MORAY INTEGRATION JOINT BOARD

CLINICAL AND CARE GOVERNANCE COMMITTEE

Thursday, 28 November 2019

Inkwell Main, Elgin Youth Café

NOTICE IS HEREBY GIVEN that a Meeting of the **Moray Integration Joint Board Clinical and Care Governance Committee** is to be held in **Inkwell Main, Elgin Youth Café**, **Francis Place, Elgin, IV30 1LQ** on **Thursday, 28 November 2019** at **13:00** to consider the business noted below.

AGENDA

7 **Care Inspectorate Thematic Review on Self-Directed Support** **41 - 106**

Report by Jane Mackie, Chief Social Work Officer/Head of Service Strategy and Commissioning

Item which the Committee will consider with the Press and Public excluded

8 **CONFIDENTIAL - Update on Recent Adverse Event**

- Information relating to any particular applicant for, or recipient or former recipient of, any service provided by the Authority;

MORAY INTEGRATION JOINT BOARD

CLINICAL AND CARE GOVERNANCE COMMITTEE

MEMBERSHIP

VOTING MEMBERS

Mr Sandy Riddell (Chair)	Non-Executive Board Member, NHS Grampian
Councillor Tim Eagle	Moray Council

NON-VOTING MEMBERS

Mr Ivan Augustus	Carer Representative
Mr Tony Donaghey	UNISON, Moray Council
Ms Pam Dudek	Chief Officer, Moray Integration Joint Board
Mrs Linda Harper	Lead Nurse, Moray Integration Joint Board
Ms Jane Mackie	Chief Social Work Officer, Moray Council
Dr Malcolm Metcalfe	Secondary Care Advisor, Moray Integration Joint Board
Dr Graham Taylor	Registered Medical Practitioner, Primary Medical Services
Mrs Val Thatcher	Public Partnership Forum Representative

ADVISORS

Mr Sean Coady	Head of Services and IJB Hosted Services
Dr Ann Hodges	Consultant Psychiatrist
Ms Pauline Merchant	Clinical Governance Coordinator, Moray Health and Social Care Partnership
Ms Jeanette Netherwood	Corporate Manager, Health and Social Care, Moray
Mrs Liz Tait	Professional Lead for Clinical Governance and Interim Head of Quality Governance and Risk Unit

Clerk Name: Caroline Howie
Clerk Telephone: 01343 563302
Clerk Email: caroline.howie@moray.gov.uk

MINUTE OF MEETING OF THE MORAY INTEGRATION JOINT BOARD

CLINICAL AND CARE GOVERNANCE COMMITTEE

Thursday, 29 August 2019

Inkwell Main, Elgin Youth Café, Francis Place, Elgin, IV30 1LQ

PRESENT

Mr Ivan Augustus, Mr Sean Coady (NHS), Ms Pam Dudek, Councillor Tim Eagle, Ms Jane Mackie, Jeanette Netherwood, Mr Sandy Riddell, Mrs Liz Tait, Dr Graham Taylor, Mrs Val Thatcher

APOLOGIES

Mrs Linda Harper

IN ATTENDANCE

Mrs Caroline Howie, Committee Services Officer as Clerk to the meeting.

1 Chair of Meeting

The meeting was chaired by Mr Sandy Riddell.

2 Declaration of Member's Interests

There were no declarations of Members Interests in respect of any item on the agenda.

3 Minutes of Meeting dated 30 May 2019

The Minute of the meeting of the Moray Integration Joint Board Clinical and Care Governance Committee dated 30 May 2019 was submitted and approved.

4 Action Log of Meeting dated 30 May 2019

The Action Log of the Moray Integration Joint Board Clinical and Care Governance Committee dated 30 May 2019 was discussed and it was noted that all items due had been completed.

5 Clinical Care Group - Update and Exception Report - Quarter 1

Under reference to paragraph 7 of the Minute of the meeting dated 28 February 2019 a report by the Chief Officer informed the Committee of progress and exceptions in Quarter 1 (April to June 2019).

During lengthy discussion complaints came under scrutiny and it was stated that receipt of complaints was an issue as the same complaint could be received into more than one area. The different systems used in NHS and Moray Council do not help the situation but work is being undertaken to alleviate any issues.

Committee were of the opinion there had been a useful discussion on some of the finer points but felt a further report on the Clinical Care Group would provide assurance.

Thereafter the Committee agreed to:

i. note the complaints and adverse events summary shown in appendix 1 of the report;

ii. note the update on Audit, Quality Assurance and Quality Improvement Activity in Health and Social Care Moray (HSCM) shown in appendix 2 of the report;

iii. note the exception reporting from HSCM Clinical Governance Group; and

iv. seek a further report on the Clinical Care Group.

6 Duty of Candour Annual Report

A report by the Head of Clinical and Care Governance presented the Committee with information in relation to how Health and Social Care Moray implemented the duty of candour legislation from 1 April 2018 to 31 March 2019.

During discussion it was stated that advice and support was provided across Moray to help understand requirements and ensure appropriate recording.

Thereafter the Committee agreed to note the content of the report and the information contained in appendix 1 of the report.

MEETING OF MORAY INTEGRATION JOINT BOARD

CLINICAL AND CARE GOVERNANCE COMMITTEE

THURSDAY 29 AUGUST 2019

ACTION LOG

ITEM NO.	TITLE OF REPORT	ACTION REQUIRED	DUE DATE	ACTION BY
1.	Clinical Care Group – Update and Exception Report – Quarter 1	Further report on Clincal Care Group to be provided to a future Committee.	28 Nov 2019	Sean Coady/ Liz Tait

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 28 NOVEMBER 2019**

SUBJECT: **CLINICAL GOVERNANCE GROUP – UPDATE AND EXCEPTION REPORT**

BY: **CHIEF OFFICER**

1. REASON FOR REPORT

1.1 To inform the Clinical and Care Governance Committee of the Moray Integration Joint Board (MIJB), of progress and exceptions reported to Clinical Governance Group (CGG) in September, October and November 2019.

2. RECOMMENDATION

2.1 It is recommended that the Clinical and Care Governance Committee consider and note the progress and exceptions highlighted in this report for the period September to November 2019.

3. BACKGROUND

3.1 The HSCM Clinical Governance Group was established as described in a report to this committee on 28 February 2019 (para 7 of the minute refers).

3.2 The assurance framework for clinical governance was further developed with the establishment of the Clinical Risk Management Group (CRM) as described in a report to this committee on 30 May 2019 (para 7 of the minute refers).

3.3 A reporting schedule for Quality Assurance Reports from Clinical Service Groups/ Departments is in place. This report contains information considered at the last 3 Clinical Governance meetings with additional information relating to complaints, incidents and adverse events reported via Datix; and areas of concern/risk and good practice.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

Audit, Guidelines, Reviews and Reports

4.1 Relevant Audits, Guidelines Reviews and Reports are tabled and discussed. These include local and national information that is relevant to HSCM, for example recommendations from Health Improvement Scotland (HIS), reports from other areas which require to be discussed and assurance given that services in Moray are aware of these and have processes in place to meet/ mitigate these recommendations.

4.2 Some of the Reports/ Guidelines shared and discussed include:

- Gosport Hospital Report
- Our Citizens' Jury Report
- Mental Welfare Commission (MWC)
- Drug Related Deaths in Scotland in 2018 – Report
- Health and Social Care Standards Self Evaluation - HSCM Submission
- Bed Space Cleaning Guidance/Checklist
- Duty Of Candour Annual Report
- Scottish Public Services Ombudsman (SPSO) Upheld complaints
- HIS Report –NHS Lanarkshire
- HIS Summary of External Inspections to NHS Scotland Boards
- Mental Welfare Commission Reports
- Older People in Acute Hospitals and Older People in Acute Care Action Plan
- HIS NHS Grampian Announced Inspection Report

Clinical Risk Management (CRM)

4.3 The Clinical Risk Management (CRM) group continue to meet weekly to discuss issues highlighted on the HSCM Datix dashboard. This includes Level 1 (requiring significant adverse event analysis and review) and Level 2 (requiring local management review) investigations and complaints with an Action Log outlining issues for escalation and tasks being updated at each meeting.

4.4 The CRM is open to service managers and team leaders to attend, and currently there is a core group of 4 staff who attend regularly. An invitation to attend the group is extended at each Clinical Governance Group meeting.

Internal Assurance Information

4.5 Incidents, Occurrences, Adverse Events, Feedback (including complaints) and Learning are discussed at each CGG meeting. Information is extracted from Datix. (see paragraph 4.5 and 4.6). Cases that have been referred to the Scottish Public Service Ombudsman (SPSO) are highlighted, and decisions and recommendations made by the SPSO to NHS Grampian, and other health boards that are pertinent to HSCM are shared, and methods of dissemination and assurance are considered.

4.6 A briefing paper on Drug Related Deaths – The Wider Scotland Picture, and Moray, was shared and discussed. This was a descriptive report which will assist the Moray Alcohol and Drug Partnership (MADP) with its current audit into measures to reduce and prevent dug related harms and deaths. This provides assurance of awareness, monitoring and identifying learning.

Areas of Achievement and Good Practice

4.7 The following list provides information on areas of achievement and good practice:

i. Mental Health has an annual learning event where learning is shared. This is evaluated very positively by attendees from across the organisation.
ii. Members of the CGG attend the Social Care Practice Governance Board Meeting which facilitates cross sector sharing and learning.
iii. GMED Clinical Governance Committee is now established and meeting regularly.
iv. District Nursing (DN) teams have been supporting an initiative in Moray recently with outreach training to home care staff within the East locality, looking at various topics to improve early identification and prevention e.g. tissue viability and catheter care .
v. An Occupational Therapist now supports the Emergency Department at Dr Gray's Hospital assisting in triage and sign-posting patients, preventing unnecessary admissions to hospital.
vi. Prevention of Lower-limb Pressure Damage & Reduction in bed stay
The National 'Check Protect Refer [CPR] for At-Risk Feet' campaign, with the aim to prevent lower-limb pressure damage and reduce bedstay, has been rolled out across Moray. Following the introduction of the campaign in 2018 in Dr Gray's, in 2019. A Highly Specialised Podiatrist rolled-out the campaign across all Moray Community Hospitals and to all the Community Nurse Teams and the Moray Wound Advocates group.
vii. Good Mental Health for All in Moray Strategy - Launch of a mental health online tool. The Moray Wellbeing Hub has been host to a partnership project (funded by Moray Mental Health Services) over the last six months to pilot a simple online tool aimed at empowering adults in Moray and those that support them, including GPs, to better communicate and navigate the services and supports that help mental health locally. You can find the tool on the Hub home page here: http://moraywellbeinghub.org.uk/mhpathways/
ix. Alignment of Community Psychiatric Nurses (CPNs) to GP practices and the development of mental health Hubs where practice size permits.
x. Mental Health Consultants in the department are currently utilising GMC (General Medical Council) questionnaires to gain feedback from patients for appraisals and service development.
xi. There has been an increased in Scotland in Drug Related Deaths and in Moray the 17 deaths recorded in 2018 is of concern. CCG reviewed a briefing paper that set out information from the 2018 Drug Related

Deaths report for Scotland and identified key points relating to Moray, taking account of the national and local data.

The Staying Alive Audit is underway and detailed analysis has been carried out, identifying thematic areas for further investigation and discussion about improvement potential. Once completed a report with specific recommendations for action will be presented to Moray Alcohol and Drugs Partnership and Clinical Governance Group.

Complaints

4.8 Due to the nature of the complaints and incidents, it is not pertinent to be too specific, as this may allow individuals to be identified
During the last quarter, a total of **16** complaints were recorded within Datix.

4.9 On review of those taking longer than 20 days, it is apparent that this was due to the complexity of the complaint, with multi-disciplinary and more than one service being involved in the investigation. On 2 occasions the complaint had been assigned to the incorrect manager which incurred a delay in responding. Complainants had been notified of the extended time required for the investigation.

HSCM Outcome of Complaints

Recording system	Service	Upheld	Partially Upheld	Not Upheld	Being Investi-gated	**Total**
DATIX n=16	GMED	1	2	0	1	**4**
	Mental Health – Adult Health	0	1	3	0	**4**
	Allied Health Professionals	3	1	0	1	**5**
	Community Nursing	0	0	0	2	**2**
	Community Hospital	0	0	0	1	**1**
Total		**4**	**4**	**3**	**5**	**16**

Incidents/Adverse Events

4.10 **Incidents recorded on Datix -** During Quarter 2 there were a total of **360** incidents recorded on Datix. Incidents are mainly NHSG related, with some incidents also pertaining to Local Authority issues as identified by Health care staff, eg Care Homes. Each incident is reviewed by the appropriate line manager, with the relevant level of investigation applied. Analysis of quarter 2 data shows that the majority of incidents (312) were resolved following a local review by the line manager. **3** incidents are currently being investigated across HSCM.

4.11 No incidents met the threshold for Duty of Candour in the last quarter. Of the **360** incidents reported on Datix there were **277** rated as negligible; **70** as minor; **3** as Moderate. There were no Extreme incidents reported during this quarter

Learning from incidents and reviews

4.12 Following a review of practice within GMED, one of the main learning points was the introduction of a new process to support early identification and treatment of a particular condition. A teaching session to support this will be added to the training schedule, with supporting learning materials circulated to all clinicians working for the service.

4.13 Following an adverse event review within Mental Health, lessons identified include; consider the review of current protocols, criteria and arrangements for admitting patients out of area when local beds are not available. Information provided to families regarding carer's support has been improved.

4.14 Following a review of an incident, District Nursing teams will check that Care Homes have the correct information and instructions regarding oxygen concentrators.

4.15 Two investigations took place regarding patient falls. In both cases all mitigating measures and equipment were found to be in place. In one case, multi-disciplinary communication was found to be very effective and communication with the patient and family was prompt and informative.

4.16 All risks held on the HSCM Risk Register are currently being reviewed and risk handlers are in the process of updating these on Datix.

Risks

4.17 New risks identified are discussed at each Clinical Governance meeting.

4.18 There have been no new risks graded as "High" during the reporting period. Each Clinical Service Group/Department discuss relevant risks during their reporting session. Any identified as increasing in risk are escalated through the reporting structure.

Issues for escalation to the Clinical and Care Governance Committee

4.19 Health and Social Care Standards (H&SCS) Self Evaluation. A local framework is to be developed to provide assurance that services are incorporating the standards into service delivery and are collating evidence that demonstrates they are working towards/achieving these. A national meeting is taking place on 4th December, to be attended by the Clinical Governance Lead, to discuss the national H&SCS draft report which will then be shared widely

Care Homes

4.20 Concerns have been raised to the group regarding incidents concerning the quality of nursing care delivery in some care homes. These concerns have been shared with the Commissioning team who are investigating. A member of the commissioning team attended the CGG group to provide a level of assurance through robust scrutiny.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019

As set out within Annex C of the Health and Social Care Integration Public Bodies (Joint Working) (Scotland) Act 2014 Clinical and Care Governance Framework.

Effective handling of complaints is used to ensure the efficient and sustainable delivery of services to meet priorities.

(b) Policy and Legal

Clinical and Care Governance requirements are set out within the Moray Health and Social Care Integration Scheme. Appropriate arrangements must be in place to ensure and evidence good governance in meeting duties under the Public Bodies (Joint Working) (Scotland) Act 2014.

(c) Financial implications

None directly associated with this report.

(d) Risk Implications and Mitigation

Moray Integration Joint Board (MIJB), Moray Council and NHS Grampian could find themselves exposed to significant risks if good governance is not in place. The purpose of this report is to oversee the processes to ensure that appropriate action is taken in response to adverse events, scrutiny reports/action plans, safety action notices, feedback, complaints and litigation, and those examples of good practice and lessons learned are disseminated widely.

Adverse events and complaints provide significant information on trends relating to risk and an encouraging opportunity for learning across the system. Regular monitoring of this is critical to ensure continuous improvement and the ambition of achieving excellence in the delivery of high quality care and treatment.

The local Clinical Risk Management (CRM) group reviews all events logged on Datix, ensuring risk is identified and managed.

(e) Staffing Implications

This activity is core to all practitioners in the front line both in terms of their professional competence and assurances in care delivery.

(f) Property

None directly arising from this report.

(g) Equalities/Socio Economic Impact

There is no requirement for an equality impact assessment because there is no change to policy required as a result of this report.

(h) Consultations

Consultations have been undertaken with the following staff who are in agreement with the content of this report where it relates to their area of responsibility:

- Chief Officer, MIJB
- Caroline Howie, Committee Services Officer
- Corporate Manager

6. CONCLUSION

6.1 This report provides a summary of business discussed at the HSCM Clinical Governance Group and provides assurance the clinical services that the Moray HSCP and the IJB are responsible for are safe and effective.

Authors of Report: Pauline Merchant, Clinical Governance Coordinator
Background Papers: held by author
Ref:

REPORT TO: **MORAY INTEGRATION JOINT BOARD ON THURSDAY 28 NOVEMBER 2019**

SUBJECT: **HEALTHCARE IMPROVEMENT SCOTLAND MORAY COMMUNITY HOSPITAL INSPECTIONS**

BY: **SEAN COADY, HEAD OF SERVICE**

1. REASON FOR REPORT

1.1 To inform the Board of the report findings from Healthcare Improvement Scotland (HIS) following announced inspection of Moray Community Hospitals in August 2019 for safety and cleanliness.

2. RECOMMENDATION

2.1 It is recommended that the Moray Integration Joint Board consider and note the:

i) positive feedback received for Community Hospitals in Moray, and the general requirements and recommendations of the report for NHS Grampian; and

ii) arrangements put in place by NHS Grampian to address the requirements and recommendations.

3. BACKGROUND

3.1 HIS inspect acute and community Hospitals throughout Scotland for cleanliness, hygiene and infection control. HIS carried out an announced inspection from 13 to 15 August 2019 focussing on the cleanliness of 9 NHS Grampian Community hospitals, including the four within Moray – Turner Hospital Keith, Stephen Hospital Dufftown, Fleming Hospital Aberlour and Seafield Hospital Buckie. The overarching responsibility for infection prevention and control is with the NHS board.

3.2 This was the first inspection of these hospitals against the HIS Healthcare Associated Infection (HAI) Standards (February 2015). Before carrying out these inspections, HIS reviewed previous inspection activity within NHS Grampian. This informed the decision on which standards to focus on during the inspection which were:

- Standard 2: Education to support the prevention and control of infection
- Standard 6: Infection prevention and control policies, procedures and guidance, and
- Standard 8: Decontamination.

4 KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 The findings of the inspection were very positive with very positive verbal feedback on the day and no recommendations or specific requirements for any Health and Social Care Moray Community hospital. The inspection report is attached at **APPENDIX 1**.

4.2 The report highlights what was being done well across NHS Grampian as follows:

- Adherence to standard infection prevention and control precautions was good.
- Staff knowledge of standard infection prevention and control precautions was good.
- The standard of equipment cleanliness was good.

4.3 What NHS Grampian could do better:

- Provide an education strategy for all staff that clearly outlines mandatory training requirements.
- Provide staff with a clear programme of standard infection prevention and control audits.
- Develop a consistent approach to the reporting of estates issues.

4.4 The recommendations and requirements from the inspection have been reviewed and an action plan for implementation across all hospitals in the NHS board has been collated. This has been approved by the Chief Executive of NHS Grampian and Chair of NHS Grampian Board. The Moray Infection Control Group meet on a monthly basis and will have oversight of the action plan. This group will seek assurance the actions are being progressed accordingly.

5 SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019
The external audit process supports good governance and provides independent assurances to the MIJB on use of its resources and the standards being achieved.

(b) Policy and Legal
There are no contractual or legal issues to report.

(c) Financial implications
There are no financial implications associated with this report.

(d) Risk Implications and Mitigation
There are no risk implications to report.

(e) Staffing Implications
There are no staffing implications directly associated with this report.

(f) Property
There are no property issues as a result of this report.

(g) Equalities/Socio Economic Impact
An equalities impact assessement is not required as there are no impacts for people with protected characteristics arising as a direct result of this report.

(h) Consultations
All staff involved in the Inspection process, Corporate Manager, Caroline Howie, Committee services officer have been consulted, any comments received have been considered in writing the report.

6 CONCLUSION

6.1 The inspection carried out by HIS for NHS Grampian resulted in six requirements and two recommendations for action, although there were no specific recommendations or requirements for community hospitals in Moray.

6.2 An improvement action plan has been developed by NHS Grampian and the Moray Infection Control Group will have oversight of the action plan and will seek assurance the actions are being progressed accordingly.

Author of Report: Sean Coady

Background Papers: HIS Announced Inspection Report & Improvement Action Plan

Ref:

Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Announced Inspection Report – Safety and Cleanliness of Hospitals

Aboyne Hospital
Fleming Hospital
Jubilee Hospital
Glen O'Dee Hospital
Kincardine Hospital
Seafield Hospital
Stephen Hospital
Turner Hospital
Turriff Hospital

NHS Grampian

13–15 August 2019

NHS SCOTLAND

We inspect acute and community hospitals across NHSScotland. You can contact us to find out more about our inspections or to raise any concerns you have about cleanliness, hygiene or infection prevention and control in an acute or community hospital or NHS board by letter, telephone or email.

Our contact details are:

Healthcare Improvement Scotland
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

Telephone: 0131 623 4300

Email: comments.his@nhs.net

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www.healthcareimprovementscotland.org

Contents

Summary of inspection

About the hospitals we inspected

NHS Grampian has 16 community hospitals. There are three Health and Social Care Partnerships (HSCP) in NHS Grampian and adult health and social care services are delivered in partnership with the respective councils of Moray, Aberdeen City and Aberdeenshire. We inspected nine hospitals across Moray and Aberdeenshire.

All nine hospitals include inpatient beds and provide medical care, palliative care and rehabilitation. The hospitals also provide a varied range of services such as minor injuries, GP treatment room services and a range of consultant-led clinics and day hospital services.

About our inspection

This inspection focused on the safety and cleanliness of these NHS Grampian hospitals. The overarching responsibility for infection prevention and control is with the NHS board. We carried out announced inspections to the following NHS Grampian community hospitals from Tuesday 13 to Thursday 15 August 2019:

Aberdeenshire Heath and Social Care Partnership

Abyone Hospital
Glen O'Dee Hospital
Jubliee Hospital
Kincardine Hospital
Turiff Hospital

Moray Health and Social Care Partnership

Fleming Hospital
Seafield Hospital
Stephen Hospital
Turner Hospital

The inspection team was made up of six inspectors with support from a project officer. Although we try to involve members of the public as public partners on our inspections, none were available for this inspection.

Inspection focus

This was the first inspection of these hospitals against the Healthcare Improvement Scotland *Healthcare Associated Infection (HAI) Standards* (February 2015). Before carrying out these inspections, we reviewed previous inspection activity within this NHS Board. This informed our decision on which standards to focus on during this inspection. We focused on:

- Standard 2: Education to support the prevention and control of infection
- Standard 6: Infection prevention and control policies, procedures and guidance, and
- Standard 8: Decontamination.

We inspected the following areas:

Aberdeenshire Heath and Social Care Partnership

Aboyne Hospital:

- general ward, and
- minor injuries unit.

Glen O'Dee Hospital:

- Morven ward, and
- Scolty ward.

Jubilee Hospital:

- Rothiden ward
- minor injuries unit, and
- emergency department.

Kincardine Hospital:

- Arduthie ward

Turriff Hospital:

- general ward, and
- minor injuries unit.

Moray Health and Social Care Partnership

Fleming Hospital:

- general ward, and
- minor injuries unit.

Seafield Hospital:

- general ward, and
- minor injuries unit.

Stephen Hospital:

- general ward, and
- minor injuries unit.

Turner Hospital:

- general ward, and
- minor injuries unit.

As we did not have a public partner on the team, we did not carry out any formal patient interviews. However, all inspectors took time to speak with patients, relatives and carers as appropriate about their experiences of the environment, staff and care. We also received 32 completed patient questionnaires from the nine hospitals.

What NHS Grampian did well

- Adherence to standard infection prevention and control precautions was good.
- Staff knowledge of standard infection prevention and control precautions was good.
- The standard of equipment cleanliness was good.

What NHS Grampian could do better

- Provide an education strategy for all staff that clearly outlines mandatory training requirements.
- Provide staff with a clear programme of standard infection prevention and control audits.
- Develop a consistent approach to the reporting of estates issues.

Detailed findings from our inspection can be found on page 8.

What action we expect NHS Grampian to take after our inspection

This inspection resulted in six requirements and two recommendations. The requirements are linked to compliance with the Healthcare Improvement Scotland HAI standards. A full list of the requirements and recommendations can be found in Appendix 1.

An improvement action plan has been developed by the NHS board and is available on the Healthcare Improvement Scotland website www.healthcareimprovementscotland.org

We expect NHS Grampian to carry out the actions described in its improvement action plan to address the issues we raised during this inspection.

We would like to thank NHS Grampian and, in particular, all staff and patients at the community hospitals for their assistance during the inspection.

The flow chart in Appendix 2 summarises our inspection process. More information about our safe and clean inspections, methodology and inspection tools can be found at www.healthcareimprovementscotland.org

Key findings

Standard 2: Education to support the prevention and control of infection

What NHS Grampian did well

During our inspection senior managers told us that NHS Grampian's mandatory training requirements had recently changed. Since June 2018, NHS Grampian is completing the foundation layer of the Scottish Infection Prevention and Control Education Pathway (SIPCEP) in place of previous hand hygiene and standard infection control precautions e-learning courses. SIPCEP is an NHS Education for Scotland computer-based infection control education programme. NHS Grampian staff will complete annual SIPCEP refresher training and in addition, clinical staff will complete *Clostridium difficile* infection modules every 2 years. These modules are available through the electronic system Turas Learn which is NHS Education for Scotland's new single, unified digital platform for health and social care staff, used by some NHS boards as their learning management system.

We were told that each staff member can use TURAS to see their individual completed and outstanding training record. Senior charge nurses confirmed that they were using Turas Learn for staff development and Turas Appraisal for staff appraisals.

Staff explained that the changeover to Turas Learn is still embedding. They told us some staff still have older paper training records in place for previous e-learning courses which are still up-to-date. When these courses expire, they will start using the SIPCEP pathway.

Across all hospitals inspected, we saw copies of paper training records available for the inspectors to review. In some hospitals we saw additional records kept by staff to demonstrate further training, for example infection prevention and control team toolbox training, face-to-face training and training specific to individual roles and specialties. We were also provided with a copy of the mandatory training requirements for domestic staff.

What NHS Grampian could do better

The statutory and mandatory staff training policy provided by the NHS board did not clearly outline the mandatory requirements for training in NHS Grampian. Senior staff we spoke with acknowledged the lack of clarity and planned to review this document. We found there was variance amongst staffs' understanding of the mandatory training requirements. Although there was evidence of staff keeping

themselves up-to-date, there was no consistency as not all staff could describe the training requirements outlined to us by senior management.

We saw various ways in which domestic staff access training and education which lacked a consistent approach. We were told that there are plans for domestic staff to have access to the electronic training systems on TURAS Learn. NHS Grampian and NHS Education for Scotland are reviewing the current content to ensure modules are relevant for estates, facilities and domestic staff job roles.

- **Requirement 1:** NHS Grampian must ensure staff are aware of NHS Grampian's mandatory infection prevention and control education requirements.

We were told that TURAS Learn cannot currently produce reports for senior staff to check uptake and compliance of staff and teams' completing mandatory training; the current system is reliant on individual staff printing off their learning record. Work is ongoing and this function should be in place mid November 2019. We saw minutes of meetings that showed this issue is being discussed and work is ongoing. Senior charge nurses are responsible for keeping paper records for review in ward areas. Senior staff could review this information on request but were currently reliant on senior charge nurses escalating any concerns around compliance.

Although we saw evidence that staff are completing training, there was no consistent or reliable systems in place to monitor the uptake of infection prevention training and to ensure staff compliance.

- **Requirement 2:** NHS Grampian must be able to evaluate the uptake of infection prevention and control training in order to respond to any unmet education needs.

Standard 6: Infection prevention and control policies, procedures and guidance

What NHS Grampian did well

Health Protection Scotland's *National Infection Prevention and Control Manual* describes standard infection control precautions and transmission-based precautions. These are the minimum precautions that healthcare staff should take when caring for patients to help prevent cross-contamination or infections. There are 10 standard infection control precautions, including hand hygiene, the use of personal protective equipment (aprons, gloves), how to care for patients with an infection, and the management of linen, waste and sharps. The transmission-based

precautions describe how to care for patients with known or suspected infections and how to help prevent cross-transmission of infections.

NHS boards are required to measure staff compliance with standard infection control precautions. The frequency of this compliance monitoring is determined by individual NHS boards. The infection prevention and control team told us that NHS Grampian requires staff in all wards to carry out monthly hand hygiene and monitoring of the care equipment audits. We were told at our discussion session that ward audits should be uploaded to an NHS Grampian electronic system so that audits can be reviewed by the infection prevention and control team and senior staff.

In addition, staff should also be completing larger healthcare associated infection audits every 6 months. These audits include all ten standard infection prevention and control precautions and allow staff to focus on areas where there is potential focus or need for improvement. We were told that the infection prevention and control team are currently reviewing the electronic portal system to capture this information in order to review compliance. Therefore, results should be discussed at meetings between the nurses in charge, operational location managers and lead nurses. These local meetings should discuss compliance, review results and offer support to staff. More information is reported under 'What NHS Grampian could do better' section below.

Across all nine hospitals inspected we saw paper copies of ward audits and noted a variation of what ward staff were recording. In some cases we found ward staff were auditing more than was required by the NHS board. For example, in one area staff were auditing all 10 standard infection control precautions every month, in another area staff had not been auditing standard infection prevention control for a length of time and other areas staff were auditing hand hygiene and patient equipment every month as required.

Across all nine hospitals ward staff were also completing care assurance reflective audits which are designed to measure and give assurances around safe and effective delivery of person-centred care. The infection prevention and control team told us they plan to remove the infection prevention and control component of these audits as they recognise this overlap has caused inconsistency and confusion for staff.

We were told by the infection prevention and control manager that there has been a decision made across NHS Grampian community hospitals that the team will not routinely audit ward areas. This decision was made due to decreased resources within the infection prevention and control team and was raised locally through the infection control committee. However, the team is available for support if necessary or where intelligence from audits indicate that wards need extra support. Staff told

us they had a good relationship with the infection prevention control team and described when and how they would contact the team for advice and support.

All staff reported the team were supportive and available when necessary. Throughout our inspection, staff demonstrated very good compliance with all standard infection prevention and control precautions. All staff were using gloves and aprons when necessary and were seen to be washing hands. We saw alcohol-based hand rub dispensers throughout wards and departments and we saw some staff carrying personal pocket-sized bottles.

Staff were knowledgeable about standard infection prevention and control precautions in a variety of scenarios and discussed a risk-based approach to transmission-based precautions. Staff indicated they would risk assess patients if they were not able to isolate patients with known or suspected infection because of their individual care needs and for their safety. We saw evidence of these risk assessments in wards where patients required them.

Across all nine hospitals inspected, 31 of the 32 patients, relatives and carers who completed our questionnaire said that staff always clean their hands.

What NHS Grampian could do better

During our inspection, we saw an inconsistent approach to completing standard infection prevention and control audits. In some areas, we saw multiple audits being completed and in one area we saw gaps for a long period of time. Staff we spoke with were unclear on what the standard approach was and what they were expected to do. All staff were completing hand hygiene audits monthly, however, not all staff said they would upload this information to the electronic portal as described to us by senior management. We raised this with the NHS board at our discussion session and senior managers told us that the audit process is currently under review to both provide clarity and reduce the burden on staff.

- **Requirement 3:** NHS Grampian must ensure there is a systematic programme of audits in place, this is clearly communicated to ward staff and they clearly understand their role in this process.

Senior management explained that nursing line management structures differ between the two Health and Social Care Partnerships of Aberdeenshire and Moray. Moray has a line management structure where the senior charge nurse reports to the service manager who is also a nurse. Aberdeenshire has an operational location manager and a clinical professional lead nurse for nursing matters. We were told that these structures are the mechanism for staff to discuss and review ward audits, education compliance and any other clinical or professional issues.

We were told in the Moray hospitals that all nurses in charge meet once a month with their service manager to discuss audit results. We were told of a shared governance structure with clear roles and responsibilities. In the Aberdeenshire hospitals, senior charge nurses told us that they met regularly with the operational location manager and have direct links available to the lead nurse if necessary.

Staff in Aberdeenshire reported that although meetings were in place with operational managers and they felt supported by these, audit and education compliance was not always discussed. In one area we inspected, it was unclear if the lead nurse had oversight of ward infection control audit results, as we saw that one ward had not completed any audits for 11 months and this had not been raised with the ward. We did not see evidence that audit results or training compliance are discussed as part of these regular meetings. We were told audit results and training compliance are only discussed if an issue has been identified, however, staff spoken with were not clear this was the case.

We were told that bi-monthly healthcare associated infection group meetings take place. Part of these meetings is to review any local audit results and training compliance. Sector reports are produced from this meeting and are shared at the infection control committee meeting. The healthcare associated infection meeting minutes we reviewed do not clearly demonstrate this process.

- **Requirement 4:** NHS Grampian must ensure that leadership and executive teams see all audit results so as to provide assurance, drive improvement and communicate any remaining risks.
- **Recommendation a:** NHS Grampian should continue to review the current structure in place to support staff in Aberdeenshire to communicate audit and training results to senior staff in a regular, agreed and consistent way.

Standard 8: Decontamination

What NHS Grampian did well

During our inspection, we saw a generally good standard of environmental cleanliness throughout all nine hospitals. Any exceptions were raised at the time of the inspection. We saw clearly defined roles specified for both domestic and nursing staff on bed space cleaning checklists. During the inspection, we looked at a range of patient equipment across all nine hospitals, including patient monitoring equipment, commodes, dressing trolleys and intravenous pumps and stands. We also looked at the patient bed spaces. The majority of patient equipment was generally clean and any exceptions were raised at the time of the inspection. Cleaning schedules were kept at each bedside and detailed who was responsible for each task. We also saw mattress checking schedules. We were provided with evidence throughout wards of

local assurance systems for the maintenance and cleanliness of mattresses, cushions and beds.

Domestic staff described the correct cleaning products they would use on sanitary fittings. They told us they had a good supply of cleaning material. They described a good working relationship with the nursing staff and domestic staff felt very much part of the overall team. We saw domestic staff use a cleaning schedule.

Nurses in charge told us that they would escalate to the domestic supervisor any issues about the standard of environmental cleaning. Domestic staff told us that they would verbally hand over any outstanding work or they would record this in their own handover notebook for the next shift coming on duty.

Domestic staff across all nine hospitals described different levels of domestic staffing resource in place. Some staff reported that extra resource had been deployed to cover afternoons and both domestic and nursing staff had noticed a difference. In other areas, staff described some challenges, for example where no regular weekend domestic cover was available. Staff said this impacted on nursing time as nurses would pick up on duties normally carried out by domestic staff. Senior managers told us that current resources are being reviewed.

NHS boards are required to monitor water safety to reduce the risks associated with water borne infections such as Legionella. To reduce the risk of Legionella, there should be regular flushing of unused or less frequently used water outlets. Across all hospitals, staff were aware of their responsibilities regarding flushing. We were provided with comprehensive water flushing regimes for all outlets. We saw a large number of unused water outlets across all hospitals. We were told by estates management and the infection prevention and control team that longstanding, unused outlets need to be reviewed and be considered for removal.

The infection prevention and control team told us about plans to introduce a process as part of ongoing audits that will ensure continued compliance with water flushing while these outlets are being considered for removal.

What the NHS board could do better

In all nine hospitals inspected, we saw some issues with the fabric of the building. Some of these issues would not allow for effective cleaning and decontamination. We noted that all the issues had been reported to the estates team. We saw:

- broken sealant around toilets, sinks and showers
- broken surfaces on wooden doors and window frames
- loose laminated flooring and skirting

- tape on damaged flooring
- missing ceiling panels in a patient waiting area
- water ingress on ceiling tiles and in patient conservatory areas, and
- damage to floors caused by water ingress.

All of these issues had been reported by ward staff to the estates team. We were told of staff reporting estates issues in a variety of ways. For example, we saw staff using written logs as well as an electronic system. This meant that in some areas there were estate issues that had been signed off as completed although they remained outstanding. In other cases, we saw estate jobs that had been reported in duplicate. We also found in some areas estates reporting systems that indicated some jobs had been outstanding for a long period of time with no planned update.

We were provided with the percentages for the facilities monitoring tool audits and found these scores were high with some showing 100% in areas we identified as having significant areas in need of repair.

During our discussion session, the NHS board told us that facilities monitoring tool audits are currently carried out by domestic supervisors with no estates and senior charge nurse involvement. The estates manager told us they rely on the senior charge nurse to report any issues identified from these audits. However, we were told that senior charges nurses do not receive a copy of the facilities monitoring tool audit results for their area. Therefore this assurance system is currently generating unreliable results. NHS Grampian told us it plans to review this with a view to involving estates in the process and providing focused training for the staff carrying out these audits. The NHS board will also consider, where possible, to introduce senior charge nurses to the process to highlight areas that may need immediate attention.

In one hospital we saw dusty ceiling vents and were told that the estates team did not currently clean ceiling vents. These vents were in different patient areas including above patient bed spaces. During our discussion session, we were told that there is a rolling plan of maintenance and cleaning schedule for these vents and that staff changes have meant this has not happened. We have been assured that this will be re-instated immediately. We will follow this up at future inspections.

- **Requirement 5:** NHS Grampian must ensure the built environment is maintained, including ceiling vents, to allow effective cleaning and to minimise cross-infection to patients, staff and visitors.
- **Requirement 6:** NHS Grampian must ensure there are robust reporting and escalation procedures in place to deal with issues regarding the built environment.

- **Recommendation b:** NHS Grampian should ensure staff carrying out facilities monitoring tool audits are appropriately supported and trained to do so.

All of the 32 patients, relatives and carers who completed our questionnaire described their ward as 'always' clean and that the equipment used by staff for their care was clean. Some patients we spoke with or who responded to our survey said the following.

Fleming Hospital:

- 'Cleaners in daily, at a time that suits me so as not to disturb me.'

Jubilee Hospital

- 'Place is spotless, couldn't ask for better.'
- 'Very happy with cleaning, best place I have seen and would have the cleaners in my own house.'

Kincardine Hospital:

- 'Everything very clean, cleaned every day.'

Seafield Hospital:

- 'Hoist cleaned every time.'

Turner Hospital:

- 'Reminded to wash hands regularly.'

Appendix 1: Requirements and recommendations

The actions Healthcare Improvement Scotland expects the NHS board to take are called requirements and recommendations.

- **Requirement:** A requirement sets out what action is required from an NHS board to comply with the standards published by Healthcare Improvement Scotland, or its predecessors. These are the standards which every patient has the right to expect. A requirement means the hospital or service has not met the standards and we are concerned about the impact this has on patients using the hospital or service. We expect that all requirements are addressed and the necessary improvements are made.
- **Recommendation:** A recommendation relates to national guidance and best practice which we consider a hospital or service should follow to improve standards of care.

Standard 2: Education to support the prevention and control of infection	
Requirements	HAI standard criterion
1 NHS Grampian must ensure staff are aware of NHS Grampian's mandatory infection prevention and control education requirements (see page 9).	**2.2**
2 NHS Grampian must be able to evaluate the uptake of infection prevention and control training in order to respond to any unmet education needs (see page 9).	**2.5**
Recommendation	
None.	

Standard 6: Infection prevention and control policies, procedures and guidance		
Requirements		HAI standard criterion
3	NHS Grampian must ensure there is systematic programme of audits in place, this is clearly communicated to ward staff and they clearly understand their role in this process (see page 11).	**6**
4	NHS Grampian must ensure that leadership and executive teams see all audit results so as to provide assurance, drive improvement and communicate any remaining risks (see page 12).	**6.9**
Recommendation		
a	NHS Grampian should continue to review the current structure in place to support staff in Aberdeenshire to communicate audit and training results to senior staff in a regular, agreed and consistent way (see page 12).	

Standard 8: Decontamination		
Requirements		HAI standard criterion
5	NHS Grampian must ensure the built environment is maintained, including ceiling vents, to allow effective cleaning and to minimise cross infection to patients, staff and visitors (see page 14).	**8.1**
6	NHS Grampian must ensure there are robust reporting and escalation procedures in place to deal with issues regarding the built environment (see page 14).	**8.4**
Recommendations		
b	NHS Grampian should ensure staff carrying out facilities monitoring tool audits are appropriately supported and trained to do so (see page 15).	

Appendix 2: Inspection process flow chart

We follow a number of stages in our inspection process.

Before inspection

The NHS board undertakes a self-assessment exercise and submits the outcome to us.

We review the self-assessment submission to help us prepare for on-site inspections.

Before

During inspection

We arrive at the hospital or service and undertake physical inspection.

We use inspection tools to help us assess the physical environment and compliance with standard infection control precautions.

We have discussions with senior staff and/or operational staff, people who use the hospital or service and their carers.

We give feedback to the hospital or service senior staff.

We carry out further inspection of hospitals or services if we identify significant concerns.

During

After inspection

We publish reports for patients and the public based on what we find during inspections. NHS staff can use our reports to find out what other hospitals and services do well and use this information to help make improvements. Our reports are available on our website at **www.healthcareimprovementscotland.org**

We require NHS boards to develop and then update an improvement action plan to address the requirements and recommendations we make. We check progress against the improvement action plan.

After

More information about our inspections, methodology and inspection tools can be found at www.healthcareimprovementscotland.org

You can read and download this document from our website.
We are happy to consider requests for other languages or formats.
Please contact our Equality and Diversity Advisor on 0141 225 6999
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REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 28 NOVEMBER 2019**

SUBJECT: **CARE INSPECTORATE THEMATIC REVIEW ON SELF-DIRECTED SUPPORT**

BY: **JANE MACKIE, CHIEF SOCIAL WORK OFFICER/ HEAD OF SERVICE STRATEGY AND COMMISSIONING**

1. REASON FOR REPORT

1.1 To inform the committee of outcome relating to the recent Care Inspectorate Thematic Review on Self-Directed Support.

2. RECOMMENDATION

2.1 It is recommended that the Clinical and Care Governance Committee:

i) notes the outcome of the recent thematic review; and

ii) approves the associated implementation action plan included in APPENDIX 3.

3. BACKGROUND

3.1 The Social Care (Self-Directed Support) (Scotland) Act 2013 came into force on 1 April 2014, with a national implementation plan for 2019-2021 and change map introduced this year, both of which form part of the national 10 year strategy for Self-Directed Support (SDS).

3.2 Moray were early adopters of the ethos and principles which underpin the legislation, undertaking a pilot project in 2012 prior to enactment of the legislation. It is acknowledged that full implementation of SDS is integral to the adult social care reform programme, with SDS running through all its work streams.

3.3 Under Part 5, section 56(3) of the Public Services Reform (Scotland) Act 2010 and associated regulations, the Care Inspectorate led on the thematic review of SDS, supported by Healthcare Improvement Scotland.

3.4 Moray were one of six partnership areas where the inspection aimed to:

- Provide an evidence based assessment of SDS implementation, measurement and quality assurance of SDS delivery and compliance with the principles and values within both the Self-Directed Support: A National Strategy for Scotland and the Social Care (Self-Directed Support) (Scotland) Act 2013 implemented on 1st April 2014.

- Ensure findings from the joint inspection activity would be examined by key stakeholders to consider and inform the opportunity for a future programme of supported self-evaluation across Scotland in all the areas not subject to the inspection.

- Give public assurance that social care and social work in Scotland is rights-based and world-class, through robust and independent scrutiny and improvement processes.

3.5 The scrutiny was conducted using seven quality indicators:

- Key performance outcomes
- Getting support at the right time
- Impact on staff
- Delivery of key processes
- Policy development and plans to support improvement in services
- Management and support of staff
- Leadership and direction that promotes partnership

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 In July 2018 a self-evaluation was undertaken to allow a current position statement with supporting documentation to be submitted to the Care Inspectorate prior to the on-site inspection which took place in October 2018. **(APPENDIX 1)**

4.2 The on-site inspection consisted of social work case file reading, service user and carer interviews along with a variety of focus groups ranging from Social Work staff, Senior Management, Partner Providers, Service Users and Unpaid Carers.

4.3 Individual inspection reports for each partnership area alongside the national report were published in June 2019 **(APPENDIX 2)**

4.4 Moray received a positive inspection with the report highlighting that the partnership had made significant progress in implementing SDS, with most people experiencing choice and control in how their personalised budgets were utilised. This has resulted in individuals achieving positive personal outcomes. The grading from the inspection showed:

Key Performance Outcomes	Grade

Supported people experience positive personal outcomes through the implementation of Self-Directed Support	Good
Supported people are empowered and have choice and control over their social care and support	Good
Staff feel confident, competent and motivated to practice in an outcome-focused and person-led way	Good
Key processes and systems create conditions that enable supported people to have choice and control	Good
The partnership commissions services that ensure supported people have a range of choice and control over their social care and support	Good
The partnership empowers and supports staff to develop and exercise appropriate skills and knowledge	Adequate
Senior leaders create conditions that enable supported people to experience choice and control over their social care and support	Good

4.5 It was highlighted that the partnership has a "well-established approach to managing the public's access to information and social care supports and services". In turn this generally provided an effective approach to signposting and early interventions and prevention. The Moray Partners in Care approach (3 tier policy) alongside SDS encouraged greater level of strategic engagement between HSCP, third sector and community supporting the development of early intervention and prevention agenda.

4.6 The 3 tier policy provided a good structure for the principles and values of SDS to become embedded in daily practice, with assessment and support plan documentation reflecting the principles of SDS.

4.7 Staff showed a "solid understanding of the values and principles of SDS" with the majority of staff reporting they felt motivated and supported by management to work in a personalised way. "The SDS team was a valued and important source of support", with members of the team being "highly motivated and knowledgeable about SDS".

4.8 The report highlighted the effort by the partnership to understand, develop and implement SDS from early on, which "demonstrated commitment and innovation in seeking to provide and deliver flexibility, choice and control" for individuals. The approach taken to stimulate the market to provide choice and control was praised in the report through the development of micro providers within the local communities.

4.9 Senior Social Work leaders were praised for their commitment to the values and principles of SDS and the partnerships continued commitment to further embed SDS noted.

4.10 There were several key recommendations from the inspection which has formed a local implementation action plan. Recommendations included to

review processes enabling to robustly record, measure and report on personal outcomes and to review recording of discussions with individuals relating to SDS. Further recommendations included to review the role of advocacy, to develop health colleague's knowledge of SDS in conjunction with the implementation of a learning and development strategy. This plan has been shared with the Care Inspectorate in response to the report **(APPENDIX 3)**

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019

The partnership has made a commitment to embed and further develop SDS as a means of promoting independent living and equalities. The Moray Strategic Plan has the principles of SDS through many of the key outcomes. One key area of focus for the partnership is continuing implementation of enabling approaches such as SDS.

(b) Policy and Legal

The partnership has a legal duty under the Social Care (Self-Directed Support) (Scotland) Act 2014 to promote the values and principles of SDS.

(c) Financial implications

The partnership has received a commitment of funds from Scottish Government for the financial years 2019/20 and 2020/21 to progress with the SDS agenda. The impact and learning gained from the financial investment needs to be evidenced.

(d) Risk Implications and Mitigation

There are no risks identified to the partnership.

(e) Staffing Implications

There are currently no staffing implications associated with the report.

(f) Property

There are no implications in relation to property or accommodation.

(g) Equalities/Socio Economic Impact

There is no requirement for an equalities impact assessment as there are no negative impacts identified. Through the continued commitment to embed SDS within the partnership, the recommendations are expected to promote equality and opportunity for the following groups: age, disability.

(h) Consultations

Consultations have taken place with Chief Social Work Officer/ Head of Service, Interim Head of Integrated Children Services, Chief Financial Officer, Commissioning and Performance Manager, Equal Opportunities Officer, Robin Paterson, Senior Project Officer; Dafydd Lewis, Senior Auditor who are in agreement with the content where it relates to their area of responsibility..

6. CONCLUSION

6.1 **This report informs the Clinical and Care Governance Committee of the recent Care Inspectorate Thematic Review of SDS and identifies the**

recommendations and actions arising from the review in the form of the SDS Implementation Action Plan (APPENDIX 3)

Author of Report: Michelle Fleming, Self-Directed Support & Carers Officer
Background Papers:
Ref:

Appendix 1

POSITION STATEMENT FOR THE THEMATIC REVIEW OF SELF-DIRECTED SUPPORT IN HEALTH & SOCIAL CARE MORAY

Partnership Relationships in the area

Health & Social Care Moray (H&SCM) has long lasting and effective working relationships with a wide range of independent, private and voluntary organisations across the Moray local authority area. In total H&SCM are involved in commissioning services relating to SDS ranging from Care Providers through to Micro-Enterprises, some on the commissioned framework, others off framework, commissioned through option 2 of SDS.

The strength of the Partnership is also reflected in the membership of our Integration Joint Board (IJB). This includes informal carers, TSI Moray (third sector interface) and Public Participation Forum (PPF) representatives.

Our summary at the end of this submission explains our SDS journey to date.

Scope of integration / delegated responsibilities

H&SCM has been established as a Body Corporate (i.e. a separate legal entity from either the Council or the Health Board), with responsibility for its governance resting with the IJB.

It has responsibility, primarily, for a range of Health and Social Care functions relating to adults (18 years and over) and is responsible for the strategic planning of integrated services.

As identified in the Moray Integration Scheme, the Adult Social Care functions that the IJB has responsibility for are as follows:-

- Social Work Services for Adults and Older People;
- Services and Support for Adults with Physical Disabilities and Learning Disabilities;
- Mental Health Services;
- Drug and Alcohol Services;
- Adult Protection and Domestic Abuse;
- Carers Support Services;
- Community Care Assessment Teams;
- Support Services;
- Care Home Services;
- Adult Placement Services;
- Health Improvement Services;
- Aspects of Housing Support, including aids and adaptions;
- Day Services;
- Local Area Co-ordination;

- Respite Provision;
- Occupational Therapy Services; and
- Re-ablement Services, Equipment and Telecare.

As identified in the Moray Integration Scheme, the Adult Health functions that the IJB has responsibility for are as follows:-

- Accident and Emergency;
- Geriatric Medicine;
- Palliative Care Medicine;
- General Medicine;
- Rehabilitation Medicine;
- Renal Medicine;
- District Nursing and aspects of Health Visiting that relate to adults;
- Clinical Psychology;
- Addiction Services;
- Women's Health Services including Family Planning;
- Allied Health Professionals;
- GP Out of Hours Services;
- Public Health Dental Services;
- Continence Services;
- Home Dialysis;
- Health Promotion;
- General Medical Services;
- Pharmaceutical Services – GP prescribing; and
- Community Mental Health and Community Learning Disability Teams.

Level of resources available to deliver SDS

The detailed table (listed below) outlines Moray Council's resources allocated to Self-Directed Support:

Element	Element Description	Gross Annual Budget 2018/19 (£)	Income Budget (£)	Net Annual Budget (£)
YBM57	MH Day Care	0	(4,000)	(4,000)
YBM58	MH Domiciliary Care	93,569	(18,500)	75,069
YM320	LD Care Purchased	5,427,279	(293,081)	5,134,198
YBM89	MH Contracts	1,312,947	0	1,312,947
YM340	LD Contracts	6,635,645	(441,430)	6,194,215
YD228	Chandlers VSH	224,155	0	224,115
YT761	Hanover SH	222,182	(176,510)	45,672
YT762	Castlehill SH	49,783	(26,000)	32,783
YT768	Varis Court	476,571	0	476,571
YT930	Area Team East	1,967,124	(87,081)	1,880,043
YT940	Area Team West	3,758,276	(187,334)	3,570,942
YE502	OT Aids	0	0	0 (Excluded)
	Total	20,167,531	(1,233,936)	18,933,595
YT777	Provider Services	14,544,671	(412,738)	14,141,933
YE503	OT Joint Store	173,046	0	173,046 (Excluded)
YM200	Employability	541,831	(28,500)	513,331 (Excluded)
	Total	**34,007,325**	(1,618,174)	32,389,151
YM310	LD Staffing	542,135		
YBM80	MH Staffing	587,170		
YT930	East Team Staffing	486,925		
YT940	West Team Staffing	690,911		
YH901	HFH Staffing	305,170		
YT920	Access Team Staffing	506,534		
YM106	SDS Team Staffing	144,572		
	Total	**3,263,420**		

The overall budget for H&SCM is £113m. We have included our block funded contracts which are currently under review, and external purchasing budgets. We

have included for your information the staffing budgets, representing the staff group that are involved in assessment and support planning. We have included our in-house provided services involved in the delivery of care and support to people. Also included is the staffing team specifically supporting SDS and particularly Option 1.

The deployment of the SDS approach is supported by the SDS Team which has five members of staff. Since the inception of SDS, this Team has developed significant knowledge and expertise in supporting the multi-disciplinary teams, Service and Team Managers in delivering SDS.

The SDS Team provides an advisory service in terms of recruitment of staff (e.g. Personal Assistants), employment law and financial record keeping. The Team also work to raise awareness of SDS by presenting to internal and external audiences. This includes presentations to HNC/D Social Care students at Moray College UHI and to the Learning Disability Forum.

What is able to be provided through SDS

H&SCM is committed to supporting people to find innovative and creative ways in which the 4 SDS options can be fully utilised. H&SCM will always operate within the parameters that SDS activities meet the agreed personal outcomes as stated in the Support Plans, are legal and meet the eligibility criteria.

Quality Indicator 1 - Key performance outcomes

1.2- Improvements in the health and wellbeing and outcomes for people, carers and families.

EVALUATION – 4/5

A key strength in supporting people to secure better health and wellbeing outcomes is the adoption of the talking points approach when discussing what is important to them and for the people they care for. This assets based approach is underpinned by Support Plans where the personal outcomes are stated and reviewed with the person and/or their carer on a timely basis. This approach has been successfully deployed across all service areas.

The adoption of this approach allows both quantitative and qualitative data to be captured and analysed by the Social Worker (or another Health & Social Care Professional) on a timely basis. H&SCM can demonstrate the effectiveness of this approach by presenting a sample of case studies, performance data from CareFirst that gives examples of the personal outcomes met, partially met and not met.

The SDS Team circulate an annual 'SDS Survey'. The last survey results were returned in January 2017 and as noted in the attached evidence was overwhelming positive. The SDS Survey has more recently been distributed for completion to Direct Payment recipients in July 2018.

In terms of areas for improvement, the Adult Community Care Performance Management Group are presently reviewing their operational performance indicators and are keen to explore how SDS and personal outcome data can help improve commissioning. The Learning Disability Transformation Project is testing a new model of contract monitoring that will improve personal outcomes.

Evidence presented to support the above comments:-

1.2.1 Annual SDS Survey (Direct Payments) Results 2017
1.2.2 SDS Good News Stories
1.2.3 Extract from Monthly Management Performance Report (May 2018) – SDS Options Selected
1.2.4 Sample Personal Outcomes that have been met, partially met or not met (extract from the annual report)

Quality Indicator 2 – Getting support at the right time

2.1- Experience of individuals and carers of improved health, wellbeing, care and support

EVALUATION – 4

Achieving a good conversation with the person receiving a service (based on a talking points approach) depends on the person knowing what the purpose of the Support Plan is for and the nature of the different SDS options that they can choose from. This is supported by a leaflet which is offered to service users and informal carers ensuring that that all people either have a name of a social care professional or a team to contact if they have any questions.

The Support Plan asks if the person is satisfied with the information provided in developing and reviewing their personal outcomes. This is also evidenced in the support plan review forms.

Moray Council operates a Contributions Policy to allow financial assessments to be undertaken looking at budget and spend rather than hours of delivery. Following the social workers assessment and development of support plan, the service user is provided with information in relation to the Contributions Policy and the financial assessment process undertaken by Community Care Finance. The service users have access to the Non-residential Care and Support Financial Assessment Process information booklet.

Complaints are approached by staff at all levels of H&SCM in a constructive way, regarded as an opportunity for learning, reflective practice and continuous improvement.

Should any individuals require additional support in relation to expressing their views and having their voice heard, Moray Council has a contract with Circles Network Moray which is an independent Advocacy Service. In addition, where an individual may have concerns or issues in relation to the support they are receiving, Circles would be able to support them in taking this concern forward.

One key area for improvement that H&SCM are focusing on is capturing case studies, including carers, across all service areas and SDS options. These case studies will be used for training purposes and the continuous improvement of service delivery.

Evidence to support the above comments:-

2.1.1 SDS Good News Stories
2.1.2 Circles Advocacy - Link to Moray Council Information regarding Circles (the Circles website is in the process of being updated at present – due to go live mid-August 2018)
2.1.3 Annual SDS Survey Results (Direct Payments) 2017
2.1.4 Support Plan and Review Template
2.1.5 Non-residential Care and Support Financial Assessment Process

2.2- Prevention, early identification and intervention at the right time.
EVALUATION – 5
H&SCM have developed a conceptual framework for the delivery of services. This is called the Moray Partners in Care (3 Tier Model) and underpins how SDS options are delivered.

At the heart of this model is an asset based/talking points approach where people are considered to be the active agents in securing their own health and well-being rather than being reliant on the expert knowledge of social care and health professionals. Central to this new relationship is the notion that an outcome based conversation should take place.

- Tier 1 - Help to help you (information and advice), universal services to the whole community and an emphasis on prevention.
- Tier 2 - Help when you need it (immediate help in a crisis, re-ablement) and regaining independence.
- Tier 3 - Ongoing support through one of the Self-Directed Support options.

These three Tiers are underpinned by the following key principles:

Principle 1: The provision of Social Care Services is not the first response. The provision of information has an important role to play in supporting more people to live independently and to make full use of the resources that a local community can offer.

Principle 2: The conversation is at the heart of what we do. Identifying positive outcomes that matter to people is based on a conversation. This level of engagement is the essential first step in delivering an outcomes based service.

Principle 3: Promoting Independence. Consistent with a preventive approach, the role of Moray Adult Community Care Service should always be to focus on empowering the service user. In particular this principle is evident in the emphasis on re-ablement, recovery or progression.

Principle 4: Providing Choice and Control. The new model embraces Self-Directed Support. If people require on-going support, Care Officers will help people identify which of the SDS options would best suit their needs.

Principle 5: Improving People Outcomes. This 3 Tier model aims to provide clarity in terms of our core process thereby reducing bureaucracy, minimising delays in providing services and improving outcomes for service users and carers. In practical terms, it means that people typically would not consider Tier 2 and 3 until their outcomes have been fully explored at Tier 1.

The 3 Tier approach and specifically Tier 3 demonstrates that SDS is integral to how we deliver ongoing support and use the talking points approach to support this aim.

This model is also the basis of a dedicated Access Team. This is often the first point of contact for people wishing to access support. Consistent with Tier 1, the Access Team will aim –where appropriate- to identify alternatives to Health and Social Care

intervention. This may be groups or clubs in the person's local area if it is considered that social isolation is an issue. Additionally the Community Wellbeing Development Team develops and support community groups to become self-sustaining. They are working with for example Dance North Scotland to support their SET Groups (Singing, Exercise and Tea Groups), Ball Groups – not only supporting Tier 1 support services but also individuals with an SDS budget are accessing this with assistance from a support worker, Boogie in the Bar – individuals from care homes, sheltered housing etc are invited and attend these events.

The Access Team is usually the first point of contact for individuals who are not already in receipt of services, who are seeking guidance and assistance in relation to their care and support. The Team comprises of various professional groups including First Contact Advisors, Social Workers, Occupational Therapists and Health Professionals (nurses). The First Contact Advisor's primary function is to signpost individuals to the community based assets which may provide them with the support they require in the first instance. The role of the Team is important as it is trying to promote independence through the use of these community based assets without the need to draw individuals into services. When it is identified that individuals require a Tier 2 service or early intervention, the Access Team will consider re-ablement or crisis intervention, generally over a 12 week period before considering whether a Tier 3 service is required. The Access Team also liaise closely with all teams and along with Link Workers will help to ensure that the right type of support (SDS or otherwise) is provided at the right time when a Tier 3 service is required.

In relation to Mental Health Services, a recent example of this type of Tier 1 (early intervention) support is provided by the Wellbeing Hubs that Penumbra have been commissioned to provide. This service also complements psychological therapy support which has been funded through the NHS.

Areas for improvement would include continuing to explore with our third sector colleagues how we can support more community based groups to be self-sustaining.

In relation to learning disabilities, people who receive a service also identified that being able to access 'mainstream' community groups and clubs is an issue for them that affect their quality of life.

Evidence to support the above comments:-
2.2.1 The Moray Partners in Care (3 Tier Policy)
2.2.2 Penumbra Well-being Hub Specification/Evaluation
2.2.3 Open Space Event Evaluation

2.3- Access to information about support options including Self-Directed Support.
EVALUATION – 4
H&SCM have a range of different ways in which people can access information about SDS.
As previously noted, the primary method by which people access information about SDS options is face to face through their social worker or health care professional.

This information establishes the foundation for the talking points conversation and establishing the mutually agreed personal outcomes.

All teams make use of a comprehensive range of SDS leaflets. In total there are six leaflets that in addition to providing a general introduction to SDS, cover the key elements of SDS. These leaflets are:-

- Here to Help You (an overview leaflet)
- Option 2 Individual Service Funds
- Unpaid Adult Carer
- Support Package
- Personal Assistant Handbook
- Information cards that cover option 1/Direct Payment Information, Initial Information Handout and Employer Information

In addition, the SDS Team circulate a quarterly newsletter for service users and informal carers and have, in partnership with TSI Moray, developed a 'PA Finder website'. An outline of the SDS options and who to contact can also be found on the Moray Council website.

We held an information session called SDS 'the journey so far' event in September 2016 which allowed for shared stories highlighting the ups and downs of people who received SDS. IRISS were contributors as they were launching their co-designed four pathways. This was followed up with a market place event for providers to showcase their provision and allow people within the community to see what paid and unpaid services were on offer in their local areas.

One area for improvement would be for the partnership to make better use of Social Media in terms of providing information on SDS options and other forms of support. In respect to other forms for service provision, H&SCM are beginning to secure many benefits from utilising this channel. An area for improvement would be the translation of the above leaflets into more accessible formats. Although there has been no requests for this information in these formats, it is acknowledged that this is task is outstanding. It is also acknowledged that it is possible that better use of leaflets could be made by ensuring a more rigorous approach to their circulation.

Evidence to support the above comments:-

2.3.1 SDS Leaflets
2.3.2 Sample of SDS Newsletter
2.3.3 The SDS Webpage @ moray.gov.uk
2.3.4 PA Finder Leaflet and website www.supportinmoray.co.uk

Quality indicator 3 - Impact on staff

3.1- Motivation and support
EVALUATION – 5

The evidence collated through analysis of high level outcome data (including the up-take of the full range of SDS options) and feedback given to Team Managers and Service Managers through supervision sessions demonstrates that there is a good understanding and commitment to the adopting an SDS approach and adhering to its underpinning principles of choice and independent living.

In addition to the support provided through regular staff supervision, a SDS Panel was established to support SDS. These meetings took place on a weekly basis and were established at an early stage of adopting an SDS approach. Over the years, the need for this group has reduced following the growth of staff confidence and the ability of team managers to address questions.

In terms of Integrated Learning Disabilities, as part of the whole systems transformational change programme, a series of workshops were delivered throughout 2017/18 with Alder Advice to explore how better outcomes could be achieved for people in the context of the Progression Model.

Whilst workshops were held several years ago with Health colleagues, led by Allie Cherry who was the National Lead looking at SDS in Health, one area for improvement would be to continue to roll out SDS awareness in a multi-disciplinary context.

Evidence to support the above comments:-

3.1.1 Terms of Reference for Integrated Learning Disability Team Meeting (Guidance)

3.1.2 Terms of Reference for the SDS Panel (Guidance)

Quality indicator 5 – Delivery of key processes

5.1- Access to support
EVALUATION – 5

The Access Team Manager monitors the Tier 1 conversations and activity through first contact referrals, and all Team Managers are responsible for authorising and monitoring the Tier 2 support plans developed by their teams.

As noted in section 2.2, H&SCM's response is informed by our Partners in care/ 3 tier model. It is only when Tiers 1 and 2 have been explored, and usually following a period of re-ablement/recovery/progression/skills development that we move to an offer of support at Tier 3, which is delivered though Self-Directed Support.

Moray uses a Resource Allocation System (RAS) which identifies an **indicative** budget. Once this is established, the person is able to identify how they wish to use it. This RAS is calculated through completion of the Supported Self-Assessment Questionnaire, initially developed by In Control. We would stress that the figure generated is an indicative budget. It offers an indication of what the person's allocation of the overall budget would be. We are confident that it is set at a level that most people should be able to make good choices over how it is spent. This level is reviewed annually to check this out. However we also understand that there are situations when adjustments are required, for example when two to one care is required, or if the person has very high care and support needs.

The effectiveness of this process is considered at the SDS Steering Group which meets every second month throughout the year.

CareFinancials is in the process of being implemented with the online personal budget calculator (RAS calculator) available for use now.

Where an individual has chosen Option 1 as their desired route of SDS, the SDS Team have a duty through the use of the CIPFA Guidance to undertake regular financial reviews. These reviews are undertaken to ensure that the individual is managing their Direct Payment accordingly in line with Financial Regulations and SDS Legislation. The Team monitor as to whether the individual has successfully been able to meet their outcomes through this option of SDS. Through the close working relationship that the Team has with the Social Work Teams, this information is shared prior to the annual care review taking place to allow for further discussion to take place with the individual.

Areas for improvement would include conducting a focus group with staff and people who use our service. This would be informed by the SDS Survey and, as part of the current performance management review, used to establish a number of appropriate service standards for the completion of assessments and support plans.

Evidence to support the above comments:-
5.1.1 Annual SDS Survey (Direct Payments) Results 2017
5.1.2 Financial Monitoring Procedure

5.2- Assessing need, planning with individuals and delivering care and support
EVALUATION – 4
An asset based approach is followed throughout the organisation and varies in each service area. Within the Mental Health Team, their focus is based on recovery. Within the Learning Disability Team, the Progression Model is followed and within Older People and Physical Disability a re-ablement focus is adopted.

It is acknowledged that SDS is wider than the four options and looks at what is available in the community and bases these community assets at the centre of any discussions. In keeping with the National Guidance at the time of support planning for SDS, individuals and their social worker would also explore the use of ordinary community based activities available to everyone. Despite having an allocated budget, individuals and social workers would explore the use of these resources to meet their outcomes.

In relation to the Integrated Learning Disability Service, a new Care, Support and Treatment Plan (CSTP) has been adopted to reflect the integrated assessment undertaken by the team, identifying individual health and care outcomes. This is a key part of the Progression Model approach which has been adopted by this service. One of the benefits of this approach is that contract monitoring and commissioning can be based on personal outcome data.

The effectiveness of our key process is evidenced through high level performance data (ASPMG monthly performance charts), supervision notes, Learning Disability Resource Allocation Meeting (RAM) minutes and file audits.

One area of improvement that the Learning Disability Transformation Project is addressing the development of a more robust process where personal outcome data will inform the strategic commissioning and contact monitoring process. The challenges in achieving this are not underestimated but when an effective system is established, the learning from implementing this approach can be mainstreamed across all service areas. Having NHS Grampian learning disabilities resources delegated to the Moray IJB and needing to move away from older block funded contracts provides an ideal opportunity to develop our skills and expertise in this area to share more widely.

Another area for development is the generation of appropriate operational service standards for the completion of key SDS tasks. These measures are currently being considered by the H&SCM Performance Team.

Evidence to support the above comments:-
5.2.1 The Learning Disability Transformation Project Initiation Document
5.2.2 Care Support and Treatment Plan Template
5.2.3 SDS Questionnaire

5.3- Shared approach to protecting people who are at risk of harm, assessing, managing and mitigating risk.
Evaluation 5
A Risk Assessment Screening Tool is completed as part of any area of work undertaken in Adult Services, and the process of completing a support plan involves

a consideration of risk. Positive risk taking is encouraged and has been underpinned by training and learning and development activities. This is supported through staff supervision sessions. Where necessary and appropriate, complex or multi-agency risk assessments are completed. Adult Protection, Mental Health and Adults with Incapacity legislation is used where appropriate and required.

When significant risks are identified and statutory duties of care are potentially compromised then those risks are captured on the service risk register. The risk register is reviewed by managers and is tabled as an agenda item at the Practice Governance Board. The regular meetings of this group are also used to disseminate organisational learning and best practice to staff.

Risk Management is supported by three Consultant Social Work Practitioners. The Consultant Practitioners provide mentoring and guidance and support to staff when a high risk is identified, and have delivered staff development sessions on risk enablement.

Areas for improvement include continuing to explore the varying degrees for accepting positive risk enablement by different staff members. This difference is also sometimes compounded with the use of different risk recording systems (the NHS use DATIX while the Council use CareFirst). Progress is being made in addressing these organisational cultural issues through on-going training.

Evidence to support the above comments:-
5.3.1 Risk Assessment Screening Tool Template
5.3.2 Positive Risk Taking Workshop PPT
5.3.3 Adult Social Care Practice Standards and Quality Assurance Procedure

5.4- Involvement of individuals and carers in directing their own support
EVALUATION – 5
Our approach acknowledges that individuals are the experts in their own lives. This is reflected in the format of the Support Plans with its focus on articulating, negotiation and agreeing with the person their personal outcomes before the SDS option can be adopted. The person's choice of option is clearly identified in the support plan, and monitored through the monthly Adult Services Performance Management Group.

The personal outcomes data considered by the Adult Services Performance Management Group and the SDS Support Survey indicate the effectiveness of this approach.

Since the implementation of the carers act on 1 April 2018, 50 Assessments for informal carers to be considered for an SDS budget in their own right have been received (as of 13th July 2018).

An area for improvement is providing more opportunities for service users and informal carers to provide feedback on the quality of the service or support they receive. This could be the purpose for more focus groups.

Evidence to support the above comments:

5.4.1 Annual SDS Survey Results (Direct Payments) 2017
5.4.2 SDS Good News Stories
5.4.3 Extract from Monthly Management Performance Report (May 2018) – SDS Options Selected
5.4.4 Template of Support Plan
5.4.5 Sample personal Outcomes that have been met, partially met or not met

Quality Indicator 6 – Policy development and plans to support improvement in service

6.1 – Operational and strategic planning arrangements.
EVALUATION - 5
The Moray Partners in Care (3 Tier) Policy presents a coherent set of high level principles for the implementation of SDS across H&SCM. This Policy predated the implementation of the SDS Act. The Strategic Commissioning Plan also gives guidance on the strategic priorities for the Partnership.

At an operational level, the staff survey and feedback from Managers through staff team and supervision sessions indicates a good understanding of the SDS process and the duties and rights of people in relation to SDS. The strength of operational arrangements is also reflected in the findings of an Audit undertaken in partnership by the Commissioning and Internal Audit Team to evaluate operational processes and the quality of service.

Moray Council identified the cost and unit (subsidised) price for our internal services ready for SDS implementation in September 2014. It was identified that the cost of our internal services needs to be one which is competitive, with our external providers, but reflects service quality and market position, facilitates market change, but also maintains a reasonable degree of market stability. The proposed prices of our internal services was identified and put forward to the Health and Social Care Services Committee on 10th September 2014. This exercise allowed us to put a financial value on our internal services which was not previously transparent, either internally or to service users. Having this transparency in cost allows individuals to make true choice in how their support is received with their allocated budget. This is effective due to the change in uptake of internal day services whereby there has been an increase in alternatives available for those with less complex learning disability, while internal services have become increasingly focused on meeting complex need.

In Moray we have used the levers of Self-Directed Support to develop a changed market place for individuals requiring social care. The provider market in Moray is limited through its geographical position in the north of Scotland and the rural nature of the area. This results in low competition for contracts, however the market in Moray is stable due to longstanding contractual relationships with providers established over time. In 2011 it was recognised that there was a clear need to develop the market to be able to offer greater choice to meet the needs surrounding the ethos of SDS. With this in mind, a Social and Micro-Enterprise Development Officer post was created and as a result there has been a healthy development of Micro-Providers in Moray. Through supporting micro providers to develop a market offer for SDS, alternative community day activities for people with Learning Disabilities have been created in Moray. In 2016 Building Bridges/Findhorn Care Farm at Findhorn Foundation was established followed by Dreamtime Community Arts in 2017. Growth in micro providers offering domestic support as a result of this new market opportunity has resulted in three main providers offering services to those in receipt of SDS budgets. The Social Micro Enterprise Development Officer developed a small business network as a result of the work with IRISS. The aim was to support individuals in receipt of an SDS budget to develop their own small

businesses. For example a Micro-Enterprise for people experiencing mental ill health led to the creation of a project at Burghead called Mindful Designs. Shared Lives is embedded through a personal budget approach too.

In 2015 H&SCM took the bold step to develop and implement a Contributions Policy allowing us to move away from a charge for a service to a contribution based on a personal budget. With the implementation of SDS and the flexibility of the way in which outcomes can be met, support is no longer always sourced in hours. Prior to the implementation of the Contributions Policy, ascertaining a charge or contribution towards the cost of a service was complex when it was not able to be broken down into hours of delivery.

The Learning Disabilities whole system transformational change programme is underpinned by focusing on personal outcomes, and these being used to inform strategic commissioning. As part of this programme of work, an updated Market Shaping Strategy is being developed and due to completion in August 2018, drawing on the work that was completed for the Market Position Statement completed in June 2014, as part of Moray Council preparing for SDS. Engagement with providers has been evident in the activities undertaken to support the work of the programme's commission work stream. This includes housing as well as care and support providers.

Areas for ongoing development, which are presently being tested through the Learning Disability Transformation Project, are to support the use of individual budgets through the use of Individual Service Agreements. Working towards achieving this aim through changing commissioning and contract monitoring arrangements is considered to be consistent with the principle of personalisation.

Evidence to support the above comments:

6.1.1 Moray Partners in Care (3 Tier) Policy
6.1.2 Market Position Statement
6.1.3 The Market Shaping Strategy for Adult Learning Disability Services (Draft Copy)
6.1.4 Contributions Policy

Quality Indicator 7 – Management and support of staff

7.3- Training, development and support
EVALUATION – 5

Since the inception of SDS in Moray, a significant effort has been placed in training, supporting and mentoring staff to successfully deliver SDS.

Training has been provided in terms of the philosophy and principles that underpin the SDS approach and how SDS will be deployed in Moray using personal outcome focused support plans. This training also complemented a series of workshops on the talking points approach and capturing and recording personal outcomes.

In relation to the Learning Disability Transformation Project, workshops were also delivered earlier this year on personal outcomes in the context of the Progression Model.

Ongoing staff supervision and team meetings have also been an invaluable means of ensuring that staff have the skills to deliver a personal outcomes/SDS approach to assessment and support planning. The SDS Team have also attended these meeting when required.

Other forms of staff support used include staff briefing sessions, team talks, SDS staff newsletters and SDS 'drop in' sessions.

The SDS Team has grown in size to meet these demands since the initial rollout of SDS. The Team have also provided staff support through the SDS Panel and Steering Group Meetings.

An identified area for improvement is the need to constantly refresh and revisit our understanding and ability to capture and record personal outcomes. It is particularly important that SMART personal outcomes are articulated. Training workshops with this focus have recently been delivered in relation to Learning Disabilities but there is a need to roll out similar workshops across all service areas.

Evidence to support these comments are:
7.3.1 Putting Outcomes into Practice (Learning Disability Services) PPT
7.3.2 Social Work Training Team Briefing on Progression PPT
7.3.3 SDS Team Brief (January 2018)

Quality Indicator 9 – Leadership and direction that promotes partnership

9.1 – Vision, values and culture across the partnership
EVALUATION – 5

The Moray Partners in Care (3 Tier) Policy is a joint policy for both social care and health staff. This was the first policy that was 'owned' by the IJB in 2015. This policy along with the Strategic Commissioning Plan supports the personalisation agenda and the realisation of our mission statement to support "*The people of Moray to lead independent, healthy and fulfilling lives in active and inclusive communities, where everyone is valued, respected and supported to achieve their own goals."* Polices are aligned to the values and principles outlined in these documents.

Through briefing sessions with elected council members and the IJB, our vision and commitment to delivering SDS is also shared with our leaders. However, the membership of our IJB has recently changed with a number of new Council members recently having been appointed as voting members. Our intention is to deliver an additional SDS briefing session to this group.

Following the publication of the most recent Audit Scotland Report on the implementation of Self-Directed Support, we have assessed our position in relation to this and identified actions for improvement.

Evidence to support these comments are:
9.1.1 Strategic Commissioning Plan
9.1.2 Moray Partners in Care (3 Tier) Policy
9.1.3 Committee Reports – Update on Progressing Self-Directed Support (10/09/2014)
9.1.4 IJB Report – Update on Progressing Self-Directed Support (10/11/2016)
9.1.5 Action Plan developed by Moray Council in relation to Audit Scotland Report (February 2018)

9.4 - Leadership of change and improvement
EVALUATION – 5

Moray has taken the bold step of putting ourselves at the forefront of national learning in relation to the deployment of SDS. Despite not being one of the early adopter sites receiving additional monies, we decided to begin to work out for ourselves what we would need to have in place to support this whole systems change. In March 2010, a Self-Directed Support Steering Group was established to look at the implementation of SDS in a pilot phase. Membership of the group included elected members, external providers and relevant professionals from within the Local Authority. A Resource Allocation System (RAS) was developed in 2010 with systems and processes put in place to test with a sample of services users who volunteered to work alongside us. The first SDS packages were implemented in early 2012. A service user and staff working group was established in 2011 with the aim to work in partnership to review and evaluate the processes introduced through SDS. This group has since developed into an SDS Working Group with the same ethos in mind. All policies that have been developed make reference to Self-Directed Support.

Getting ready included engaging with a national expert, Sam Newman to inform our thinking and developments. This meant that we were in a good place to partner with the Institute for Research and Innovation in Social Services (IRISS) as part of their PILOTLIGHT innovation programme, looking specifically at SDS and Mental Health SDS and Social/Micro Enterprises. This led to the development of national resources and learning shared across Scotland.

Moray also have worked with the Scottish Government on considering SDS and residential care, the outcome of this has now been published (September 2017), and is with the Scottish Government for action. We have been at the forefront of ISF testing, and the development and implementation of a Contributions Policy and working with Micro Enterprises.

We have also had staff undertake a research project on capturing and recording personal outcomes.

The Learning Disability Transformation Project is also at the forefront of innovation in Scotland in terms of how an SDS approach can support the realisations of people's aspirations for independent living who have a learning disability, through a whole systems approach including integrated outcome focussed assessments and support planning, using our in-house provided services very effectively and changing our approach to commission for outcomes and contract monitoring on that basis too. The Learning Disability Project is also utilising Open Space technologies to support more meaningful engagement with people who have a learning disability. This programme developed from an investment made through the integrated care fund to initially begin an accommodation review; we realised that a whole systems approach was required. We researched what best practice in England and Wales was telling us, and engaged a key partner, Alder Advice who had extensive experience in this area to support us in our change.

By having the foresight to create culture and environment where we have encouraged thinking about new ways of working and being agile and iterative in our approach, we have encouraged our staff and people who have and are using SDS to be innovative and not afraid to try things. This has required leadership that has welcomed and supported change, and managed through a programme management approach.

One area of improvement is how we can ensure that we circulate as widely as possible the learning from the above projects. This is now a key consideration in relation to the Learning Disability Transformation Project.

Evidence to support these comments are:
9.4.1 SDS Residential Care Project Report
9.4.2 Contributions Policy
9.4.3 SDS Option 2 Individual Service Fund Project Evaluation

SUMMARY

(Please detail below how the partnership operates strategically, describing the decision making process)

Since 2010, Moray has been committed to making sure SDS works for the people who have ongoing care and support. This has included setting up a strategic steering group and developing an implementation plan. From the outset we have included service users and carers, providers and elected members in this change.

By recognising and understanding the scale of the change required in our system and being confident in our ability to try things out, we developed an approach which meant that we were ready for implementation of the Act in advance of it coming into force. This included looking nationally at how other areas were moving forward with new approaches, interrogating and considering these and taking the learning back to inform our system development and approach in Moray. This is evident in our work with Sam Newman and Alder Advice, both national leaders. This lead to our implementation of our Partners in Care/3 Tier model in 2013, and its adoption by the Shadow IJB across Health and Social Care Moray in August 2015. It led to the development of the transformational change work in learning disabilities in 2017-2019.

Our Partners in Care/ 3 Tier model provides the philosophy and rationale that informs our offer to people who are looking for support. It informs strategy development, strategic commissioning, and budget alignment, as evidence in for example the work commissioned from Penumbra, focussing on our Tier 1 and 2 offers to people experiencing mental health distress. Our peer support service, also delivered through Penumbra is evidence of our asset based approaches. Our involvement in the SRN's Making Recovery Real programme was possible because of having this framework to base our offers on. The involvement of Moray Wellbeing Hub, the user led organisation in Moray is further evidence of the asset based approaches we appreciate here in Moray.

We have a clear management structure in terms of SDS related decisions, and policy development. This has included working in partnership with Internal Audit to provide an independent assessment on whether our system is working the way we designed it to.

At an operational level, multi-disciplinary teams and individual professionals are empowered to take a positive risk taking approach when agreeing the personal outcomes with people. Team and Service Managers provide on-going support as part of this activity.

At a strategic level, the SDS Steering Group provides direction and key strategic, including budget decisions are overseen by the Operational Management Team (OMT), the Senior Management Team (SMT) and ultimately the IJB.

care inspectorate

Thematic review of self-directed support in Scotland

Moray local partnership report

June 2019

HAPPY TO TRANSLATE®

Contents

1. About this report

Background

Self-directed support: a national strategy for Scotland was published in October 2010. This was a 10-year strategy which set the agenda for self-directed support in Scotland. The subsequent Social Care (Self-directed Support) (Scotland) Act 2013 was implemented on 1 April 2014. The strategy and legislation were designed to encourage significant changes to how services are provided. They require public bodies to give people more say in decisions about local services and more involvement in designing and delivering them.

Fundamental principles of self-directed support are built into the legislation: participation; dignity; involvement; informed choice; and collaboration. Further principles of innovation, responsibility and risk enablement were added. Social care should be provided in a way that gives people choice and control over their own lives and which respects and promotes human rights.

The thematic review

This report forms part of a thematic review led by the Care Inspectorate, which was undertaken jointly with Healthcare Improvement Scotland. The inspection teams included associate assessors with lead roles in self-directed support in partnerships and other organisations across Scotland.

The review looked at the implementation of self-directed support in six partnerships across Scotland: East Lothian; East Ayrshire; West Dunbartonshire; Shetland; Moray and South Lanarkshire. The specific findings from and recommendations for the individual partnerships visited are reported separately in these local partnership reports.

As part of the thematic review we have also published an overview report. This sets out the key messages and recommendations from the review. We hope that all partnerships across Scotland and organisations interested in self-directed support will be able to learn from these findings.

The focus of our thematic review

The main purpose of the review was to improve our understanding of the implementation of self-directed support to support improvement in the delivery of this important agenda in Scotland. We sought to find out if the principles and values of self-directed support were being met and delivering positive personal outcomes.

Under this overarching inspection question, we explored the extent to which the partnerships had ensured that:

- people were supported to identify and achieve personal outcomes
- people experienced choice and control
- people felt positive about their engagement with professionals and services
- staff were enabled and empowered to implement self-directed support
- the principles and values of self-directed support were embedded in practice
- there was information, choice and flexibility for people when accessing services.

This local partnership report sets out our findings, evaluations and recommendations against the following themes:

- Key performance outcomes
- Getting support at the right time
- Impact on staff
- Delivery of key processes
- Policy development and plans to support improvement in services
- Management and support of staff
- Leadership and direction that promotes partnership.

Approach to the partnership inspection

To find out how well self-directed support is being implemented in Moray, we gathered the views of staff across social work, health and provider organisations. We carried out an online survey between 27 June and 13 July 2018, aimed at gathering the views of staff in relation to self-directed support. In addition, we worked with partnerships and invited them to coordinate a supported person questionnaire to ensure we got their perspective on how self-directed support had shaped their experiences of receiving services. The survey was completed by 117 staff and the supported person questionnaires were completed by 23 people.

We read the files of 60 supported people who received a social work assessment and subsequent care and support services and 20 files of people who had been signposted to other services at the point of enquiry. During the inspection we met with a further six supported people and 14 unpaid carers to listen to their views about their experiences of services. We also spoke to various staff from a range of agencies who worked directly with supported people and unpaid carers.

Staff survey and case file reading analysis

Where we have relied on figures, we have standardised the terms of quantity so that ‘few’ means up to 15%; ‘less than half’ means 15% up to 50%; ‘the majority’ means 50% up to 75%; ‘most’ means 75% up to 90%; and ‘almost all’ means 90% or more.

Evaluations

Evaluations are awarded on the basis of a balance of strengths and areas for improvement identified under each quality indicator. The evaluation is not a simple count of strengths and areas for improvement. While each theme within an indicator is important, some may be of more importance to achieving good outcomes for supported people and unpaid carers that they are given more weight than others. Similarly, weaknesses may be found which impact only on a small number of individuals but be so significant, or present such risks, that we give them greater weight. All evaluations are based on a thorough consideration of the evidence.

Definitions

"Self-directed support options" refer to the four self-directed support options under the legislation:

- **Option 1:** The individual or carer chooses and arranges the support and manages the budget as a direct payment.
- **Option 2:** The individual chooses the support and the authority or other organisation arranges the chosen support and manages the budget.
- **Option 3:** The authority chooses and arranges the support.
- **Option 4:** A mixture of options 1, 2 and 3.

'Supported people' or 'people' describes people who use services or supports as well as people acting as unpaid carers for someone else.

'Good conversations' are the conversations that take place between supported people and staff. These conversations allow an understanding to develop of what is important to, and for, supported people on their terms. This allows the identification of desired personal outcomes for the supported person.

'Personal outcomes' are defined as what matters to supported people in terms of the impact or end result of activities. These can be used both to determine and evaluate activity.

'Staff' includes paid staff working across health, social work and social care services; this includes staff from all sectors statutory and third and independent sectors involved directly or indirectly in the provision of advice, care and support.

'Providers' refers to organisations that employ and manage staff in the provision of advice, care and support. These organisations can be from the statutory, third or independent sector.

'The partnership' refers to the Integration Authority which has statutory responsibilities for developing strategic plans and ensuring that the delivery of the functions delegated to the local authority complies with the integration delivery principles.

‘Independent support’ including independent advocacy is impartial, can take many forms and may be provided by different organisations. It does not involve providing direct care or related tasks; rather, it helps people make informed decisions about self-directed support**.**

2. Key performance outcomes

Supported people experience positive personal outcomes through the implementation of self-directed support

Summary

The partnership had made significant progress implementing self-directed support. Most supported people experienced choice and control in how they used personalised budgets and were achieving positive personal outcomes as a result. There were established approaches for getting feedback from supported people about their outcomes. Whilst the partnership collected some relevant performance information, it had more work to do to embed a systematic approach to capturing information about supported people and unpaid carers' outcomes and experiences across all services and demonstrate how it was used to drive improvement.

Evaluation – Good

Supported people and carers were clear that the partnership had made significant progress in implementing self-directed support and that this was making a difference in people's lives. For some people, relationships they had developed with their personal assistants had been transformative in delivering positive outcomes.

We met staff and managers who demonstrated a strong commitment to providing choice, control and support for people in achieving personal outcomes. They recognised that through good conversations they could help supported people and unpaid carers identify the personal outcomes they wanted to achieve.

Most supported people had choice and control over how they used the four self-directed support options and most people were achieving positive personal outcomes as a result of this. Significantly, where supported people experienced issues relating to capacity, for most supported people, this did not prohibit the individual's choice and control over their support. Supported people and/or their representatives felt listened to and that their views had been taken into account.

The nationally reported data on self-directed support showed high levels of direct payments in Moray. The proportion of the population in Moray in 2016/17 receiving direct payments was well above the national average. Older people were the largest proportion of people receiving self-directed support in Moray and this was above the national average.

Performance in direct payments was high compared with other authorities and was found to deliver good outcomes. However, there may have been a specific driver for this performance. There was less choice of services in rural communities which limited the self-directed support options available for some people. In some instances, this meant that Option 1 was realistically the only option that would deliver outcomes for supported people and unpaid carers. Supported people also experienced challenges in employing people or accessing bespoke services in more rural communities.

Most supported people were positive about the outcomes they had experienced through self-directed support. Some had experienced delays in receiving changes to their support and amended self-directed support funding and this delayed achieving positive outcomes.

Positively we found that in the majority of cases support provided to unpaid carers had led to improved outcomes for both the supported person and the unpaid carer. The partnership recognised that ongoing work was required to deliver improved outcomes for eligible carers across Moray.

While the partnership did not use specific outcome measurement tools, it had worked hard to develop assessment, support plan and review templates that had the capacity to record the extent to which positive personal outcomes were being achieved. They could also capture supported people's perspectives on the extent to which the self-directed support principles and values were being applied throughout the process. The tools were not yet consistently used across all service areas. However, we considered that they were a promising development which provided a clear opportunity for the partnership to gather and use meaningful individual and aggregated data about supported people's outcomes and experiences of self-directed support.

Managers were aware that they needed to further develop how the partnership better recorded and captured data on outcomes as a result of self-directed support on both an individual and aggregated basis. They had yet to routinely collate performance information relating to interventions for people across the range of support needs at all levels of complexity.

The partnership had a self-directed support steering group and this group had considered the purpose and use of existing performance measures around self-directed support options and personal outcomes. There was consensus that the data had not yet been used to best effect in driving improvement in performance and that performance measures and use of performance information should be reviewed. The partnership had commenced a review of its performance measures and this was being overseen by chief officers.

Recommendation for improvement

The partnership should ensure that it is able to robustly record, measure and report on the personal outcomes being achieved as a result of self-directed support on an individual and aggregated basis.

3. Getting support at the right time

Supported people are empowered and have choice and control over their social care and support

Summary

The partnership had a well-established approach to managing the public's access to information and social care supports and services. Generally, this provided an effective approach to signposting and early intervention and prevention. The provision and impact of short-term focused interventions for supported people with moderate levels of need was particularly noteworthy. Overall, supported people knew about self-directed support and the options available to them and they had experienced choice and control over their care and support. Independent advocacy could be used more effectively to support people with self-directed support choices. The partnership demonstrated creative approaches to providing and disseminating information. There was room for improvement in planning for refreshing information and evaluating the extent to which supported people had good and timely access to quality information.

Evaluation - Good

In advance of the self-directed support legislation the partnership had agreed and developed an approach called The Moray partners in care (3 tier policy) (see appendix 1). This policy set out how it would manage the public's access to information about social care supports and services. This model reflected self-directed support principles. It placed a strong emphasis on having good conversations with people and identifying personalised outcomes at each tier of the policy. The aim was to ascertain the most appropriate level of intervention or signposting to community services for people at the first point of contact.

The access team was the first point of contact for all referrals to social care and community occupational therapy services. A personal outcomes and asset-based approach underpinned the work of the team. This team focused on prevention through providing information, advice and signposting to community and universal services (tier 1). There was short-term focused intervention available for supported people that needed immediate help in a crisis, reablement and regaining independence (tier 2). This included people with moderate levels of need. We considered that tier 2 was a promising and effective approach which essentially provided a front door focus on prevention and early intervention. This approach assisted with urgent and critical case work and with issues of capacity and flow through health and social care. For the majority of people supported through this approach, this had prevented the need for further longer-term formal service intervention. Positively some people with moderate needs accessed self-directed support options in the short-term as part of a personal outcome approach to prevention and rehabilitation.

Most supported people and unpaid carers were aware of self-directed support and knew the four options available to them. Supported people told us that their views and what mattered to them was respected by workers and that they had received the right information at the right time to allow them to make informed decisions about their care. Most supported people had experienced choice and control over the care they received resulting in positive personal outcomes.

Staff were confident that supported people had access to independent support services, including advocacy but evidence of their use in case files and the low number of referrals to advocacy services did not support this view. Without advocacy services reaching people when needed, the most vulnerable people may not be able to exercise their rights to choice and control over their care and support.

Case records indicated that overall, care support and individual self-directed support options were subject to regular review. Nonetheless, this was not the experience of all of the supported people we met. We heard of instances of reviews not taking place beyond an initial review of care and support and this was confirmed by staff we met. A few supported people expressed frustration that social workers did not always ensure proactive contact with supported people once their care and support was established. They told us that this had contributed to delays in reviewing care, support and their self-directed support options which in turn impacted their opportunity to make changes to options and/or support thereby limiting their choice and control.

The Moray partners in care approach and the implementation of self-directed support had encouraged a greater level of strategic engagement between the partnership, third sector and community resulting in the development of early intervention and prevention activities. We met a range of service providers who confirmed the partnership's strategic intention to continue investing in tier 1 and tier 2 services focused on providing early intervention, advice and information. This was working well in tier 2 services and we saw several examples of commissioned short-term outcome focussed work.

The partnership had taken positive action to promote take up of power of attorney within its approach to early intervention. We saw evidence of this within case records and in discussions with staff. However, the consideration and use of power of attorney powers was not well recorded.

The access team, the first point of contact, provided a range of verbal and written information. This was underpinned by a resource bank and a systematic approach to keeping up to date with the availability of the network of community support services. Less positively, this information was not systematically shared beyond the access team.

Notwithstanding the limited use of advocacy services; we were confident from our engagement with service providers, supported people and staff that most supported people had been offered the right kind of public information and support to help them understand how to direct their support or that of their family. A few supported people that we met expressed that public information about self-directed support could be more visible and that this may improve the take-up and impact of self-directed support.

Overall, however, the partnership was creative in its approach to developing and disseminating information. It established a social and micro enterprise development officer post in 2013 to stimulate micro markets within Moray. Central to the role of the social and micro development officer was informing communities and supported people about self-directed support and the variety of options and approaches available. Significant work had been undertaken with service providers in developing micro services to meet personal outcomes. This work included 'rolling roadshows', other public events and engaging with local businesses and third sector services. The partnership continued to support the development of micro businesses.

The partnership had developed a personal assistant finder website to provide supported people with easy access to information about employing personal assistants. While not without its challenges, the personal assistant finder service was a positive initiative designed to assist supported people to identify and employ personal assistants.

In response to the Audit Scotland self-directed support 2017 progress report, the self-directed support team undertook some self-evaluation activity, following which the partnership noted its intention to develop an information portal. This work had not been shared across the partnership, for example, the access team had not been consulted about this work and was unaware of the intended development.

We found varying views from staff about the quality of self-directed support public information, including variation in the extent to which providers themselves offered information. The partnership was committed to providing and reviewing good quality public information about self-directed support. There was room for improvement around governance and planning for refreshing information. There was also potential to improve evaluation of the extent to which supported people had good and timely access to quality information across Moray.

Recommendation for improvement

The partnership should ensure that supported people have access to independent advocacy when they need it to support decision-making around self-directed support options, choice and control.

4. Impact on staff

Staff feel confident, competent and motivated to practice in an outcome-focused and person-led way

Summary

Social work staff had a solid understanding of the values and principles of self-directed support. The majority of staff felt motivated and supported by managers to work in a personalised way and expressed confidence in exercising professional autonomy in the delivery of self-directed support. The self-directed support team was a valued and important source of support and advice for staff across the partnership. Members of the team were highly motivated and knowledgeable about self-directed support. Social work and social care staff felt well supported by this team. Health staff had less visible and active roles in supporting self-directed support. Moving forward, work was required to further develop and use health staff to support the delivery of self-directed support.

Evaluation - Good

Social work staff had a solid understanding of self-directed support principles, including the importance of signposting. Staff valued the individual advice, support and training they received from the self-directed support team. They were confident about having positive conversations with supported people about what mattered to them and around self-directed support options. Providers that we met were also aware of the self-directed support principles and how these were implemented in practice.

Knowledge and understanding of self-directed support values and principles extended to other staff groups and there was evidence of collaborative working across partnership services. For example, commissioning, finance and business support staff had, over time, developed a good understanding and positive approach to self-directed support principles and worked to make systems reflective of this. Alongside this, operational staff understood that they needed to ensure that relevant information was recorded to support the whole system to deliver personalised budgets and support the effective delivery of self-directed support.

Advanced practitioners were deployed across services; their roles had developed differently in response to the services in which they were based with some providing professional supervision to staff. The advanced practitioners we met were confident in their knowledge of self-directed support and were well motivated and experienced practitioners. They continued to work as practitioners and experienced workload capacity challenges which impacted the extent to which they were able to fulfil some of the planned aspects of the post. This included sufficient time to mentor staff and provide them with opportunity to reflect on their practice.

The partnership identified supervision as a key means by which managers received feedback on self-directed support practice and provided support to staff. Both the access and self-directed support teams spoke positively about the support and supervision they received. As indicated earlier in this report, the partnership had deployed the Moray partners in care (3 tier policy) across the partnership. This approach was embedded across health and social care partnership, provider and community services. It therefore supported delivery of self-directed support principles and values in practice by health and social work staff.

While health staff applied the three-tier policy which was in line with the values and principles of self-directed support, they were less confident about the detail of self-directed support. It was evident that there was a gap in awareness and training for health staff to equip them to support the delivery of self-directed support. The partnership had identified the continued roll out of self-directed support awareness in a multi-disciplinary setting as an area for improvement but had yet to set out their approach to achieving this.

Recommendation for improvement

The partnership should develop health colleagues' knowledge of and confidence in self-directed support to enable them to support its ongoing delivery.

5. Delivery of key processes

Key processes and systems create conditions that enable supported people to have choice and control

Summary

A range of self-directed support information was available for stakeholders. The Moray partners in care (3 tier policy) provided a good structure for responding to needs in line with the principles and values of self-directed support. This 3 tier approach was widely understood and embedded across health and social care services. The partnership had worked hard to develop assessment and support plan templates that could effectively reflect self-directed support principles and practice. We saw good evidence of these working in practice, including a high proportion of good quality assessments and outcome focused support plans. The partnership needed to ensure that reviews took place consistently for supported people. Social work staff understood the value of positive risk-taking and felt supported by their managers to manage risk effectively. Overall, we found that staff, especially social work staff employed an asset-based approach with people though this could be further developed in services for older people.

Evaluation – Good

On the whole supported people found self-directed support processes in Moray easy to use. The majority of supported people had positive experiences when accessing support. The partnership used the national eligibility and priority framework. This was open and transparent with the majority of supported people being advised of their assessed level of eligibility and priority. We saw good evidence that signposting had been considered and discussed and the majority of people experienced positive outcomes from this.

There was pressure on the capacity of partnership staff to respond to tier 3 referrals which provided ongoing support, potentially through a personalised budget using one of the self-directed support options. We noted that some changes had been made to try and better manage people repeatedly in contact with the access team. This may have assisted with the smoother operation of this team but may have inadvertently resulted in longer waiting times for allocation for a tier three response for full assessment, planning and support.

There was clear evidence that the partnership was committed to an asset-based approach, but this had yet to be fully embedded. Further work was required to strengthen an asset-based approach in older people's services. Some service providers also acknowledged that implementing and embedding an asset-based approach was a continuing area of development for their staff.

An important element of the learning disability service transformation approach was increasing individuals' choice and using an asset-based approach in supporting people to achieve positive outcomes. The emphasis on an asset-based approach and positive risk taking genuinely seemed to facilitate maximum choice and control for people with learning disabilities.

The partnership had worked hard to develop an assessment and care plan template which could effectively reflect self-directed support principles and practice. The new care, support and treatment plan which had been developed by the learning disability service further strengthened this approach and had the potential to be rolled out to other service areas. In the main there was good evidence of these in the case files read, including a significant proportion of good quality assessments and outcome focused care plans

Whilst the majority of the personal plans we read were rated as good or better, there was room for improvement in the quality of personal plans. For example, contingency arrangements were evident in only a few records (12%). There had been a lack of proactive consideration given to contingency planning and this remained an area for improvement and one that was missed in the work to develop the assessment/care plan templates.

Carer assessments had been offered and accepted in the majority of the case records that we looked at and the majority of unpaid carers had an adult carer's support plan. The support provided to the majority of unpaid carers allowed them to continue caring for the supported person.

The partnership used a resource allocation system that identified an indicative budget. They used the same self-directed support self-assessment questionnaire for every supported person to calculate the indicative budget. Budgets were mainly authorised according to the assessment and self-assessment questionnaire, and staff reported that the processes were set up effectively.

There was variation in the process of approving budgets across partnership services. Budgets and support packages provided by the learning disability service were considered at a resource allocation group. Budgets for all other services were approved via the line management structure. Delegated financial authority was provided at varying levels of authorisation for head of community care, service managers and team managers. There was transparency around budget approval arrangements. Budgets levels were consistent across different care groups and were allocated without delay.

We concurred with managers' views that indicative budgets were "set at a level that most people should be able to make good choices over how to spend it". There was mixed evidence about whether or not people had enough information about their budgets thereby potentially impacting opportunity for choice and control. The partnership had work to do to evidence discussions with supported people about their allocated budgets and how this would be used to direct their support creatively and flexibly.

A self-directed support panel considered consistency and transparency around budget decision making across teams. This provided an opportunity for reflective learning. The partnership self-directed support steering group monitored the effectiveness of the resource allocation process.

The partnership had some mechanisms for seeking feedback from supported people on their satisfaction about the level of choice and control. Partners knew that they needed to provide more opportunities for supported people and informal carers to provide feedback on the quality of the service or support that they received and their experiences of self-directed support processes.

The partnership used Carefirst client information system and recognised that its functionality had become increasingly limited in support for evolving self-directed support practice. The partnership was considering options around an alternative client information system, but this was at a very early stage.

Whilst there was evidence that most supported people had choice and control over the kind of support they received, there could be delays in care at home packages and personal assistants being sourced, especially in some remote rural areas. This was largely due to available workforce and capacity issues. There was evidence that the personal assistant finder website, despite some limitations, had helped supported people to find and recruit personal assistants and carers.

While initial reviews were taking place consistently, subsequent reviews were not happening with the frequency that they should have. This appeared to be a problem in most service areas and in particular the east and west long-term teams. If a supported person or their unpaid carer was struggling this was unlikely to be picked up by the service unless the individual or family proactively contacted the service or the situation reached crisis point. This limited the partnership's opportunity to identify and manage risks in a timely manner. It also had the potential to impact people's ability to control their care and support on an ongoing basis. People in receipt of direct payments were amongst the service areas where reviews had been delayed. The partnership was working hard to address this and had reduced the number of delayed direct payment reviews.

Most the staff we met understood the importance and value of positive risk taking and were comfortable in working with it. Staff felt supported by their managers to manage risk effectively. The corporate risk register acknowledged the importance of positive risk taking and senior managers were supportive of staff taking this approach.

We saw evidence of appropriate consideration about how positive risk taking and protection was balanced between the person and the practitioner in the majority of the case records that we read. We heard about examples of positive risk taking through individual service funds. The mindful designs project was an example of this. This micro-enterprise set up by three supported people, highlighted work undertaken around positive risk taking in partnership with supported people, health and social care services.

Determining issues with capacity is a key factor for informing risk assessment and risk management. We found that the partnership was particularly strong in undertaking capacity assessments in a timely manner consistent with supported people's needs. This was evident in all of the records that we read where the supported person required such an assessment.

The partnership move from a charging policy to a contributions policy was partly prompted by a desire to improve equality of access, and to promote choice and control and shared risk-taking. This, along with changes in the use of language, was a positive initiative by the partnership to support a cultural shift; for example, moving away from the concept of formal day care to considering co-productive and self-identified solutions.

There were still some cultural differences in the approaches to risk management and positive risk taking between some agencies, with some elements of the NHS seen as only tending to see risk in terms of trying to eliminate it. There was also work to do, to help some families and local communities understand the benefits of positive risk taking.

Recommendation for improvement
The partnership should ensure more explicit recording of discussion relating to self-directed support information, options and personal budgets.

Recommendation for improvement
The partnership should make sure that supported people and unpaid carers receive regular reviews of their care and support to maximise the opportunities for ongoing choice and control.

6. Policy development and plans to support improvement in services

The partnership commissions services that ensure supported people have a range of choice and control over their social care and support.

Summary

There was strong evidence that the Moray partnership had been working consistently since 2010 to understand, develop and implement self-directed support. The partnership's approach demonstrated commitment and innovation in seeking to provide and deliver flexibility, choice and control for supported people. There was a shared understanding across social work staff, commissioners and finance about self-directed support and how it should work. The partnership had a clear commitment to developing supports and services which reflected self-directed support principles. It had co-produced and piloted an approach to delivery of support under Option 2 and was building on learning from this to embed the approach in practice. The partnership was working within the constraints of rural geography and sought to find alternative solutions to provide choice and control for people. Its approach to stimulating market activity had resulted in a more varied range of services and micro-providers providing support in communities, but there were still limitations on choice for some people living in Moray. Performance information was not routinely evaluated and was not being used effectively to drive improvement across services.

Evaluation - Good

The Moray strategic commissioning plan 2016-19 specified the partnership's intention to fully embed self-directed support. The partnership provided three supplementary self-directed support implementation plans which had been developed and used between 2014 and 2018 and supported progress towards this goal. The Moray partners in care (3 tier policy); the design of assessment, planning and support templates; and the transformation of learning disability services using the progression model were all examples where self-directed support values and principles were embedded in operational planning and service delivery. The majority of partnership staff and providers agreed there was a shared understanding across supported people, carers, providers and commissioners of what self-directed support is and how it worked. Nonetheless, we considered that there was more work for the partnership to undertake in developing and achieving shared understanding of self-directed support across all stakeholders.

Commissioning staff were closely involved in the partnership's work in delivering personalised services and support. Commissioning, finance and business support staff had developed a good understanding of the objectives and benefits of self-directed support and worked hard to make key processes and systems supportive of this. They were active participants in the self-directed support steering group and were well versed in the principles and values of self-directed support. They worked closely with procurement and finance officers to ensure that new services and contracts were based on self-directed support principles, although they noted that

the council's standing orders on procurement still created some challenges for flexible procurement.

We saw examples of services that had been commissioned in a way that supported flexibility and innovation to meet personalised outcomes for individuals, including the development of micro enterprises that could offer support in personalised and flexible ways.

Learning disability whole system service transformation had afforded the opportunity for social work and health operational staff and commissioning services to work closely together. Through this there was a strong focus on designing personalised outcomes for people with learning disabilities with complex needs through the use of individual service agreements rather than time and task approaches. Collaborative relationships with housing providers were also evident in the redesign of services for people with learning disabilities.

There had been significant changes in approach to service provision since self-directed support was implemented in the partnership. Moray Council had decommissioned services and encouraged the provision of bespoke packages of care through stimulating potential within the provider market. The partnership had developed a market position statement in 2014 and a separate market shaping strategy for learning disability services in 2018. Both strategies were explicit in setting out opportunities for service providers and inviting providers to the table to discuss these opportunities. Staff and service providers confirmed this had stimulated the market and a significant number of providers had engaged in the market development discussions. A few service providers that we met confirmed that they had developed micro services as a result of the partnership's approach to market development.

The partnership had invested proactively in the development of early intervention and prevention services, such as the mental health wellbeing centre managed by Penumbra and the carers centre managed by Quarriers, with the access team supporting access to prevention and early intervention services.

The partnership had recognised that in keeping with the ethos of self-directed support, there was a need to afford greater choice, control and flexibility under Option 2. The partnership had explored ways to implement self-directed support Option 2 through undertaking a pilot project focused on devolving both the personalised budget and technical support planning to a third party through an individual service fund (ISF). It co-produced a process with a number of service providers to test this approach, including developing a memorandum of understanding between the individual service fund service provider, the Moray council and supported person or representative. Whilst the pilot involved small numbers, it had been evaluated positively with good outcomes being reported by supported people, staff and service providers. At the time of the self-directed support review, the partnership was using the learning from the pilot to drive forward individual service funds being managed by third party service providers with a view to embedding this approach within self-directed support practice.

The partnership aimed to shift the balance of care at home provision. The local authority was providing 60% of care at home services and it was aiming to reduce this to 20% with 80% being delivered by external service providers. This was a challenging target for the council due the lack of service providers, particularly in rural areas. The partnership was taking a number of actions at a strategic level to try and address this, for example, reviewing contractual arrangements and providing support for the development of micro-businesses.

The partnership had developed outcome focused contract monitoring in some learning disability and mental health commissioned services, but this had yet to be developed across all service areas and commissioned services.

The partnership had a financial monitoring procedure in place for undertaking financial reviews of direct payments. This was consistent with Chartered Institute of Public Finance and Accountancy (CIPFA) guidance. The partnership had worked hard to reduce a back log of financial reviews. This had released significant resources arising from underspend in personalised budgets. They were continuing to work on this and were moving towards quarterly financial reviews with supported people particularly in the early stages of a package of support. This would help supported people to manage their budgets and identify any problems with financial management at an early point when it was easier to resolve.

Performance information was not routinely evaluated and was not being used effectively to drive improvement across services. Senior managers were aware that performance information did not support robust evaluation of progress in implementing self-directed support. They had begun working on revised performance information and measures and this was being overseen by chief officers.

A number of activities sought to involve people and communities in the commissioning of services and supports, including:

- consultation with supported people about issues identified in the self-directed support steering group
- the involvement of providers through market facilitation exercises
- the annual survey of people receiving direct payments
- the learning disability open space event held in March 2018
- a service providers forum
- the self-directed support working group which involved service users and carers.

While these activities were valuable, they had yet to be underpinned by a communication and engagement strategy.

Recommendation for improvement

The partnership should establish a clear system for capturing self-directed support performance information and this should be evaluated and used to drive positive change and improvement.

Example of Good Practice

Mindful Designs Project
Health and social care Moray participated in the pilot light pathways, facilitated by IRISS and sought to explore the possibility of self-direct support budgets being used to create small businesses. To support this, a small business network was established in September 2014. A group of three individuals chose to explore the use of personal budgets to create a small business. The small business network provided information and support to develop their thinking. They identified a common business interest and explored this with the social and micro enterprise officer in conjunction with their respective social workers.

This project challenged health and social care Moray's internal processes and thinking around risk enablement and the use of personalised budgets to support positive personalised outcomes for the individuals through a shared small business venture. The individuals pooled their personal budgets and secured premises and equipment for their small business 'mindful designs' producing items with wood. The individuals came together with a shared purpose and provided peer support for their own health and wellbeing. Since this time, they have established a sustainable business, whilst using their business as peer support for their own health and well-being.

7. Management and support of staff

The partnership empowers and supports staff to develop and exercise appropriate skills and knowledge

Summary

The partnership had invested in awareness raising and training staff around self-directed support in its early days. This had positively impacted workers knowledge understanding and confidence of self-directed support and how they practised. We found some significant gaps around current training and development for staff around self-directed support. The partnership had no training needs analysis or learning and development strategy which covered self-directed support. There was a need for a more strategic approach to providing ongoing training and learning and development opportunities for health and social care staff on self-directed support.

Evaluation - Adequate

The self-directed support team was the main vehicle for delivering training around self-directed support within the partnership. It was a valued resource and was integral to the provision of advice and support offered to staff about self-directed support. It was clear that the partnership had placed a significant focus on training for social work staff ahead of the implementation of the self-directed support pilot. This had positively impacted social work staff's confidence in promoting and implementing self-directed support.

Newly appointed staff met with the self-directed support team as part of their induction process. The team sought to undertake self-directed support refresher sessions with community care teams twice yearly. This team was responsive to learning and development requests from individuals and teams thereby supporting self-directed support practice.

Managers of integrated teams were confident in their knowledge of self-directed support. Social work staff were provided with supervision and felt well supported by their line managers and by the self-directed support team. There was a focus on reflective practice; however, workforce capacity limited opportunity for this to take place.

Health staff uptake of training ahead of the implementation of the self-directed support pilot had been limited. Evidence of ongoing self-directed support training for health staff was also limited. The lack of partnership self-directed support training needs analysis; self-directed support learning and development strategy and action plan was a factor in the lack of health staff visibility and engagement in self-directed support.

An organisational development plan and separate work plan underpinned the partnership's approach to supporting staff during transformation of health and social care integration. While the partnership's strategic commissioning plan 2016-19 had identified implementing self-directed support as one of the partnership's improvement programmes, there was a lack of detail around health and social work staff's learning and development needs to successfully achieve this.

Work had commenced on developing a social work training strategy linked to health and social care Moray and Moray council strategic objectives, but this was at a very early stage.

There was no overarching approach to self-directed support training across the partnership. While learning and development activity had been included in self-directed support strategic group implementation plans this was not underpinned by a partnership self-directed support training needs analysis, learning and development plan or training calendar. The most recent self-directed support strategic group implementation plan identified the need for refresher self-directed support and outcomes training for social work staff however the timeframe for completion had not been established.

The partnership acknowledged that it had yet to put in place strategic approaches for evaluating quality and impact of training and that it was working towards this. For example, senior managers told us that training delivered as part of the community learning disability transformation project would be evaluated, including the quality and impact of training. They planned to use learning from this project to inform future development of strategic approach to quality assuring training.

Recommendation for improvement

The partnership should develop and implement a learning and development strategy to address health and social care workforce self-directed support learning and development needs.

8. Leadership and direction that promotes partnership

Senior leaders create conditions that enable supported people to experience choice and control over their social care and support.

Summary

Senior social work leaders demonstrated commitment to self-directed support values and principles and had focused on personalised outcomes approach over a significant period of time. The partnership's shared vision supported the personalisation agenda and confirmed that continuing to embed self-directed support across services was a priority for the partnership. The self-directed support steering group, chaired by a senior officer and attended by a range of senior managers, set the strategic direction for the implementation of self-directed support. Implementation plans underpinned the work of this group but there was room for improvement in the level of detail in these plans. Early policy and practice development had supported self-directed support implementation and facilitated mainstreaming of self-directed support and personalised outcomes approach in social work practice. Cultural change had progressed well in social work services, but further work was required to bring health colleagues fully on board. The partnership had made significant progress with the implementation of self-directed support. To further develop this agenda, it needed to take a strategic and whole-system approach across health and social care to fully ensure implementation, evaluation and continuous improvement.

Evaluation - Good

The health and social care Moray strategic commissioning plan 2016-19 demonstrated a correlation between the vision of the partnership and the principles of self-directed support. The partnership's shared vision supported the personalisation agenda and confirmed that continuing to embed self-directed support across services was a priority for the partnership.

Senior leaders were clear that the principles of self-directed support were coherent with the principles of other agendas in health provision and that they remained committed to embedding self-directed support. The self-directed support team had delivered sessions to the integration joint board to strengthen understanding about personal outcome approaches and support cultural shift; senior managers recognised that this would be an ongoing process.

Senior leaders were highly motivated and enthusiastic about self-directed support; they understood the values and principles well. Leaders and managers valued and were strongly committed to facilitating creative approaches to delivery of health and social care support through self-directed support. The partnership had been pro-active in looking at best practice and engaging in national and local pilots and self-directed support was now the standardised approach for delivering social work services.

The majority of service providers and social work staff confirmed that senior leaders within their own organisations and across organisations were committed to the principles and values of self-directed support. Around half of health staff that responded to our staff survey also agreed with this.

The partnership had adopted a collaborative approach within and across organisations in delivering self-directed support. There was a significant focus on the role of the self-directed support team in providing information and improving awareness about self-directed support for both colleagues and within communities. Whilst this was clearly valued by staff and supported people, the partnership had not evaluated the effectiveness of its communication to all stakeholders about self-directed support.

The partnership had made significant progress embedding a personalised outcomes approach within social work and social care services and delivering the four self-directed support options within their Moray partners in care (3 tier policy). However, whilst health colleagues understood and implemented the Moray partners in care (3 tier policy), senior leaders acknowledged that there was more work to do with health colleagues in raising awareness and knowledge about self-directed support and implementing this in practice across services. This was consistent with our findings. We also noted that the Moray partners in care (3 tier policy) had not been reviewed since health and social care integration.

The self-directed support steering group set the strategic direction for the implementation of self-directed support. This was an active group which met regularly. It was chaired by a senior officer and attended by a range of senior managers, integrated service managers, finance, commissioning, and self-directed support team. The steering group was well supported by senior managers who oversaw key strategic and financial proposals. Implementation plans underpinned the work group however there was room for improvement in the level of detail in the plans which were not SMART.

It was evident that the partnership welcomed and supported change and improvement activity. Evaluation and improvement activity appeared to be on an issue by issue basis rather than being underpinned by a strategic approach. The partnership recognised that improving performance information would inform and support future developments in self-directed support and were working towards this aim.

Moray council had demonstrated early commitment to developing and implementing self-directed support within social work services. The partnership had taken an iterative approach underpinned by a clear strategic direction in developing and implementing self-directed support in Moray. The partnership continued to develop self-directed support in response to emerging challenges. Through this approach, self-directed support was integrated across the partnership's social work and social care services. They had been able to deliver flexible and responsive services that were designed to meet personalised outcomes.

While the partnership had made significant progress, it had work to do in improving the implementation and evaluating the impact of self-directed support across the wider partnership. Evaluating their approach to supporting health colleagues to develop their knowledge and confidence around the implementation of self-directed supported was an example of this. This was important moving forward to embed self-directed support across the partnership which was a priority for the health and social care partnership.

Recommendation for improvement
The partnership should regularly evaluate the effectiveness of communication about self-directed support and its impact within self-directed support delivery in the partnership.

Recommendation for improvement
The partnership should ensure that it takes a whole system strategic approach to supporting implementation, evaluation and continuous improvement of self-directed support across health and social care. This approach should ensure that partners are fully involved, and the partnership can demonstrate a shared approach to the implementation of self-directed support.

Example of Good Practice

The learning disability transformation project was a good example of a strategic approach to delivering whole system change with health, social work and wider partners.

Learning disability transformation change programme

Health and social care Moray learning disability service was undertaking a programme of transitional change with the aim of delivering better personal outcomes for supported people and ensuring that future services were sustainable in a challenging economic climate,

The partnership recognised that better outcomes could be achieved for people with learning disabilities through a greater focus on longer term life planning. The basis of the transformational change programme was the progression model which was a systems wide approach for working towards better outcomes, reducing future demand and service costs.

The delivery of the model required a systems wide approach that encompassed Moray health and social care community learning disabilities team, commissioning in its broadest sense and support of health and social care Moray. The transformational change project aimed to profoundly affect the culture and future approach to learning disabilities. It included:

- new ways of professional practice including the way in which professionals interacted with supported people and their families
- revision to the operational framework within which health and social care services operated
- changes to the role and models of health and social care Moray services
- introduction of improved systems for commissioning, including new relationships with commissioned services supporting a more effective operation of the commissioning cycle underpinned through personal budgets and self-directed support.

The intended outcomes from the project were aligned with the vision and outcomes identified in the Moray learning disability partnership board strategy. The work stream was successfully underpinned by a project management approach. At the time of the self-directed support review, 32 people with learning disabilities had experienced change to their living circumstances using an outcome focussed individual budget approach with care and support commissioned to meet individuals' aspirations.

Appendix 1

Moray partners in care (3 tier policy)

The Moray partners in care (3 tier policy) was one of the first joint policies adopted by the health and social care Moray integrated joint board. This was an asset-based approach involving outcome-based conversations at each of the three tiers to identify which tier was best suited to supporting individuals' desired outcomes. The approach was underpinned by five key principles consistent with self-directed support values and principles and national health and wellbeing outcomes.

The access team was central to delivery of this approach at tier one and tier two levels. This team demonstrated an integrated approach to their work with regular liaison with health and social work colleagues. Tier one focused on prevention through providing information, advice and signposting to community and universal services. We read 20 case records relating to individuals that did not receive a personalised budget and found that signposting was discussed with the person in 19 out of 20 records. The majority of case records evidenced that signposting reduced the need for formal service intervention. Staff that we met emphasised that signposting was the responsibility of staff working at all levels of the tiers and we found evidence supporting this assertion in just under half of the 60 case records we read where people had accessed a personalised budget via self-directed support options (tier three).

Tier two 'help when you need it' focused on immediate help in a crisis, reablement and regaining independence. Intervention at this tier was focused mainly on people that met moderate or substantial eligibility criteria and was short-term and focused on early intervention to promote independence. This tier essentially provided a front door focus on prevention and early intervention. It assisted with urgent and critical case work and assisted with issues of capacity and flow and for the majority of people prevented the need for further formal service intervention. Discussion with staff and case record findings demonstrated that some people accessed self-directed support options throughout this short-term involvement as part of a personal outcome rehabilitative approach.

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Thematic Review of Moray Self Directed Support

Improvement Action Plan (2019/2020) August 2019 v.22 8 19

This action plan addresses the 9 recommendations made by the Care Inspectorate following the publication of their thematic review of SDS in Moray in June 2019.

The Action Plan will be for the period August 2019 to July 2020.

Recommendation for Improvement (as per CI)	Expected Outcome	What will be done	Start	Finish	Lead Officer
Theme: Key performance outcomes					
1.The partnership should ensure that it is able to robustly record, measure and report on the personal outcomes being achieved as a result of self-directed support on an individual and aggregated basis.	At a H&SCM partnership level:- • The H&SCM performance framework is reviewed and incorporates an analysis of both SDS related quantitative & qualitative data. At a Service level:- • Both quantitative & qualitative data is effectively used for the commissioning &	1.1 Facilitate a workshop with Health & Social Care colleagues that will review Support Plan documentation specifically in terms of recording personal outcomes (Snr Performance Officer) 1.2 Hold discussions with Community Care Stats to ensure Business Objects can run reports based on any changes (Support Officer (Research & Information))	Sept Sept	Jan Dec	Tracey Abdy

	decommissioning of services. Specifically, the reasons for personal outcomes being met or not met. At a Team Level:- • Social Work & Health colleagues are confident to use both quantitative & qualitative data to inform their interventions and to provide effective support for people who access health & social care services in Moray.	1.3 Test revised Support Plan/Care Support & Treatment Plan Forms (Issues Log submitted to staff) (tbc)	Oct	Dec	
		1.4 Generate revised personal outcome performance reports on a monthly then quarterly basis from CareFirst. Reports submit to the SDS Steering Group and are incorporated into the Partnership Performance Management Framework (Snr Performance Officer & Support Officer (Research & Information))	Oct	Dec	
		1.5 Workshop held to review Issues Log and to consider outcomes related performance reports generated (tbc)	Feb	Feb	
		1.6 As part of the review of the Support Plans/Care Support & Treatment Plan forms, develop a training programme that will support health & Social Care colleagues to articulate SMART personal outcomes, the adoption of talking points approach and how quantitative and qualitative information can be used to improve professional practice. (Snr OD Advisor)	Oct	Nov	
		1.7 The Practice Governance and SDS Steering Group approve the revised Care Treatment & Support Forms (Service Manager)	Mar	Mar	
		1.8 SMART Personal Outcomes Training	Nov	Nov	

		& Development Programme is agreed by the SDS Steering Group (Snr OD Advisor)			
		1.9 Implement SMART Outcomes Personal Training & Personal Outcomes Training & Development Programme (Snr OD Advisor)	Dec	July	
Theme: Getting Support at the right time					
2.The partnership should ensure that supported people have access to independent advocacy when they need it to support decision-making around self-directed support options, choice and control.	At a Service Level:- • The Independent Advocacy Contract is reviewed to help ensure that it supports people with their decision making in relation to SDS. At a Team Level:- • Individuals are fully informed about SDS and confident in promoting formal, independent advocacy.	2.1 As part of the contract review process, commissioning colleagues analyse the use of formal advocacy data in the context of SDS decision making (Snr Commissioning Officer)	Oct	Nov	Roddy Huggan
		2.2 As per Commissioning timeline, revised contract specification developed (Snr Commissioning Officer)	Dec	Jan	
		2.3 As per commissioning timeline contract submitted for tender (Snr Commissioning Officer)	Feb	Feb	
		2.4 Guidance for Health & Social Care staff to promote formal, independent advocacy is revised and developed. This would also include explaining the support that can also be provided by the SDS Team (Commissioning & Performance Officer (Policy & Procedure))	Sept	Sept	
		2.5 Revised guidance is agreed at the SDS Steering Group and Practice Governance Groups (SDS Officer)	Oct	Oct	
		2.6 Up-take rates of Advocacy services is	Nov	Nov	

		monitored on a quarterly basis by the SDS Steering Group (baseline to be established) (Snr Performance Officer)			
Theme: Impact on Staff					
3. The partnership should develop health colleagues' knowledge of and confidence in self-directed support to enable them to support its ongoing delivery.	At a H&SCM partnership level:- • To work with health colleagues to increase their understanding of SDS and the underpinning principles; • Senior Management Health colleagues are confident in their knowledge of SDS • Develop an SDS induction training for senior health colleagues to complete in relation to SDS At a Team level:- • Establish if there is an on-line training portal for front line health practitioners where the online SDS training can sit for colleagues to complete as part of their induction.	3.1 A programme of highly participative SDS workshops is developed for MDT health staff (tbc) in relation to the underpinning principles of SDS. Health colleagues also invited to personal outcome training 1.7. (Snr OD Advisor)	Oct	Nov	Sean Coady
		3.2 Workshops are agreed by SLG	Dec	Dec	
		3.3. The programme of workshops is delivered (tbc)	Jan	July	
		3.4 An on-line training resource for frontline practitioners is sourced and approved by the SDS Steering Group (Snr OD Advisor)	Jan	Jan	
		3.5 Online SDS training resource is promoted and made available (tbc)	Feb	Ongoing	
		3.6 Impact on the training and development activities is evaluated and reported to the SDS Steering Group (tbc)	July	July	
Theme: Delivery of key Processes					
4. The partnership should ensure more explicit recording of discussion relating to self-directed support information, options and personal budgets.	At a Service Level:- • Ensure that we can demonstrate transparency in relation to the SDS option	4.1 As part of the review of the Support Plans/Care Support and Treatment Forms (1.1 & 1.3)ensure that the forms facilitate the capturing of SDS conversations (SDS Officer)	Sept	Dec	Sean Coady

	chosen and that people are provided with the appropriate information and support to make an informed decision. At a Team Level:- • Team members are confident in capturing the key salient points in relation to SDS options and discussions.	4.2 As part of the development and implementation of a Personal Outcomes based Training and Development Plan (1.7, 1.8 & 1.9), ensure that colleagues are confident and able to complete the revised form (tbc)	Oct	July	
		4.3 The SDS Steering Group receives reports allowing them to monitor and analyse responses given (Snr Performance Officer)	Dec	July	
		4.4 As per 8.1-8.7 of this Project Plan, ensure that, as part of the quality assurance process evidence of conversations is collated (SDS Officer)	Sept	Aug	
5. The partnership should make sure that supported people and unpaid carers receive regular reviews of their care and support to maximise the opportunities for ongoing choice and control.	At a H&SCM Partnership Level:- • The proportion of reviews outstanding after 12 months (service standard) should be incorporated as part of the Partnership Performance Management Framework. At a Team Level:- • MDT colleagues are able to support the review of personal outcomes in a timely manner and that service users are supported to maximise choice and control over their package giving them the flexibility to move option to achieve this.	5.1 Review the Unpaid Carers Contract to ensure clarity concerning roles & responsibilities for undertaking Care Plan Reviews (Snr Commissioning Officer)	Sept	Sept	Sean Coady (for supported people) & Jane Mackie (unpaid carer)
		5.2 As part of the development of a Partnership Performance Management Framework (1.4), develop a 12 month service standard for the completion of Support Plan/Care Treatment & Support Plan Reviews for supported people and unpaid carers (Snr Performance Officer).	Oct	Dec	
		5.3 Develop an improvement action plan that will ensure that the backlog of outstanding reviews can be completed within a realistic timescale for supported people and unpaid carers for (Snr Performance Officer)	Oct	Dec	

		5.4 Performance reports are submitted to both the SDS Steering Group and ASPMG to allow the effective monitoring of the completion of reviews (Snr Performance Officer)	Dec	July	
Theme: Policy development and plans to support improvement in services					
6. The partnership should establish a clear system for capturing self-directed support performance information and this should be evaluated and used to drive positive change and improvement.	At a H&MSCM Partnership Level:- • Health & Social Care Moray should be able to use both quantitative and qualitative personal outcomes data to drive systems wide improvement and support transformational change	6.1 As part of the development of a Partnership Performance Management Framework (1.4), ensure personal outcome reports are generated that not only capture both qualitative and quantitative data but also service standards. (Support Worker (Research & Information & Snr Performance Officer)	Oct	Dec	Tracey Abdy
		6.2 Personal Outcome Reports –including service standards- are interrogated by ASPMG on a quarterly basis (Snr Performance Officer & SDS Officer)	Dec	Ongoing	
		6.3 Personal Outcome Reports–including service standards- are interrogated by the SDS Steering Group on a monthly basis (Snr Performance Officer & SDS Officer)	Dec	Ongoing	
		6.4 Personal Outcome Reports are interrogated by the Strategic Commissioning Group on a monthly basis (Snr Performance Officer & Commissioning Manager)	Dec	Ongoing	
Theme: Management and support of staff					
7. The partnership should develop	At a H&SCM Partnership Level:-	7.1 A Training Needs Audit is undertaken	Oct	Nov	Jenny O'Hagan

and implement a learning and development strategy to address health and social care workforce self-directed support learning and development needs.	• To ensure all key staff –across both health & social care- receive SDS training appropriate to their needs and H&SCM further strengthens it approach to personalisation	which is focused on further embedding SDS across health and social care (Snr OD Advisor)			& Health colleague (tbc)
		7.2 Based on the insights gained from the audit, an overarching SDS training and personal development programme aimed at IJB members, senior management and Health & Social Care front line members of staff is developed. The training & development programme will incorporate 3.1-3.6 & 4.2 of this improvement action plan and induction and on-going refresher training (Snr OD Advisor)	Dec	Dec	
		7.3 The SDS Training and Development Programme is approved by the SDS Steering Group, OMT,SMT and IJB (Snr OD Advisor)	Dec	Jan	
		7.4 The SDS Training and Development Programme is implemented (Snr OD Advisor)	Jan	July	
		7.5 To review training delivered and obtain feedback from attendees to develop training material and plans for next year (Snr OD Advisor)	July	July	
Theme: Leadership and direction that promotes partnership					
8. The partnership should regularly evaluate the effectiveness of communication about self-directed support and its impact within self-directed support delivery in the partnership.	At a H&SCM Partnership Level:- • Capture the lived experience of accessing SDS (all options) At a Service and Team Level:-	8.1 To develop a rationale for undertaking quarterly telephone surveys of people who access SDS (options 1-4) (SDS Officer)	Sept	Oct	Roddy Huggan
		8.2 SDS Steering Group agree to the	Oct	Oct	

	• The findings and key insights gained from the engagement activities is reported to Health & Social Care MDT colleagues	telephone survey audit. Insights reported to this Group (SDS Officer)			
		8.3 Audit is implemented (SDS Officer)	Nov	Every quarter	
		8.4 To develop a rationale for an annual postal survey (SDS Officer)	Dec	Dec	
		8.5 SDS Steering Group agree to the postal survey rationale. Key insights reported back to Steering Group (SDS Officer)	Jan	Jan	
		8.6 Postal Survey Implemented (SDS Officer)	Feb	Feb	
		8.7 To develop a rationale for an annual focus group of people who use SDS and Carers (SDS Officer)	Mar	Mar	
		8.8 SDS Steering Group agree to the annual focus group rationale. Key insights reported back to Steering Group (SDS Officer)	May	May	
		8.9 Findings disseminated to all Teams, SLG and IJB (SDS Officer)	July	July	
9. The partnership should ensure that it takes a whole system strategic approach to supporting implementation, evaluation and continuous improvement of self-directed support across health and social care. This approach should	At a H&SCM Partnership Level:- • The right stakeholders are present and have direct input into the development of SDS	9.1 Review the membership of the SDS steering group to ensure that there is a health representation. (SDS Officer/Steering Group)	Aug	Sept	Jane Mackie
		9.2 Consider how to most effectively engage with colleagues and stakeholders	Aug	Oct	

ensure that partners are fully involved, and the partnership can demonstrate a shared approach to the implementation of self-directed support.	• Leadership and governance which allows for wider partners to have an active input and remain informed as to key updates relating to SDS. • Ensure clear and consistent linkages the Strategic Commissioning Group, Localities and Practice Governance Groups	in the context of the new H&SCM management and locality structure (SDS Officer/ Steering Group) 9.3 As per the actions outlined in this Improvement Plan, Performance Reports, Lived Experience Insights are circulated to SLG, the Strategic Commissioning Group, Locality Management Groups and IJB (SDS Officer)	Every Quarter	Every Quarter	