



# Joint inspection of adult services

Integration and outcomes

**Fife health and social care partnership**

November 2022

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## **PART 1 – About our inspections**

### **Background**

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

### **Legislative context**

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

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

### **Ministerial strategic group report**

In February 2019, following a review of progress with integration, the Ministerial strategic group (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 redeveloped our approach to joint inspections. Our inspections seek to address the following question:

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

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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.

## Covid-19

At the time of our joint inspection of Fife health and social care partnership, partnerships across the country were continuing to experience a range of significant pressures related to the Covid-19 pandemic. The impact of the pandemic on service delivery and staffing across health and care services has been extreme and unprecedented. At the beginning of the pandemic, emergency measures changed the way care, support and treatment was provided. This impacted on the ability to visit people at home during lockdown. The Care Inspectorate and Healthcare Improvement Scotland recognise that all health and social care partnerships are currently in transition from emergency response to recovery. Our inspections are not focused on examining partnerships’ responses to the pandemic, but we will make every effort to understand and account for its impact on partnerships, providers, people and carers.

## National issues and context

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

Audit Scotland produced a social care briefing in January 2022. This highlighted that across the country:

- increasing demand has led to tighter eligibility criteria being applied for accessing care and increasing levels of need, and
- the 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 that support staff to work in a more integrated way is another area where there is a national challenge. This includes sharing information across and between agencies. It has been highlighted and addressed in Scotland's digital health care strategy which was produced by the Scottish Government and COSLA in October 2021.

### Explanation of terms used in this report

When we say **people**, we mean adults between 18 and 64 years old who have physical disabilities and complex needs.

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

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

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

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

There is an explanation of other terms used in this report at appendix two.

## **PART 2 – A Summary of our inspection**

### **The partnership area**

Fife health and social care partnership delivers services over seven localities and serves a population of 374,130 (2020). 51.4% of the population are male and 48.6% female. Between 1998 and 2020 the total population increased by 7.7%.

Population projections for 2028 estimate that the overall population of Fife will increase by just 0.1% between 2018 and 2028. However, this figure includes a 4% reduction in the 16-64 age group and a 19% increase in people over 65 years old.

In the 2011 census, 94.3% of the Fife population identified as either White Scottish (85.7%) or White British (8.6%).

Fife contains a mix of rural and urban areas. The Scottish Urban Rural Classification categorises 67.1% of the population as living in 'Other Urban Areas,' 15.4% in 'Accessible Small Towns', and 17.5% in 'Accessible Rural' locations. The south and west are dominated by urban areas and an industrial economy whilst the east and north are mainly rural and agricultural. Two-thirds of people live in the larger centres: Dunfermline, Glenrothes, Kirkcaldy and the group of towns forming Levenmouth.

Fife continues to suffer from long standing socio-economic issues that limit its economic growth; earnings and productivity are lower than the national averages; business start-up rates remain below the Scottish averages; rates of youth unemployment are higher than the Scottish average; areas of deprivation persist in some parts of Fife.

Data for 2020 showed that 20% of Fife's population was living in the most deprived SIMD quintile which matched the Scottish average. This figure disguises significant variance across localities. In Levenmouth, 49% of the population fall within this definition whereas in North East Fife, the corresponding figure is just 0.97%.

In the 2011 census the numbers of those in Fife self-identifying as having a physical disability, was 7,187 per 100,000 population. As of 1st July 2022, 582 people aged between 18-64 were recorded on the social work business system as having a main or secondary category of physical disability. Physical disability was listed as the main category for 357 adults and as the secondary category for a further 225 people, where additional conditions (such as learning disability, dementia, mental health) were recorded. On average, individuals in this group were in receipt of three services each.

### **Summary of our inspection findings**

The inspection of Fife health and social care partnership took place between June 2022 and October 2022.

In our engagement with people and carers, we received 270 completed surveys and spoke to 42 people and 17 carers, in 46 conversations and four focus groups.

In our engagement with staff from the health and social care partnership, we received 854 completed staff surveys, spoke to 121 members of staff and had discussions with the leadership team at four partnership meetings.

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

### **Key strengths**

- Most people had positive experiences of integrated and person-centred health and social care, which supported an improved quality of life.
- Many people and carers told us that they were listened to by workers who treated them with dignity, respect and kindness.
- Almost all people had support from a key worker during assessment, review and care planning processes. Overall, when people had the support of a key worker, coordination was good.
- The widespread adoption of collaborative approaches with external care providers improved the partnership's ability to respond to and recover from the pandemic.
- The Fife partnership's senior leadership team and extended leadership team had developed a strong collaborative culture. Most staff strongly agreed or agreed that joint working was supported by line managers and leaders.

## Priority areas for improvement

Key area	Priority for improvement
1 - Key performance outcomes	<ul style="list-style-type: none"> <li>The partnership should continue to develop and refine its processes for capturing robust data on outcomes and ensure that this drives targeted efforts to improve outcomes for people and carers.</li> </ul>
2 - Experience of people who use our services	<ul style="list-style-type: none"> <li>The partnership should make sure that it has an integrated approach to providing information and advice, so that people understand their condition and are supported to make informed choices about their care and treatment.</li> </ul>
5 - Delivery of key processes	<ul style="list-style-type: none"> <li>The partnership should improve how it responds seamlessly from the point of view of people and carers by developing a model of integrated practice, with defined processes for its core services.</li> <li>The partnership should improve its processes for anticipatory care planning, including monitoring the number of plans completed and how effectively they support positive outcomes.</li> </ul>
6 - Strategic planning, policy, quality and improvement	<ul style="list-style-type: none"> <li>The partnership should consistently monitor performance and outcomes at a locality level to balance responding to local needs with a consistent response across localities.</li> </ul>
9 - Leadership and direction	<ul style="list-style-type: none"> <li>Leaders should continue to evaluate the effectiveness and impact of their approaches to organisational development as it is rolled out across the wider workforce, including understanding staff experiences of change and of continuing increases in demand.</li> </ul>

## 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.

<b>Key quality indicators inspected</b>		
<b>Key area</b>	<b>Quality indicator</b>	<b>Evaluation</b>
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	Good
	9.4 Leadership of change and improvement	

## **PART 3 – What we found during our inspection**

### **Key area 1 - Key performance outcomes**

**What key outcomes have integrated services achieved for people and carers who use services in Fife?**

#### **Key messages**

- National performance indicators suggested that the Fife partnership's health and social care services were delivering outcomes in line with the outcomes being delivered across Scotland as a whole.
- Outcomes relating to supporting carers to continue in their caring role and to look after their own health were less consistent than outcomes for people.
- The impact on health and wellbeing outcomes at key points of the pandemic was significant. The pandemic exacerbated many of the factors which were undermining good outcomes and also led to increasing demand for partnership services.
- The partnership was monitoring people's experiences against the National Health and Wellbeing Outcomes in a series of questions within its social work review process. It was taking positive steps to improve the effectiveness of the review process in capturing outcome data.

#### **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. These help partnerships to review progress towards achieving the national health and wellbeing outcomes. The national health and wellbeing outcomes are the outcomes set out in legislation to describe what people can expect from integrated health and social care.

These national performance indicators suggested that health and social care services in the Fife partnership were delivering outcomes in line with the outcomes being delivered across Scotland as a whole. There were very few statistically significant differences between Fife and Scotland across the core suite of integration indicators.

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

National health and wellbeing outcome	Inspection finding
1	<ul style="list-style-type: none"> <li>Most people were supported to look after their health and wellbeing as much as possible.</li> </ul>
2	<ul style="list-style-type: none"> <li>Almost all people were supported to live as independently as possible.</li> </ul>
3	<ul style="list-style-type: none"> <li>Most people felt they were treated with dignity and respect, but people were less positive about having choice and control.</li> </ul>
4	<ul style="list-style-type: none"> <li>Most people had a better quality of life because of the health and social care services they received.</li> </ul>
6	<ul style="list-style-type: none"> <li>Outcomes relating to supporting carers to continue in their caring role and to look after their own health were less consistent than outcomes for people.</li> </ul>
7	<ul style="list-style-type: none"> <li>Almost all people felt safe.</li> </ul>

The national health and wellbeing outcomes are described in full at appendix four.

Our findings for national health and wellbeing outcomes 2, 4, 6 and 7 in the Fife partnership were consistent with performance reported in the core suite of integration indicators.

For outcome 1 the national indicators suggested that almost all people in Fife were supported to look after and improve their own health and wellbeing. Our finding was less positive. Most people with physical disabilities and complex needs were supported to look after their health and wellbeing as much as possible by both NHS and social care practitioners. This included occupational therapists, physiotherapists and speech and language therapists, who provided advice, interventions, aids, and equipment. Most people were supported to participate in community groups and activities to avoid loneliness and isolation. A few were supported to improve their health by addressing alcohol and substance misuse. A few others did not have opportunities to improve their own health, for example, by taking exercise, losing weight or stopping smoking.

There were important differences between our findings and the performance reported in the core suite of indicators in relation to national health and wellbeing outcome 3: the percentage of people with positive experience of care at their GP practice. The Fife partnership was performing below the Scottish average for the national indicator. In contrast, throughout the inspection, we found that most people with physical disabilities and complex needs had positive experiences of support from their GP practice. The national indicator reflects the experiences of a random sample of the whole population who are registered with a GP. It is positive that people with physical disabilities and complex needs had a better experience.

The national indicators for the Fife partnership also suggested that most people agreed that health and social care services were well coordinated. For people with physical disabilities and complex needs and their carers, the picture was more complex. Most people agreed that services communicated and worked well with each other but only felt coordinated if they were supported in residential settings or by very intensive packages of care. Some carers specifically said that services were not coordinated.

Whilst health and social care services in the Fife partnership supported most or almost all people to experience good outcomes, this was not the case for some people. A few of these people had outcomes that fell well short of the expectations set out in the national health and wellbeing outcomes.

The reasons why some people were not supported to experience good outcomes were often complex and not attributable to a single factor.

Shortfalls in capacity played a significant part, particularly in social care services like care at home, day services or respite provision. Occasionally, delays in major housing adaptations or access to appropriate housing also impacted on people's outcomes.

A few people were assessed as needing less care than they felt they needed. For a few others, poor outcomes were magnified by the pandemic limiting options to respond to their needs. This led to them feeling that services were unsupportive.

These factors interact with each other and can result in poorer outcomes in several areas. Reductions in the availability of care at home created greater demands on carers and reduced the ability to offer people choices. Reductions in respite provision, as an inevitable consequence of the Covid-19 pandemic, undermined support for carers. Limited options to respond to people's needs contributed occasionally to an increased risk of unsympathetic and inflexible responses.

The partnership was monitoring people's experiences against the National Health and Wellbeing Outcomes in a series of questions within its social work review process. It was positively working to improve the effectiveness of the review process in capturing outcome data. Through its Re-imagining the Third Sector initiative, it had also been developing a more focused, streamlined and person-centred approach to monitoring outcomes and processes with the third sector.

### **Impacts of the Covid-19 pandemic**

Comparison of the health and care experience survey results for 2022 with the results of the previous survey in 2020, shows that for both the Fife partnership and for Scotland, positive responses to all questions were lower. Overall, this indicates that levels of satisfaction with health and social care in Fife and across Scotland as a whole have declined during the pandemic. In the Fife partnership, the differences between the two years, though statistically significant, are relatively small given the scale of the pandemic's impact. This is consistent with the huge effort made by staff to maintain outcomes for most people, despite all the challenges they faced.

The impact on outcomes at key points of the pandemic was significant, either because of disruption to the level and availability of support or because lockdown also removed activities and groups within communities that were beneficial. This meant that not only did the pandemic exacerbate many of the factors which were undermining good outcomes for some people, but it also led to increasing demand for partnership services at the same time.

The pandemic impact meant that it was virtually impossible to identify whether health and social care services in the Fife partnership were supporting positive trends in people's health and wellbeing over time.

In the Fife partnership, as in the rest of Scotland, the pandemic caused considerable volatility in delayed discharges and emergency admissions. The partnership successfully implemented changes and monitored their effectiveness during this period to maintain performance close to the Scottish average.

The Fife partnership's responses to support their staff during the pandemic were effective in mitigating some of the negative impacts on outcomes for people and carers. For example, some staff commented that working online led to improved communication.

## **Evaluation**

- Good

## **Key area 2 - Experience of people and carers**

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

### **Key messages**

- Most people had positive experiences of integrated and person-centred health and social care, which supported an improved quality of life.
- Many people and carers were supported by health and social care workers who listened to them and treated them with dignity, respect and kindness.
- In general, people who needed help with care and support were able to access that help, although some people had to wait substantial periods of time for the right care and support to become available.
- Carers experienced the biggest impacts from the limited capacity of care and support services. They needed to fill the gap when the care and support that was available was less than that needed to ensure the person's health and wellbeing.
- Around half of people and carers, including some who were already receiving support, said they did not know how to access information they needed.

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

Most people had positive experiences of integrated and person-centred health and social care, which supported an improved quality of life for them.

Although people often did not know if the health and social care services that supported them were organised in an integrated way, they generally thought that their workers communicated well with each other. Where this was the case, people felt that workers had the same understanding of what was important to them and worked together to help them achieve positive outcomes. Good communication helped to ensure that people got the right help at the right time.

People who lived in care homes and supported living facilities, or who received high levels of support in their own homes, experienced benefits from effective communication between the workers supporting them. In these situations, provider staff liaised with other professionals on behalf of the people they supported, resulting in services which appeared truly seamless to the people using them.

Many people and carers told us that they were listened to by staff who treated them with dignity, respect and kindness. Such relationships were highly valued and where they existed, people were generally more understanding about delays or temporary reductions in service delivery. Staff supported people to maintain their health and wellbeing and encouraged them to build on their strengths. People gave examples of staff, including district nurses, occupational therapists, care workers and social workers, going above and beyond to help them live the best lives they could. One said:

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“The support workers do a brilliant job. They are very helpful and encourage me to do as much as I can for myself. I really like their attitude.”

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In general, people who needed help with care and support were able to access that help. Some people had to wait substantial periods of time for the right care and support to become available. Most people were also able to access the healthcare and treatment services they needed, either through their GP surgery or, once they were known to services, through the specific teams and professionals that provided the service they needed. Again, sometimes people had to wait for help, but some explicitly acknowledged and accepted the impact of the Covid-19 pandemic on service delivery.

People supported by integrated teams such as the Fife Rehabilitation Service, based in the Sir George Sharp unit at Cameron hospital, often had a very good experience of person-centred services being delivered seamlessly. This experience was the result of a range of factors that were highly valued by the people and carers who benefitted from them and which had the potential to be replicated in other services.

Some people and carers experienced a reduced quality of life because they did not get enough care, or the type of support they needed was not available or easily accessible to them. A few people felt treated unfairly because they received less help than other people whose circumstances seemed similar to their own.

Some people and carers experienced reductions in care and support because the capacity of services had reduced during the Covid-19 pandemic and had not returned to the levels that had been available before the pandemic. Other people did not know how to access support or had been assessed as needing less support than they felt they needed. A few people did not receive any support for weeks or months after their care package failed. A few other people had experienced a change in their circumstances, but the health and social care partnership had yet to review their support. A small number of parent carers of young adults with complex needs were bewildered by the world of adult health and social care and had found the transition process unclear and unhelpful.

## Good practice example

The Sir George Sharp unit provided Fife-wide assessment and rehabilitation for people under 65 with physical disabilities due to neurological conditions. In practice, it mainly worked with people who had multiple sclerosis or acquired brain injury, and with younger stroke patients. It operated with a multi-disciplinary staff team and had good links with both acute and primary care services.

People and carers identified a number of elements that made their experience of support from the Sir George Sharp unit so positive. These elements clearly resulted in improvements in the wellbeing, experience and outcomes of both people and carers.

- A truly person-centred approach, with staff making a real effort to understand what was important to the person and supporting them to achieve it.
- Clear respect for people's wishes and choices, for example: providing good community support when a person didn't want to be an in-patient.
- The whole team working together to understand how their respective inputs could support the best outcomes for the person.
- Proactive joint working with other professionals, even with services that might not normally be involved (for example, local authority health and safety officer).
- Support for psychological and emotional needs and access to psychotherapy and counselling.
- Re-assessing and responding to changing needs at the right time and on an ongoing basis.
- Support being available for as long as the person needed it.
- Ongoing and easy access to services such as physiotherapy and occupational therapist.
- Easy access to accurate information at any point through responsive staff such as the multiple sclerosis nurse.

The service recognised that there were a number of areas where they could make improvements and had plans in place to do so. These included:

- a dedicated social work link
- improving links with housing and adaptations services
- shared electronic access to information
- reviewing the service model and staff roles
- improvements to their building.

One person said:

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“We are so lucky – they all know each other well so talk to each other whenever needed. They work just like one big team.”

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Few people and carers felt they had an opportunity to provide feedback on the quality of service they had received. Whilst more people had positive experiences of health and social care services than negative ones, a few people described very difficult experiences that they had found traumatic. A few people who experienced problems with service providers, found that their care was withdrawn following a complaint. A few people and carers said they were not listened to or believed, and were spoken to without kindness or respect. Some said that the response they received to a complaint meant that they would be very reluctant to complain again.

Carers experienced significant impacts from the limited capacity of care and support services. They needed to fill the gap when the care and support that was available was less than that needed to ensure the person's health and wellbeing. In some cases, carers found their caring role very challenging, with adverse effects on their physical and mental health. Whilst some carers felt very well-supported, many felt isolated and struggled to continue providing the level of care that they needed to. In some cases, carers also found it very challenging to co-ordinate all the treatment and support services that were involved in supporting the person that they cared for. Few carers had an adult carer support plan and those who did were unable to describe how the plan made a positive difference to their lives.

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

Most people and carers felt that services worked together to help them improve and maintain their health and wellbeing and to live as independently as possible for as long as possible. Whilst physiotherapists, speech and language therapists and occupational therapists tended to be involved when a specific need arose, people felt that these services were responsive, and they received timely help that enabled them to maintain their health and wellbeing as far as possible. Some people benefitted from good relationships with health professionals who remained involved with them over long periods of time, knew them well and supported them to achieve the outcomes they wanted.

People were enabled to continue living independently in their homes and connected with family and friends, by good access to aids and equipment and to minor adaptations. We also saw several examples of people who did not receive formal support from the partnership being supported by community groups and low threshold services. They experienced an improved quality of life as a result of this support. One person told us:

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"It helps me to live independently in my own flat which makes me happy, and I couldn't do it without assistance."

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Some people were prevented from living fully as part of their communities by challenges related to unsuitable housing. In some cases, people experienced social isolation and significant negative impacts on their wellbeing due to long waits, both for suitable properties and for major adaptations that would allow them to live

comfortably in their own homes. We met some people who were living in residential care but wanted to be in their own homes.

Several carers expressed significant concern about what would happen to the person they cared for if something happened to them, either in a crisis situation or because their physical ability to provide care was declining. We did not see examples of people being supported with emergency or future planning and some carers lived with high levels of anxiety as a result of this.

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

Most people felt that they had a say in planning and reviewing their care and participated in regular reviews of their care plans, although they were generally not clear about the difference between partnership and provider reviews.

In some cases, people's sense of control was limited by not fully understanding how processes and systems worked, including: assessment processes and eligibility criteria, the roles of different professionals in supporting them, their right to choice through self-directed support. Some people did not know if they had a social worker, as they had not understood the role of social work services in supporting them. One person said:

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"I just have to take the help I get given."

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Around half of people and carers, including some who were already receiving support, said they did not know how to access information about health and social care services and about their options and rights. A few people said they did not have enough information about their condition and what it might mean for them. People told us that if they needed information, they searched for it on the internet or asked their friends or neighbours. Carers who were supported by the carers' centre were invariably positive about the information and support they received, but almost all said that they had found out about the centre by chance. Some people said that lack of information, or wrong information, had led to decision-making delays or to them making wrong choices which impacted negatively on their quality of life.

When people described a positive or negative experience of accessing and using information, this was often linked to whether they had consistent relationships with staff. They felt confident about accessing information when they had support from workers who knew them, understood what was important to them and could help them apply the information to their own circumstances. When people did not have a consistent relationship with staff who could support and advise them, they found it difficult to access and meaningfully use the information they needed. One person eloquently described this experience:

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"I don't have the information I need. I can't get the information because I'm not asking the right questions, but I can't ask the right questions because I don't know what they are."

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### **Impact of the Covid-19 pandemic**

Most people did not focus on their experiences during the pandemic. They felt they had moved on from the pandemic and were much more concerned with their current experience of services. They mentioned the challenges of isolation, loss of independence, hospital treatment delays, unavailability of respite and day services, reductions in homecare, cancelled reviews and being unable to recruit a personal assistant. They described how more services were now recovering but day services and respite were still not back to pre-pandemic levels. A few reflected on how stretched services were because of staffing issues and were generally understanding about this.

### **Evaluation**

- Good

## **Key area 5 - Delivery of key processes**

### **How far is the delivery of key processes in the Fife partnership integrated and effective?**

#### **Key messages**

- The social work contact centre played a key role in responding to initial referrals and enquiries according to well-developed and documented processes.
- Few people had anticipatory care plans in place, although care providers did ensure hospital passports were kept with the person. There was limited evidence of emergency or future planning.
- Almost all people had support from a key worker during assessment, review and care planning processes. Overall, at times when people had the support of a key worker, coordination was good.
- A model of integrated practice for the partnership's core health and social care services for adults was still to be defined. This meant that it was difficult for the partnership to monitor and refine its approach to ensure it was getting the maximum benefits from integrated working.
- Whilst partnership staff were keen to support people to have choice and control over their care and treatment, their ability to do so in practice was limited by the range of available services and sometimes by restricted capacity in those services.

#### **Processes to support early intervention and prevention**

The partnership had invested in developing and implementing processes for people to access a range of activities and services in the local community that promoted and maintained good health and wellbeing. These included The Well, an advice service that signposted people to support in relation to loneliness, financial and food insecurity, mental health, caring responsibilities, social care and physical activity. It had also developed On Your Doorstep, an online directory of local community organisations and resources. The number of people accessing these resources was increasing, but some staff within the partnership and the third sector thought their effectiveness could be improved.

The partnership had responded to increased demand and limited resources by focusing its eligibility criteria for social care on those with critical needs. The social work contact centre played a key role in responding to initial referrals and enquiries according to well-developed and documented processes. Contact centre staff undertook an initial assessment of people's eligibility and transferred those assessed as having substantial or critical needs to locality social work teams for comprehensive assessment. Those who were already allocated to a social worker or who were receiving services were transferred to the appropriate teams. Where people had low or moderate needs, the contact centre provided an immediate response, including signposting people to relevant services in the community. This had the benefit of enabling people to access support in the community even if they did not meet social work eligibility criteria.

A few of the people we had conversations with during our engagement activities had not received formal support from the partnership, but benefitted from involvement in support groups and activities provided by organisations such as the Thistle Foundation, Mind, Headway and the Fife carers' centre.

NHS Fife had a well-developed set of resources for health promotion and a locality health promotion team working to address health inequalities across the Fife partnership's seven localities. In our engagement with people and review of records we saw good coordination with addiction services. For a few people, opportunities to help them to improve their health in other ways such as losing weight were missed. Most people had good access to equipment, minor adaptations and telehealth care which supported their independence and wellbeing.

Few people had anticipatory care plans in place, although care providers did ensure hospital passports were kept with the person. There was limited evidence of emergency or future planning. This was a concern for people and for their carers, who were worried about what would happen to the person they cared for if they were no longer able to continue caring.

The lack of focus on anticipating and preparing for future need had the potential to contribute to less positive performance in some areas. These included delayed discharges and the timely identification of suitable care at home or complex packages of care.

Achieving the potential benefits of early intervention and prevention activities depends on evaluation of their effectiveness. Some individual practitioners evaluated whether preventative activities or early interventions were effective in the course of their practice or through review processes. Wider evaluations were limited and did not include the views of people, carers and wider stakeholders.

Overall, there were good examples of early intervention and prevention supporting people to achieve better outcomes. These were not underpinned by effective processes which supported staff to consistently identify and deliver opportunities for early intervention and prevention and evaluate their effectiveness.

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

The legislation governing health and social care integration in Scotland requires that health and social care services are delivered in a way which is integrated from the point of view of people and carers. This means that people and carers should experience services that are as seamless as possible. Each partnership's delivery of integrated services depends on effective coordination of the partnership's processes for access to and assessment, planning and delivery of health and social care across three different sets of processes and systems:

- Community health services delivered by NHS practitioners.
- Social work (including occupational therapy).

- Social care provision delivered either directly by staff employed by the council or commissioned from registered residential services, care at home or support providers in the third and independent sector.

The Fife partnership did not have a set of integrated processes that supported staff to share information and provide a completely integrated response. However, it successfully established comprehensive integrated processes within the integrated community assessment and support service/hospital at home service. These significantly contributed to facilitating timely discharge from hospital and reducing emergency admissions.

The care programme approach and adult support and protection procedures had more developed integrated processes than adult social care in general, reflecting the specific requirements of practice and legislation in these areas.

The partnership had also developed defined processes to respond to carers through an integrated approach with the carers' centre and an integrated process for following up people who had experienced a fall. It had recently put in place integrated approaches to tackle challenging issues for people with complex needs, such as the complex case panel and housing priorities working group, although it was not clear that these were fully embedded.

Beyond these examples, the partnership had still to define a model of integrated practice for its core health and social care services for adults. As a result, there were clear process within social work services and clear processes within health services but integrated processes for how they worked together were not sufficiently defined.

Comprehensive person-centred processes were in place for people who were eligible for social care (Personal Outcome Support Assessment (POSA)). Appropriate assessments and reviews were in place for almost all people. Most people's views were at the centre of care, support and treatment planning. Social work had clear processes for care planning with social care providers.

Health professionals were contributing to positive outcomes through clear NHS referral and assessment processes and recording systems. There were clear protocols for the Fife trauma service.

The lack of integrated processes to consistently support joint working between health and social care professionals meant that coordination between health and social work depended on the practice of individual practitioners. Practitioners routinely communicated and shared information by telephone and email. Staff at all levels understood each other's roles. There were many positive examples of staff working together to enable people to remain living independently.

Almost all people had support from a key worker during assessment, review and care planning processes. There was no process for deciding who was best to take on a coordinating role. For most people this was a social work staff member such as a social worker, occupational therapist or social work assistant. On occasion,

specialist nurses for specific conditions like multiple sclerosis or Huntington's disease took on this role. Key worker roles were also undertaken by staff from social care providers, especially in care homes and where there was intensive care at home. Overall, when people had the support of a key worker, coordination was good.

The partnership operated separate electronic information systems for health and social work. Each of these systems had benefits in terms of supporting health staff to work together effectively with other health staff and social workers to work effectively with occupational therapists. Within each sector, systems enabled information to be shared and for practitioners to easily identify who else was involved in supporting a particular person to avoid duplication. Each system had a role in supporting efficiency as well as providing a seamless experience for people and carers within either health services or social work. However, opportunities to support efficiency and a seamless experience across health and social care was limited because the systems were not integrated.

The partnership was developing a digital transformation programme to develop new systems to better support integration, innovation and agile working. This was beginning with the implementation of a new social work business system. Some staff expressed frustration about the lack of systems to support more integrated working and had questions about how the new systems would improve this.

Overall, understanding whether the partnership's processes delivered services in a way which was integrated or seamless from the point of view of people and carers was difficult. This was because the systems and processes were not designed with that in mind. As a result, the extent to which people experienced a seamless response currently depended on the efforts of staff to work around the limitations of these processes.

A model of integrated practice for the partnership's core health and social care services for adults was still to be defined. The absence of defined integrated processes which could be evaluated made it difficult for the partnership to understand whether integration of health and social care was contributing to better outcomes. It also meant that the partnership was unable to effectively monitor and refine its approach to ensure it was getting the maximum benefits from integrated working, and the best use of available staff capacity across health and social care.

Where the partnership had described and identified integrated models such as the integrated community assessment and support service/hospital at home, it was able to introduce effective performance measures which allowed it to successfully evaluate and refine how these worked. Similarly, monitoring processes for carers' support highlighted that adult care and support plans were not being completed by social workers. This led the partnership to invest in additional staff capacity that would be focused on improving performance in this area. For these integrated services, processes were defined clearly enough to allow their contribution to outcomes to be effectively evaluated.

People and carers were generally unaware of or uninterested in the way services were organised except to the extent that they could access the care, support and treatment they needed at the right time and in the right place. Having a continuous relationship with services they could quickly access advice and support from when their needs changed, was very important to them. Most people were able to access the support they needed from health and social work at the time they needed it.

For some, significant delays in the availability of home care led to significantly poorer outcomes. Reduced availability of respite care had a negative impact on carers' outcomes. The partnership had a range of performance measures for social work processes which highlighted that it was considerably below its target for delivering critical initial assessments.

Making effective use of health and social work practitioners' capacity required their interventions to be time limited. Compared with most health practitioners, social work practitioners were involved for longer periods of time and had a greater role in the coordination of care. However, in most instances, their involvement was still time limited and focused on the completion of assessments and reviews.

People did not always experience the continuity of relationship with services that facilitated easy access to the advice and support they needed. However, the involvement of social care providers resulted in some of the best examples of integration supporting good outcomes in the partnership. This was evident in care homes and supported living environments, or where the person was receiving intensive homecare. Skilled provider staff provided day-to-day coordination of healthcare interventions and worked periodically with social work staff to review and refine the person's care package. Provider staff also focused on enabling the person to maintain relationships and live their life as they wanted to.

People receiving support and treatment from integrated health services such as the Fife rehabilitation service or the health services that were co-located at Lynebank community hospital also had very positive experiences and outcomes. These types of services offered continuity and easy access if people's needs changed. A continuous relationship with services was maintained even though interventions were time limited.

In contrast, some of the poorest outcomes occurred when there was no member of staff who could undertake a co-ordinating role. This was often in between the times when a key worker was allocated by the partnership to undertake reviews. In many cases, care at home provision was not intensive enough for the provider to play a role in coordinating care and treatment. Outcomes for carers were particularly poor where no care or support were provided, either because the person was not eligible for support or because a provider could not be identified.

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

Most people were involved in discussing their care, support and treatment options in a way which fully recognised their rights, views and preferences. Assessments,

plans and reviews were generally shared with people in a format they could understand. In some cases, parallel processes meant that people had to consider different plans from providers, social work and NHS staff, but these generally evidenced a consistent understanding of what people wanted and needed.

Whilst partnership staff were keen to support people to have choice and control over their care and treatment, their ability to do so in practice was limited by the range of available services and sometimes by restricted capacity in those services. The partnership's approach to localities and its developing initiative to 're-imagine' the third sector, promoted access to a variety of local and accessible community resources that promoted self-management and supported people to build on their own strengths. The continuing impact of the pandemic meant that opportunities were not as fully developed as they could be.

The partnership was in the process of implementing improvements to their delivery of self-directed support (SDS). SDS offers four options through which people can organise their support.

- Option 1 is where they receive money to pay for care themselves (also known as direct payments).
- Option 2 is where the person directs the support.
- Option 3 is where the local council arranges the support.
- Option 4 is a mix of the previous 3 options.

Social work staff discussed SDS options with most people, which positively supported a culture of choice and control. However, we found that people generally understood the term SDS to apply only to direct payments and had not been effectively supported to understand the extent of the choice offered through self-directed support. The partnership had a relatively low number of people receiving services through direct payments and people had significant difficulty in recruiting personal assistants. Whilst people using direct payments generally appreciated having control over their services, some found the responsibility difficult to manage and a few had not had a review for a substantial period of time.

The partnership provided opportunities for people to access information and advice in their communities and the carers' centre was a good source of advice and support to many carers. However, many people and carers did not know about these resources and had difficulty in getting the information and advice they needed. Where they did have information, they still sometimes had trouble in understanding how the information applied to their own personal situation, and in using it to make meaningful decisions. The partnership did not have a systematic approach to ensuring that people could consistently access and meaningfully use the information they needed from their first point of contact.

### **Impact of the Covid-19 pandemic**

The pandemic had a significant impact on the delivery of early intervention and prevention in the partnership. Lockdowns and other restrictions directly contributed to higher levels of need from increased isolation and loneliness and had a

detrimental effect on mental health. The requirement to focus capacity on critical need resulted in significant challenges to maintaining early responses which would prevent an increase or escalation in other people's needs. At the same time, reductions in health and social care capacity, delays in treatment and increased demands on carers all ultimately led to increased demand for health and social care in the longer term.

Covid legislation changed requirements during the pandemic but in the Fife partnership, staff had worked hard to maintain existing processes for assessment, care planning and reviews for most people. The process of ensuring that everyone had an up-to-date assessment or review remained a significant challenge in the context of increasing need.

There was scope to improve how processes delivered an integrated response to need but in the short term, the most significant impact on outcomes was a result of shortfalls in the availability and capacity of services. These shortfalls had become increasingly significant as a result of the pandemic.

The partnership highlighted that the willingness of staff in all sectors to take a flexible and innovative approach had helped to address the significant challenges caused by issues with care providers' ability to recruit and retain staff.

The partnership had successfully introduced more integrated arrangements across health and social care in response to the pandemic:

- A daily huddle bringing together a range of health and social care managers, to focus on how to use capacity across the system to facilitate timely discharge.
- Increased collaborative working and effective commissioning with third and independent sector care providers
- Frontline staff indicated that working remotely online using Microsoft teams increased effective integrated working and communication.

## Evaluation

- Adequate

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

### How good are commissioning arrangements in the Fife partnership?

#### Key messages

- The integration joint board (IJB) had published a comprehensive and ambitious strategic plan 2019 – 2022 which identified actions to improve outcomes for people and carers. It demonstrated that the IJB had an integrated approach to strategic planning and commissioning.
- The Covid 19 pandemic had a significant impact on the partnership's ability to implement the actions in the strategic plan. This was largely unavoidable as the pandemic required the partnership to focus on crisis management. Over time, the partnership successfully made up some ground. Sometimes this included incorporating lessons learned during the pandemic into longer-term developments or partially implementing some of its original plans.
- The widespread adoption of collaborative approaches with external care providers improved the partnership's ability to respond to and recover from the pandemic.
- Performance reports did not reflect localities. As a result, the partnership was unable to effectively monitor if a balance between meeting local needs and maintaining consistent responses between localities was achieved.

#### Commissioning arrangements

The integration joint board had published a comprehensive and ambitious strategic plan 2019 – 2022 which identified actions to improve outcomes for people and carers. The commissioning intentions and actions applied to a wide range of health and social care functions, activities and services and demonstrated that the IJB had an integrated approach to strategic planning and commissioning. The plan had a clear focus on early intervention and prevention. This included developments across health and social care, from offering testing and rapid treatment for people at risk of hepatitis C to reducing loneliness. The IJB had developed a commissioning strategy and a carers strategy to provide more detail on how it would achieve its strategic plan objectives.

The actions in the strategic plan did not include the development of arrangements which increased health and social care integration at a service level. Most actions focused on improving an aspect of health or social care that would be delivered through separate and discrete services. This may have resulted in the partnership missing some opportunities to improve people's and carers' experiences and outcomes through operational integration of health and social care services.

Senior managers explained that the next strategic plan, which they had begun developing, would have a greater focus on integration at a service level and outcomes for people and carers. A new strategic needs assessment was being produced to ensure that this plan was based on an up-to-date assessment of the needs of the partnership's population. This showed a positive focus on understanding how the pandemic had impacted on the needs of the population.

The pandemic had a significant impact on the partnership's ability to implement the actions in the strategic plan. This was largely unavoidable as the pandemic required the partnership to focus on crisis management. Over time, the partnership successfully made up some ground. Sometimes this included incorporating lessons learned during the pandemic into longer-term developments or partially implementing some of its original plans. Results were often mixed, enabling support to be provided in different ways. At the same time some people and carers had to cope with a reduced volume and frequency of support. This illustrated that implementation of commissioning intentions during the pandemic was a dynamic process. Plans had to be adjusted and refined in response to a unique set of circumstances.

The partnership designated seven localities following a consultation exercise in 2019. These matched the partnership's community planning localities. Locality planning had only just been fully established in the partnership before the start of the Covid-19 pandemic. During the pandemic, these arrangements had been paused and had only restarted in March 2022 and locality plans had not been fully implemented because of this. The partnership was developing effective mechanisms for spreading learning across all localities. Performance reports did not reflect localities. As a result, the partnership was unable to effectively monitor if a balance between meeting local needs and maintaining consistent responses between localities was achieved. Senior managers highlighted that localities would have a key role in driving future approaches to health and social care integration through the next strategic plan.

The partnership had just agreed a well-developed participation and engagement strategy and had invested in a participation and engagement team to deliver it. The introduction of the team increased capacity to deliver effective locality planning. The team had begun extensive engagement activities to inform the partnership's response to key post pandemic challenges such as the redevelopment of day services. This demonstrated that the partnership had a strong commitment to understanding people's experiences and views to inform future plans.

The integration joint board had taken steps to monitor the implementation of its strategic plan and commissioning strategy. Progress was described in detail in the partnership's annual performance report 2020/2021. It had assessed progress in implementing its commissioning strategy in a commissioning strategy update in February 2021. The majority of actions had been at least partially implemented. The partnership's carers strategy set out clear processes for monitoring implementation. However, these were not followed, and the partnership did not provide an annual progress report for the period of implementation prior to the pandemic.

Senior managers within the partnership were reviewing all existing strategies to identify which priorities should be carried forward to the new strategic plan. This was a positive approach to ensuring that the partnership had capacity to implement the priorities in its new strategic plan effectively within the next three years. They also intended to refresh their carers strategy.

The commissioning strategy made clear and explicit links to the integration joint board's medium-term financial strategy (2021 – 2024). It set out a clear approach to decision-making and governance to progress financial sustainability. The integration joint board's strategic risk register highlighted a significant risk that the partnership's financial challenges would impact on its ability to deliver its strategic plan objectives. Senior managers expressed confidence that effective financial planning would underpin the development of the new strategic plan.

### **Good practice example**

The partnership had developed Pinpoint Care, an approach that involved using geographical mapping to improve the availability of care at home. This mapping information was available to providers directly and facilitated effective collaboration with commissioners and other providers to find solutions to shortfalls in care at home capacity. The partnership's commissioning team also demonstrated an understanding of the need to balance the efficient use of available capacity with continuity of care and continuing to respond to the preferences of people who needed support.

The partnership paused procurement activities during the Covid-19 pandemic. It effectively refocused its commissioning and contract management activities on supporting and collaborating with external providers to continue providing support and to keep people and staff safe during the pandemic. The partnership provided advice and practical support with accessing personal protective equipment and maintaining effective infection control procedures. They had also developed and expanded collaborative working through a substantial initiative to "Reimagine the third sector," with an emphasis on building capacity in the sector to support people to live independently and to increase the availability of early intervention and prevention support.

The partnership successfully collaborated with care homes to establish a care home hub to support care homes that were experiencing staffing issues. It also established a strong collaborative approach to working with care at home providers. The widespread adoption of collaborative approaches improved the partnership's ability to respond to and recover from the pandemic.

The partnership was about to restart the tender process to put in place a framework agreement for care homes for adults. The tender appropriately reflected the health and social care standards and aimed to improve outcomes for people. Effective procurement arrangements also allowed the partnership to rapidly instigate a new tender process for respite provision following the closure of a four-bedded respite unit.

A shortfall in social care capacity is being experienced in most areas across the country and this was evident in the Fife partnership, both in terms of an increase in demand and reduced capacity, particularly in care at home services. The partnership had identified a high risk on its strategic risk register that external providers would not be able to maintain their services. It had prioritised payments for

weekend working and ensured that these were passed on in staff terms and conditions. However, there were indications that the escalating cost pressures from rising fuel prices were already having an impact, particularly on staff delivering care at home.

The partnership was taking positive steps to respond to the care at home challenge by increasing block contracting to ensure that providers could have predictable income to improve staff terms and conditions. However, the partnership's ability to adopt radically different commissioning arrangements and terms and conditions was constrained by the need to keep within the available budget.

The partnership prioritised available capacity to support hospital discharge and had been successful in reducing delays. It was seeking to consolidate and sustain this through the development and implementation of a comprehensive home first strategy. In the medium term, prioritising hospital discharge may have contributed to an increased risk that people in the community could not access the right support when they needed it. On occasion the partnership relied on emergency short-term placements in care homes to meet people's needs until capacity to support them in their own homes became available. This was not providing the best outcome for those individuals. Overall, this meant that the partnership was facing increasing challenges in achieving its strategic commissioning intention of reducing reliance on institutional care.

## **Evaluation**

- Good

## **Key area 9 – Leadership and direction**

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

### **Headline findings**

- The partnership's senior leadership team and extended leadership team had developed a strong collaborative culture. Most staff strongly agreed or agreed that joint working was supported by line managers and leaders.
- The integration joint board (IJB) had redeveloped its approach to care and clinical governance through the establishment of the Quality Matters Assurance Group in July 2021. This group had an integrated focus on care and clinical governance across health and social care.
- The partnership had successfully implemented a new organisational structure between May and November 2021. It had established a collaborative culture among its leadership team and was already improving its approach to integration.
- Efforts to secure the commitment of the wider workforce to transforming services and the leadership team's vision for transformational change were at an early stage.
- The partnership faced significant workforce challenges, many of which were exacerbated by the Covid-19 pandemic. Its workforce strategy demonstrated that it was looking to address them positively across the whole health and social care workforce.

### **Leadership of people across the partnership**

The partnership's senior leadership team and extended leadership team demonstrated a strong collaborative culture. Senior leaders were committed to a shared vision and values which was underpinned by a series of success statements that leaders had co-produced.

Using the European Foundation for Quality Management (EFQM) model for improvement, the partnership had put in place an extensive process to support the senior leadership team to develop individual objectives that were in line with its longer-term strategic objectives. The process reflected a clear focus on delivering the national health and wellbeing outcomes and implementing the integration delivery principles. The process supported a positive culture and effective collaborative way of working. This allowed individual team members to take leadership on specific priorities but still emphasised the importance of collaborating and supporting colleagues to achieve success. A survey of the extended leadership team showed that the goal of creating a collaborative culture had been successfully achieved.

Leaders demonstrated a clear shared commitment to transforming services with a focus on improving outcomes for people. Some managers felt that the new approach had already helped to support progress towards greater levels of integration.

In the staff survey conducted for the inspection, most staff strongly agreed or agreed that joint working was supported by line managers and leaders. A positive example of this was encouraging flexibility to allow district nursing and intermediate care team staff to work together to bridge gaps.

Leaders demonstrated that they valued all staff, and this was strongly embedded in the partnership's success statements. It was also evident in the iMatter survey, where results indicated that staff generally felt appreciated for their work, were treated fairly and consistently and received enough helpful feedback to do well. Feedback from the third and independent sector representatives was included in the director's newsletter, promoting a sense that they were full and active members of the partnership. The partnership made training available to third and independent sector organisations and had developed an integrated workforce plan which included the third and independent sector workforce.

Some staff indicated that they felt valued by their immediate line managers more than senior managers. This was because they felt they had to respond to continuous demands from senior managers. Senior managers demonstrated awareness of the need to balance supporting resilience among staff following the pandemic with responding to increasing needs within the population.

### **Leadership of change and improvement**

Leaders across the partnership had used evidence to jointly identify and set priorities for change and improvement, particularly in relation to reducing delays in discharge from hospital.

The integration joint board had redeveloped its approach to care and clinical governance through the establishment of the Quality Matters Assurance group (QMAG) in July 2021. This group had an integrated focus on care and clinical governance across health and social care. It had taken positive steps to ensure that an integrated approach would be maintained by rotating the chair of the group between associate medical director, associate director of nursing and the social care lead. The group also had a useful focus on assurance of the partnership's capacity to embed a culture of engaging with people. The QMAG had an extensive work plan and was using a wide and expanding range of quality indicators to identify priorities for quality improvement across health and social care services.

Implementation of the new organisational structure between May and November 2021, was the most significant change the partnership had accomplished in recent years. The change was driven by recognition that previous arrangements were not effective in delivering integration and were sometimes entrenched in siloed working and competition. It focused on redesigning the partnership's leadership teams by moving away from hierarchical structures to a distributed leadership model. Distributed leadership models focus on growing leadership practice across people at all levels of the organisation to build capacity for change and improvement.

Efforts to secure the commitment of the wider workforce to transforming services and the leadership team's vision for transformational change were at an early stage. The partnership had continued to take an organisational development approach focused on delivering culture change. It had invested in two organisational development workers to take forward a programme to promote behaviours and culture that would support the transformation of services.

Some staff felt that they had been required to adapt to constant change. This was consistent with results from the staff survey which indicated that only slightly more than half of staff agreed or strongly agreed that the senior leadership team ensured that change affecting services was managed in a safe and responsive way. This may reflect the impact on staff resilience of the rapid changes required by the pandemic.

The integration joint board had recently produced a new workforce strategy. This was a comprehensive and well-developed document which covered all the partnership's workforce, including staff employed by the NHS, council, third sector and independent sector. It was based on the six-step process and five pillars approach set out in Scottish Government guidance and was developed by a group with representatives from all sectors. The partnership faced significant workforce challenges, many of which were exacerbated by the Covid pandemic, and its workforce strategy demonstrated that it was looking to address them positively across the whole health and social care workforce.

## Evaluation

- Good

## Conclusions

The Fife health and social care partnership was in the process of two significant transitions. The first was the transition out of controls and restrictions from the Covid-19 pandemic. The second was the transition towards greater integration of services. This was driven by the successful implementation of a new organisational structure and the establishment of a more collaborative culture and effective collaborative working among members of the senior leadership team. The success of the new leadership arrangements was a considerable achievement, especially during the pandemic, and the positive effects were evident across the partnership.

The pandemic had significant impacts on people and carers and staff across all sectors. As a result, the partnership was experiencing both an increasing need for support and a reduction in the availability of the support it could deliver. The huge efforts of staff had enabled the partnership to continue to deliver good outcomes to most people that were broadly in line with performance across Scotland as a whole. At the same time, some people had poorer outcomes. This presented a challenge: how to recognise the commitment and effort from staff, whilst still acknowledging that some people and particularly their carers had negative experiences. Also, not everything could be attributed to the pandemic and some things were better or worse because of what was in place before the pandemic arose.

Another interesting issue was the apparent difference between how staff and people and carers made sense of the transition from Covid-19 restrictions. Staff described a continuous experience of relentless demands and needing to adapt to ongoing change. People and carers reflected on the often very negative impact during the pandemic but were more concerned about the support they had now.

At the same time, many of the pandemic related challenges like the reductions in capacity because of a limited social care workforce are experienced by all partnerships and may be beyond what a single partnership can overcome on their own.

Last of all, the Fife partnership has made considerable progress since implementing a new organisational structure and senior leadership arrangements. The timing of this inspection meant that we were not able to see the impact of this approach.

Collaborative working was strong among the leadership team and there were positive relationships across staff in all sectors to build on. It will take time to develop more integrated processes. Leaders were committed to change and transformation, but this will take time to become embedded throughout the whole organisation. The partnership had invested in additional capacity to achieve this. Success will depend on effectively evaluating each development and using the results to refine the approach and most importantly, making sure that the voices and experiences of people and carers are at the centre of this.

## Appendix 1

### Inspection methodology

The inspection methodology included the key stages of:

- information gathering
- scoping
- scrutiny
- reporting.

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

- discussions with service users and their carers
- staff survey
- submitted evidence from partnership
- case file reading
- discussions with frontline staff and managers
- professional discussions with partnership.

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

### Quality improvement framework and engagement framework

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

- The National Health and Wellbeing Outcomes framework. These outcomes are specified by the Public Bodies (Joint Working) Scotland Act 2014 to describe what integrated health and social care should achieve. They aim to improve the quality and consistency of outcomes across Scotland and to enable service users and carers to have a clear understanding of what they can expect.
- The Integration Planning and Delivery Principles. These are also specified by the Public Bodies (Joint Working) Scotland Act 2014 to describe how integrated services should be planned and delivered.
- The Health and Social Care Standards. These seek to improve services by ensuring that the people who use them are treated with respect and dignity and that their human rights are respected and promoted. They apply to all health and social care services whether they are delivered by the NHS, councils or third and independent sector organisations.

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

## Quality indicators

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

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

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

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.
Agile working	Being ready to change the way people work by allowing them greater flexibility in their working hours and where they work, using technology. It also can include changing how people work together or their role.
Aids and adaptations	This means equipment and changes to people's homes which help with everyday tasks so that they can live independently. Examples include grab rails, bath and shower seats, wheelchairs, special mattresses and communication aids.
Anticipatory 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.
Capacity	Capacity is the maximum amount of care, support or treatment that day service or individual member of staff can provide.
Care and clinical governance	The process that health and social care services follow to make sure they are providing good quality and safe care, support and treatment.
Carers' centre	Carers' centres are independent charities that provide information and practical support to unpaid carers. These are people who, without payment, provide help and support to a relative, friend or neighbour who 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.
Complex needs	People have complex needs if they require a high level of support with many aspects of their daily lives and rely on a range of health and social care services.

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

Future planning	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.
Health and social care integration	Health and social care integration is the Scottish Government's approach to improving care and support for people by making health and social care services work together so that they are seamless from the point of view of the people who use them.
Health and social care partnership	Health and social care partnerships are set up to deliver the integration of health and social care in Scotland. They are made up of integration authorities, local councils, local NHS boards and third and independent sector organisations.
Health promotion	The process of enabling people to improve and increase control over their own health.
Hospital at home	Services that treat patients in their own home rather than occupying a hospital bed. They are managed by a dedicated team with of health professionals who are responsible for the person's care and treatment.
ICASS	Integrated assessment and support service – a team of health and social care staff in Fife. The team ensures that the delivery of care plans is well coordinated, and that individuals receive tailored support based on their identified needs
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.

Low threshold services	Easy access services that people do not have to meet set standards or criteria to access, for example drop-in centres or conversation cafes. Low threshold services are often seen as a way of stopping people's health and wellbeing getting worse.
Microsoft Teams	An IT platform that allows people to meet and work together on the internet
National health and wellbeing outcomes	Standards set out in Scottish legislation that explain what people should expect to get from health and social care integration.
National Performance Indicators	Measures that are used to evaluate how well organisations are doing in relation to a particular target or objective. For example, the Scottish Government uses national performance indicators to understand how well health and social care partnerships are achieving good health and wellbeing outcomes for people.
Organisational development	A way of using strategies, structures and processes to improve how an organisation performs.
Outcomes	The difference that is made in the end by an activity or action. In health and social care terms, the difference that a service or activity makes to someone's life.
Personal assistant	Somebody who is employed by a person with health and social care needs to help them live the best lives they can. People who need care can ask a health and social care partnership for a direct payment so that they can employ a personal assistant.
Person-centred	This means putting the person at the centre of a situation so that their circumstances and wishes are what determines how they are helped.
POSA	Personal outcomes and support assessment. This is a process used in the Fife health and social care partnership to assess people's social care needs and plan the social care services that will help them meet their needs.
Prevention	In health and social care services, prevention is about activities that help to stop people becoming ill or disabled, or to prevent illness or disability becoming worse.

Procurement	The process that health and social care partnerships use to enter into contracts with services to provide care or support to people.
Public Health Scotland	A national organisation with responsibility for protecting and improving the health of the people of Scotland.
Quality indicators	Measures that are used to evaluate how good a process is – how efficient and effective a process is in achieving the results that it should.
Rehabilitation	The process of helping a person to return to good health, or to the best health that they can achieve.
Residential care	Care homes – places where people live and receive 24-hour care.
Respite care	Temporary care that is provided for someone with health and social care needs, usually to provide a break for the person or their carer. Respite care is often provided in a residential setting but can also be provided via short breaks for the person and/or their unpaid carers.
Scoping	The process of examining information or evidence to understand what it means.
Scrutiny	The process of carefully examining something (for example a process or policy or service) to gather information about it.
Seamless services	Services that are smooth, consistent and streamlined, without gaps or delays.
Self-directed support	A way of providing social care that allows the person to make choices about how they will receive support to meet their desired outcomes.
Service providers	Organisations that provide services, such as residential care, care at home, day services or activities.
Short breaks	Opportunities for disabled people and/or their unpaid carers to have a break. Its main purpose is to give the unpaid carer a rest from the routine of caring.
Strategic needs assessment	A process to assess the current and future health, care and wellbeing needs of the community in order to inform planning and decision making.

Supported living	Housing with attached support or care services. Supported living is designed to help people to remain living as independently as possible in the community.
Third sector	Organisations providing services that are not private or statutory. The term is often used to refer to voluntary organisations but can also refer to community organisations or social enterprise organisations
Workforce plan	A plan that sets out the current and future needs for staff in the organisation, and how those needs will be met.

## Appendix 3

### Six-Point evaluation scale

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

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

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

An evaluation of **very good** will apply to performance that demonstrates major strengths in supporting positive outcomes for people. There are very few areas for improvement. Those that do exist will have minimal adverse impact on people's experiences and outcomes. Whilst opportunities are taken to strive for excellence within a culture of continuous improvement, performance evaluated as very good does not require significant adjustment.

An evaluation of **good** applies to performance where there is a number of important strengths which, taken together, clearly outweigh areas for improvement. The strengths will have a significant positive impact on people's experiences and outcomes. However, improvements are required to maximise wellbeing and ensure that people consistently have experiences and outcomes which are as positive as possible.

An evaluation of **adequate** applies where there are some strengths, but these just outweigh weaknesses. Strengths may still have a positive impact but the likelihood of achieving positive experiences and outcomes for people is reduced significantly because key areas of performance need to improve. Performance, which is evaluated as adequate, may be tolerable in particular circumstances, such as where a service or partnership is not yet fully established, or in the midst of major transition. However, continued performance at adequate level is not acceptable. Improvements must be made by building on strengths whilst addressing those elements that are not contributing to positive experiences and outcomes for people.

An evaluation of **weak** will apply to performance in which strengths can be identified but these are outweighed or compromised by significant weaknesses. The weaknesses, either individually or when added together, substantially affect peoples' experiences or outcomes. Without improvement as a matter of priority, the welfare

or safety of people may be compromised, or their critical needs not met. Weak performance requires action in the form of structured and planned improvement by the provider or partnership with a mechanism to demonstrate clearly that sustainable improvements have been made.

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

## Appendix 4

### The National Health and Wellbeing Outcomes

- **Outcome 1:** People are able to look after and improve their own health and wellbeing and live in good health for longer.
- **Outcome 2:** People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
- **Outcome 3.** People who use health and social care services have positive experiences of those services, and have their dignity respected.
- **Outcome 4.** Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
- **Outcome 5.** Health and social care services contribute to reducing health inequalities.
- **Outcome 6.** People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.
- **Outcome 7.** People using health and social care services are safe from harm.
- **Outcome 8.** People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
- **Outcome 9.** Resources are used effectively and efficiently in the provision of health and social care services.