living with mental illness. Some laws in Scotland require that the local council must appoint an MHO to work with those living with mental illness. Their duties include:<br>• protecting health, safety, welfare, finances and property<br>• safeguarding of rights and freedom<br>• duties to the court<br>• public protection in relation to mentally ill offenders. |
| 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. |

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| 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. |
| Outcomes | The difference that is made in the end by an activity or action. In health and social care terms, the difference that a service or activity makes to someone's life. |
| Personal assistant | Somebody who is employed by a person with health and social care needs to help them live the best lives they can. People who need care can ask a health and social care partnership for a direct payment so that they can employ a personal assistant. |
| Person-centred | This means putting the person at the centre of a situation so that their circumstances and wishes are what determines how they are helped. |
| Prevention | In health and social care services, prevention is about activities that help to stop people becoming ill or disabled, or to prevent illness or disability becoming worse. |
| Primary Care Mental Health Team (PCMHT) | The PCMHT is a nurse led service providing assessment and follow up for people who have common mental health problems. For example, depression, anxiety, and adjustment disorders. PCMHTs are usually staffed by mental health nurses, mental health practitioners and psychologists, and have strong links with GP surgeries. |
| Procurement | The process that health and social care partnerships use to enter into contracts with services to provide care or support to people. |
| Public Health Scotland | A national organisation with responsibility for protecting and improving the health of the people of Scotland. |
| Quality indicators | Measures that are used to evaluate how good a process is – how efficient and effective a process is in achieving the results that it should. |
| Rapid Re-housing and Support (RRS) | This is an Inverclyde service which focuses on rehousing people that have experienced homelessness. The service aims to provide people with support and a settled housing option as quickly as possible in order to avoid long stays in temporary accommodation. |

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| Rehabilitation | The process of helping a person to return to good health, or to the best health that they can achieve. |
| Residential care | Care homes – places where people live and receive 24-hour care. |
| Respite care | Temporary care that is provided for someone with health and social care needs, usually to provide a break for the person or their carer. Respite care is often provided in a residential setting but can also be provided via short breaks for the person and/or their unpaid carers. |
| Single point of access (SPOA) | To help people get support at the right time. A single point of access ensures that people needing health and social care support only need to contact one service. That service will ensure they are matched with the most appropriate response, depending on their needs at the time. |
| Seamless services | Services that are smooth, consistent and streamlined, without gaps or delays. |
| Self-directed support | A way of providing social care that empowers the person to make choices about how they will receive support to meet their desired outcomes. |
| Service providers | Organisations that provide services, such as residential care, care at home, day services or activities. |
| Short breaks | Opportunities for people who need care and support and/or their unpaid carers to have a break. Its main purpose is to give the unpaid carer a rest from the routine of caring. |
| Short term detention certificates (STDC) | An order made by a psychiatrist with the consent of a mental health officer. A STDC may be granted if a person has a mental disorder, is at risk and/or poses a risk to others, and their decision-making ability is impaired. It allows for a person to be detained in hospital for up to 28 days in order to provide treatment. |
| Strategic needs assessment | A process to assess the current and future health, care and wellbeing needs of the community in order to inform planning and decision-making. |
| Supported living | Housing with attached support or care services. Supported living is designed to help people to remain living as independently as possible in the community. |
| Telecare | Telecare is the use of technology to provide health and social care to people in their own homes. It can include |

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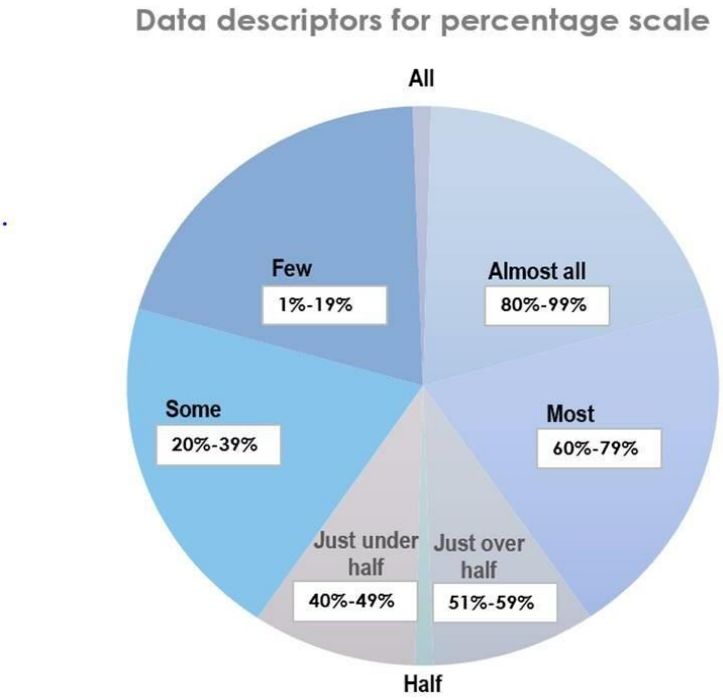
| | communication systems, alarms and monitoring of health status and symptoms. |
| Third sector | Organisations providing services that are not private or statutory. The term is often used to refer to voluntary organisations but can also refer to community organisations or social enterprise organisations. |
| Workforce plan | A plan that sets out the current and future needs for staff in the organisation, and how those needs will be met. |

## Our Data Descriptors

Our data descriptors are terms used to explain volumes of data. These avoid the use of percentages, for example where one hundred percent of people shared a view, we say all people shared this view. Where less than 20 percent of people felt a specific way, we say a few people felt this way. Where between 51 and 59 percent of people were treated with kindness, we say just over half of people were treated with kindness.



# 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.

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