Joint inspection of adult services

Integration and outcomes – focus on people with a learning disability

East Ayrshire Health and Social Care Partnership

August 2026

Contents

PART 1 – About our inspection

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, and the contribution of non-statutory partners to integrated arrangements, individually and as a partnership.

Inspection focus

In response to the Ministerial Strategic Group's 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 East Ayrshire health and social care partnership was the seventh in the series of inspections, and the first to consider the inspection question through the lens of people with a learning disability.

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.

National issues and context

The Scottish Government has sought improvement in the quality of life for people with a learning disability through *The same as you?* (2000) and *The Keys to Life (*2013). This will be further enhanced through legislation relating to learning disability, autism and neurodivergence, currently at the consultation stage.

Developing systems which support staff to work in a more integrated way is another area where there is a national challenge. This includes sharing information across and between agencies. This has been highlighted in Scotland's Digital Health Care Strategy, first produced by the Scottish Government and COSLA in October 2021 and annually renewed through accompanying delivery plans.

PART 2 – A summary of our inspection

Summary of our inspection findings

This inspection took place between January 2026 and August 2026. In our discussions with people experiencing care, we spoke with or heard from 134 people and carers, receiving 62 completed questionnaires and meeting with 72 people in interviews and focus groups. This included 98 people accessing support - 30 across eight focus groups, 19 in individual conversations and we received 49 questionnaires. We also listened to 36 carers, 23 in individual conversations and we received 13 questionnaires. Staff support for both meeting with individuals and with focus groups with people was key to supporting people to articulate their views. These relationships were characterised by warmth, kindness, respect and a deep knowledge of the people they supported and what mattered to them.

In our engagement with staff from the health and social care partnership, we received 199 completed staff questionnaires, spoke with 102 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

- People experienced good, person-centred care and were treated with compassion, dignity and respect.
- There was a wide range of care and support available to people, depending on their wishes and needs. Staff worked well together to creatively support solutions to complex care and housing issues. This encompassed housing, accommodation with support, telecare, the ‘Coming Home’ policy and the dynamic support register.
- There was strong joint working with well-developed relationships between staff working in different organisations. This was enhanced by co-location. Senior managers and leaders worked well together in an integrated manner. This positively modelled the benefits of integration to others.
- The work of the Community Learning Disability Team demonstrated a strong person-led and outcome-focused approach.
- The partnership had effective and robust systems and processes to support the work it did with people. This included very successful implementation of self-directed support and effective, person-centred approaches in relation to the Adults with Incapacity legislation.

Priority areas for improvement

- The partnership should relaunch its programme of annual health checks. These provide effective routes to early intervention and prevention as well as addressing health inequalities.
- The partnership should accelerate the delivery of future care and emergency plans, including adult carer support plans. They are a critical means of ensuring the continuity of care.
- The partnership should engage with frontline staff to ensure they feel adequately supported around assessment, re-assessment and review of packages of support at resource allocation meetings. This is particularly where staff have to communicate difficult or challenging news to people experiencing care who are awaiting funding decisions.
- The partnership should seek to gather and analyse the outcome-based data it produces from its work with people. This would support strategic planning and more positive decision-making for people with a learning disability.

Key Quality Indicators Inspected		
Key Area	**Quality Indicator**	**Evaluation**
Experience of people and carers	People and carers have good experiences of integrated and person-centred health and social care	**Good**
	People's and carers' experience of prevention and early intervention	
	People's and carers' experience of information and decision-making in health and social care services	
Key performance outcomes	People and carers have good health and wellbeing outcomes	**Good**
Delivery of key processes	Processes are in place to support early intervention and prevention	**Good**
	Processes are in place for integrated assessment, planning and delivering health and care	
	Involvement of people and carers in making decisions about their health and social care support	
Strategic planning, policy, quality and improvement	Commissioning arrangements	**Good**
Leadership and direction	Leadership of people across the partnership	**Good**
	Leadership of change and improvement	

PART 3 – What we found during our inspection

Key Area - Experience of people and carers

Key messages

- Most people had a good quality of life with support to access a wide range of activities of their choice in the local community. These afforded opportunities to maintain relationships with their family and friends.
- People had positive experiences of joint working between different organisations, whatever their health and care needs.
- Most people felt listened to and were supported to live as independently as possible.
- Many people had positive experiences of prevention and early intervention activity.
- The partnership was able to demonstrate good, integrated working on a range of issues relating to housing, discharge planning and ongoing support, which contributed to the principles of the Coming Home policy.
- Opportunities for people to influence assessment and planning was good, through the use of outcome-focused tools. However, they had little influence over the approval of funding for support.
- Not all carers were formally recognised, creating a risk that they may not have received support that might otherwise be available to them. The Carer's Centre provided good support when requested.
- There was a culture where carers felt strongly caring was their responsibility and did not wish to change that.

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

People were confident their care and support worked well together most of the time. There were good examples of social work, health and advocacy services working closely to ensure a shared understanding of what was important to the person. Similarly, most people cited positive joint working across support providers, advocacy services and health staff. This included the community learning disability team who were a group of professional staff from a number of different health disciplines such as physiotherapy, occupational therapy, psychiatry, speech and language therapy and dietetics. This staff group worked exclusively with people with a learning disability and as a consequence had a wealth of knowledge, skills and experience in this regard.

In most instances people were well supported by staff to receive the care and support they needed, making their life better. Staff were kind and respectful of people's rights.

People received support and care that helped them stay as well as possible for as long as possible on most occasions. This included accessible and positive primary care services. There were integrated approaches to delivering this support across social work, service providers and the community learning disability team. There was also support for building independent living skills and confidence. Most people had experience of services that helped them to build on their strengths and develop skills and abilities. This included how services provided support, encouraging independence through activity. Other positive supports included consistency of staff which enabled trusted relationships, the use of technology, and provision of occupational therapy. These were important factors, building on people's own strengths and assets which was empowering and acknowledged the value of their lived experience.

People spoke positively about the staff they directly engaged with almost all the time. They felt that staff adhered to core values of treating people with dignity and respect and listened to what people had to say. This was crucial as this reflected a person-centred approach and an understanding and commitment to core health and social care values.

A majority of carers were supported in providing the level of care they wanted to. This included access to carer support groups, and service providers making efforts to maintain family relationships. Some carers had less positive experiences and did not have access to the right support including primary care and social work, to respite or to the right information at the right time. Waiting lists for some services were lengthy, and the recently revised eligibility criteria and lack of clarity around funding decisions had a negative impact on getting help when needed. Some carers were neither aware of, nor had, an adult carer support plan and did not feel listened to by social work staff. Reductions in support provision for the cared-for person added to carer strain and anxieties. The partnership identified a person as a carer if they provided 'hands-on' care, and therefore some carers missed out on opportunities for support.

For those receiving support, East Ayrshire Carers Centre played a key role, including the provision of adult carer support plans from convenient bases in Kilmarnock, Cumnock and Dalmellington. Helpful support offered included advice on benefits, fuel and energy use, and social, leisure and respite opportunities. Many carers spoke of the weight of their responsibilities and duties but would not wish to change this. This meant the partnership was not required to provide all the necessary care and support; and depended on an ageing group of carers, with many beyond the normal working age. In many cases there had also been a reluctance on the part of carers to make plans for when they were no longer able to provide as much support. This was an incredibly sensitive issue and one of the outcomes was that the partnership lacked some data that would be useful to allow it to prepare for how people's support needs may change in the future.

While most people said that services enabled people to stay connected to their communities and social networks, the views of carers were more mixed. Carers said there was occasionally a negative impact due to a range of factors. These included last minute changes to the staffing timetable and gaps in evening and weekend support, but the main source of frustration was not receiving funding or having funding removed for social support.

Regular feedback, from people experiencing care, to day services and independent sector service providers was limited. East Ayrshire Carer Centre represented the views of carers at a strategic level and some partnership decisions had been influenced as a result. This reflected the importance of ensuring feedback channels were available for people to readily use.

"…you can say what you think about everything"

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

Overall, access to health and social care was positive and straightforward. There was a particularly prompt referral route to the community learning disability team for GPs, other health professionals, social care workers and service providers. The community learning disability team had a wide range of knowledge, skills and experience and provided good, person-centred support when required. Some people living independently were confident enough to call health professionals and social workers themselves. Knowing who to contact during normal working hours and out of hours, supported prevention and early intervention.

People were confident that support staff had in-depth understanding of their complex health conditions. However, they were less confident in staff's ability to recognise and identify changes in their presentation that may indicate a deterioration in their health. A few people spoke positively about living independently, describing how regular contact with health professionals and social workers helped them to maintain their wellbeing. They explained that these visits enabled support needs and changes in health to be identified promptly, allowing appropriate support or health interventions to be put in place. This demonstrated how effective communication, partnership working and regular review can support intervention and prevention.

Most people spoke about having good relationships with health professionals including GPs, psychiatrists, psychologists, the community learning disability team nurses and other community learning disability team members. They commented on the promptness of responses and having confidence that monitoring and support promoted their health and wellbeing.

People who had experienced stays in hospital spoke about the benefit of their usual community staff supporting them. This provided continuity of care, supported improved health and wellbeing outcomes and avoided unnecessary delays in discharge. Support also included giving advice on healthy eating, keeping safe, and monitoring long-term physical and mental health conditions. In these circumstances people's experience of support directly and positively impacted on their health. This was positive, and the partnership had the opportunity to consider how it ensured these approaches became consistent practice.

Most people spoke about referrals to the community learning disability team being responded to directly and visits arranged without delay. For example, this included support to people, from physiotherapists after falls or changes in their mobility, to support them to continue living as independently as possible. Support to gain daily living skills and assessment and provision of equipment to promote independence and strengthen confidence was also highlighted.

The partnership invested time and resource in technology enabled care. Having a responder service as part of this had supported people to live independently and get the support they needed if their health or care needs changed. This meant people experiencing care were assured that they would be adequately supported when pursuing independent living.

This was reinforced by support, advice and a wide range of activities at day centres and day opportunities, which improved people's physical health, and general and mental wellbeing. For many people this also enabled them to gain skills to enable them to live independently in the community and maximise their full potential.

People spoke about the benefit of regular respite, when available, in a consistent setting as staff knew their health and support needs well and were proactive in having in-depth knowledge of their health conditions. They were able to seek prompt medical advice when required. For future care planning, this supported these people and their carers to have good experiences of transition when long-term care was needed.

There was a lack of recording of future care planning/contingency planning in place for most people. Where these plans were evidenced in the records, they were however of good quality. They demonstrated involvement of the person or welfare guardian in making decisions. Furthermore, they showed appropriate reviews taking place in response to any changes in health and care needs or changes in the person's wishes.

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

Most people and nearly half of carers said they got information when they needed it. Social workers, local area coordinators, advocacy services and to a lesser extent GPs were key in making people aware of support available to them. The community learning disability team had easy-read appointment letters, and service providers consistently ensured that people had information in an accessible and manageable format. This helped ensure that individual practice reflected the broader aims of the independent advocacy strategic plan 2024-27, which prioritised provision of accessible information and advice.

However, carer experiences were not consistently positive. Often, they did not have correct, up-to-date information and some did not understand or know about self-directed support or respite options. Having accurate information in a manner and at a time of one's choosing is a fundamental part of ensuring people's voices are heard and their choices are communicated. Ensuring people's views about information were consistently positive would help ensure better experiences. There were some guardianship issues that impacted negatively on people's decision making and ability to exercise choice and control. This included where there were delays in reviewing guardianship orders, and where family members who were guardians, but not providing hands on care, were not included in their relative's assessment, planning or review processes. Addressing all these issues was important in respect of national policy of making sure services work well for everyone who uses them.

Overall, most people's views and wishes were central to the support they received. Most people experiencing care agreed they were supported to make decisions about their care. These choices were respected by services. This reflected well on the partnership's values underpinning its practice.

Evaluation

- **Good**

Good practice example

Inspectors met and spent time with a number of people using the UCAN day service, as well as staff, at their base. This was primarily a day service, operating on Mondays to Fridays although in some cases people were accessing support beyond that range, through their involvement with UCAN. A wide range of services were offered, with some building-based at UCAN and some based outwith UCAN, in the wider community. The service provision was delivered by motivated and enthusiastic managers and staff, offering a wide range of appropriate activities. The service was very popular, offering a wide range of supports. People accessing the service spoke very positively about their experience there and the quality of their engagement with staff. People appreciated the flexibility of the support at UCAN and the potential to explore different interests. There was also a strong and positive ethos of encouraging volunteers to support staff where appropriate.

Key Area – Key performance outcomes

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

Key messages

- The partnership had no adults with a learning disability placed inappropriately out of area. It was building positively on existing good practice around its support for people to live, with the right support, in East Ayrshire.
- The partnership effectively promoted independence, building on people's own strengths and assets, and capacity for self-management.
- Most adults with a learning disability had an improved quality of life because of the person-centred services they received. Reviews were regular and access to additional health services was timely.
- Despite initial progress the partnership had temporarily stopped annual health checks for people with a learning disability. When undertaken, they were purposeful and brought about meaningful change for people.

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

Public Health Scotland publishes an annual core suite of integration performance indicators for every health and social care partnership in Scotland. There are 23 indicators in total. The first nine indicators reported are based on the national health and care experience survey, published by Public Health Scotland, which asks about experiences of accessing and using various health and care services. While East Ayrshire health and social care partnership's performance against indicators 1-9 in the data release from July 2025 was better than the Scotland average for seven of the nine indicators, this position had weakened in July 2026. Crucially, this performance data relates to the population as a whole, meaning it had limited use when referring to adults with a learning disability. The partnership itself had limited performance information specifically relating to people with learning disabilities. This made evidencing outcomes, undertaking strategic needs analysis, and planning services more difficult for this specific group.

For these inspections, we focus on national health and wellbeing outcomes 1-7. From conversations with people with learning disabilities and carers, and from reviewing records, we found that the partnership was generally supporting positive outcomes for people against these national outcomes.

The national health and wellbeing outcomes

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

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

Almost all people, carers and staff reported that people were supported to be as independent as possible. Records demonstrated that self-management approaches were routinely promoted. Almost all people reported feeling able to look after and improve their own health and wellbeing and live in good health for longer. This suggested that people felt early intervention and preventative approaches were contributing positively to their wellbeing.

People benefitted from a broad range of community and social supports which helped them maintain good health and wellbeing. Individuals and carers highlighted the value of day opportunities, social supports and organisations such as UCAN which enabled people to develop skills, maintain independence, build relationships and achieve personal outcomes. Support plans routinely incorporated community resources such as leisure facilities, community clubs, faith groups and befriending services.

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

The Scottish Government's Coming Home Report highlighted the importance of people with learning disabilities receiving care in appropriate settings close to home. The partnership had established a co-ordinated approach to monitoring and reviewing out-of-area placements through a dedicated co-ordinator. People and carers were appropriately involved in these reviews and, at the time of inspection, 18 people lived out of area in placements that reflected their wishes and assessed needs.

Almost all our survey respondents reported that people were supported to live as independently as possible. People, including those with disabilities and long-term conditions, reported feeling able to live independently and within their own communities wherever reasonably practicable.

Community supports played a significant role in helping people remain connected and active within their communities. This promoted independence, maintained skills and reduced social isolation. However, recent changes to eligibility criteria had reduced the range and extent of social supports available to some people. The partnership needed to continue monitoring the impact of these changes on individuals and their outcomes.

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

Case records demonstrated that people were generally able to exercise choice and control over their care and support. Staff knew individuals well, understood their preferences and worked collaboratively with multi-disciplinary colleagues to develop personalised support arrangements.

Almost all people received a health and social work review annually, or at appropriate intervals, and these reviews generally involved the person and their carers. Social work reviews were particularly focused on personal outcomes and care plans were adjusted to reflect changing needs and circumstances. Almost all people, carers and staff expressed confidence that services worked well together to support positive outcomes. These strong working relationships between practitioners contributed to positive experiences for people using services.

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

Almost all case records we reviewed demonstrated that people were maintaining or improving their quality of life. Individuals were supported to make choices and retain control over important aspects of their lives. Staff demonstrated a strong understanding of personal preferences and aspirations.

The social work assessment and care management frameworks *My Life, My Plan* and *My Life, My Review* were centred on personal outcomes and provided a structured approach to outcome-focused conversations. Practitioners worked with people and, where appropriate, carers and other agencies to identify, review and monitor progress towards agreed outcomes.

Where intervention was required to improve wellbeing or functioning, outcomes were rated as good or better in all cases reviewed. Access to specialist multi-disciplinary services was timely and effective. A wide range of professionals, including occupational therapists, speech and language therapists and mobility specialists, contributed to supporting people to achieve their outcomes.

Although outcomes were routinely reviewed at an individual level, there was no formal system for aggregating or analysing outcome data across services. Many health records were appropriately often more task-focused and specific in nature. This made it more difficult to combine them with social care records. As a consequence, it was difficult to generate combined outcome-focused data covering the whole range of a person's experiences of support from health and care services.

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

The introduction of annual health checks for adults with learning disabilities represented an important initiative aimed at addressing recognised health inequalities experienced by this group. While initial progress had been made, the suspension of the programme, due to uncertainty about ongoing funding, in mid-2025 meant that many people had not received these checks, limiting opportunities to identify unmet health needs and intervene early.

The partnership's ability to identify and respond to health inequalities was constrained by limited performance information relating to people with learning disabilities. A lack of comprehensive data relating to health inequalities made service planning and performance monitoring more difficult. This risked creating further inequalities as a result of decision-making without all the underpinning evidence.

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

The partnership did not routinely collate outcome data relating to carers, limiting its ability to understand the effectiveness of support provided and to inform future planning. Case records showed that carers were almost always offered an adult carer support plan, although uptake was variable and reasons for declining support were not routinely analysed.

Health and social work staff signposted carers to the Carers Centre and service providers actively considered carers' needs during home visits and care reviews. However, some health staff viewed support for carers as primarily a social work responsibility. This occasionally resulted in carers not being identified or their needs not being assessed in a timely manner.

Support services such as the Ayrshire Independent Living Network were highly valued by carers, helping them manage self-directed support budgets and reducing the stress associated with caring responsibilities.

The partnership recognised that reductions or changes in services had increased pressure on carers and negatively affected their capacity to sustain their caring role. Just over half of people had an identified carer and, although carers were usually involved as part of the wider support team, only some had completed adult carer support plans. This indicated inconsistency in practice and opportunities for improvement in recognising and supporting unpaid carers.

Outcome 7: People using health and social care services are safe from harm

Access to multi-disciplinary services and interventions was timely and effective. Where people experienced deterioration in wellbeing or functioning, multi-disciplinary teams responded appropriately and achieved good or better outcomes in all cases reviewed.

Although there was limited evidence of anticipatory care plans and emergency or contingency planning, multi-disciplinary responses to emergency situations and unplanned care needs were effective. In almost all instances, these interventions helped prevent hospital admission or the need for respite care.

Evaluation

- **Good**

Key Area - Delivery of key processes

How far is the delivery of integrated processes in the East Ayrshire partnership effective in supporting positive outcomes for people with a learning disability?

Key Messages

- Co-location positively impacted joint working and information sharing. This extended into joint visits by different professionals to people experiencing care. This included health, social work and social care staff.
- There was robust and helpful communication between different organisations providing support.
- Self-directed support was well-established in practice and there was a visible commitment to person-centred and person-led working.
- Processes around incapacity and appointeeship were robust, supportive and transparent.
- Local area coordinators provided a clear early intervention option as well as ongoing support and liaison throughout the partnership. This exemplified confidence in the capacity of the third sector to support positive outcomes.
- There was clear evidence of good working relationships between operational managers in health and social care. The different roles of people within organisations were well understood.
- Future care planning required more explicit reference within case recording. This would help clarify why there was reluctance on the part of carers to engage with this process.

Processes to support early intervention and prevention

There was a good range of services promoting prevention. There was clear evidence of early intervention and prevention where needs or risks changed and appropriate timeous action was taken. The quality of the early interventions was good or better in almost all cases. This promoted a personal and assets-based approach inclusive of third sector service providers and others.

Most social work and health staff and almost all third sector staff considered their assessment, planning, review and risk assessments to be joint. This was a clear strength and demonstrated a positive culture. This would be enhanced by formalising the sharing of key documents rather than upon request. Regular integrated meetings to discuss joint cases were commonplace. These provided clear opportunities for sharing information to support assessment, risk and care planning. However, easily shared templates were not widely used.

A small, motivated local area coordinator team worked across East Ayrshire to create and support social networks for adults with a learning disability. It engaged well in early intervention and prevention either directly or through coordination with other partnership services. It linked well with social work and played an integral role in supporting people with a learning disability.

Almost all cases where an emergency response was required were supportive. This often prevented emergency respite or hospital admissions. This demonstrated good quality in terms of practice across the partnership.

The partnership had a dedicated resource to manage corporate appointeeship and access to funds. It worked closely with the Office of the Public Guardian to ensure funds were available quickly for both day-to-day needs and one-off expenses. There was also extensive use of prepaid cards to provide quick access to funds when required without compromising monitoring.

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

The My Life, My Plan assessment and care management guidance provided a good outline of a person-centred approach for staff. An assessment was present in almost all records we read. Positively, all assessments were undertaken in accordance with guidance timescales.

Assessments were not routinely shared, although collaboration was good or better in almost all cases. Clearer communication protocols would enhance the joint nature of assessment between teams and professionals. Care, support and treatment plans were commonly present but again were mostly owned by individual agencies with only a quarter being coordinated or shared.

Case recording guidance was available to social work and the community learning disability team. Case recording across the partnership was person-centred, clear and helpfully detailed the necessary information to understand a situation and the proposed actions required to support a person's needs. Similarly care plans were clearly recorded in almost all of the cases we reviewed. These offered a detailed and person-centred outline of the support required and how it was to be achieved.

The community learning disability team model was supported by separate clear guidance regarding referral, triage and assessment. There was an open referral system which covered transition referrals and led to triage, assessment and specialist assessment, according to need (e.g. learning disability and dementia). The community learning disability team often shared their assessments with social work and referred to social work where they believed it necessary. Social work equally communicated any issues with the community learning disability team especially around the need for capacity assessment and adult support and protection issues. Although not formally fully integrated, current processes offered effective assessment, care and treatment with a relatively seamless although separate response.

Staff demonstrated they understood one another's professional roles, duties and statutory responsibilities. It was apparent that there were positive relationships between social work teams, the community learning disability team, local area coordinators and service providers.

Information sharing between the community learning disability and social work staff centred on dialogue between the various professionals. Co-location and an integrated health and social work management structure aided this. This was viewed positively by staff as they often benefitted from a joint social work and nursing management perspective. This helped address the challenge of health and social work staff using different information systems. More formalised or systematic sharing of information would enhance this position and improve the overall quality of assessments and reviews. With the exception of mental health officers, staff could not access other agencies systems. This meant that relevant information would often need to be recorded twice, once on each system, which increased the risk of errors in recording.

It was also clear in most cases that there was a key worker either in the community learning disability team, social work team or service provider organisation. Where a key worker was not in place, this meant the review team was taking on a care management role reducing its effectiveness to carry out reviews.

To support a more integrated approach the partnership put in place three locality-based communities of practice to provide a shared space to network, learn, problem-solve and build relationships. However, these were self-facilitating groups and would benefit from a more formal approach.

Most third sector staff indicated they had regular integrated meetings to discuss joint cases. Furthermore, they stated that communication was open, effective, and felt able to seek advice and guidance, especially from the community learning disability team where complex behavioural support was needed.

Chronology practice guidance for social work was in place. Practitioners fully understood the importance of chronologies and noted good training was available. However, the social work recording system was limited and did not fully support chronology use. Some staff resorted to a manual approach instead. Positively, almost all records we read contained a risk assessment. However, these were mostly single agency with only some being coordinated or shared. The quality of integrated care, support and treatment planning was good or better in most cases. The partnership provided good guidance to staff around issues regarding adults with incapacity. Staff understood this well. However, there was a need to maintain a clear, shared understanding of capacity and decision-making, in order to maintain consistency of approach. Recording systems needed to offer more clarity regarding someone's guardianship status. Staff engaged in supported decision making with training available to promote inclusive communication and person centred practice. The process for assessing capacity was informed by a multi-disciplinary approach including the deployment of a decision specific screening tool. It promoted a robust and thorough process. Some processes were delayed due to the number of people requiring such an assessment, the process of application for statutory orders and availability of local solicitors to administer financial guardianship. Reassuringly, staff were clear about capacity, had access to communication tools to support their work, and sought advice directly from their local legal services.

The resource allocation group had recently made changes to the decision-making processes to approve care packages to align with council policy and budgetary control. Despite clear processes, some staff found this approach to allocating resources stressful. This was impacting their morale as professional assessors. Senior managers recognised that ensuring staff felt valued and held in positive regard was important in addressing any concerns about psychological safety, arising from the challenges of their role in this setting.

The composition of the resource allocation group was well-balanced, with representatives from health and social work backgrounds, administration and finance. However, the high number of people involved contributed to the way some practitioners experienced this forum. Adding to the pressure was that decisions were communicated verbally to people and families by the assessing worker. Staff reported that this contributed to an increase in complaints where requests for assessed support were not approved. In some cases, this strained relationships with families and led to requests for a change of worker.

Although resource pressures were clearly evident, resource allocation group members demonstrated an understanding of individual's needs. Relevant practice-based questions were asked during the resource allocation group, alongside members displaying a knowledge of the cases being discussed.

There was a view amongst staff that reductions in service increased risk for some individuals. That said, the resource allocation group decision making panel we observed was well informed and demonstrated consideration of the individual circumstances, with empathetic consideration of the impact their decisions could have for people. This was demonstrated by clear discussions about potential alternatives to support people.

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

Systems and processes between the sectors supported good outcomes for people. Discussion with people about self-directed support was at least partly evident in almost all the records we read. Discussion with carers regarding self-directed support was also evident in some cases and supported by carers feedback. Future care planning and multi-agency contingency or emergency planning was an area for improvement across the partnership, with less than half of those people whose records we read having an explicit plan. While good evidence submitted by the partnership included a template called 'My Back Up Plan', more prominent use of this would improve a recorded and documented approach to assessment and review.

There was a single commissioned advocacy service that offered support to people with a learning disability. Staff were aware of and consistently referred to this service which was described as helpful and responsive for this care group.

There were frequent and integrated reviews of peoples' care. However, they were mostly completed by single agencies. Positively, they clearly considered peoples' ongoing and other needs and were present in all records we read. Coordination and sharing of outcomes needed strengthened. Commendable arrangements were made to include the involvement of the person and their carer in almost all cases with the quality being good or better in almost all cases. Some carers had contrasting views.

Reviews were well informed but did not always include service providers. However, initial information sharing with service providers was undertaken in most cases. When issues of risk or incapacity were raised by service providers, the partnership responded quickly and involved service providers in elements of the response, especially around assessments of capacity. This demonstrated that service providers were positively viewed as partners in most cases and essential to involving people in decision making.

Evaluation

- **Good**

Good practice example

Local area coordinators provided a very effective, efficient and empowering service, working with people whether individually, or groups ranging from small to large. The specific work was geared around what was important to or would benefit the people they supported. They demonstrated a positive, enthusiastic and 'can-do' approach to their work.

Key Area – Strategic planning, policy, quality and improvement

How effectively do commissioning arrangements in the partnership support positive outcomes for people with a learning disability?

Key messages

- The partnership showed strong, evidence-based approaches to strategic commissioning, with a clear focus on community services, early intervention, and carer support, where carer support plans were in place.
- Commissioning processes were robust with a mixed economy of care model. The contractual framework emphasised quality of care and promoting positive outcomes for people. However, there were some challenges in ensuring local capacity and choice across health and social care services.
- Contract monitoring was well-developed, with strong engagement mechanisms. Direct feedback to the partnership, from people receiving services from externally commissioned service providers was limited.
- There was limited evidence that the partnership directly collected, analysed and reported feedback from people and carers receiving services.

Strategic planning

The partnership's Strategic Plan (2024–2027 update) was a well-presented, public facing document that outlined the partnership's intentions. The strategic plan's priorities aligned well with other relevant strategies. The plan was well-structured and accessible to stakeholders. It was extensively consulted upon through a major engagement exercise with a range of stakeholders as part of wide-ranging participation and engagement and communication strategies.

The plan clearly articulated shared priorities, with a strong emphasis on enhancing community-based services, promoting prevention and early intervention and supporting carers. The strategic aim to shift the balance of care from institutional towards community settings was clearly prioritised. The partnership had clear priorities and plans at a strategic and service level. However, locality and team level priorities did not always expressly connect with strategic plans.

While the partnership's approach to locality planning was long established, it had not yet led to locality commissioning approaches. There were productive and business-like planning relationships with NHS Ayrshire and Arran. Several planning forums at senior and operational levels took place regularly. The partnership benefitted from the additional capacity and expertise available as part of the wider NHS Ayrshire and Arran and adjacent Ayrshire council areas' planning arrangements.

Planning documents generally adhered to SMART principles and were used appropriately for performance management and accountability. However, some lacked clarity regarding future investment and disinvestment. This limited the partnership's ability to assess progress, address incomplete actions, and apply learning from previous initiatives. The preparation of specific care group strategies, including one for people with a learning disability, with detailed SMART action plans, would be beneficial to better highlight the particular tasks that the partnership intended to take to improve the lives of people and carers.

The partnership had a co-operative relationship with the local authority strategic housing body and other individual housing providers. Areas of positive joint working included the development of a range of housing with support developments. The housing contribution statement in the partnership's strategic plan fully set out what housing agencies could deliver together with health and social care organisations. The Carers Strategy Group played a major role in planning and service development of services for carers. Carers Centre representatives participated effectively in the partnership's wider strategic planning activities.

Strategic commissioning framework and contract monitoring

The partnership's key planning groups for commissioned services were the Strategic Commissioning Board and the Commissioned Services Steering Group. These effectively oversaw the detail and decision-making of the implementation of the partnership's strategic commissioning priorities. There were good working relationships between the partnership and key officers in the council's procurement, legal and housing services to assist in taking forward the partnership's commissioning priorities. Good progress had been made in delivering these.

The integration joint board provided good direction on strategic commissioning plans and the partnership's overall procurement strategy. The partnership had a strong strategic approach to commissioning services, underpinned by an informed understanding of needs and demand. Commissioning decisions aligned with strategic investment priorities. There were major challenges in ensuring local supply, capacity, quality and choice across health and social care services.

Medium-term commissioning intentions were adequately expressed, via a market analysis informed 'Commodity Strategy'. A 'Partnership Provider Statement' set out the partnership's intention to move towards a more collaborative commissioning approach. These documents required revision and updating to better inform market facilitation and to articulate the partnership's ethical commissioning principles. Procurement and contract management processes worked effectively to deliver commissioning intentions that cooperated with services from third and independent sector partners. These approaches supported good outcomes for people and carers, supported opportunities for early intervention and prevention and facilitated collaboration with third and independent sector organisations.

The partnership had a social care contracts team, with contract officers dedicated to particular service types. This team was effective in fostering positive relationships and collaboration with externally commissioned service providers. Contract management was well developed and effectively supported the partnership's commissioning objectives. The commissioning team was responsive and provided valuable support, to externally commissioned service providers. Contract monitoring data was reported to senior leadership. Out-of-area contracts were monitored effectively. Engagement mechanisms were strong, with the partnership facilitating quarterly service provider forums.

Staff turnover in the commissioning team, meant that 'interim' arrangements were in place. This had limited the team's capacity to maintain and promote their relationships with externally commissioned service providers and to provide support to any service providers who required or requested it. We were assured the partnership recognised this and that the adverse effect of this would be mitigated as new relationships developed. The partnership employed different methods to monitoring its own directly provided services compared to externally commissioned services. More standardised approaches to all commissioned services, irrespective of sector, would be beneficial.

Quality assurance, self-evaluation and improvement

The partnership adopted a multi-layered approach to quality assurance, integrating assessment, care planning, review, and caseload management to evaluate service quality and people's and carer's experiences. Professional supervision, in part, further supported assurance processes.

A well organised, embedded governance framework was overseen by a health and care governance group. This brought together elements from established quality assurance models rather than following a single integrated framework. There were appropriate links to the relevant NHS Ayrshire and Arran forums. The activity of the health and care governance group was a work in progress; with a recognition it was weighted towards healthcare and could address more social work and social issues. There was a developing focus on social work and social care services, although there was not a clear timescale for when the partnership would know this had been achieved. We recognised that this reflected one of the challenges of implementing the integration legislation, as there were well-established and effective clinical and care governance frameworks for health staff, which did not necessarily relate to the work delivered by the partnership.

The partnership had undertaken a range of purposeful self-evaluation activities. These activities varied considerably in terms of the scale and detail. A major and comprehensive Best Value Service Review of service planning and redesign was underway.

This provided a framework for assessing the effectiveness of options available for future service delivery. A programme of reviews covering the period 2025-2027, approved by the strategic commissioning board, included adult care at home and housing support services alongside learning disability adult day services. These reviews were contributing towards improvement in learning disability services and achieving the partnership's strategic objectives.

Staff's perception of the partnership's approach to quality assurance was broadly positive. Over three-quarters of staff reported that the rights, dignity and views of people who used services guided the planning, delivery and improvement of services and that feedback from people and carers was used to continually improve care services. A slightly lower proportion advised that the partnership consulted with staff and provided feedback on how their views improved and shaped services. Most staff said that services were continually monitored and evaluated to support improvement, although the partnership was not linking personal outcomes data to reporting.

Externally commissioned service providers had their own quality assurance methods. Most provided feedback on the views of people who used their services to the partnership. There was limited evidence that the partnership directly collected, analysed and reported feedback, from people and carers receiving services from third and independent sector service providers, to inform future service delivery.

Evaluation

- **Good**

Good practice example

The partnership benefitted from the work of a group of officers who cooperated closely in planning and commissioning for housing solutions. This improved and enhanced access to suitable housing provision with related support for adults with a learning disability. The group had productive relationships with the council's strategic housing body and housing and care service providers regarding capital and revenue investment. This operated alongside those with a strong knowledge of people regarding their housing and support needs. Their work meant the partnership was able to plan for a range of housing options, from newbuild to retrofits, utilising technological supports and aids and adaptations. This work was well articulated through the partnership's Housing Contribution Statement.

Key Area – Leadership and direction

How has leadership in the partnership contributed to good outcomes for people with a learning disability and their carers?

Key findings

- The integration joint board was effective in supporting integration. Senior managers and leaders in a variety of roles were committed to working together. The benefits of this were evident across the system.
- A number of Best Value Service Reviews were underway in relation to learning disability services. These had generated a lot of evidence which, at the time of the inspection, was being used to inform a learning disability strategy and renewed vision. There was a strong commitment on the part of senior leaders to embed integration. This was focused on the relational and cultural aspects of different organisations coming together, rather than merely adjusting systems or processes.
- Change as a consequence of increased demand and increased cost of resource had required strong leadership from the integration joint board. The partnership had a robust approach to meeting challenge, based on a review programme informed by changes to eligibility criteria and by innovative cross-sector working in areas such as accommodation with support.

Leadership of people, change and improvement

We found evidence of an active integration joint board, issuing a range of competent directions across a range of areas. Not all members had direct and detailed experience in relation to learning disability services but a sufficient overview. This led to informed decision-making although there was more nuance to decisions affecting this care group than others. Change and improvement was driven by evidence-based analysis, such as the best value service review programme. Overall, we found a collaborative culture, based on good relationships and a shared value base.

Staff views about integration were mixed. They described the benefit of co-location and joint working. They also, however, expressed doubt about whether full integration had or could be achieved. Senior leaders and managers felt that there had been significant progress but more could be achieved. Fostering and embedding a culture of relational practice was seen as key. This would allow workers and professionals from all disciplines to work towards clearly defined goals. It was acknowledged that there was some way to go in achieving this. It was nevertheless commendable that there was a focus and commitment from senior leaders in this regard.

There were several good examples of integrated work. There was an ambitious commitment by leaders to ensuring that all visits to people experiencing care should include both health and social work staff. There were many examples of staff co-location and its positive impact in making communication easier and more effective. Frontline and service managers met every quarter to look at practice issues from an integrated perspective. There were benefits from staff being able to spontaneously discuss issues with colleagues from other teams, due to their workspaces being in adjacent rooms.

We also saw evidence of integration within the management structures. These arrangements worked effectively and we saw mutual recognition and respect of people's different professional backgrounds. Allied to this, there were robust arrangements for professional supervision and support. In this regard, integration was working effectively. We were aware of concerns at frontline level of, for example, one profession being managed by another. In practice, people were managed within their professional groups. Were this to change, we were assured that the partnership had the means to adapt its systems for managing and supporting staff.

Within key processes and structures, there was mixed evidence of integrated working. For example, social workers or team leads did not attend community learning disability team meetings with health colleagues. There was health representation at the resource allocation group, but it was heavily balanced towards local authority staff. We were assured that under normal circumstances there would be additional representation from health. This was limited at present due to operational requirements but was noted as an area to be addressed. Ensuring a good and balanced mix at key meetings such as these was vital. Both meetings play key roles in shaping outcomes for people experiencing care. That was best served by ensuring representation from across the partner agencies.

The partnership faced significant financial pressures, requiring savings of more than £6m within adult support and care for 2026/27, as of 31 March 2026. The partnership had rightly taken steps to ensure it could address this, including through its Best Value Service Review programme. One of the key areas of activity related to this was the recent revision of service eligibility criteria. The application of these criteria, especially through reviews was challenging. Leaders felt they had made efforts to explain the necessity of change but frontline staff felt that they were very much the 'face' of what were usually reductions in support. They described this as having a negative impact on them emotionally, psychologically and sometimes physically. They were also concerned that the decision-making processes around funding sometimes felt inconsistent and therefore unpredictable.

It was clear, not least to senior managers and leaders, that changes to eligibility brought about other challenges. We were told about issues for people experiencing care who had utilised self-directed support. Staff and managers spoke of how they felt there had been an over-provision of support historically. Adjusting this, in conjunction with enforcing eligibility criteria created genuine difficulties for people experiencing care as well as for staff involved and there was a need to ensure the partnership's communication on this was effective. We found limited evidence that there had been completely effective communication in this regard.

The partnership did not have a strategy specifically in relation to learning disability. This was because it sought to derive evidence from the programme of Best Value Service Reviews that was mostly completed. These reviews had been successful, with good engagement alongside in-depth dialogue and benchmarking with other partnerships. The output of these reviews would help inform the content of a learning disability strategy, intended to 'go live' in April 2027. Building on the engagement from the review process would be essential for the partnership in demonstrating this work was person-led.

One key strand which should feature in the strategy relates to accommodation with support. The partnership worked closely with the local authority strategic housing body and other housing providers and was able to demonstrate significant development in the level and choice of accommodation with support offered. A housing manager had been redeployed to work with social work. These close links had contributed to an increase in appropriate new-build and retrofitted housing and paved the way for new developments to meet projected demand. Allied to this was a clear commitment and determination to utilise technology-based care. Health and social care priorities became a prominent focus in the local authority's Strategic Housing Investment Plan.

Evaluation

- **Good**

Our conclusions

In this inspection we sought to evaluate the degree to which integrated services supported positive outcomes for adults with a learning disability. In particular we sought to focus on the perspective of people experiencing care.

We found that most people with a learning disability received good-quality care that was respectful of their rights and treated them with dignity and value. There was a firm commitment to the importance of relational practice.

This was underpinned by strong working relationships between different agencies, especially where different professionals were co-located. It was particularly evident in the work to address housing needs and in the work with services like UCAN and the local area coordinators.

This approach was promoted and modelled by senior managers and leaders. While some areas like IT systems were not fully integrated, there was an emphasis on integrating culture and practice. This directly contributed to better experiences for adults with a learning disability.

The partnership needed to ensure it had all the building blocks in place to deliver services that were sustainable and outcome focused. This meant ensuring that the programme of annual health checks was revitalised. Further work was necessary to ensure that carer support plans and future plans were more widely in use. There was also a need to continue recognising the impact on staff of increased workloads and resource pressures.

The partnership had an opportunity to develop a new learning disability strategy to support all this work. They had chosen to commence with a programme of Best Value Service Reviews. These provided a strong and robust evidence base to support its strategy.

In summary, the partnership demonstrated a number of key strengths across the range of its activity. The partnership had achieved these good results despite the challenges posed by the financial climate, demography and the increasing complexity of support required by people. It was also important to recognise that at the time of inspection there had been significant change in the leadership team of the local authority and the partnership, with a number of people leaving their roles. While this did not directly affect services for adults with a learning disability, there was a risk that significant change in senior leadership could impact on performance. The partnership and local authority had responded promptly and effectively to this challenge, swiftly implementing interim arrangements whereby very experienced officers, already operating at a senior level, stepped into the gap. A formal recruitment process was also put into place quickly, to confirm more permanent arrangements.

As a consequence of all these factors, we were assured that the partnership was well-set to fulfil its vision for learning disability services. This meant the partnership would not just maintain these positive results but have the foundation and the means to improve even further.

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 people experiencing care
- staff survey
- submitted documentary evidence from partnership
- case file reading of health and social care records
- discussions with frontline staff and managers
- professional discussions with partnership.

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

Quality improvement framework and engagement framework

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

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

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

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

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

Quality indicators

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

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

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

Engagement framework

Our engagement framework underpins how the Care Inspectorate and Healthcare Improvement Scotland undertake and report on engagement with people experiencing care. The framework consists of 12 statements. The 12 statements are:

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

No.	People	Carers
		improve their own life and wellbeing.
8.	The health and social care and support I receive, help me to remain in and be part of my community.	The health and social care support the person I care for receives helps them to connect or remain connected with their local community or other social networks.
9.	Health and social care staff understand and acknowledge the role of my family and friends in providing me with care and support. Services work together to ensure that as far as possible, my family and friends are able to provide support at a level that feels right for them.	Health and social care staff understand and acknowledge my role as a carer. Staff work together to ensure, that as far as possible, I am able to provide support at a level that feels right for me.
10.	My carers and I can be involved in how health and care services are planned and delivered in our area, including a chance to say what is and isn't working, and how things could be better.	I and the person I care for can easily and meaningfully be involved in how health and care services are planned and delivered in their area. This includes a chance to say what is and isn't working, and how things could be better.
11.	I'm confident that all the people supporting me work as a team. We all know what the plan is and work together to get the best outcomes for me.	I'm confident that all the people supporting the person I care for work as a team. We all know what the plan is and work together to get the best outcomes for the person I care for us.
12.	The health and social care and support I receive has made life better for me.	The health and social care support that the person I support receives makes life better for us.

Appendix 2: Report terms and meanings

Explanation of terms used in this report

Term	Meaning
Adult carer support plan	Under the Carers (Scotland) Act 2016, 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.
Anticipatory care plan	See Future Care Plan
Best Value Service Review	Best Value Service Reviews (BVSRs) are a requirement on public bodies to seek continuous improvement in performance. A BVSR is an assessment of the need for the services that an organisation provides and the way in which they are delivered, resulting in proposals/options to improve these services and their efficiency. The BVSR process also provides a framework for assessing the effectiveness of each available option.
Capacity	Capacity is a crucial concept in establishing whether and to what degree a person may make decisions about themselves. It is defined in the Adults with Incapacity (Scotland) Act 2000 as follows: *"…the ability of an individual to understand information relevant to a decision or action and to appreciate the reasonably foreseeable consequences of taking or not taking that action".*
Carers Centre	Carers Centres are independent charities that provide information and practical support to carers. Carers are people who, without payment, provide help and support to a relative, friend or neighbour who cannot manage without that help. Carers Centres are sometimes funded by health and social care partnerships to provide support.
Commissioning	Commissioning is the process by which health and social care services are planned, put in place, paid for and monitored to ensure they are delivering what they are expected to.

Term	Meaning
Community Learning Disability Team (CLDT)	The CLDT is a community-based team. It consists of a range of health professionals in different disciplines, who work together to provide assessment and treatment for people with a learning disability.
Complex needs	Complex needs may describe the high level of support with many aspects of their daily lives a person requires. This may often be variable or unpredictable.
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.
Local area co-ordinators	These practitioners work with people with a learning disability and their families, supporting access to inclusion in their communities and developing independent activities and services.
Day services	Care and support services offered usually during daytime hours on weekdays. These services often blend building-based support with wider support for people in the community.
Early intervention	Early intervention is about doing something that aims to stop the development of a problem or difficulty before it becomes worse.
Eligibility criteria	A system used by local authorities to determine whether a person has needs that require a social care service to be provided.
Emergency planning	A process of creating a plan 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. This may be because of some kind of emergency, for example if a carer falls ill.
Future care plan	Unique and personal plans that people prepare, potentially 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.

Term	Meaning
Health and social care integration	Health and social care integration is the Scottish Government's approach to improving care and support for people. By ensuring health and social care services work together, services should be seamless from the point of view of the people who use them.
Health and social care partnership	Health and social care partnerships are bodies set up to deliver the integration of health and social care in Scotland. They are made up of local councils, local NHS boards and third and independent sector organisations.
Independent sector	Non-statutory organisations providing services, generally as a business rather than as a registered charity (see also 'Third sector').
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.
Outcomes	Personal outcomes are defined as what matters to a person. More broadly. outcomes can reflect the impact of an action, or inaction, on people's lives.
Partnership or HSCP	East Ayrshire Health and Social Care Partnership who are responsible for planning, managing and delivering health and social care services to adults who live in East Ayrshire.
People experiencing care	People who are being supported or their unpaid carers.
Prevention	In health and social care services, prevention is about activities that help to stop people becoming ill or disabled, or to prevent illness or disability becoming worse.
Procurement	The process of entering into contracts with services to provide care or support to people.
Public Health Scotland	Scotland's national public health body. It leads and supports work across Scotland to prevent disease, prolong healthy life and promote health and wellbeing.

Term	Meaning
Quality indicators	Measures that are used to evaluate a process e.g. how efficient and effective a process is in achieving the results that it should.
Seamless services	Services that are smooth, consistent and streamlined, without gaps or delays.
self-directed support	The statutory duty approach to providing social care. This empowers the person to make choices about how their support will meet their desired outcomes.
Service providers	Organisations that provide services, such as residential care, care at home, day services or activities.
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 interest companies or social enterprises.

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 service provider or partnership with a mechanism to demonstrate clearly that sustainable improvements have been made.

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

Appendix 4: The National health and wellbeing outcomes

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

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

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

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

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

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

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

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

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

The Partnership Area

East Ayrshire is located in the southwest of Scotland, covering 490 square miles. There is a mix of both urban and rural communities. The population of East Ayrshire is 120,750. The population profile is made up of 16.7% of people aged 0-15 years, 61.4% aged 16-64 years and 21.8% aged 65 and over. The overall population is projected to decrease by 1.2% by 2030. There is an expected 11.2% increase in those aged 65 plus, in the same time-period.

As at the 2022 Census there were 5,982 people with a ‘combined learning disability, learning difficulty or developmental disorder’ living in East Ayrshire. The population of people with learning disabilities in East Ayrshire is younger than the overall population with 28.5% under 16, almost 66% aged 18 to 64 and just over 5% aged 65 and over. There is a higher proportion of males than females with a learning disability than the overall population – 59:41% as against 48:52%.

East Ayrshire has the seventh highest level of deprivation amongst Scottish local authorities. 31.3% of the population live within the most deprived Scottish Index of Multiple Deprivation Quintile. 71.1% of East Ayrshire residents are in employment compared to 74.5% across Scotland. A higher proportion of the 16-64 population claim out of work benefits than nationally (3.6% and 3.1% respectively).

Health inequalities are prominent in East Ayrshire. Life expectancy and health life expectancy is lower than across Scotland. More than a third (36.7%) of adults have at least one long-term illness (22.1% nationally). The rate of deaths in East Ayrshire (aged 15-44 years) is 165.5 per 100,000 population compared to the Scotland rate of 111.7.

Health inequalities are further reflected in the population of people with learning disabilities. While 46% of the population without learning disabilities report being in ‘very good’ health, this is 30% for people with learning disabilities. The proportion of people reporting ‘very bad’ health at the 2022 Census was 1.8% for people without learning disabilities and 4.3% for people with learning disabilities.