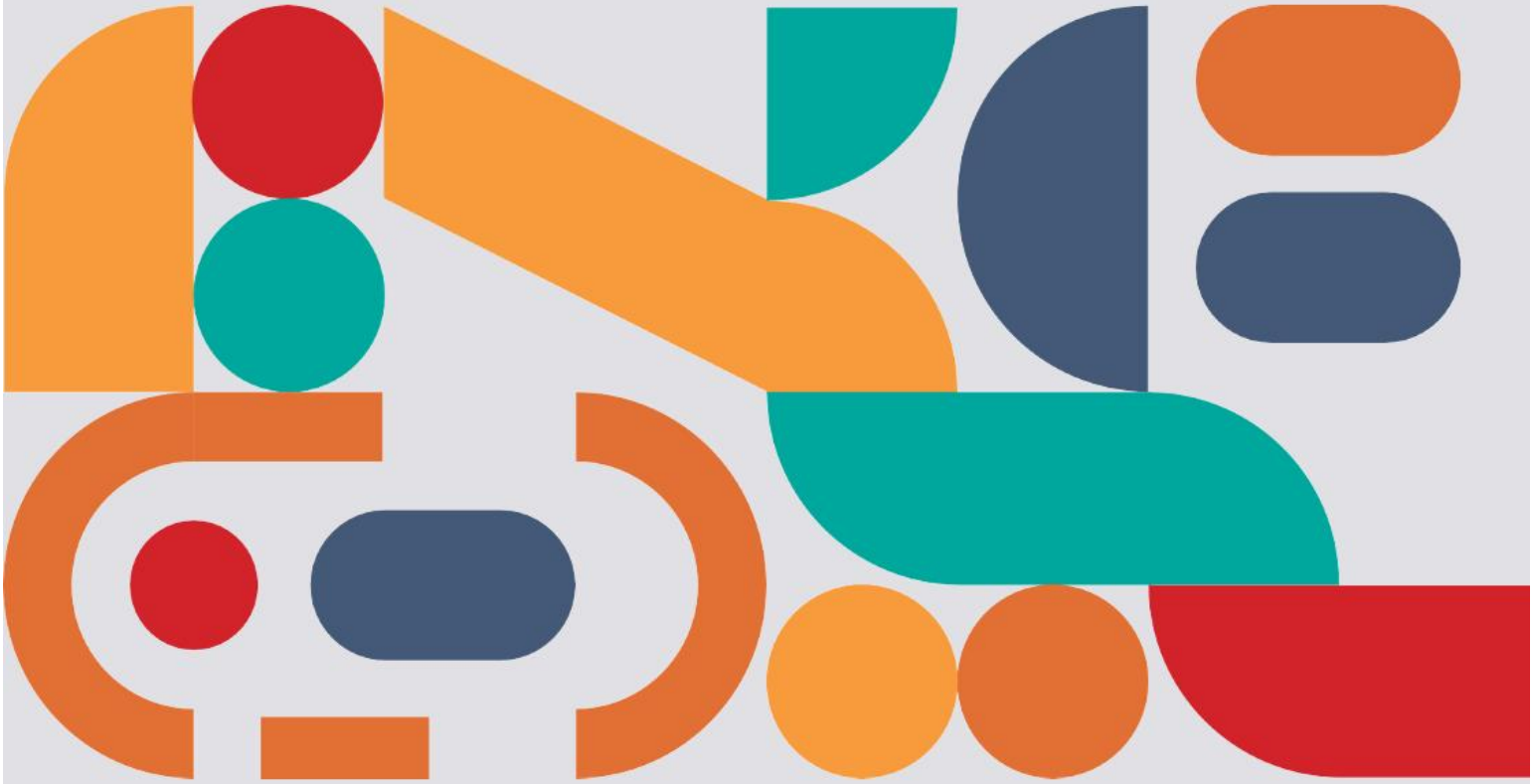

Joint inspection of adult services

Integration and outcomes

Midlothian health and social care partnership

November 2023

Contents

PART 1 - About our inspections

Background

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

Legislative context

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

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

Ministerial strategic group report

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

- Strategic inspections are fundamentally focussed on what integrated arrangements are achieving in terms of outcomes for people.

- Joint strategic inspections examine the performance of the whole partnership – the health board, local authority and integration joint board (IJB), and the contribution of non-statutory partners to integrated arrangements, individually and as a partnership.

Inspection focus

In response to the Ministerial Strategic Group for Health and Community Care recommendations, the Care Inspectorate and Healthcare Improvement Scotland have redeveloped our approach to joint inspections. Our inspections seek to address the following question:

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

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

National issues and context

At the time of our joint inspection of Midlothian health and social care partnership, partnerships across the country were continuing to experience a range of significant pressures following on from the Covid-19 pandemic. During the pandemic there were extreme and unprecedented impacts on service delivery and staffing across health and social care services.

At the beginning of the pandemic, emergency measures changed the way care, support and treatment were provided. This impacted on the ability to visit people at home during lockdown. The Care Inspectorate and Healthcare Improvement Scotland recognise that all health and social care partnerships still face significant challenges from both an increase in demand and capacity challenges from difficulties with recruitment and retention. Our inspections are not focussed on examining partnerships' responses to, or recovery from, the pandemic, but we will make every effort to understand and account for its impact on partnerships, providers, people and carers.

Some of the issues and challenges highlighted for the Midlothian partnership in this report are national issues that are being faced by many other partnerships. A number of reports have detailed these challenges including Audit Scotland's NHS in Scotland 2021 and Social Care Briefing 2022. These reports and our inspections, have highlighted that across the country:

- Demand for health and social care is increasing.

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

Details of all the reports can be found in the reference list in Appendix 5.

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 (Convention of Scottish Local Authorities) 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 have physical disabilities and complex needs.

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

When we refer to **the health and social care partnership,** or **the partnership**, or **the Midlothian partnership**, we mean Midlothian health and social care partnership who are responsible for planning and delivering health and social care services to adults who live in Midlothian.

When we refer to **staff** or **workers**, we mean the people who are employed in health and social care services in Midlothian, 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 2.

PART 2 - A summary of our inspection

The partnership area

Midlothian health and social care partnership has a population of 94,680 and is one of four partnerships across the NHS Lothian area. Fifty-two percent of the population are female, and 48% are male. The population has been rising since 2006 with a 1.6% increase from 2020, higher than the Scottish average (0.3%). Further population predictions estimate an increase of 13.8% by 2028. The key reason for this is due to net migration where there are more people moving into the area than are moving out. There are above average populations of children and older working people and a below average population of people aged 75 years and older. The latter is predicted to grow by over 40% between 2018-2028.

The majority of the population lives in larger towns and villages in the northern part of the partnership. The main towns include Penicuik, Bonnyrigg, Dalkeith, Newtongrange and Gorebridge. The southern half of the partnership is predominantly rural, with a small population spread between a number of villages and farm settlements.

The Scottish Index of Multiple Deprivation data shows that approximately one-third of people in Midlothian live in areas considered to be the most deprived. There are three communities in the top 20% of most deprived areas in Scotland. These are all in East Midlothian and include the areas of Gorebridge, Mayfield and Woodburn [Dalkeith and District]. Life expectancy in these areas can be significantly less (up to 12 years) than for people living in more affluent areas of Midlothian.

In the 2011 Census 6.9% of people identified as living with a physical disability which was close to the Scottish average of 6.7%. In 2019 there were around 4,800 people between the ages of 16-64 years who had a physical disability which included people born with impairment, those who had had an injury and those whose disability developed as a result of an illness. In 2022, 3,292 adults (aged 18 years and over) who were known to the adults and social care team had physical disability recorded as their primary care group**;** 5,681 people had a blue badge and 1,200 people were recorded as wheelchair users. Approximately 10% of adults in Midlothian were carers, and two-thirds of these were women.

Summary of our inspection findings

The announced inspection of Midlothian health and social care partnership took place between May 2023 and September 2023.

In our discussions with people and carers, we received three completed surveys, spoke to 30 people with physical disabilities and complex needs, 14 carers and undertook two focus groups. The survey returns were particularly low, despite agreement with the partnership to pause a local carer survey during the inspection period. In our engagement with staff for the health and social care partnership, we received 77 completed staff surveys, spoke to 70 members of staff and undertook four professional discussion sessions with the leadership team.

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

Key strengths

- Most people with physical disabilities and complex needs had positive experiences of integrated and person-centred health and social care, which supported an improved quality of life.
- There was a positive and effective approach to early intervention and prevention support. This was prioritised across the workforce and made a demonstrably positive impact on peoples' outcomes.
- The partnership had embarked on a whole systems approach to embedding a strengths-based outcomes approach to planning, delivery, and evaluation of its services. This included the introduction of a single system to support monitoring and evaluating how outcomes were being met across all services.
- The partnership had a culture of integration which was evidenced through a number of integrated teams, services and decision-making processes.
- Having shared access to health and social care records contributed to positive outcomes for people. Not all staff in all teams had shared access to records. The partnership should find ways to widen access where possible.

Priority areas for improvement

- The partnership should continue to address support for carers, as their experiences were less positive than those of people receiving care and support.
- The partnership should make sure that it has an integrated approach to providing information and advice, so that people can make informed choices about their support, care, and treatment.
- The partnership should ensure that staff are supported to be more confident in their knowledge of and in applying self-directed support so people receiving support can be clearer about their rights and choices.
- The partnership should build on their strong relationships with providers in developing sustainable solutions to providing care.

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	**Good**
	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 and carers who use services in Midlothian?

Key messages

- The partnership placed importance on gathering and using good quality data about people's outcomes.
- Support for self-management, early intervention and prevention in particular was positive.
- Midlothian's national health and wellbeing indicator for people supported to look after their own health and wellbeing was higher than the Scottish average.

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 partnership placed importance on gathering and using good quality data about people's outcomes. This was reflected in its strategic planning work, for example in embedding the 'Midway' which was the partnership's overall approach to delivering a personal outcomes approach. Most people in Midlothian experienced good health and wellbeing. Midlothian could evidence how it supported people to manage their own health and wellbeing and to improve or maintain their quality of life. Outcomes for carers were not always as positive with a few carers who felt they did not get the support they needed to continue in their caring role. The partnership recognised this and was working to improve its support for carers. For example, the partnership had begun some scoping work to develop a carers cooperative which would act as a single point of contact for carers.

From conversations with people and carers, and from reviewing their health and social care records, we found that:

National health and wellbeing outcome	Inspection finding
1	• Almost all 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	• Some carers felt supported to continue in their caring role.
7	• Most people with physical disabilities were kept safe from harm

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

Midlothian's national health and wellbeing outcome indicator for people having support to look after their own health was higher than the Scottish average. Third sector and the wider community services had a positive impact on people and carers in supporting them to look after their own health.

For a few people and carers access to early help was not always consistently available when they needed it.

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.

The partnership worked well, including with other key agencies to support this. A number of programmes and initiatives were in place to support people to live independently at home including meeting different levels of care required. This demonstrated a strong commitment to supporting people around this outcome.

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

People talked positively about their experience of engaging with staff in services. Most people rated the care they received as positive overall. Some people talked of being treated with "kindness" and for those receiving social care, most indicated they had been treated with compassion and understanding.

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.

There were a wide range of factors supporting people to experience good outcomes that improved over time. For example, the partnership had successfully improved outcomes through close collaborative working, including between social work and housing.

For other people, improved outcomes had been experienced after being discharged from hospital. In these cases, occupational therapists had ensured the living environment was adapted appropriately. In some cases, this helped to promote greater autonomy. Health interventions such as speech and language therapy had also supported a continuing increase in people's confidence and independence. The advanced physiotherapy service based in GP practices supported people through early intervention. However, there were long waiting times for ongoing physiotherapy services for some people.

For some people, their main aim was to maintain quality of life at its present level. This was achieved by reducing the progression of conditions, making deterioration more manageable. Again, there were examples of good communication between people, their unpaid carers, paid providers and health and social work staff.

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.

Midlothian's national health and wellbeing outcome indicator for carers feeling supported to continue caring was lower than the Scottish average. Some carers were providing care at a level they no longer felt able to continue with. Many described feeling that the impact of caring had grown and continued to grow. The Covid-19 pandemic had made the caring role harder. A few carers did not always feel they were treated with dignity and respect.

Some carers had an adult carer support plan, and this had helped identify supports for them. However, for some carers this was not the case, and there had been little action taken in response to their plan.

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

There had been a slight reduction in Midlothian's performance in relation to health and wellbeing outcome seven in comparison to the level achieved in 2020. However, most people with physical disabilities were kept safe from harm.

Impacts of the Covid-19 pandemic

The Covid-19 pandemic had affected a lot of people in Midlothian negatively. This included reductions in support, access to the community and community-based services and social isolation more generally. The partnership had put significant effort into re-establishing services, but the long-term health burden would continue for some time. For some people experiencing care, the negative impact was not reversible quickly, if at all. This should be recognised in 'good conversations' with people about what matters to them.

In addition, the partnership continued to have difficulties with recruitment and retention across a number of posts and roles. This had a negative impact on being able to meet peoples' and carers' needs.

The partnership had made positive developments in testing the chest heart and stroke digital support pathway for long Covid. Early feedback identified a number of factors to address. These included the need to ensure that the information was available in other languages; ensuring that any digital difficulties were resolved; and that personal outcomes should be included in the patient outcome data.

Evaluation

- Good

Key Area 2 - Experience of people and carers

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

Key messages

- Most people felt that services worked well together, that staff listened to them and worked hard to deliver services that made a positive difference in their life.
- Generally, people and carers were treated with kindness, dignity and respect as a result of the commitment to and evidence of embedding a 'good conversations' approach that aimed to deliver person-centred care and outcomes focused support.
- Most people and carers experienced improved health and wellbeing as a result of early intervention and prevention support.
- On the whole, people had the right level of support at the right time, although this did not always happen consistently enough, due in the main to challenges with recruitment and retention of staff.
- Some carers struggled to get the support they needed to look after their own health and wellbeing and to be able to continue caring.
- Information and advice about services, support, options and rights was not always easy to find.

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

Most people felt that health and care services worked well together and the support they received had improved their quality of life and enabled them to maintain and/or improve their health and wellbeing. Although some people did not get the level and type of support they felt they needed, and had both positive and negative experiences of support.

There was a focus on maintaining peoples' independence as much as possible. This included people living in a residential care setting. For example, provision of 'in-house' physiotherapy positively affected people's health and quality of life. People and carers were generally unfamiliar with the term 'integration', but they had a sense that services were 'joined up' and that staff in different services spoke to each other. This meant they felt staff were working together to improve things for them. A few people felt that services did not talk to or collaborate with each other.

Most people received help and support at the right level, right time and right place. Support from the local carers organisation and independent advocacy was valued by people and carers to help get the right support in place. However, some people experienced long waits for their support to be arranged. For example, where providers were unable to offer the required level of support due to unavailability of care staff, some people chose option one, self-directed support. However, they encountered similar difficulties due to the limited availability of personal assistants.

This had a negative impact for those people affected in achieving their personal outcomes.

People and carers felt staff worked hard to try and respect their preferences and felt supported to live independently and take part in their local communities.

> One person said that the support they received gave them “a bit of joy back in [their] life.”

Most people and carers felt that they were being listened to, that their needs were understood, and that staff were focussed on meeting their needs as far as possible. This led to people saying they felt respected and valued by partnership staff. Most people who used services felt they were treated with dignity and respect and their views and preferences were valued.

Where needs were higher or more complex this could be more difficult. Mechanisms for decision making around provision and funding were relatively straightforward. But more clarity was needed around how individual budgets could be used and what options and rights people had through self-directed support. People felt that not all staff members were clear or confident in describing this. This included some carers not having flexibility in ensuring that both their and their cared for person’s budget met their needs. This negatively impacted both the person receiving support and the unpaid carer.

Most people were accessing physical health care appropriately through single health specific services that addressed their health care needs. However, some people found it hard to access specialist provision. Some people said that staff did not always understand their health condition.

The partnership demonstrated a strong commitment to embedding personal outcomes throughout their services. It was a strategic driver supported by ongoing training and infrastructural change. People and carers said that staff worked hard to understand what was important to them.

An ’end of engagement’ questionnaire had recently been introduced to review service provision against peoples’ identified personal outcomes. Whilst it was too early to evaluate the full effectiveness of this, this was positive. Some themes were starting to emerge which were informing future personal outcomes training.

Carers’ experience of health and social care was not always as joined up and the support provided did not always help them to feel able to continue caring. A few carers said they did not feel respected or valued. Some carers said adult carer support plans were only put in place so they could access respite services. Whilst carers found these beneficial both for themselves and the person they cared for, they were insufficient to meet the carers’ needs. Some carers said that there was limited action taken after having an adult carer support plan. A few carers did not have an adult carer support plan and not all social work staff discussed the option with them when there were opportunities to do so. The partnership had commissioned a local

carers organisation to undertake a range of early intervention and prevention work including completing adult carer support plans. Carers were able to offer feedback through the organisations' bi-annual carer survey. Most carers were positive about the support they received from the carer organisation but less so about support from social work staff.

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

The partnership in Midlothian had made significant investment with a wide range of stakeholders to support early intervention and prevention approaches. People and carers found this contributed to being able to be as independent as possible and get help from wider community supports. Examples of early intervention approaches to promote better quality of life included Green Health Prescribing and Midlothian Active Choices run by Midlothian Active Leisure. Both services aimed to improve peoples' physical activity levels and support them to combat social isolation. People reported feeling more confident, less isolated, and having improved sleep. In addition, Midlothian staff, including physiotherapists and occupational therapists, supported people with self-management approaches.

The partnership commissioned local area coordinators to help people and carers find support opportunities in their local communities. We saw evidence of this during our file reading. People spoke positively about the role they played as did staff members that we spoke to. Low threshold preventative support was provided by a range of commissioned services including a wellbeing service which helped people with long-term conditions. This was very highly regarded both by people using the service and staff referring to the service. It enabled them to have greater autonomy in managing their own health and wellbeing. People also highlighted the ease of access to the service which included a recently developed direct referral pathway for the physical disability and long-term conditions team.

People often referred to and appreciated the difference aids such as grab rails and other smaller items made to maintaining or improving independence. They were able to access this service from a local third sector organisation easily and quickly. Some people described this support as invaluable. Some people however, experienced longer waiting times for equipment. This had a negative impact on their ability to participate in their community and outside activities. For some people, more specialist equipment took longer to be provided. For example, specialist wheelchairs and hoists were complicated to arrange.

People who lived in residential care settings experienced support that ensured they were able to do as much for themselves as possible. People said that they were encouraged to complete whatever part of an activity or task they were able to do independently. Staff knew the people they supported well, and support was tailored to people's interests, choices and abilities as far as possible. One person described what this meant for them:

> "I can remain living independently and have a meaningful life".

There was evidence of future care planning taking place to support people to be able to identify and put in place preventative strategies. Some people had had discussions to plan for the future and there had been focussed work with people living in residential care settings. However, few people outwith care settings had had the opportunity to discuss this.

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

People and carers had mixed experiences of finding accessible information and advice. Just under half of people said they were given accurate information which was helpful in understanding their rights and options. They were supported to make meaningful choices and their decisions were respected. They also positively described the pacing of being given health information related to their condition which helped them in coming to terms with the impact of it. People who received services were more likely to be satisfied with the level of information they received than their unpaid carers.

Information about available services was not easy to find unless people knew what to look for. The partnership made information available online around supporting mental health and wellbeing and through a local disabled persons' organisation but links to both were not particularly visible. The partnership website could be difficult to navigate.

> As one person said, finding information "is always a struggle".

The partnership was aware of this from feedback and had begun the process to make changes to the layout, structure and language on their website. This work was ongoing at the time of the inspection.

People and carers understanding of self-directed support varied. Some felt their options had been fully explored and that they had made an informed choice. Others felt that staff were not always confident in their own understanding and were therefore not clear on options and rights. Some people described a lack of flexibility around the use of allocated budgets. This was particularly apparent when both the person and unpaid carer had individual budgets. The mechanisms to make best use of these to meet both the persons' and carers' needs could be complicated. The partnership had put in place a comprehensive improvement plan to continue the roll out of self-directed support.

Some people felt that information around eligibility criteria was not as clear as it could be. It was difficult to find information about eligibility criteria online. Whilst people and staff felt that the processes for decision making and funding for support was straightforward, the information explaining it was not. More could be done to make information about eligibility criteria available in accessible formats.

Even when people and carers felt listened to, their support needs and preferences were not always met. This was due, in part, to both providers' inability to recruit care staff, insufficient numbers to meet rising demands and people's difficulty finding personal assistants where they had chosen self-directed support option one. The partnership had begun to look at options to address this through their commissioning processes. Furthermore, this was exacerbated in particular areas of Midlothian including Penicuik, Pathhead and Fala. This negatively impacted on peoples' experience of support and carers not having the right support to be able to continue caring. Consequently, those carers felt tired, and some felt that their views were not respected or listened to.

Impact of the Covid-19 pandemic

Not all services had returned to their pre-covid levels. This, together with the difficulties getting the right level of support for cared for people, led to carers feeling under increased pressure to provide a level of care they did not always feel was sustainable. This was exacerbated by the difficulties in recruiting care and support staff.

Evaluation

- Good

Good Practice Example

Third sector wellbeing service

The wellbeing service had been running in Midlothian since 2015 and was highly regarded by people using and practitioners referring to the service. It offered support for people living with a long-term condition or facing difficult life situations. There were wellbeing practitioners based in GP practices throughout Midlothian supported by peer volunteers. Referrals to the service could be made by a GP or health or social care professional. A new referral pathway had been developed for teams within the organisation, including the physical disabilities and long-term conditions team. Support included one-to-one coaching and group-based lifestyle management and mindfulness courses.

In 2022-23, 1142 referrals were made to the service with 82% of people seen within four weeks of their referral. Fifty-eight percent of referrals were made by a GP and 70% of people referred were women. 4674 appointments were offered and 72% were taken up. Over half of the people referred lived in areas with Scottish Indicators of Multiple Deprivation (SIMD) quintiles one and two and over a third experienced at least three different health inequalities.

The support is based on the Midway principles where people have a ‘good conversation’ to identify what matters to them. Elements of the House of Care Model are used to prepare both practitioners and people using the services to have a good conversation based on the persons’ strengths and abilities and their personal outcomes.

People’s wellbeing was measured by completing a wellbeing questionnaire which when analysed by the Public Health Scotland Local Improvement Support Team found an average statistically significant improvement increase in well-being of eight points.

Key Area 5 - Delivery of key processes

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

Key messages

- The partnership had a strong focus on early intervention and prevention. These services were being delivered effectively in partnership with independent and third sector organisations.
- A range of integrated working arrangements were contributing to effective integrated practice.
- There was a clear commitment to, and evidence of a personal outcomes approach being embedded across the partnership.
- Shared access for health and social work staff to each other's recording systems enhanced joint working. However, this was not available to all staff and more could be done to roll this out further.
- Future care and emergency planning with people and unpaid carers was not happening consistently enough.

Processes to support early intervention and prevention

The partnership had a strategic commitment to ensuring that early intervention and prevention approaches were embedded across all adults' services with a range of initiatives and services in place to support this. The partnership worked hard to ensure that these services were readily and easily accessible. There was evidence these approaches were integrated across all sectors. For example, the physical disability and long-term condition team made direct referrals to a third sector organisation providing wellbeing support. Evidence from the organisation's annual report demonstrated an improved sense of mental wellbeing in people using the service. Further, they were jointly developing new support arrangements under the partnership's neurological conditions pathway.

Whilst processes for future care planning in care settings had been successfully introduced, there was limited evidence of these in community settings. The partnership identified district nurses were the most likely staff group to have these conversations, but their workloads and work demands did not leave sufficient time for them to do this. In addition, nurses were one of the staff groups that the partnership struggled to recruit to. The partnership had widened the role and scope of the local carer's organisation through commissioning work on emergency planning to help address this.

Frailty and falls remained one of the top 10 reasons for admission to hospital in Midlothian and the partnership had a number of initiatives to help address this. For example, provision of an advanced physiotherapist within six GP practices ensured that people referred had early help with mobility and musculoskeletal problems. Over half of people received self-management information and almost all did not require to be seen by the GP. Wider community initiatives were available through Midlothian Active Choices which also helped to address social isolation. Staff

involved in signposting to these services described the interventions as a "gamechanger" for those referred.

Improvements to equipment, adaptations and telecare services were key for helping people to continue to live independently. The partnership had recently updated their equipment and adaptations guidance with an increased focus on self-management. Changes had been made to the social work recording system to facilitate easy access to telecare. Staff across the partnership had access to housing briefings and housing options training which focussed on early identification of problems before waiting until people presented in crisis.

A direct pathway to social work was in place from the local carers organisation which negated the need for further referral. Most requests made through this route were submitted to the relevant resource panel. Carers who received information and individual casework from the carers organisation said this increased their confidence in their caring role. However, not all carers were aware of the support available. For example, whilst some carers had been able to have mini breaks through the Wee Breaks scheme, not all carers were aware of this opportunity.

There was emerging evidence of the impact of the partnership's focus on early intervention and prevention, but more work was required to demonstrate this. The partnership had introduced a process of outcome mapping using a cloud-based software system. Their strategic ambition was for all services to be using this to demonstrate and evidence how the partnership's activities were improving people's outcomes. Approximately 40% of services were using this system at the time of inspection.

Good Practice Example

Carer support

A local carer organisation was commissioned to provide carer support around early intervention and prevention. This included delivering advice and information for finance support which they did in partnership with two other local third sector organisations; providing emotional support through a counselling service and peer support; carrying out adult carer support plans and developing future and emergency plans for carers.

There was a strong relationship with the partnership, and carers lives were improved significantly through using the organisation's services:

- 88% of carers felt more confident in their caring role.
- 90% of carers felt more informed.
- 84% experienced an improvement in their health and wellbeing.
- 62% felt actively involved in shaping the care and support for their cared for person.

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

There was clear evidence of an integrated approach to assessment, care planning and treatment interventions through a number of integrated teams across the partnership. Most reviews taking place were integrated but they were not always timely. The partnership had plans to review this.

Although some staff acknowledged that differences in language and culture across health and social work could hinder effective joint working nevertheless there were several supporting factors. These included co-located teams, strong relationships and good communication, multi-agency reviews and a history of integrated management arrangements.

There were examples of collaboration across partnership, third and independent sector staff. Occupational therapists were mentioned in particular for their advice on moving and handling. They responded quickly and their advice was beneficial in ensuring care staff were supporting people effectively. The partnership had a single point of access across many teams with a 'no wrong door' approach enabling people to access support regardless of their referral route. Working in the same building mitigated against not being able to share information electronically. Two-thirds of staff within the physical disability and long-term conditions team were able to access both NHS and social work electronic recording systems. This was commendable and made a significant contribution towards supporting peoples' outcomes.

Funding decisions were made through a series of resource panels which met regularly. Staff viewed these as a fair and consistent way to reach decisions quickly. Services were not always provided timeously once agreed. Delays in providing services were attributed to a combination of an increase in numbers of referrals, an increase in the complexity of peoples' needs and difficulties in the recruitment of care staff. Some of the delay was attributed to longer waiting lists for occupational therapy assessments. A waiting list letter had recently been developed by the physical disability and long-term conditions team with self-management and signposting information. This was positive but it was too early to evaluate its effectiveness in supporting people both whilst waiting for formal services and whether the information resolved their presenting difficulties.

There was some evidence of support to people experiencing health inequalities. For example, staff used different techniques and tools to support people with cognitive and communication support needs. The health and social care partnership health inclusion team was available to work alongside staff and people who experienced health inequalities. Where they had been involved this had been positive.

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

Most people were involved in making decisions about their care and support arrangements. There was strong commitment to an asset based personal outcomes approach which was embedded across services. There were regular opportunities for 'good conversations' training and trauma informed practice which meant staff across the partnership were confident in having 'good conversations' with people and carers. Several key organisational factors contributed to embedding the Midway approach. This included developments to the social work recording system to incorporate a personal outcomes approach with prompts at various stages. This was monitored effectively through regular file audit and case management through supervision.

We saw limited numbers of people who required application of adults with incapacity processes. However, where people lacked capacity or had cognitive or communication support needs, there were good links across relevant teams including speech and language therapy. Almost all people were being supported to use strategies to support self-management of their condition.

Whilst most staff were confident talking about self-directed support which was seen as integral to everything they do, not all staff across the partnership were clear on the options and rights available to people. The partnership's self-directed support planning officer supported staff by delivering short briefings, offering individual case advice and help to navigate self-directed support processes which were relatively straightforward. However, not all staff were aware of this support, and this meant some people were not clear about the range of options and choices available to them. Recruitment and retention of care staff, regardless of which self-directed support option was chosen, remained a key barrier to people being able to have their preferred choice of care and support. Some areas were more significantly affected than others, for example in Penicuik and Pathhead. This was particularly difficult where people required two care staff for some activities. It was further exacerbated where people chose self-directed support option two, and providers charged a higher rate than allocated in their budget. This resulted in families having to either top this up or not have all the support they needed.

There were wider opportunities for people and carers to contribute feedback to the partnership about their experiences and to the development of new services. For example, co-production was a factor of the partnership's digital and implementation delivery plan 2022-2025. The partnership identified this as a key mechanism for taking forward the level of change required to meet rising demands. Whilst this was positive, the plan was in its early stages, and it was too early to evaluate its effectiveness. There were bi-monthly carer engagement meetings which ensured the partnership understood the profile of carers in Midlothian and their feedback meaningfully contributed to improvement.

Impact of the Covid-19 pandemic

During the Covid-19 pandemic there had been a loss of local authority care home beds which were used for respite breaks. This had a negative impact for carers, as private alternatives were more costly. Learning taken from the Covid-19 pandemic around the use of technology for support and communication was being taken forward. However, there remained increased pressures on the workforce, staff were tired and there was a continuing increase in demand for services, especially for those with long-term conditions.

Evaluation

- Good

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

How good are commissioning arrangements in the Midlothian partnership?

Key messages

- The integration joint board had published a comprehensive strategic plan with clear actions to improve outcomes for people and a focus on early intervention and prevention.
- There was a clear integrated approach to strategic planning and commissioning. This included specific plans/commissioning intentions in relation to people with physical disabilities.
- There were good working relationships with commissioned services across the third and independent sectors.
- The partnership's planning arrangements were not always effective in demonstrating how it met local needs, particularly in areas where people were more likely to experience health inequalities.
- Pressure on social care support was particularly acute in relation to availability of care staff. As a result, people and carers did not always get the level of support they expected.

Commissioning arrangements

The integration joint board had published a comprehensive strategic plan for 2022-2025 which identified actions to improve outcomes for people and carers. The commissioning intentions and actions applied to a wide range of health and social care functions, activities and services and demonstrated that the integration joint board had an integrated approach to strategic planning and commissioning. The plan had a clear focus on early intervention and prevention which was demonstrated by grouping plans in three areas:

- Early intervention and prevention
- Support and treatment
- Crisis and emergency.

A wide range of early intervention initiatives were available across health and social care. Examples included Midspace, an online mental health and wellbeing service providing information, advice and self-management support; and Forward Mid, a disabled person's organisation that provided an annual comprehensive directory of services for disabled people. The partnership had invested in a number of organisations to support people with physical disabilities, complex needs and sensory impairment. There was evidence of some innovative approaches around short breaks for carers. Effective quarterly reporting mechanisms were in place for commissioned services which demonstrated positive progress against identified quantitative and qualitative indicators. The partnership's annual report 2022-2023 identified more indicators and actions were on target than not and there was evidence of a joint approach to risk management. The integration joint board had developed a carers strategy and digital implementation plan to offer more detail on how their strategic aims would be achieved. The partnership still had to update their

current procurement policy 2018-2023. There was no evidence that this was underway, but there were plans for undertaking a wider commissioning review.

The partnership published their joint strategic needs assessment in 2019 and were in the process of updating this during the inspection period. The planned update had been paused due to the Covid-19 pandemic. This was a positive step given the level of change the partnership was embarking on and the need to have accurate and up to date data to base this on. The partnership had formally identified two localities by dividing the area into west and east. In practice, it had worked more closely with the community planning partnership in forging links with those local communities which had more of a sense of belonging. It was commendable to engage with communities at a more authentic level, however, it was not always clear how evidence was gathered, and the needs of communities were understood and responded to. This was particularly important for those people living in areas of lower Scottish Indicators of Multiple Deprivation who were more likely to experience higher health inequalities.

The partnership had developed an integrated physical disability service plan for 2023-2024. This sat within the overall framework of their strategic plan and set out the background for partnership working across third sector organisations. Progress was evident through quarterly performance reports using the partnership's governance assurance framework. This plan was at an early stage but detailed that some mid-year progress had been made against identified performance indicators. In addition, the physical disability service was using an outcomes mapping tool to record and evaluate activity against outcomes, rather than merely capturing service outputs. This work was at an early stage but was positive and demonstrated the partnership's significant commitment to embedding a whole system outcomes-focussed approach to health and social care.

The partnership had published their public engagement statement in 2021 which was based on the national community engagement principles. They used a standard engagement template setting out the partnership's clear expectations to focus on peoples' outcomes and what success would look like. A number of planning officers and associated planning groups were central to this. This illustrated the partnership's commitment to ensuring people experiencing care, third and independent providers could contribute to planning and commissioning. It also offered assurance to the integration joint board that these activities were being undertaken in partnership with a range of stakeholders. For example, the carer planning officer had a very good understanding of carer issues and worked closely with the local carers organisation to help inform the carers strategy. However, the disability planning officer post had been decommissioned after difficulties in recruitment when the post became vacant. This led to a gap in engagement with local disabled peoples' groups and loss of confidence from local disabled people. The planning group had recently restarted which was positive but there was a sense that lost ground had to be recovered.

Third and independent sector providers were positive about their relationships with the partnership. These had strengthened during the pandemic with a much greater need for collaboration, trust and transparency. The partnership convened 'engagement summits' twice-yearly which were seen as effective for communication, although providers felt that their decision-making processes could be slow.

Midlothian faced challenges in providing social care support and as a result people were not always readily able to access the support they needed. The partnership had a well-developed approach to quality assuring care providers. Dedicated officers supported people and frontline staff to address issues and concerns with providers efficiently and promptly. This service was well thought of and valued by people who used it. It helped maintain positive working relationships with providers and ensured that peoples' outcomes were prioritised.

Recruitment and retention of care staff were major issues for providers and for people and carers looking to recruit personal assistants. The partnership had put plans in place to address these difficulties. This included undertaking risk assessments for service areas and consulting with people using services and unpaid carers to understand their views.

However, pressures on budgets were very real. It was a challenge to ensure resources could be committed to addressing long-term needs when short-term demand was so high. The partnership was fully conscious of this dilemma. It was positive that it placed the value it did in early intervention and prevention. There were some restrictions to this. For example, respite was and had been difficult to tailor to the needs of everybody. There was also some confusion amongst people experiencing care around the amount of respite they could access. This did not feel consistent for them. The partnership was trying to ensure there was a clearer understanding of people's access to respite.

Evaluation

- **Good**

Key Area 9 - Leadership and direction

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

Key messages

- The partnership had an ambitious, strong commitment to an outcomes-focussed culture at both strategic and operational levels.
- The integration joint board had strengthened its approach to care and clinical governance through the introduction of their governance assurance framework and total quality management system.
- Joint working was supported by a well-established integrated management infrastructure.
- The partnership faced significant workforce challenges and had devised a series of measures to address these through their first integrated workforce strategy.

Leadership of people across the partnership

The current senior management team was established at the beginning of the Covid-19 pandemic. It had a shared vision and an effective collaborative commitment to renew the strategic focus on how services were planned and delivered. This included expanding the level of joint working and integration across all sectors to ensure people received the right support at the right time. The partnership fostered positive relationships with stakeholders around an outcomes-focussed approach in planning and delivering services which successfully contributed to this.

Midlothian had a range of mechanisms which supported integrated service delivery, development, and improvement activity. This included an integrated management structure for many adults' services which had been in place for some time, integrated and collocated teams, integrated planning and financial allocation resource panels and an integration manager on the senior management team. This provided staff with a solid foundation for integrated working. The integration manager led a number of development and improvement work strands. Almost all staff agreed that joint working was supported and encouraged by their managers and just over half of staff agreed that the senior leadership team had a clear vision to improve health and social care services for people with physical disabilities and complex needs. Although some staff felt communication about development and improvement activity could be piecemeal and so it was difficult to ensure that there was a clear understanding of the work and developments in other teams.

Leaders demonstrated they valued staff with the introduction of their staff communication, engagement and experience delivery plan for 2023-2024. This followed an iMatter survey finding around the lack of visibility of senior managers. The partnership worked in collaboration with over 200 members of staff to produce the delivery plan which will be reviewed annually. Whilst this represented a positive step, just under half of staff in our staff survey agreed that senior leaders were visible. The partnership intended to continue with regular engagement around its strategic aims. This had the potential to further increase senior leadership visibility.

The partnership had effectively supported staff with embedding an early intervention and prevention approach across health and social care. Most staff had the training and advice to support them in their role. The partnership had introduced a significant amount of organisational change around their strategic priorities with a strengthened focus on peoples' outcomes.

The Midway approach was well established within the partnership and had driven asset and strengths-based practice for over a decade. Significant numbers of staff, including the extended management team, had received 'good conversations' training and there was a confidence amongst most staff that people and carers had a say in how their care was provided. However, some health-based staff were unaware of the Midway approach and had a limited awareness of the availability of 'good conversations' training.

Leadership of change and improvement

The senior leadership team had initiated a significant amount of change and development to shift the focus towards early intervention and prevention and embed a whole system approach to outcomes-focussed working. They acknowledged the ambition and scope of these changes which, at the time of inspection, were still in the process of being implemented and evaluated.

In tandem with these changes the health and social care partnership had developed a new governance assurance framework implemented from April 2023. The framework aimed to address the organisational complexity of previous reporting and risk management arrangements. It was aligned to their total quality management system which provided assurance across their strategic, financial, workforce and planning activities. It enabled the integration joint board to monitor governance across four domains; safety; effectiveness; person-centred and regulatory and used an impact rating to highlight areas of confidence and risk. This gave the senior leadership team a better understanding of how integration was working to improve outcomes.

The framework was initially tested with allied health professions, including the physical disability and long-term conditions team. Their first quarterly report submitted in March 2023 highlighted a number of improvement areas. These included not meeting national performance indicators on waiting times and a lack of internal indicators. A series of quantitative measures was in development to address this.

The partnership was developing their Midway approach at a system wide level to support a real culture shift to "facilitating and not fixing". They were using a cloud-based software system and had developed a system wide outcomes mapping process across all adults' services. The system supports data recording, monitoring and analysis to evaluate how outcomes are met at a team, service and organisational level. Just under half of the partnership's teams were using the system with plans to roll it out across all integrated services. This represented a

significant commitment towards changing organisational processes and infrastructure towards being outcomes focussed.

Midlothian had three communities in the top 20% of the most deprived areas in Scotland. Reducing health inequalities was therefore one of the partnership's strategic priorities. Efforts to address these underlying inequalities were set out in the integration joint board's equalities outcomes and mainstreaming report 2021-2025. However, the progress report for 2021-2022 identified more areas rated as not being met or only partially met than completed. The partnership had invested in their aim to address the determinants of poor health and wellbeing by appointing two public health practitioners. This represented a significant investment for a smaller partnership and ensured close working relationships with Midlothian's local intelligence support team. This had helped to develop a better understanding of the needs of local communities and identify development priorities. Successful delivery of these priorities will enable the integration joint board to achieve its aim to ensure that they are able to reflect and respond to local communities more accurately.

Midlothian health and social care partnership published its first integrated workforce plan in December 2022. This was a comprehensive and well-developed document based on the six-step process and five pillars approach set out in Scottish Government guidance and was developed by a group with representatives from all sectors. The partnership faced significant workforce challenges with 10.6% of the estimated jobs available in Midlothian in 2021 going to the health and social care sector. This was lower that the Scottish average of 15.9%. There is a large retail, manufacturing and construction sector in the area with high levels of employment making it a competitive marketplace. The strategy was looking at innovative ways to address this across the whole workforce.

Opportunities for wider joint work was achieved through the Lothian Strategic Development Framework published in 2022. This referred to the four Lothian and Edinburgh integration joint boards and NHS Lothian collectively described as the Lothian health and care system. The Framework acknowledged the reality for timescales for recovery from the Covid-19 pandemic and the negative impact on performance and outcomes for people. However, it enabled linking of interdependent approaches with chief officers of the four integration joint boards meeting monthly. Examples of potential collaboration under discussion included streamlining hospital at home services whilst taking account of local infrastructures and addressing the difficulties in recruitment and retention of key health and social care staff.

Evaluation

- Good

Conclusions

The pandemic continued to have a significant negative impact on people, carers and staff across all sectors. The challenges faced by the partnership affected the availability and quality of support it could deliver. These included recruitment and retention of staff and care staff, increasing numbers of people seeking support and an increasing complexity of needs in those seeking support. This was exacerbated in certain geographical areas which had faced historical recruitment challenges. In addition, the partnership faced a projected population increase of over 13% in the next few years due in large part to the areas house building programme.

Staff were working incredibly hard within this context to deliver good outcomes for people that were broadly in line with Scotland as a whole. In some areas the partnership's performance was higher than the Scottish average. These included:

- more people rated the care they received as good or excellent.
- more people said the care they receive helped them to maintain or improve their quality of life and
- more people said they were able to look after their own health.

There was a clear commitment from the leadership team for a significant whole system change around better supporting peoples' outcomes. The outcomes mapping work was one of the tools that underpinned a whole system change to 'facilitating and not fixing' which was commendable. Leaders recognised the scale and ambition of these changes and that they would take time to become embedded and longer for their impact to be evaluated at a population level. Significant progress had been made in changing the partnership culture toward early intervention and prevention with strong collaborative working with the third sector. However, success will require strengthening commissioning processes to be more defined and ensuring the monitoring and evaluation through for example the governance assurance framework takes place across all services. The decision not to work with defined localities placed risks in being able to capture gaps in local areas.

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 ministerial strategic group's proposals in relation to collaborative leadership, working with the third and independent sector, strategic planning and commissioning, clinical governance and engaging people, carers and the wider public.

Quality indicators

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

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

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

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

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

The 12 statements are:

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

Appendix 2

Term	Meaning
Adult carer support plan	Under the Carers (Scotland) Act, every carer has a right to a personal plan that identifies what is important to them and how they can be supported to continue caring and look after their own health. This is called an adult carer support plan. Adult carer support plans are required to include plans for how the cared for person's needs will be met in the future, including when the carer is no longer able to provide support.
Agile working	Being ready to change the way people work by allowing them greater flexibility in their working hours and where they work, using technology. It also can include changing how people work together or their role.
Aids and adaptations	This means equipment and changes to people's homes which help with everyday tasks so that they can live independently. Examples include grab rails, bath and shower seats, wheelchairs, special mattresses and communication aids.
Capacity	Capacity is the maximum amount of care, support or treatment that day service or individual member of staff can provide.
Care and clinical governance	The process that health and social care services follow to make sure they are providing good quality and safe care, support and treatment.
Carers' centre	Carers' centres are independent charities that provide information and practical support to unpaid carers. These are people who, without payment, provide help and support to a relative, friend or neighbour who cannot manage without that help. Carers' centres are sometimes funded by health and social care partnerships to provide support.
Commissioning	Commissioning is the process by which health and social care services are planned, put in place, paid for and monitored to ensure they are delivering what they are expected to.
Complex needs	People have complex needs if they require a high level of support with many aspects of their daily lives and rely on a range of health and social care services.

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

Future 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.
Health and social care integration	Health and social care integration is the Scottish Government's approach to improving care and support for people by making health and social care services work together so that they are seamless from the point of view of the people who use them.
Health and social care partnership	Health and social care partnerships are set up to deliver the integration of health and social care in Scotland. They are made up of integration authorities, local councils, local NHS boards and third and independent sector organisations.
Health promotion	The process of enabling people to improve and increase control over their own health.
Hospital at home	Services that treat patients in their own home rather than occupying a hospital bed. They are managed by a dedicated team with of health professionals who are responsible for the person's care and treatment.
iMatter	A tool to improve the experience of staff who work for NHS Scotland.
Independent sector	Non-statutory organisations providing services that may or may not be for profit.
Integrated services	Services that work together in a joined-up way, resulting in a seamless experience for people who use them.
Integration joint board	A statutory body made up of members of the health board and local authority, along with other designated members. It is responsible for the planning and delivery of health and social care services.
Localities	Agreed sub-areas within a health and social care partnership area. The partnership should make sure it understands and responds to the different needs of people in different localities.
Low threshold services	Easy access services that people do not have to meet set standards or criteria to access, for example drop-in centres or conversation cafes. Low threshold services are often seen as a way of stopping people's health and wellbeing getting worse.

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

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

Appendix 3

Six-point evaluation scale

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

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

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

An evaluation of **very good** will apply to performance that demonstrates major strengths in supporting positive outcomes for people. There are very few areas for improvement. Those that do exist will have minimal adverse impact on people's experiences and outcomes. 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 and wellbeing outcomes

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

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

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

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

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

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

- **Outcome 7.** People using health and social care services are safe from harm.

- **Outcome 8.** People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

- **Outcome 9.** Resources are used effectively and efficiently in the provision of health and social care services.

Appendix 5

Reference list

- Audit Scotland, Social Care Briefing, January 2022 - https://www.audit-scotland.gov.uk/publications/social-care-briefing

- Audit Scotland, NHS in Scotland 2021, February 2022 - https://www.audit-scotland.gov.uk/publications/nhs-in-scotland-2021

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- Health, Social Care and Sport Committee's scrutiny of the NHS at 75 – what are some of the key issues in 2023? - 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/House of Care - Person-centred care: guidance for non-executive directors - gov.scot (www.gov.scot)

- Warwick Edinburgh Mental Wellbeing Score - Collect, score, analyse and interpret WEMWBS (warwick.ac.uk)

- Public Health Scotland - Health and Social Care | Local Intelligence Support Team (LIST) | Health Topics | ISD Scotland