Joint inspection of adult services

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

Inverclyde Health and Social Care Partnership

May 2024

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 made proposals for improvement. In relation to scrutiny activity, the MSG proposed that joint inspections should better reflect integration, and specifically, that the Care Inspectorate and Healthcare Improvement Scotland should ensure that:

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

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

Inspection Focus

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

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

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

The inspection in the Inverclyde Health and Social Care Partnership was the fourth in the series of inspections, and the first 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 Inverclyde, 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.

Many areas are still in recovery from the Covid-19 pandemic. Impacts may include a reduction in the number and type of services available and a backlog of health concerns that were not dealt with during the pandemic. The long-term impact of long covid is not yet fully understood but requires a response from services.

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

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

Developing systems which support staff to work in a more integrated way is another area of national challenge. This includes sharing information across and between agencies. The issue has been highlighted and addressed in Scotland's digital health and care strategy[5] which was refreshed 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 Inverclyde partnership**, we mean Inverclyde Health and Social Care Partnership who are responsible for planning and delivering health and social care services to adults who live in Inverclyde.

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

[1] Audit Scotland, Social Care Briefing, January 2022 (https://www.audit-scotland.gov.uk/publications/social-care-briefing)
[2] Audit Scotland, NHS in Scotland 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/)
[5] https://www.gov.scot/publications/scotlands-digital-health-care-strategy/

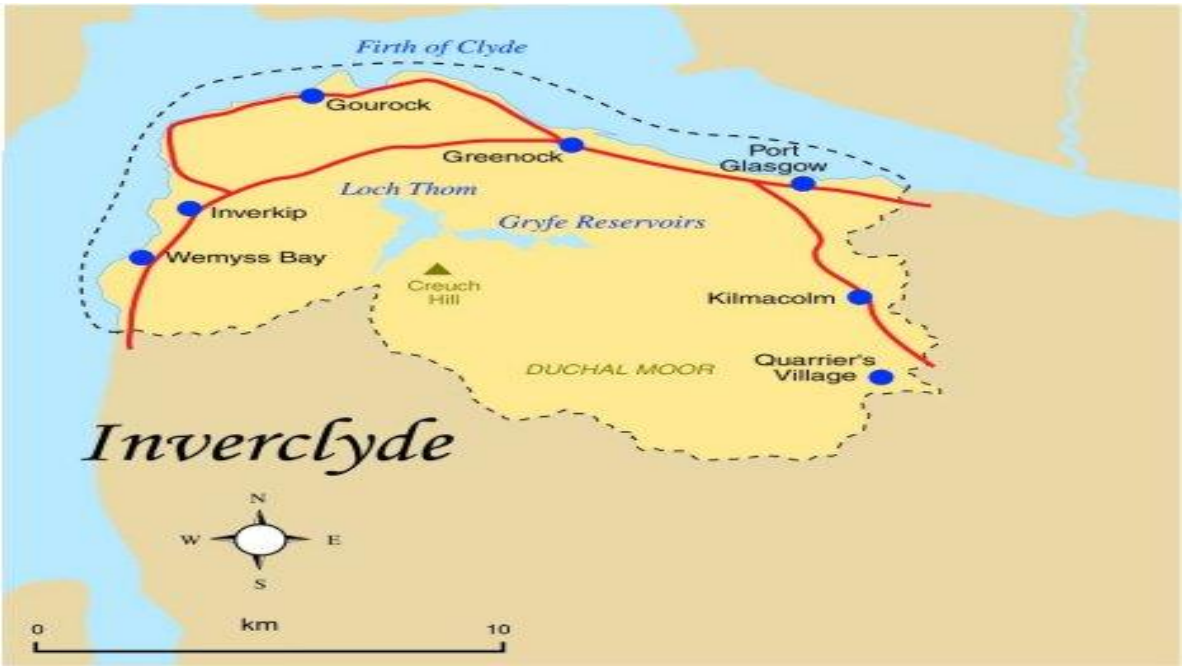
When we refer to **leaders,** or **the leadership team,** we mean the most senior managers who are ultimately responsible for the operation of the health and social care partnership.

There is an explanation of other terms used in this report at Appendix 2.

PART 2 – A summary of our inspection

The Partnership Area

Inverclyde is situated on the south bank of the Clyde estuary. Its main towns are in the north part of Inverclyde and along the coast: Greenock, Gourock, Port Glasgow, Inverkip and Wemyss Bay:



In 2023, the health and social care partnership changed its locality planning structure from six to two localities, West Inverclyde and East Inverclyde.

Unlike most council areas, Inverclyde's population has been getting smaller over the past 20 years. It had an estimated population of 76,700 at 30 June 2021, the fifth smallest in Scotland.

Life expectancy for people within Inverclyde is 74.3 years for men and 78.6 years for women. This is below the Scottish average (men 76.8, women 81). Healthy life expectancy is also lower in Inverclyde at 58.4 years for men and 59.7 years for women (compared with the Scottish average of 61.9 years for women and 61.7 for men). Much of the population of Inverclyde are white Scottish (93.8%, at 2011 census).

Approximately 43% of the population of Inverclyde (33,948 people) live in the top 20% most deprived data zones in Scotland. The rest of the population are relatively evenly spread across the other deciles. Deprivation is a major contributor to inequalities in health and has a significant impact on many of the issues that Inverclyde addresses in its strategic plan.

GP registers in Inverclyde show consistently high rates of diagnosed mental illness, at 1.26 per 100 people, compared with the national average of 0.94. The number of people admitted to hospital for psychiatric reasons is counted over a three-year period. This figure is also significantly higher in Inverclyde than in the rest of Scotland, at 409.4 per 100,000 people, compared with 242.8. More people in Inverclyde are also prescribed drugs to treat anxiety, depression and/or psychosis: 24.09% of the population compared with the national average of 19.29%.

Inverclyde has a longstanding history of integration with one of the earliest partnership arrangements in Scotland. A Community Health and Care Partnership was formed in 2012 with teams co-located and merged to support positive outcomes for citizens. Inverclyde Health and Social Care Partnership (HSCP) was formed in 2014, in line with the Public Bodies (Joint Working) (Scotland) Act 2014.

Inverclyde was severely impacted by the Covid-19 pandemic, with one of the highest death rates in Scotland. Leaders in the health and social care partnership identified that the area was still very much in recovery. They were working on a new strategic commissioning plan that would take account of this and support them with ongoing recovery and improvement. The partnership had recognised the significant impact of the pandemic on unpaid carers and had identified this as a priority area for development.

Summary of our Inspection Findings

The inspection of Inverclyde Health and Social Care Partnership took place between October 2023 and March 2024.

In our discussions with people and carers, we received 32 completed surveys, spoke to 41 people and 12 carers and undertook two focus groups.

In our discussions with staff in the health and social care partnership, we received 149 completed staff surveys, spoke to 95 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 living with mental illness in Inverclyde had positive experiences of health and social care services that contributed to good outcomes for their health, wellbeing and quality of life.

- The partnership's vision focused on inclusion and compassion. It was committed to investing in community-based early intervention and prevention initiatives to support whole population mental health and wellbeing.

- Leaders promoted a collaborative culture, which was broadly understood by staff and communities. Longstanding integrated and co-located services provided a good basis for the provision of seamless services.

- The partnership had robust contract commissioning processes and there were good relationships with providers.

Priority areas for improvement

1. The partnership should develop processes for capturing information about the outcomes of people living with mental illness and their unpaid carers. This should include meaningful opportunities for people to feed back about their experience of services. The partnership should use this information to support plans for improving outcomes.

2. The partnership should support staff in mental health services to identify and respond to the needs of unpaid carers of people living with mental illness. It should monitor the impact of its approach.

3. The partnership should review the effectiveness of its arrangements for integrated and co-located teams, with a view to maximising opportunities for delivering seamless services for people living with mental illness.

4. The partnership should ensure that all staff working in mental health services are confident in the principles and practice of self-directed support, to maximise choice and control for people and unpaid carers.

5. The partnership should strengthen its oversight and governance of social work practice, with particular reference to the statutory functions of mental health officers.

6. The partnership should agree and implement its approach to identifying and addressing priorities for improving mental health services. This should include agreement on how it will monitor the progress and impact of improvement activities.

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	**Adequate**
	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	**Adequate**
	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 Inverclyde?

Key Messages

- The partnership was delivering positive health and wellbeing outcomes for people experiencing mental illness.
- The partnership was above the national average for positive responses to the national integration indicators relating to living independently, improved quality of life and feeling safe.
- Outcomes for unpaid carers of people experiencing mental illness were less positive than those for the people themselves.

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

Public Health Scotland publishes annual 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 for the whole population of the area around the national health and wellbeing outcomes set out in legislation. The Inverclyde partnership was performing above the Scottish average in just under half of the integration indicators.

The Inverclyde partnership did not have a system for recording or collating information about outcomes for people living with mental illness, or for their unpaid carers. This meant that the partnership did not conclusively know how health and social care services contributed to people's wellbeing and outcome data could not be used to inform improvements in mental health services.

There were some opportunities to gather information about outcomes, but these had not been fully implemented. For example: primary care mental health services used the Core Net 10 outcomes measurement tool but did not analyse or use the data it provided to inform service improvement. Some reviews used an outcomes-based review template which included the option to complete outcomes web, but the staff did not use the web. The community mental health team (CMHT) had tested the use of Outcomes Star methodology to measure outcomes but found it too complicated for regular use in a busy service.

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

National health and wellbeing outcome	Inspection Finding
1	Most people were supported to look after their health and wellbeing as much as possible.
2	Almost all people were supported to live as independently as possible.
3	Most people living with mental illness 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 living with mental illness 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.

Most people living with mental illness experienced positive outcomes due to receiving the treatment and support they needed from health and care services. Good outcomes experienced by people often resulted from single agency input rather than from integrated working. People did not always receive the right level of help at the right time or in the right place. Wider community and third sector services had a positive impact on people by supporting them to look after their own health and wellbeing.

Inverclyde's integration indicator for people being able to look after their health very well or quite well was slightly below the Scottish average.

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.

Almost all people living with mental illness were supported to live independently. A range of services provided effective support that helped them to become and remain connected with their community, family and friends. A few people described feeling lonely and isolated.

There was limited opportunity for people to choose the services which best fit their needs and wishes in the community. Both statutory and third sector services were experiencing challenges with recruitment and retention which impacted on capacity to deliver services. This, coupled with increasing demand for mental health services, also led to some delays in people accessing the services they needed.

Inverclyde's integration indicator for people feeling they were supported to live as independently as possible was above the Scottish average.

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

Most people felt that health and social care staff respected their rights, treated them with dignity and kindness and valued their opinions. People were particularly positive about care and support received from the third sector.

Inverclyde's integration indicator for people rating their care and support as excellent or good was above the Scottish average.

Some people found it very difficult to make contact with their GP practice and felt unhappy that they could not always see a GP when they wanted to. This led to reports of negative experiences with GP practices.

Inverclyde's integration indicator for people with positive experiences of the care provided by their GP practice was below the Scottish average.

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.

Integrated health and social care services supported an improved quality of life for people living with mental illness. People experienced improved physical and mental health, improved relationships, more engagement with their communities, and better housing outcomes. There were examples of collaborative working with third sector services that had successfully improved outcomes. A few people found it difficult to access mental health services when they experienced co-existing substance misuse or homelessness. This was contributing to a poorer quality of life for some people.

Inverclyde's integration indicator for people agreeing that services had an impact on maintaining or improving their quality of life was above the Scottish average.

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.

Unpaid carers of people living with mental illness were not routinely supported to look after their own wellbeing or to manage their caring role. A few carers had their own health concerns and were particularly vulnerable to carer stress. Some carers could have experienced improved outcomes through an early referral to the carers' centre or the offer of an adult carer support plan or young carer's statement.

Inverclyde's integration indicator for carers feeling supported to continue in their caring role was below the Scottish average.

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

Most people experiencing mental illness felt safer in their homes and in the community due to the health and care support they accessed. People took fewer risks with their safety and had improved their independent living skills.

Inverclyde's integration indicator for people supported at home feeling safe was above the Scottish average.

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 Inverclyde?

Key Messages

- Most people had positive experiences of health and social care services which enhanced their quality of life.
- Most people experienced good relationships with staff who knew them well.
- Most people felt that they were listened to and involved in planning and reviewing their treatment and care.
- Some people felt they would have benefitted from earlier treatment and support.
- Some people felt their choices were limited and wanted more information about their options for treatment and care.

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

Most people living with mental illness in Inverclyde experienced an improved quality of life through health and social care services that helped them to improve and maintain their health and wellbeing. This included improvements in physical and mental health, housing circumstances, relationships, social life and work skills and reduced alcohol and drug use.

In general, people supported by the community mental health team (CMHT) felt they had good access to the advice, support, treatment and care they needed, both from the CMHT and third sector providers. People described the CMHT as responsive, providing assistance when they needed it, even when their own workers were not available.

> "They picked me up and carried me through it. I'm so grateful to them".

Most people felt they were listened to by staff in health and social care services and that their views were valued. Some people had been supported by the same staff for many years. They appreciated warm and positive relationships with workers who knew them well. However, not all people felt they were treated with dignity and respect. Some people's poorer experiences were linked to restrictions imposed by statutory orders. A few people felt they were treated impatiently or unkindly or were ignored by the staff teams making decisions about their care and treatment.

Almost all people experienced positive changes in their lives due to the health and care services they received. This was often through the support of single agencies and staff teams. Many people living with mental illness needed support with other areas of their lives and were supported by more than one service. These could include the CMHT, the alcohol and drug recovery service, assessment and care management teams, the rapid rehousing and support team, children and families

social work, justice social work and third sector care and support providers. Where this was the case, people had mixed experiences of 'joined-up' working. Some clearly had 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 and holding separate reviews. Whilst single agency information might be shared across services, people experienced separate relationships with different teams and workers. Most people with learning disabilities and mental ill-health and their unpaid carers felt that care and treatment was well coordinated through the community learning disability team.

Unpaid carers' experiences of health and social care services were mixed. About half of people providing unpaid care to people who were living with mental illness thought that their role was recognised. They felt involved in decisions about the person's care and treatment. Some said that support from the carers' centre was helpful, and a few had accessed short breaks which helped them to continue in their caring role. Others found it hard to get information and felt their opinions and needs were not considered, even at key points such as discharge from hospital. Some unpaid carers did not know that they were entitled to support and information under the provisions of the Carers (Scotland) Act 2016.

Some carers lived with the person they cared for and provided practical support, while others lived in their own homes but had regular contact with the person, keeping an eye on their wellbeing. Caring for people who had a mental illness was particularly emotionally demanding for unpaid carers, and they experienced high levels of worry and stress. Several carers felt a significant reduction in stress when they knew that the person they cared for was safe and receiving appropriate treatment and care*:*

> 'She is now a transformed person, living her best ever life. My life is transformed...from constant panic calls, to being able to rest easy.'

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

Inverclyde had a wide range of low threshold and community-based initiatives to support positive mental health and wellbeing in its general population. However, people did not always get the help they needed at the right time, at the right level or in the right place.

Some people who needed help with their mental health for the first time, or for the first time in a while, felt that help was not available until they reached crisis point. They felt that help at an earlier stage would have prevented them from reaching that crisis. Some said they were passed between the community and primary care mental health teams. Some people who were feeling suicidal or had made a suicide attempt and were not currently supported by the CMHT, described having to travel alone to mental health assessment units in Glasgow City and being sent home without support.

Many people had difficulty with access to primary care, with long waits on the telephone and uncertainty over the right time to call. Some people were unclear about the new arrangements in primary care and did not understand why their appointments were with advanced nurse practitioners rather than GPs. Some people, newly referred to the CMHT, experienced delays in referrals being actioned. There were also some delays with care packages being put in place.

In contrast, most of the people who were already receiving services from the CMHT had good experiences of timely support and treatment. They found that services provided through the CMHT were responsive when their needs changed. People were supported with coping and self-care skills, managing their own medication, living healthy lifestyles and reducing risk-taking behaviours. They were offered annual physical health checks at the CMHT physical health clinic. All of this helped people to improve their own health and wellbeing and to maintain it for as long as possible.

People generally felt that health and social care services helped them to live as independently as they could, and to become and remain connected to their families, friends and communities. They attended community cafes and groups and went on days out and shopping trips. They experienced less reliance on family and greater confidence in making decisions and living independently. This had a corresponding positive impact on the quality of life of unpaid carers.

Some people were not confident about what their future held. People were not routinely supported to consider their future care needs and how they wanted these to be met. Neither were they encouraged to plan for potential future challenges such as unpaid carers no longer being able to provide care or their own mental or physical health getting worse. The chance to discuss and plan for circumstances such as these might have alleviated some of their concerns. Some carers felt that their lives would have been easier had they been referred to the carers' centre at an earlier stage.

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

People living with mental illness in Inverclyde were generally supported to express their views and make meaningful decisions about their care and treatment. However, they had different opinions about access to good quality, accessible information. Most relied on the workers who supported them to provide the information they needed. In these circumstances, information was tailored to their needs and people felt it helped them to make good decisions. People had good access to interpreting and translating services. More generally, some people and unpaid carers had found it difficult to access information about health and social care services and about their rights. Some unpaid carers needed better information about guardianship and power of attorney roles. Some people did not understand information provided in standard written formats.

Most people were supported to attend reviews where they could share their views about the support they needed and received. Some did not experience reviews taking place regularly. Reviews were not always accessible or comfortable for the people who were the subject of them, and some people highlighted that they preferred staff to attend on their behalf. They expressed confidence that their workers knew and would express their point of view at the review.

Overall, most people, including those subject to statutory orders, felt that their views were listened to and valued and that they were helped to shape their care and treatment in the way they wanted. A few felt that their care was too restrictive and would prefer to have more independence.

People were not always able to make the choices they wanted to because there was a limited range of options available to them. There were few choices of care and support provider, and with limited availability, people sometimes experienced delays and felt resigned to taking the service that had space. The choice of residential services was particularly limited. This meant that some people who needed a residential placement had to wait a long time. A few had to move away from Inverclyde to access a service, for example, specialised provision for people with alcohol related brain damage.

Some people were supported by advocacy services to understand and exercise their rights. Despite the availability of advocacy, very few people living with mental illness, or their unpaid carers were aware of their rights to make choices about care services through self-directed support. Few knew that they could have the opportunity to influence future care and treatment through the use of advance statements or future care plans.

Whilst people were regularly asked to provide feedback to third sector providers people and unpaid carers did not generally feel they had an opportunity to provide feedback on the overall effectiveness of the services that supported them. Neither people nor unpaid carers were aware of any opportunities to provide structured feedback to the partnership. Some people did not know how to complain about the services they received, although a few people had been supported to make complaints.

Evaluation

Good

Key Area 5 - Delivery of key processes

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

Key Messages

- There was a range of community-based, early intervention and prevention initiatives to support people's mental wellbeing.
- The community mental health team was fully integrated. However, there were some challenges in information sharing and joint working across service/location boundaries.
- Procedures, policies and systems were not consistently understood and applied.
- Self-directed support was not routinely implemented in mental health services.
- Unpaid carers were not routinely identified and supported.

Processes to support early intervention and prevention.

The Inverclyde partnership was committed to a whole-system approach to positive mental health and wellbeing for everyone in Inverclyde. It supported a wide range of community and third sector mental wellbeing initiatives and was developing a trauma-informed workforce.

The Primary Care Mental Health Team supported people with lower-level mental health needs. People could self-refer to the team. The team had strong links with community link workers and with a range of voluntary and community initiatives that could support good mental health. The partnership had invested in the delivery of distress brief interventions and seen a 139% increase in referrals during 2022/3.

The community mental health team (CMHT) provided treatment and care for people living with serious and complex mental illness. A number of third sector providers offered one-to-one support to people supported by the CMHT, helping them to live independently in the community. This included befriending, independent living skills, assistance with education and employment activities, shopping and leisure pursuits. Many people living with mental illness benefitted from such activities to maintain and improve their wellbeing. Some people had less positive outcomes when this support was not in place.

At the time of the inspection, Inverclyde CMHT was experiencing significant capacity challenges due to staff vacancies and demand pressure. There was provision for urgent referrals to be seen within 72 hours and referrals were screened daily. For routine referrals, people often waited for up to eight weeks for a full assessment (against a target of four weeks), and even longer for allocation of a keyworker. This meant that opportunities for treatment and support at the earliest stage were lost. There were also some delays in accessing support services, particularly residential placements.

Some people were supported to improve their own wellbeing with self-management techniques, such as sleep routine, mood management, medication management, falls avoidance, weight management, tenancy support. Where such interventions were in place, they were generally effective in improving outcomes.

The CMHT hosted a physical health clinic to carry out annual health checks for people using its service. At the time of the inspection, the clinic was not fully staffed and there was a backlog of referrals. In addition, around half of people failed to attend their appointments. The service recognised that the physical health clinic was not maximising its potential to support people's physical health and was considering ways to address this.

The partnership did not have a process in place to ensure that staying well plans, future care plans or advance statements were completed with people who would benefit from them. This meant that opportunities to identify and address deteriorating health at an early stage were missed. The partnership did not know how many of the people supported by mental health services had plans in place, or what the impact of the plans was in maintaining positive health and wellbeing.

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

There was a coherent and integrated structure for the delivery of mental health services in Inverclyde and the wider NHS Greater Glasgow and Clyde area. This included local social and community supports and specialist mental health resources hosted by Glasgow City Health and Social Care Partnership. The location of some services outwith Inverclyde created barriers to accessing treatment for some people. This particularly applied when people in mental health crisis had to travel to mental health assessment units in other parts of the NHS Greater Glasgow and Clyde area.

Glasgow City Health and Social Care Partnership hosted mental health services for NHS Greater Glasgow and Clyde. It had led on the development of integrated policy and operational documents to support consistency in mental health services across the health board area, including Inverclyde. This work was undertaken through a collaborative approach between the board and its six associated health and social care partnerships, under the umbrella of the 'Moving Forward Together' programme. The shared documents included: adult mental health and addictions services guidance, protocol for learning disability and mental health interface working, CMHT interface guidance, physical healthcare policy, care programme approach guidance, CMHT operational framework and policy. Each partnership was expected to 'localise' the documents to take their own circumstances into account.

In Inverclyde, most documents were not in routine use and had not been adapted to reflect the Inverclyde context. The Inverclyde CMHT operational framework had not been updated since 2013. This meant that people living with mental illness in Inverclyde may not have experienced integrated services in the way that was intended or expected in the broader Greater Glasgow and Clyde area.

The Inverclyde CMHT was fully integrated and locality assessment and care management teams were co-located. These working arrangements had the potential to underpin excellent collaborative working. However, the partnership had not evaluated whether it was achieving maximum benefit from its working arrangements and there were some challenges to joint working.

Some people and their families were supported by other teams as well as the CMHT, for example: assessment and care management teams, children and families or justice social work, or the rapid rehousing and support team. Where this was the case, the partnership did not have an expectation that one service would lead on the person's care, support and treatment. Different teams and providers used different processes for assessments (including risk assessments), plans and reviews, reflecting the different requirements of their roles. Although assessments, plans and reviews were sometimes shared between services, this was not always the case. This meant that individual workers did not always have a full picture of a person's circumstances. They did not always know what issues other services were supporting the person with or what outcomes they were working towards. There was potential for services to be working separately on some of the same issues or to focus on different priorities that were not compatible with each other. Very few people were supported using the care programme approach, even when complex needs suggested that this would have been helpful in improving their outcomes. In these circumstances, health and care services for people living with mental illness were not delivered seamlessly. Services could not support people to think about the overall outcomes they wanted from treatment, care and support. Some people experienced poorer outcomes as a result.

As a whole, Inverclyde Health and Social Care Partnership had a clear commitment and well-developed approach to addressing health and social inequalities. For example, during the period of the inspection, it started a targeted piece of work to respond to inequalities in a neighbourhood of Port Glasgow. The partnership recognised that many people living with mental illness were at risk of poorer outcomes due to co-existing issues. These might include, for example, homelessness, long-term physical health conditions, and alcohol and drug use. The partnership did not have processes in place to ensure a collaborative approach between the services supporting people with these issues; this was a missed opportunity to address inequalities.

People with learning disabilities who were living with mental illness were supported by the integrated community learning disability team (CLDT). In most cases, where people with learning disabilities needed treatment or support with mental illness or other issues, services were co-ordinated through key workers in the CLDT. Where this was the case, it meant that one service had an overview of the person's circumstances. The keyworker could ensure that all health and care services were delivered in line with the person's needs, preferences and desired outcomes. This led to positive outcomes for most people with learning disabilities who were experiencing mental illness.

The Inverclyde CMHT was a fully integrated team of health, social work and social care professionals. It allocated and maintained oversight of cases through a single point of access (SPOA), supported by two multi-disciplinary team meetings each week. The primary care mental health team participated in the SPOA meetings to agree appropriate allocation of cases, based on level and complexity of need. This collaborative approach was an effective way to prioritise the allocation of resources where they were most needed.

Within the CMHT, keyworkers and care managers were allocated via the multi-disciplinary team meetings. These roles were generic and were confidently undertaken by nursing, occupational therapy or social work staff. There was evidence of effective clinical oversight of NHS staff who managed core clinical functions. For some other staff, service pressures meant that there was limited opportunity to exercise their individual professional skills. As a result, people using the service did not fully benefit from the full range of professional expertise within the integrated team. For example, better use of occupational therapists' skills could have provided a greater focus on rehabilitation. This could have promoted independent living and reduced reliance on the CMHT. Social work expertise could have enhanced outcomes-focused and asset-based practice and ensured that people's rights to choice and control under self-directed support legislation were maximised.

All staff within the CMHT used the EMIS web electronic patient record system hosted by NHS Greater Glasgow and Clyde. This led to very effective information sharing between the services that used EMIS web, as all professionals had access to all records. This included staff in the community learning disability team and the alcohol and drug recovery service. However, there were barriers in information sharing with teams who did not have access to EMIS web, for example, assessment and care management teams and GPs. The primary care mental health team duplicated their recording on EMIS web and EMIS PCS so that both CMHT staff and GPs could see the information. There were particular challenges in relation to social work mental health officer (MHO) records. Mental health officers used EMIS web which most social work staff could not access. It was concerning that senior managers with responsibility for governance and oversight of statutory social work functions did not have access to EMIS web.

The partnership did not have an agreed shared approach to supporting people who provided unpaid care to friends or relatives living with mental illness. There was a lack of clarity across staff groups about what constituted an unpaid carer, which meant that the carer role was not always recognised. This was more likely to be the case when unpaid carers did not live with the person they cared for, or when people did not give permission for carers to be given information about their care and treatment. The role of young carers for parents living with mental illness was also not always identified. There were few referrals to the carers' centre or offers of an adult carer support plan or young carer's statement.

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

The partnership's strong culture of inclusion and valuing people was visible in warm relationships between people living with mental illness and the workers who supported them. Many people had been receiving care and treatment for many years and staff knew them well. This was key in supporting positive outcomes and experiences for people. It meant that people mostly experienced person-centred support, were treated with respect and were supported to make choices and decisions that were right for them. Yet this was not always the case, partly because standard processes and templates for assessment, planning and review in the CMHT were not designed to support an outcomes-focused or asset-based approach.

Where people were subject to statutory orders, there was evidence in most cases that services worked together to make sure that the person's views were considered, and their rights were respected. People were offered advocacy services and some people clearly benefitted from advocacy support. However, oversight and governance of social work practice within the CMHT was not robust. There was a risk that lack of oversight of the MHO team could lead to people's legal rights being compromised. We did not always see full MHO records in files where we expected to see them. Inverclyde had a very low completion rate for social circumstances reports to support short-term detention certificates, which meant that decisions to restrict people's liberty were potentially made without a full understanding of their circumstances. The health and social care partnership had recognised the need to strengthen social work governance. They had reorganised the MHO team and were moving to recruit a new social work service manager for mental health services to work alongside the existing NHS service manager.

The partnership provided general information about mental health and wellbeing through leaflets and websites. This included details of services that could support positive mental health. Staff in statutory, third sector and community-based organisations, including the carers centre, provided more personalised information when people needed it.

Mental health staff did not routinely provide people with information about their rights to self-directed support (SDS). There was a perception among staff that SDS was not suitable for people living with mental illness. This meant that most people were not fully aware of their right to choice and control in relation to their care and support. The partnership had made a significant investment in training staff to have meaningful discussions about SDS. This was having a positive impact on other areas of work. The partnership recognised the need to target training and support to staff working in mental health services.

In some cases, the choice of care for people living with mental illness was limited by the range and availability of services to meet their needs. More consistent use of advance statements and future care planning would have further enhanced choice and control. Nevertheless, where appropriate, most people were provided with advice and support to encourage self-management of their condition. This gave them an opportunity to exercise control over their own wellbeing.

Unpaid carers of people living with mental illness were not routinely made aware of their rights to information, involvement and support under the Carers (Scotland) Act 2016. Where the person gave their permission to share information with their unpaid carer, they were involved and provided with relevant information in most cases. Yet we saw very few examples where unpaid carers were offered support to improve or maintain their own wellbeing.

There was limited opportunity for people to feed back their views to the partnership about the services they received. The partnership subscribed to Care Opinion, and this was beginning to produce meaningful feedback in some areas of activity, although it was not used by people living with mental illness. In some cases, people were supported to provide meaningful feedback at their reviews, but some reviews were completed without the person being involved. The primary care mental health team and in-patient services had processes in place for gathering patient feedback. Neither were currently in a position to analyse and act on it.

Evaluation

Adequate

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

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

Key Messages

- The integration joint board was in the process of preparing a new strategic plan. This would come into effect from 2024.
- The partnership had a market facilitation and commissioning plan (2019-24) and was in the process of renewing this.
- The partnership had robust contract commissioning processes and there were good relationships with providers.
- The partnership had a commissioning focus on initiatives that supported positive mental wellbeing across its whole population.
- The partnership was still to develop its future commissioning intentions for supporting people living with mental illness.

Commissioning arrangements

The commissioning of mental health services in Inverclyde, as part of the NHS Greater Glasgow and Clyde board area, benefitted from the board's strategic approach to mental health. In August 2023, the board had approved their refreshed strategy for mental health services, 2023-28. Glasgow City Health and Social Care Partnership hosted mental health services for the board. A range of workstreams, with membership from all six partnerships in the board area, ensured a collaborative approach to implementing the strategy. The board-wide Mental Health Programme Board had responsibility for implementing the strategy at board level.

The Inverclyde Health and Social Care Partnership had a comprehensive strategic plan for 2019-24. The plan took a whole population approach, with a clear commitment to maximising opportunities for early intervention and prevention. It was built around six 'big actions' or themes, rather than around distinct client groups and had been regularly refreshed to reflect updated priorities due to the pandemic. It was supported by an outcomes framework, developed in 2023-4, that explicitly linked local priorities with the national health and wellbeing outcomes. At the point of the inspection, a new plan was under development, building on information from a joint strategic needs assessment that had been completed in 2022. It was proposed that the new plan would be structured around four themes, one of which was mental health and wellbeing. This supported the partnership's focus on a whole-system approach.

In line with its current plan, the partnership had worked hard to develop a range of integrated approaches to support the mental health and wellbeing of all its citizens. The mental health and wellbeing fund, supported by the health improvement team, allocated ring-fenced funds to local community groups. This mechanism for distributing funding was widely considered to be effective. The partnership had successfully invested in scaling up their distress brief intervention programme. It also participated in "Inverclyde Cares." This was a strategic network of public, private and third sector organisations that supported the community-led "Compassionate

Inverclyde" movement. Compassionate Inverclyde was evaluated in 2023 as producing a range of positive outcomes for individuals and communities.

The partnership was committed to including the third and independent sector as partners in strategic planning and service delivery. Council for Voluntary Sector (CVS) Inverclyde was fully involved in the development of the new strategic plan and had a clear understanding of the partnership's vision. A dedicated post had been created within the organisation to promote understanding of the partnership's strategic ambitions across the third sector. Despite this, some providers still felt that the partnership's approach to co-production could be improved.

The partnership had a market facilitation and commissioning plan (2019-24). The plan described how the partnership would work collaboratively with relevant stakeholders to shape the health and social care market in Inverclyde. There was a focus on collaboration and early intervention, reflecting the priorities of the wider strategic plan. The market facilitation group, which included third sector representation, was key to driving implementation of the plan. The group considered information from relevant stakeholders to support the development of commissioning plans for different client groups. For example, an event was held in November 2023 to consult with unpaid carers about the priorities for the new carers' strategy 2024-29.

The partnership intended that locality planning groups would also influence commissioning plans. It realigned locality planning groups in 2023, reducing their number from six to two. The partnership identified that having fewer localities would provide a more meaningful opportunity for communities, providers and people to input into service planning. This reorganisation was relatively recent and it was too early to evaluate its effectiveness in informing commissioning activities.

Third and independent sector providers reported very good relations with the contract management team and there were robust processes in place for monitoring contracts. This included consideration of people's outcomes, although the partnership did not have a standard approach to outcomes-based commissioning.

Despite a generally well-developed approach to commissioning health and social care services, the partnership did not have current commissioning plans for the particular health and care needs of people living with mental illness. Its pre-covid priority for this group was to embed a recovery focus into mental health services. Priorities understandably shifted with the pandemic to supporting the operation and development of key services. However, the partnership did not routinely collate evidence about the effectiveness of commissioned services in improving outcomes for people living with mental illness. It did not have a planned approach to gathering the views of people who used the services and their unpaid carers. There was no robust data about type or level of need (or unmet need). This meant that there was a lack of evidence to support the formulation of a commissioning plan for this group of people.

The partnership commissioned services from a range of providers to support people living with mental illness in the community. There was a monthly mental health integrated resource allocation group meeting, attended by partnership staff and providers. The meeting considered the allocation and management of individual care packages. It had a focus on both responding to need and managing budgets. The fact that both health and social work staff could access third sector resources supported the integration principle that keyworkers could be allocated from any discipline within the CMHT. Staff could monitor the activity of some third sector support services through weekly spreadsheets that providers completed and returned, detailing their activity. This enabled keyworkers to respond quickly if people's level of need changed. Financial pressures and challenges with staff retention among providers meant that support and care was not always available at the time or intensity that people needed it. There was a shortage of residential provision for people with complex needs, which was a contributing factor to some people being in hospital longer than they needed to be. It was positive that staff reported no barriers to accessing support services, other than availability.

The partnership was aware that it needed to focus attention on service responses to people living with mental illness. They expected their new strategic plan to have a focus on providing more support to people in their own communities. In line with this intention, they hoped to commission services that could provide a higher degree of community support for people living with mental illness. There was a suggestion that the Inverclyde Mental Health Programme Board would work together with the commissioning team to identify and progress commissioning requirements in relation to mental illness, but this process was not yet established. It was too early for us to evaluate the effectiveness of the partnership's future plans for commissioning their mental health services.

Evaluation

Good

Good Practice Example

Women's Supported Living Service

Staff in the community learning disability team identified a gap in provision for vulnerable women. There were challenges in supporting women who wanted to live independently, but needed a high level of support and were at risk of exploitation in the community.

The partnership worked with a local registered social landlord and a third sector support provider to develop a service response. The resulting housing support service, operational in August 2021, provided a resource across two service areas: learning disability and mental health. It enabled seven women with learning disabilities and/or mental ill health to live in their own tenancies, with flexible and responsive support. Robust telecare arrangements offered tenants the reassurance of being able to call for help at any time. The service was provided as an addition to an existing service that had been developed collaboratively between Inverclyde and Renfrewshire health and social care partnerships.

The service worked in an integrated way, with staff from the support and housing providers and the partnership working together to provide personalised responses to each tenant.

The partnership identified a range of positive outcomes for the women supported by the service, including:

- Being able to live more independently than previously
- Improved mental health and reduced mental health in-patient admissions
- Being more involved in their local community
- Improved family relationships
- Feeling and being safer.

Key Area 9 – Leadership and direction

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

Key findings

- Leaders promoted a shared culture of collaboration, compassion and inclusion, which was broadly understood by staff and communities.
- There was an integrated approach to workforce management.
- Leaders had a clear commitment to promoting good mental health and wellbeing for all the people of Inverclyde. There was less focus on the specific needs of people living with mental illness.
- There had been a significant turnover of leadership and management staff in the two-year period prior to our inspection. This had adversely affected consistent leadership of mental health services.
- Clinical care and governance systems were effective, but the professional governance of social work functions needed to be strengthened.
- Leaders did not have good evidence about the effectiveness of mental health services in Inverclyde that could support them to identify and set priorities for change and improvement.

Leadership of people across the partnership

The Inverclyde Health and Social Care Partnership had a relatively new senior leadership team. They were committed to a collaborative culture, underpinned by a shared vision and values. They actively encouraged a whole-system, compassionate and person-centred approach that recognised the impacts of poverty, inequality and trauma on the wellbeing of their citizens. Senior leaders were confident that collaborative working was strong because they had adopted integrated and co-located working and integrated management structures at an early stage. These arrangements clearly supported collaborative working, but closer attention to processes and systems could have further improved both its quality and extent. The partnership faced significant challenges. Many senior officers had been in post for less than 12 months prior to the start of the inspection. Inverclyde had been severely impacted by the Covid-19 pandemic and was still in recovery. Financial pressures, geographical issues and challenges with recruitment and retention all impacted on the partnership's capacity to fully implement their vision.

Positively, senior leaders demonstrated that they valued their staff. The partnership had a three-year integrated workforce plan (2022 – 2025), which included the third and independent sector workforce. Progress had been made on the plan, with a range of creative measures underway to recruit and support staff. This included reviewing social care job profiles to ensure pay parity with healthcare assistants and a 'grow your own' initiative to support staff undertaking social work qualifications.

Staff across all sectors were largely confident in the leadership and direction provided by the senior leadership team and believed that their managers supported joint working. This was consistent with the results of the partnership's iMatter survey which highlighted that staff felt well informed, appropriately trained and developed and treated fairly. They felt that leaders promoted the health and wellbeing of staff.

The partnership had a well-embedded clinical and care governance framework. Clinical and care governance groups at service level linked into both the HSCP and NHS Greater Glasgow and Clyde clinical and care governance forums. The clinical and care governance group for mental health, recovery and homelessness considered matters reported through mental health services and escalated these as required. This included information from the integrated incident review group shared with the alcohol and drug recovery service. This was an effective process for escalating concerns and sharing learning to inform improvement across all six NHS Greater Glasgow and Clyde partnerships.

There was evidence of good single agency quality assurance processes for NHS staff working in mental health services. The nursing core care assurance audit tool for mental health inpatient & community services was used effectively. Analysis of data from the audit had resulted in funding for a practice development nurse to lead on the implementation of identified improvements.

However, staff in mental health services were not always clear about policies, systems and processes. There was no routine governance or quality assurance of social work practice within the community mental health team, including the statutory functions of mental health officers (MHOs). There was no self-evaluation across the range of mental health services. This meant that the partnership did not know if staff and people were getting the maximum benefit from its integrated service arrangements.

Leadership of change and improvement

The partnership's overall commitment to improving the mental health and wellbeing of Inverclyde's people was evident. In line with national and partnership strategic priorities, early intervention and prevention was a key focus for change and improvement. In contrast, there was a limited focus on improving targeted health and social care services for people living with mental illness.

The partnership's strategic priorities were organised by six 'big actions' or themes. Operationally, activities were structured in four service areas. Support and treatment for people living with mental illness was managed through the mental health, recovery and homelessness service. This service had been impacted by several changes in senior leadership in the two-year period of our inspection scope.

NHS Greater Glasgow and Clyde's clinical governance arrangements provided a level of assurance for mental health services during the leadership transitions. Operational services benefitted from committed staff working in line with long-established custom and practice. Nevertheless, the partnership's overall governance and leadership of integrated mental health services in Inverclyde was adversely affected. At the point of our inspection, senior leaders did not have access to meaningful data about the performance, quality or impact of their mental health services. This meant that they could not be confident about the effectiveness of integrated processes and commissioning arrangements in delivering seamless services and good health and wellbeing outcomes for adults living with mental illness. They were therefore not able to identify current priorities for change and improvement.

There was evidence that, prior to the two-year period of our inspection scope, the partnership had initiated a range of improvement work in mental health services. A mental health and wellbeing needs assessment had been completed in 2019, and an internal review of the CMHT service in 2020. Challenges presented by the pandemic, coupled with the number of changes in the leadership team, meant that there had been a lack of continuity to drive forward identified improvement priorities. In the case of the CMHT review, momentum had been lost completely and progress had stalled. The MHO team carried out a service redesign following an external review of the service in 2021. This included the appointment of two additional MHOs and investment in a dedicated team leader post. There was also an ongoing current review of the primary care mental health team. The MHO and PCMHT reviews reported through the mental health programme board, which had both service user and carer representation. The reviews themselves would have been strengthened by including the perspectives of people living with mental illness and their unpaid carers.

Senior leaders recognised the need to strengthen the leadership and governance of integrated mental health services in Inverclyde and took steps to do so during the inspection. Further recruitment was underway to appoint a social work service manager for the CMHT to strengthen the professional governance of social work functions. This would support the establishment of a senior management team for mental health services.

The partnership had recently developed a draft terms of reference for the integrated Inverclyde mental health programme board (MHPB). It stated that the purpose of the board was "to provide leadership to the range of mental health service improvement programmes in Inverclyde." It would report to the integration joint board. The partnership was still considering how the MHPB would support a coherent approach to local planning and commissioning of mental health services, taking account of both locally identified priorities and the ambitions of the NHS Greater Glasgow and Clyde strategy.

Evaluation

Adequate

Conclusions

The people of Inverclyde experience high levels of deprivation and health and social inequalities. The prevalence of mental illness in Inverclyde is higher than for Scotland as a whole. The health and social care partnership was committed to tackling inequality. It benefitted from a long history of integrated and co-located services and championed values of compassion and inclusion. It had significantly invested in low threshold, community-based initiatives that would support the mental health and wellbeing of its whole population.

The partnership had been less focused on health and social care services for people who were experiencing mental illness, and who needed treatment and targeted social care support. Inverclyde was badly affected by the Covid-19 pandemic and was still in a period of recovery at the time of our inspection. There had been a high turnover in management and leadership staff with responsibility for mental health services in the two years prior to our inspection. This combination of factors meant that the partnership had not had the capacity to progress previously identified improvements and did not have a clear picture of the current effectiveness of its services.

Most people living with mental illness still experienced positive outcomes from the treatment and care they received. These positive outcomes were supported by warm relationships between staff and people, custom and practice in operational services and the partnership's values of collaboration, compassion and inclusion.

People's outcomes were not always as good as they could be. Systems and processes needed to be updated and used to underpin consistent, person-centred and rights-based practice. Oversight and governance of information sharing, and the quality and performance of integrated services needed to be strengthened. People and unpaid carers needed a way to provide feedback about the effectiveness of mental health services in helping them to achieve the outcomes they wanted, and to be confident that their views would be taken into account. The partnership needed to develop a comprehensive plan for the future of health and social care services for people living with mental illness.

The partnership was aware that it needed to focus attention on its mental health services and had already taken some steps to do so. New staff had been appointed. A new strategic plan was under development. The recently refreshed NHS Greater Glasgow and Clyde strategy for mental health services, and the implementation processes supported by Glasgow City Health and Social Care Partnership, provided a timely opportunity to support improvement.

The partnership needs to work collaboratively to develop robust improvement and commissioning plans for its mental health services. It needs to put in place suitable structures and processes to support implementation of its plans. Given the partnership's key strengths and its early response to the findings of the inspection, we have a good level of confidence that it will be able to make the improvements required. This will contribute to more consistent and sustainable positive health and wellbeing outcomes for adults living with mental illness and their unpaid carers.

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
Evidence submitted from partnership
Reviewing records
Discussions with staff and other stakeholders
Professional discussions with partnership.

The underpinning Quality Improvement Framework was updated to reflect the shift in focus from strategic planning and commissioning to focus on people's 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 carers' 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 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
5.1	Processes are in place to support early intervention and prevention
5.2	Processes are in place for integrated assessment, planning and delivering health and care
5.4	Involvement of people and carers in making decisions about their health and social care support
6.5	Commissioning arrangements
9.3	Leadership of people across the partnership
9.4	Leadership of change and improvement

Engagement framework

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

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

The 12 statements are:

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

	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.
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: • protecting health, safety, welfare, finances and property • safeguarding of rights and freedom • duties to the court • 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.

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.

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

	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.

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.