Integrated inspection of care at home: Falkirk Health and Social Care Partnership

November 2025

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About this inspection

Introduction

The Care Inspectorate's vision is for world-class social care and social work in Scotland, where everyone, in every community, experiences high-quality care, support and learning, tailored to their rights, needs and wishes.

Our mission is to provide public assurance about the quality of social care, social work and early learning services, promote innovation and drive continuous improvement. We collaborate and take action where experiences and outcomes are not meeting individual needs.

Test of change

To better understand whether people's and carers' experiences of care at home services were positive, the Care Inspectorate undertook a test of change. This test combined elements of the Care Inspectorate's regulatory and strategic inspection methodologies and used a bespoke quality framework. It was underpinned and structured by the European Foundation for Quality Management (EFQM) excellence model[1] for quality improvement. The integrated inspection's objectives were to:

- Develop, implement and evaluate a methodology of integrated strategic and regulatory inspection in a test health and social care partnership area
- Ensure that the integrated methodology was based on an inclusive approach, including the partnership, people, carers, care at home service providers, strategic and regulatory inspection teams and other stakeholders in the test partnership area
- Identify how effectively the partnership's commissioning arrangements were contributing to good outcomes for people and carers
- Assess the quality of care at home services provided in the partnership area
- Report on the results and learning from the integrated inspection
- Identify and agree on the next steps for integrated regulatory and strategic inspection activity.

Learning from the integrated inspection and the next steps for any future integrated regulatory and strategic inspection activity will be the subject of a separate report.

[1] Quality indicators are based on the EFQM 2020 model.

The focus of this report is the test of change integrated inspection of care at home services[2] in the Falkirk health and social care partnership area. The inspection sought to address the following question:

How effectively were the health and social care partnership's commissioning arrangements contributing to good outcomes for people and carers?

Inspection methodology (see Appendix 1)

The inspection took place between April and September 2025. The inspection team consisted of regulatory and strategic inspectors from the Care Inspectorate. The methodology included:

Inspecting 27 regulated care at home services	Surveys of people and carers with 434 responses	Two staff surveys with 571 responses
8 discussions with a total of 22 people and carers	20 focus groups with a total of 80 frontline staff	17 meetings with a total of 22 leaders and managers
Reading 59 sampled people's case files	Surveys of 118 regulated care at home services across Scotland	Reviewing a partnership self-evaluation statement with supporting evidence

Explanation of terms used in this report

When we refer to **people**, we mean adults aged over 18 years old who use care at home services. When we refer to **carers**, we mean the friends and family members who provide care for people and are not paid for providing that care.

When we refer to **cases** and **records,** we mean the records of the sampled people's case files that we read.

When we refer to the **health and social care partnership**, or the **partnership**, we mean those in the Falkirk health and social care partnership who were responsible for planning and delivering health and social care services to adults who lived in the Falkirk health and social care partnership area.

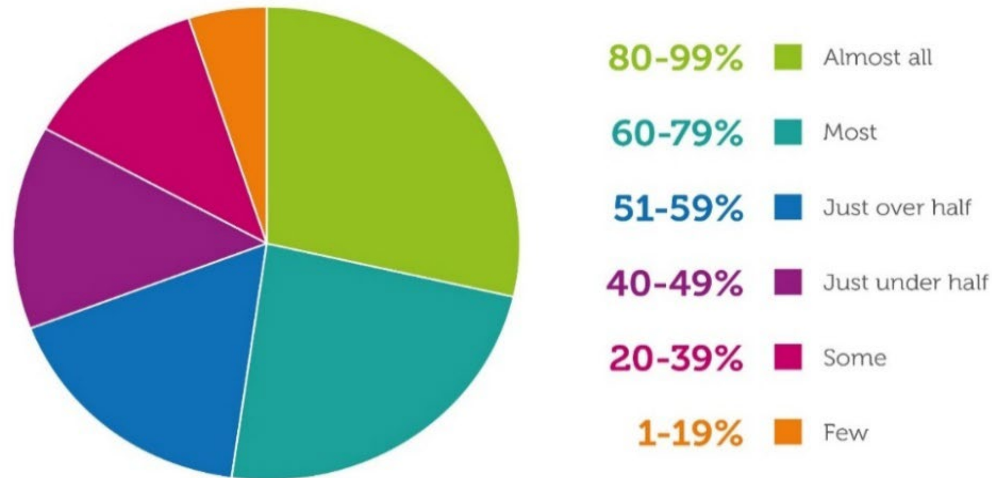
[2] Services registered with the Care Inspectorate as providing care at home and services with a dual registration for care at home and housing support.

When we refer to **staff**, we mean the people who work in social work and social care services in Falkirk health and social care partnership, including those in the statutory, third and independent sectors as part of the partnership. This included:

- care at home staff
- social workers
- occupational therapists
- social care officers
- administrative, including business support/planning/commissioning staff; and
- managers.

When we refer to **leaders,** we mean the most senior managers who were ultimately responsible for the operation of the partnership's social work and social care services. There is an explanation of other terms used in this report at **Appendix 2**.

Figure 1: Data descriptors for percentage scale



Source: Care Inspectorate

Note: Throughout this report, we refer to the proportion of people, carers, staff, or service providers who reported on a particular issue. For example, "Almost all people were positive about the care and support they experienced from their care at home service". How we describe these proportions is shown in Figure 1 above.

Key messages

The inspection findings are addressed to the wider partnership of which care at home services, social work, and social care services are key elements.

Key strengths

- **Positive outcomes**: Almost all people were positive about the care and support they experienced from their care at home service. These services delivered positive outcomes.
- **Effective commissioning**: Overall, there were well-developed and robust strategic commissioning arrangements in place for care at home services.
- **Collaborative culture**: Strong multi-agency leadership and collaboration were evident, supported by robust governance and strategic risk management arrangements.
- **Person-led care practice**: Staff demonstrated a shared commitment to involving people in their care, with personalised planning and outcome-focused assessments and reviews.
- **Preventative approaches**: Care at home services were integrated within an effective framework of various preventative, early intervention and community-based wellbeing initiatives.
- **Market insight**: The partnership showed a strong understanding of the local care at home market, aligning investment with strategic priorities and medium-term commissioning goals.
- **Performance monitoring**: Effective systems were in place to accurately monitor performance and identify areas for improvement, though the sustainability of some recent improvements was uncertain due to financial constraints.
- **Workforce planning**: A comprehensive workforce strategy supported recruitment and retention planning, role clarity, and professional leadership across teams. Filling some key roles remained challenging.

Priority areas for improvement

- **Self-directed support**: Procedures and staff practice needed improvement to help facilitate more consistent use and promote genuine choice for people and carers.
- **Carer's support**: Carer assessments should be linked to a broader range of support services, including respite options.
- **Hospital discharge pathways**: Care at home commissioning practices should better support the continuity of care after a hospital discharge.
- **Performance frameworks**: These should include the inclusion of personal outcomes and qualitative indicators. These would improve self-evaluation priorities.

- **Transformational change:** This was not happening at the required pace to meet the partnership's substantial challenges and deliver the partnership's strategic wider priorities.

Overall impact

The partnership's commissioning arrangements delivered positive outcomes for a very high proportion of people in receipt of care at home services, with generally high satisfaction levels. However, due to the scale of service delivery, an important number experienced less than good outcomes. Similarly, while most carers felt supported, a notable proportion reported unmet needs.

These findings indicated that, overall, care at home services were being commissioned to deliver good quality care successfully. Service improvement was still needed, in some areas, to better deliver a more consistent positive pattern of good outcomes for people and carers.

Evaluations

Our evaluations were made in reference to the quality framework developed as part of the test of change integrated inspection. The following evaluations have been applied to the key areas inspected. Further information on the six-point scale used to evaluate the key areas can be found in **Appendix 3**.

Key Area	Evaluation
1. Purpose, vision and strategy	Good
2. Organisational culture and leadership	Good
3. Engaging stakeholders	Good
4. Creating sustainable value	Good
5. Driving performance and transformation	Good
6. Stakeholder perceptions	Good
7. Strategic and operational performance	Good

What we found during this inspection

Key area 1: Purpose, vision and strategy

Summary
The partnership outlined a clear vision for care at home services. It was well understood and focused on person-led care, prevention, and carer support. Governance of the commissioning process was inclusive, though social work governance needed strengthening. Strategic risk management was thorough, addressing key challenges such as workforce and financial sustainability. While leaders articulated a future care at home service model, its implementation had stalled. This risked progress on tackling system-wide problems.
Evaluation: Good

1.1 Vision, values and strategic direction

Vision and strategic direction

The partnership set out a clear and ambitious vision for care at home services, strongly aligned with national health and wellbeing outcomes. The strategic plan (2023–2026) clearly explained this vision. Leaders worked purposefully to promote the partnership's vision with staff and other stakeholders.

The vision was well understood and supported by most staff and wider stakeholder groups. Most staff agreed that the partnership's senior leadership team had a clear shared vision about how care at home helped to improve outcomes for people who received services and their carers. The vision was well-integrated into strategic plans and operational frameworks. Integration Joint Board members and senior managers shared a strong commitment to delivering positive outcomes for people and carers.

Leaders effectively oversaw the development of a range of approaches to managing and improving care at home services. They demonstrated a sound understanding of service performance linked to commissioning and financial frameworks.

Governance and risk management

Governance arrangements were comprehensive and inclusive. The Integration Joint Board and its supporting groups had suitable representation, including people, carers, the third and independent sectors.

The Integration Joint Board's performance, audit and assurance committee had good oversight across its remit. Strategic commissioning arrangements for care at home services were regularly reviewed and reported through appropriate governance structures.

The partnership's care at home services were delivered by the in-house and externally commissioned services. The partnership recognised that social work governance required to be strengthened across all services, and a social work

governance group was being developed. This group aimed to give social work a stronger presence within overall care governance arrangements. The development of this group was a positive step toward reinforcing professional standards and identity. Its integration within the broader governance framework was essential to maintain an overall integrated approach.

The clinical and care governance management group, with broad representation, was accountable for service quality and care standards, and played a key role in managing operational and strategic risks. Its reporting is aligned with national priorities on people's safety, clinical effectiveness, and person-led care. The group reported to the Integration Joint Board's performance, audit and assurance committee. This committee maintained a good understanding of strategic risk, with major risks escalated to the Integration Joint Board's strategic risk register.

The partnership took a thorough and well-structured approach to assessing and managing strategic care at home service risks, and these were reviewed regularly. The risk register identified key challenges, particularly around commissioning, provider sustainability, and workforce capacity, alongside mitigating actions.

Significant restructuring and organisational changes across the partnership were being implemented. The partnership's leadership team focused their efforts on the immediate care at home priorities, ensuring that the essential building blocks of service delivery and governance were in place.

Leaders outlined a potential future model for care at home services. Its implementation was paused. This was due to several organisational and financial reasons. There were risks that leaders were not achieving their transformational agenda for care at home at the required pace. This adversely impacted the partnership's wider strategic priorities.

Key area 2: Organisational culture and leadership

Summary
Collaborative working was strong across both strategic and operational levels, with respectful and proactive engagement with partners. Leadership was professional and supportive, though local authority staff felt less positive compared to those working in the independent sector. While leaders communicated well with frontline staff, some areas of uncertainty remained. Strategic priorities were evidence-based, with a clear focus on improvement and outcomes. The partnership showed commitment to transparency, improvement, and valuing contributions across sectors.
Evaluation: Good

2.1 Leadership of people and culture

Collaborative working was well embedded in the partnership at both strategic and operational levels. This ethos extended to externally commissioned care at home service providers and other partners. A professional and respectful culture within care at home services was evident. Commendably, staff engagement was a key driver of change, and leaders actively valued and sought contributions across sectors. Initiatives such as the visible leadership and financial communication plans strengthened transparency and dialogue around budget pressures and service redesign. Support for Integration Joint Board members was consistent, with various development programmes in place. However, the variability in board members' understanding of care at home services indicated that further capacity-building was required.

Professional leadership was strong. Staff felt listened to, were supported and respected by their managers and leaders. Most agreed, across all sectors, that changes which affected services were managed well by their managers. However, staff working in the local authority sector were less likely to share this view.

Leaders demonstrated that they strongly valued the role and contribution of the third and independent sectors in achieving good outcomes for people and carers. Engagement with these providers was proactive. While most care at home providers aligned themselves with the partnership's vision, the extent to which their views and those of people and carers informed strategic decisions should be strengthened.

There were productive working relationships, which affected care at home services, with NHS Forth Valley. For example, the 'shifting the balance of care' pilot project, which intended to move care from hospitals towards community settings.

2.2 Leadership of change and improvement

Priorities for change and improvement were evidence-based. Leaders supported a positive culture of improvement. Most staff agreed that senior managers communicated well with frontline staff.

Leaders had a strong commitment and focus on continuing to improve the quality of care and support and delivering good outcomes for people and carers. They had a good level of awareness about how well services were performing and whether changes to systems and practices were delivering and improving outcomes for people and carers.

Senior managers led change well in most instances, engaging and communicating effectively with relevant stakeholders and monitoring the impact of changes implemented. However, despite clear strengths, there was sometimes a distance between leaders' and frontline staff views on how well strategic priorities were being implemented.

Good Practice Example – 'Shifting the Balance of Care'

The Scottish Government's commitment to shift the balance of care away from hospitals towards community settings and to improve access to local services is aligned with the partnership's strategic plan. To improve how people were discharged from hospital and ensure that they got the right care at the right time and place, an additional £2.027 million for year 2025/26 was made available by NHS Forth Valley. This supported the partnership's implementation of a 'shifting the balance of care' test of change. If successful, a future business case would be presented, as part of the 2026/27 budget setting process, and be maintained on a recurring basis.

The test involved discharging upwards of 32 people from one hospital site. Using a 'discharge to assess' model, people involved received an assessment of their needs at home over a period of up to 21 days, offering 24-hour care where needed, including care home, mobile emergency care and care at home services. The project commenced in June 2025. It involved:

- Provision of 24-hour care to support discharges, including access to care at home, telecare, occupational therapy, equipment and adaptations, rehabilitation and reablement.
- Working with people to start planning their discharge with realistic predicted discharge dates at admission.
- Processes and pathways around expected outcomes, flow within the service to support ongoing discharges with key performance indicators.

Anticipated benefits included:

- People receiving care in their own home or in a homely setting
- Reduction in the number of people delayed awaiting a hospital discharge
- Reductions in the length of hospital stays for people awaiting discharge
- Reductions in the proportion of people moving directly from hospital to long-term care homes
- Reductions of whole system costs.

While the project was in the initial stages of implementation, early results were promising. Good practice was taking place in multi-disciplinary working and the integration of resources (staff and financial). This led to less care at home overall provision than estimated and enabled people to access services in the community.

Key area 3: Engaging stakeholders

Summary
Most people were actively involved in planning their care, with person-led approaches widely adopted. Some people were supported to self-manage their wellbeing, aided by tools such as 'Living Well Falkirk' and other community resources. Forums like VOICE supported engagement with carers. Third sector organisations, supported by grant funding, played key roles in the planning and delivery of services. Staff felt valued and supported, with strong teamwork and effective communication. However, the paused in-house service redesign had lowered morale in some of these teams.
Evaluation: Good

3.1 Involving people, carers and other stakeholders

People

Commendably, almost all people were actively involved in planning their care and support, with services tailored to personal needs. Despite some limitations related to assessment procedures, eligibility criteria, and available resources, most care plans were person-led. Staff widely agreed that people were engaged in planning, delivering, and reviewing care at home services. Some people were offered access to community resources, including local groups and carer support services, to help manage their wellbeing.

Information on community resources was available in a useful online directory through the local third sector interface, CVS Falkirk. An online, easy-to-use 'Living Well Falkirk' tool offered self-management advice to help people stay as fit and able as possible. Care at home providers actively shared information on local resources which people could access and benefit from. Most staff felt that people were supported to maintain independence and engage with their communities.

Carers

A small number of carers were meaningfully involved in strategic planning. Regular VOICE forums hosted by the carer's centre facilitated dialogue between carers, the partnership and third sector representatives. These forums informed the development of the Falkirk Carer's Strategy and its implementation. Carer's representatives, supported by the carer's centre were members of the Integration Joint Board.

Third and independent sector organisations

Communication and engagement across sectors were ongoing success stories for the partnership. It was implementing a comprehensive communication and engagement strategy (2024–2027), supported by detailed action plans and toolkits. Engagement activities included consultations, surveys, and direct interactions.

CVS Falkirk and Scottish Care representatives had prominent roles on relevant strategic planning and wider service development groups. There were regular, well-attended and received care at home providers' forums. While externally commissioned service providers had mostly positive experiences of their engagement with the partnership, some expressed concerns about being fully heard on operational issues.

Grant funding for the third sector interface and a range of third sector agencies supported these organisations to deliver prevention and early intervention support to different care groups, including carers. A detailed consultation with third sector providers on the partnership's mid-term financial plan helped to incorporate their views on future financial planning, including grant funding and service levels.

3.2 Impact on staff

As reflected positively in our regulated care service inspections, almost all staff reported feeling valued, motivated, and committed to delivering high-quality, outcome-focused care. The partnership's in-house service's engagement mechanisms included supervision, team meetings, appraisals, newsletters and the 'iMatter' annual survey. These contributed to staff development and feedback. Supervision and appraisal processes were consistent across sectors, supporting staff confidence and professional growth. Most staff felt adequately resourced to do their job and that workloads were manageable.

While managers were involved in service development, operational staff had fewer opportunities to contribute to service planning. Most staff felt that their feedback was used to improve services and that leadership was inclusive of people, carers, and staff in service design. The in-house care at home service operated with five management layers per locality, which supported supervision and quality assurance but led to some inconsistent policy interpretation and practice across the different localities.

Teamwork was strong across multi-disciplinary teams, including social work, care at home service providers, occupational therapy, and nursing professions. Staff from externally commissioned providers reported higher morale compared to in-house teams, where uncertainty due to the paused service redesign had reduced staff confidence.

Key area 4: Creating sustainable value

Summary

The partnership had a range of effective preventive and early intervention activities that helped improve people's wellbeing through rehabilitation, reablement, and community engagement. Care at home services helped people stay independent and feel less isolated, with smooth transitions and timely support.

Assessments and reviews were mostly timely and person-led. Some people experienced problems with communication and choosing their service provider, particularly when leaving hospital. Adult carer support plans were in place for under half of carers, with some unable to access services due to a lack of their own plans. Revised eligibility criteria aimed to prioritise people's critical and substantial needs, but staff understanding varied, leading to differing access to services in some instances.

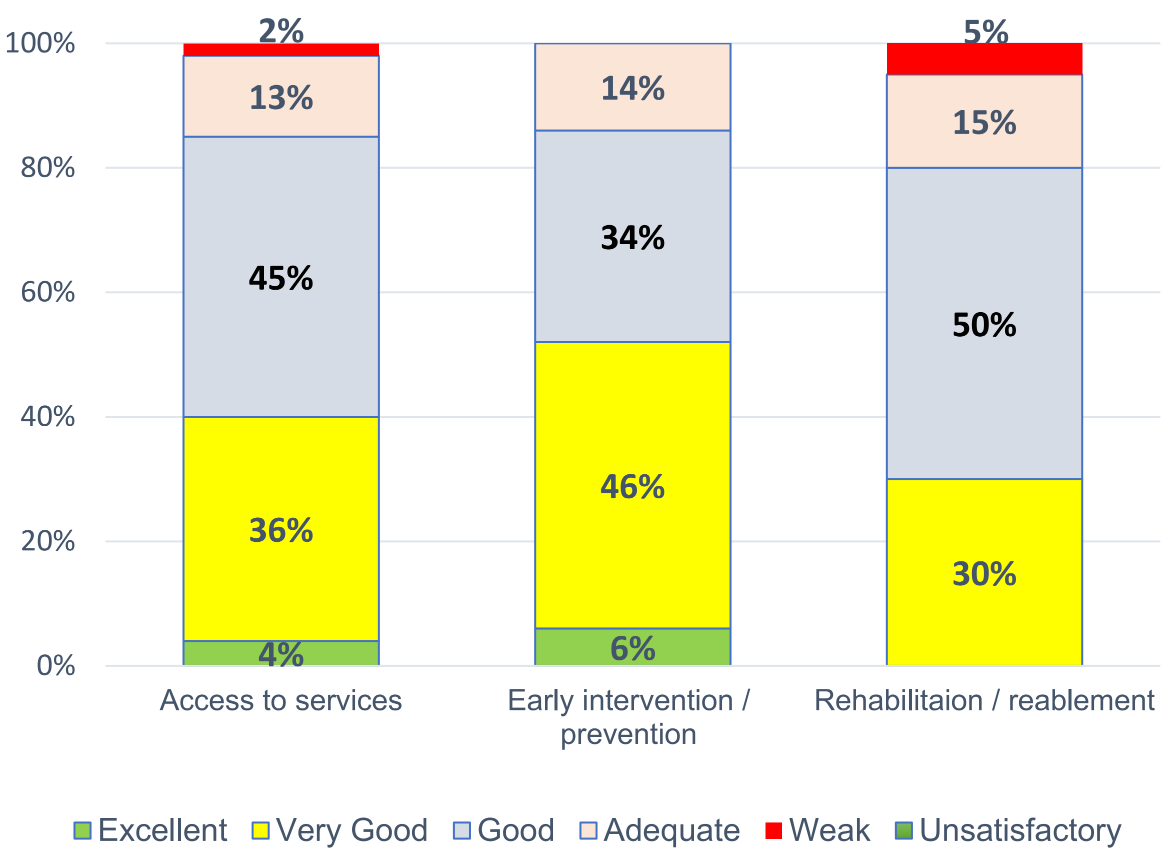
Significant workforce recruitment and retention challenges existed, particularly in occupational therapy and care at home roles, affecting service resilience. Workforce planning was a key focus, but challenges such as high sickness absence and turnover threatened services' sustainability. Development work focused on wellbeing, leadership, and trauma-informed practice. Staff felt supported and confident, with access to training and supervision. Across all sectors staff appreciated the learning opportunities available.

Evaluation: Good

4.1 Processes were in place to support early intervention and prevention

The partnership had a range of well-coordinated early intervention and prevention activities in place with clear evidence of positive impacts on people's wellbeing and outcomes. It had made effective efforts to ensure that people had access to rehabilitation and reablement as well as the provision of equipment and adaptations as part of their care at home service. This helped people live more independently. Where people received time-limited interventions, these consistently supported improvements in their wellbeing. The effectiveness of these interventions, from the records we read is shown in Figure 2 below.

Figure 2: Effectiveness of access, prevention and early intervention and rehabilitation and reablement processes



Source: Care Inspectorate

Care at home service providers encouraged people to be physically active and involved in their community, helping to reduce their social isolation. Transitions to, and from, reablement and rehabilitation services were generally well-managed, with staff encouraging people's self-management and independence. This contributed to sustained improvements in people's health and wellbeing over the longer term. Contracting arrangements that promoted independence were viewed positively by most care at home service providers.

The NHS ReACH allied health professions rehabilitation care group team and the in-house reablement team were key contributors to early support, enabling people to remain at home and connected to their communities. Social care services also supported participation in community activities that helped people to remain connected to their local community and to those who were important to them.

4.2 Processes were in place for coordinated assessment, planning and delivering care at home

Assessments, reviews and care planning

Almost all people felt involved in their care planning. Assessment processes were timely and outcomes-focused. The quality of which was consistently good or better. Social care officers played a central role in assessment and review processes, though their involvement varied across teams. This led to inconsistencies in access to equipment and service delivery timelines.

Reviews were routinely undertaken and responsive to changing needs. Most involved the person and/or their carer and led to care plans being updated accordingly. Keyworker involvement was evident and contributed positively. However, reviews led by duty workers or care at home service providers in isolation were sometimes less effective due to not knowing the person well enough and a lack of partnership input.

A few people, carers and staff raised concerns about reviews focussing on reducing services rather than meeting people's assessed needs. In some cases, reductions in support were, at least in part, driven by financial constraints rather than person-led planning.

Figure 3: Effectiveness of assessment, review and care planning processes

Source: Care Inspectorate

Care plans were present in almost all records and were of good quality, with a strong emphasis on personal outcomes. Risks, and how to address them, were actively considered. Staff reported that clear guidance on risk management, and positive risk-taking was available to them. Our regulatory inspections rated care planning as

generally good or better. The effectiveness of these processes, as assessed from the records we read, is shown in Figure 3 above.

Some staff noted delays in updating care plans and insufficient pre-visit information, negatively impacting the quality of support. Communication gaps were evident in some cases, particularly when people were being discharged from hospital, affecting their continuity of care.

Most of the records we read showed that when emergencies happened, people got the right help quickly. However, hospital discharge planning was inconsistent, with variable quality in single shared assessments. In some cases, an emphasis on hospital flow compromised person-led outcomes and carer involvement.

Eligibility criteria

A revised eligibility criteria for accessing and allocating resources was approved by the Integration Joint Board in March 2025. The partnership prioritised people's and carers' critical and substantial needs. The policy was in its early stages of implementation. As a result, some staff had gaps in their knowledge and did not always understand how to apply the eligibility criteria. This has led to differing access to services for some people.

Resource allocation panels were in place for different care groups and service types. The panels aimed to promote risk enablement and prevent over-provision. However, panel decisions were sometimes seen by people, carers and staff as leading to service reductions, negatively affecting people's and carers' experiences of the service. Delays in panel decisions led to long waits in services being put in place for a few people.

Adult carers' support plans

The carer's centre carried out carer assessments and developed adult carer support plans. Of the records we read, most people had a carer. Adult carer support plans were in place for just under half of the carers, with most plans good or better. Some carers were unable to access services because they did not have an adult carer support plan. Just under half of the support plans met the eligibility criteria for critical or substantial needs and were referred to the partnership's social work services for further assessment. Carers who did not meet these thresholds were signposted to community resources. In some cases, there was limited evidence that additional support was provided following the completion of a support plan. Just over half of carers were adequately supported to maintain their own health.

4.3 Recruitment, retention, deployment and safe staffing

The partnership's challenges in relation to staff recruitment and retention were particularly felt in frontline care at home, social work, and occupational therapy roles. Targeted strategic actions included collaboration with Scottish Care, reablement-focused training, and alignment of qualifications with Scottish Social Services Council standards. These initiatives produced some positive outcomes, notably through the introduction of an advanced practitioner role, which enhanced career progression for social workers and occupational therapists.

Despite these efforts, occupational therapy vacancies remained a problematic issue, contributing to delays in assessments and people receiving provision of equipment and adaptations.

In-house care at home services' absenteeism rates were at around 10%, a recruitment pause, staff vacancies and turnover, further strained workforce capacity and the sustainability of some care at home providers. These issues placed significant risks to the timely delivery of improvement plans and the long-term sustainability of care-at-home services. Addressing these pressures was critical to maintaining service quality and resilience.

The partnership accurately monitored externally commissioned care at home service provider contracts to ensure safe staffing, compliance with the Protecting Vulnerable Groups scheme checks, and adherence to the Health and Care (Staffing) (Scotland) Act 2019. Weekly staffing audits were undertaken within in-house services to maintain safe care delivery.

Recruitment challenges were particularly acute in the third and independent sectors, where less competitive terms and conditions hindered staff recruitment. Many care at home service providers relied on international recruitment, which was constrained by visa regulations. People, carers and staff highlighted the need for improved induction and contextual training for international staff to ensure positive experiences of care and outcomes for people and carers.

4.4 Workforce development and support

Workforce planning and support

Workforce planning was a strategic priority for the partnership, with a clear focus on staff wellbeing, trauma-informed practice, promoting independence, team cohesion, and leadership development. Almost all staff were professionally registered, with a small number within the permitted timeframe to register. Staff demonstrated a strong understanding of their roles and responsibilities, supported by effective professional leadership and management oversight.

Community care and care at home teams benefited from accessible managerial support, although some inconsistencies were noted in the frequency of team meetings and supervision.

Supervision of care at home staff was generally conducted every six months, with increased frequency when issues arose. Direct practice observations for care at home staff occurred quarterly or more often if needed. Senior care at home staff experienced less consistent supervision, though they reported confidence in accessing managerial support when required. Supervision practices were strengths-based, promoting reflection, learning, and action planning.

In our inspections of regulated care services, staff reported high levels of confidence in their roles and access to appropriate training, policies, and procedures. The annual 'good conversations' appraisal process was strengths-focused and complemented by regular one-to-one discussions. A revised supervision policy had been consulted on, with an action plan in development. The findings were reflected in some of our staff survey results, shown below in Figure 4.

Figure 4: Staff survey – workforce development

Statement	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
I have access to the right training and development opportunities	42%	46%	8%	2%	2%
I am supported and feel confident in my role/job	30%	54%	9%	3%	4%
I have regular supervision which includes making sure my workload is manageable	30%	43%	12%	10%	5%
I feel listened to, supported and respected by leaders	24%	48%	11%	12%	5%

Source: Care Inspectorate

Learning and development

The partnership's well-resourced social work workforce development team delivered a comprehensive range of learning opportunities for care at home staff. As a result, staff were well placed to support the delivery of existing and developing services by maximising their skills and learning. Training opportunities were provided by third and independent sector providers to their own staff, during induction and on an ongoing basis.

Positively, the partnership's training schedule was available to care at home staff across all sectors. Training was delivered through a blend of online modules and limited face-to-face sessions, allowing staff to tailor learning to their roles.

Mandatory and trauma-informed training aligned with Scottish Social Services Council requirements. Despite challenges in releasing staff for training, opportunities were highly valued and contributed to consistent practice across sectors.

Staff consistently reported that training prepared them well for their roles and supported their professional development. They were given all the training they needed to do their job well. Innovative recruitment and learning initiatives included a proactive young workers forum, engagement with schools and colleges, and participation in careers fairs. These efforts increased interest in social care careers among school leavers. Collaborative placements with the Scottish Centre for Simulation and Clinical Human Factors, supported by NHS Forth Valley, further enhanced learning opportunities.

Key area 5: Driving performance and transformation

Summary
The partnership showed strong, evidence-based approaches to strategic and operational planning, with a clear focus on community services, early intervention, and carer support. Its strategic plan was informed by a comprehensive joint strategic needs assessment and aligned with commissioning and workforce strategies. Commissioning processes of care at home services were robust with a mixed economy of care model. The contractual framework emphasised quality of care and promoting positive outcomes for people. However, there were challenges, including limited access to self-directed support options and continuity of care after a hospital discharge. Contract monitoring was well-developed, with strong engagement mechanisms. Feedback from people receiving services from externally commissioned providers was limited. Quality assurance activities were established, but self-evaluation activity was intermittent and lacked strategic alignment. Financially, the partnership faced significant challenges, including a significant overspend on care at home services. Short-term mitigations were used, but long-term sustainability remained a major risk. Strategic financial planning and cost-efficiency measures were introduced, yet concerns persisted around third and independent sector capacity and sustainability. Many ingredients for successfully delivering and overseeing person-led services were evident. However, the limitations of the commissioning framework, partial feedback mechanisms and the need for additional self-evaluation planning were areas for improvement that would help enhance people's and carers' outcomes.
Evaluation: Good

5.1 Strategic and operational planning

The partnership demonstrated a robust, outcome-focused approach to strategic and operational planning, underpinned by evidence and collaboration. Its strategic plan (2023–2026) clearly articulated shared priorities, with a strong emphasis on enhancing community-based services, promoting prevention and early intervention, and supporting carers. The plan was well-structured and accessible to stakeholders.

Strategic planning was effectively informed by a comprehensive joint strategic needs assessment (2023), which provided rich demographic, health, and social care data. The strategic plan aligned with the partnership's commissioning intentions for care at home services, supported by coherent financial and workforce frameworks.

Locality profiles informed planning but were not yet fully embedded. Operational delivery was structured through locality-based planning, with improvement plans in place for in-house care at home services. Locality delivery groups, comprising health, social work, carers, and third sector partners, were established, though their implementation remained in their early stages.

Planning documents generally adhered to SMART principles and were used appropriately for performance management and accountability. However, some lacked clarity regarding future investment and disinvestment. Self-evaluation processes were underdeveloped. This limited the partnership's ability to assess progress, address incomplete actions, and apply learning from previous initiatives.

5.2 Commissioning arrangements

Strategic commissioning

The partnership had a strong strategic approach to commissioning care at home services, underpinned by a sound understanding of the local market. Commissioning decisions were well-informed and aligned with strategic investment priorities and outcomes. Medium-term intentions were clearly expressed and implemented through a well-established care at home contractual framework.

Despite persistent challenges in ensuring service supply, capacity, quality, and choice, the partnership maintained a mixed economy of care model. Its in-house provision accounted for approximately 20% of care packages, primarily focusing on reablement and people with complex care needs.

Substantial efforts were being made to develop a whole system commissioning model, preventing people from being admitted to hospital and supporting people being discharged from hospital, and promoting people's independence. The strategic aim to shift the balance of care from institutional towards community settings was clearly prioritised.

Commissioning framework

Implemented in April 2024, the care at home contractual framework was well informed by comprehensive market analysis and benchmarking. Service specifications were detailed and explicitly linked to early intervention, reablement, and outcome-focused care.

Care at home service providers were evaluated using a 90:10 quality-to-cost ratio, with quality assessed via Care Inspectorate evaluation grades. This approach reflected a commitment to working with high-performing providers aligned with national care standards. The framework led to reduced hourly unit costs, increased system capacity, and a broader provider base.

There were some difficulties with the framework's implementation. By design, it encouraged a position where service providers bid for packages of care with self-directed support option three. This restricted alternative self-directed support options for people and carers. The introduction of an e-brokerage system was positively received by care at home providers, for its usability and early access to care planning information. However, its effectiveness in planning people's discharge from hospital was inconsistent, particularly where there was incomplete or inaccurate information on people's needs or preferences.

The lack of continuity of care following a hospital stay for more than seven days was a major issue for some people, carers and service providers. It was not always possible to ensure people's care and support would return to the same staff or provider after hospital discharge. While there were workarounds, for example, accessing self-directed support option two, this unintended by-product of the

framework caused unnecessary difficulties for people and carers. The framework also presented barriers for specialist providers, whose capacity to bid was constrained by generic service specifications. Senior managers acknowledged these limitations and planned to address them in a scheduled April 2026 framework review. Providers raised concerns about national financial pressures, including increased employer costs and living wage compliance, urging the partnership to uphold its ethical commissioning principles.

Contract monitoring

Contract management was well developed and effectively supported the partnership’s commissioning objectives. The commissioning team was responsive and provided valuable support, particularly in workforce development to externally commissioned providers. Performance data from monitoring activities was routinely reported to senior leadership. Engagement mechanisms were strong, with Scottish Care hosting fortnightly forums and the partnership facilitating quarterly sessions. These forums reflected a genuine commitment to collaborative commissioning.

Most externally commissioned service providers reported that they could provide feedback on the views of people who used their services to the partnership. However, there was limited evidence that the partnership regularly collected its own analysed feedback, from people and carers receiving services from third and independent sector providers, to inform future service delivery. Service providers had their own quality assurance methods.

5.3 Quality assurance, self-evaluation and improvement

The partnership adopted a multi-layered approach to quality assurance, integrating assessment, care planning, review, and caseload management to evaluate service quality and people’s experience. Professional supervision and appraisals further supported assurance processes.

Most staff indicated that people’s views informed planning and improvement. However, only just over half felt that carers’ feedback was consistently used to enhance care at home services. Care at home service providers largely agreed that the partnership had effective quality assurance mechanisms and supported their own self-evaluation efforts.

Self-evaluation activities were undertaken with varying degrees of depth and scope. While an internal audit of the strategic plan was completed and locality planning was informed by evaluation, these processes lacked consistency across all areas.

The partnership did not clearly set out how priorities for self-evaluation were determined. A more strategic and coordinated approach was needed to ensure that insights from quality assurance directly informed improvement planning. Aligning self-evaluation with strategic priorities would enhance service delivery.

5.4 Management of resources

The partnership faced significant financial challenges, some of which were national in scope, with a £7.036 million overspend in 2024–2025. Of this £5.405 million was in care at home services. Reliance on non-recurring reserves to address these overspends highlighted long-term sustainability risks.

Recent actions, such as introducing a medium-term financial plan, improved oversight. Resource allocation panels and care package reviews delivered £0.8 million in recurring savings. Efforts to align costs with national benchmarks increased efficiency. However, in-house service underspends were mainly due to staffing vacancies rather than improved productivity.

Stakeholder feedback pointed to ongoing concerns about the nature of care reviews, third sector capacity, and the viability of externally commissioned providers. Risks remained high for the transformation programme, especially if current and medium-term financial recovery plans were not fully implemented. This would significantly hinder the long-term financial sustainability of care at home services and the drive to shift the balance of care towards community settings.

Key area 6: Stakeholder perceptions

Summary
Almost all people receiving care at home services were satisfied with their care, felt respected and supported by staff who understood their needs. People got on well with staff, and they felt respected and listened to by those who supported them. Continuity of care was sometimes interrupted after hospital stays longer than seven days due to the reallocation of services through the e-brokerage system. Carers were generally well-supported when they accessed the right services, though delays in assessments and limited respite options created challenges. Respite services were valued but often hard to access, especially in emergencies. Feedback systems varied, with in-house services showing high satisfaction levels. Externally commissioned services had their own mechanisms. Uptake of self-directed support options was low due to the contractual framework design, lack of staff awareness and perceived complexity.
Evaluation: Good

6.1 People's and carers' experiences of person-led care at home services

People's experience

Almost all people were content with the care and support they experienced from their care at home service. Staff always or very often helped people to find ways to do things that mattered to them. People got on well with staff, and they felt respected and listened to by those who supported them. Most people commented that staff knew them well, including what they liked, and what was important for their care. These positive findings were reflected in our inspections of regulated care services and our people's and carer survey results, as shown in Figures 5 and 6 below.

Figure 5: People's and carers' survey – satisfaction with service

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Do not know
I am happy with my care and support	61%	35%	1%	1%	2%
I am fully involved in my care and support	42%	42%	1%	9%	6%

Source: Care Inspectorate

Figure 6: People's and carers' survey – views on service delivery

Statement	Always	Very Often	Some-times	Rarely	Never
I get on well with staff	80%	17%	3%	0%	0%
I feel respected and listened to by staff who support me	78%	16%	5%	1%	0%
Staff have enough time to support me	63%	23%	11%	2%	1%
Staff help me to find ways to do what matters to me	60%	22%	10%	4%	4%
Staff support me to do things for myself	60%	25%	9%	3%	3%
I am told about changes to my support	47%	17%	18%	11%	7%
I know when to expect them	46%	33%	17%	3%	1%
I know who is coming to support me	31%	35%	26%	6%	2%

Source: Care Inspectorate

Alongside care at home, many people accessed additional services such as adaptations, equipment, occupational therapy, telecare, rehabilitation and reablement. Access to these services was good or better in most cases. However, time constraints, particularly 15-minute visits, were frequently cited as barriers to delivering truly person-led care. These limitations affected meal preparation, personal care, and medication support, reducing choice and independence.

Some people commented that they always knew who was coming to support them, that they knew when to expect them and were always or often told if there were going to be changes to their support.

The continuity of care was a recurring issue raised by some people and carers. The impact of staff absence, annual leave, staff turnover or the introduction of new staff meant that the staff who attended did not always know people's needs well. Some people's experience of care at home services was less positive as a consequence.

Where people expressed a specific wish in relation to their care, for example, for personal care, to be delivered on a same-sex basis, service providers advised that they made a concerted effort to ensure this happened. However, this was not always the case.

Service providers advised that post-hospital discharge arrangements disrupted carefully established work, for example end of life care. While self-directed support

option two was a potential 'workaround' resolution, this was dependent on the assessing worker having the 'right' type of conversation with the person, the person feeling capable of taking this route, and the timescales involved in accessing self-directed support option two.

Where a person selected their care at home service provider via self-directed support option two, they needed, on most occasions, to be discharged home first with a provider they may not necessarily choose. This meant the system was sometimes task-focussed and impersonal. It did not fully take into account people's choices or wellbeing.

Carer's experience

Carers were generally well-supported, with most staff affirming their role as active partners in care. From the records we read, where there were carers, we looked at whether they were supported to look after their own health and wellbeing. The overall effectiveness of the partnership's response to the carer was rated as good or better in most cases.

The carer's centre played a key role in early intervention and prevention. Referral waiting times were approximately six weeks. Carers with critical or substantial needs required further assessment from the partnership's community care teams. There could be long waiting times for this. This led to delays and difficulties for carers to be able to get support when they needed it. This was particularly so at short notice, as some carers continued caring until they reached a crisis point.

Not all community care team staff had a full understanding of how adult carer assessments were initiated or completed. Knowledge gaps among staff regarding carer assessments and unclear responsibilities when no lead professional was assigned created risks of carers not having their needs met. A central contact officer helped coordinate referrals, but access to services such as respite could be long.

Positively, the partnership's residential care respite provision levels were above the Scotland average. Carers accessed respite via the short breaks bureau. The partnership had 'block booked' beds to assist in guaranteeing some availability at any given time. However, gaining access to these services could be problematic. Planned respite often had to be booked many months in advance. It was particularly difficult to source emergency respite, even in a crisis.

The limited availability of local overnight respite options meant that it was sometimes secured from outside the partnership area, which sometimes meant people experienced respite some distance from their home or their visiting relatives. More positively, when respite was provided, carers valued the service highly.

A reduction in the availability of care home respite alongside the uncertainty of a respite break going ahead as planned, meant that some people were using a small proportion of their 'allocated' number of days per year.

A few carers used self-directed support to access different forms of respite as part of their care package. They had converted their monetary equivalent of their respite days allocation to securing differing respite forms or obtaining resources that supported them in their caring role. Flexible respite options, other than overnight residential care, were limited. A flexible respite scheme was under review. It was unclear what the resulting proposals would be. This created uncertainty for carers.

Senior managers recognised the need to develop a wider variety of locally available respite options, but there had been limited progress.

Feedback from people and carers

Feedback systems varied across services. The in-house service offered complaint forms, phone contact, and surveys, with results indicating high satisfaction levels. Observational feedback was also used. Externally commissioned services had their own feedback mechanisms. Out with formal service provider contract monitoring returns, which had limited information on feedback from people and carers, the partnership was less knowledgeable about the satisfaction of people using externally commissioned services.

While most people felt confident that any concerns that they had about their service would be addressed, a minority reported uncertainty about follow-up. Opportunities for involvement in service design and delivery were limited, particularly within in-house services.

Feedback from people and carers during our inspections of regulated care services was positive. Almost all people were happy with the service that they received.

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

Most people felt encouraged to do things for themselves, with personal plans reflecting their own priorities. In our inspections of regulated care services most staff said that their service had the right balance between keeping people safe and being independent. The in-house reablement team demonstrated a strong focus on goal-oriented support, enabling people to regain or maintain independence after a hospital discharge.

This short-term intervention, available for up to six weeks, also facilitated continuity of care through 'bridging' arrangements. While externally commissioned services emphasised a reablement approach, implementation was limited, primarily due to time constraints.

Access to occupational therapy was significantly constrained by extended waiting times, often six to nine months for both locality-based assessments and the ReACH team. Despite this, the ReACH team exhibited flexibility in responding to urgent needs, often serving as an alternative referral route for equipment provision. This approach was particularly beneficial for people at risk of falls, with urgent referrals also facilitated through GPs and district nurses.

The partnership performed above the national Scottish average levels for the delivery of telecare for those in receipt of care at home services. Community alarms provided a useful reassurance to people and their carers that help could be available quickly. Telecare, including community alarms and systems like Canary and Just Checking, were effectively integrated into assessment and care planning. These tools were especially valuable in supporting people with cognitive or learning disabilities, contributing to more robust, evidence-based assessments.

Locality-based pharmacy technicians provided timely, on-demand support to care staff. Their involvement in medication assessment, review, and staff training enhanced the quality of medication management. Collaborative work with GPs to optimise prescriptions further supported people's health and wellbeing.

6.3 People's and carers' experience of information and decision-making in care at home services

Information about care at home services was available through multiple sources, including the partnership, Falkirk Council, CVS Falkirk, and the carer's centre. These all had a range of good information to help people and carers consider their options and access services. These included eligibility criteria and what to expect from the service. However, information, accessibility and awareness varied. Some people and carers struggled to locate relevant information. Some care at home staff were a good source of information for people and carers about how to find out about other services. However, this was inconsistent across services.

The carer's centre had previously collaborated effectively with the Racial Inclusion, Supporting Empowerment organisation and the Minority Ethnic Carers of People Project. This had led to increased referrals from the black and minority ethnic communities for care at home and carers' assessments and adult carers' support planning. There was limited evidence of existing measures routinely in place to engage with people who were 'seldom heard' and/or whose first language was not English, about their particular needs.

While most staff reported that people and carers were routinely supported to exercise choice and control over their care, uptake of self-directed support options one, two and four was significantly below the national average.

Staff confidence and awareness of self-directed support were limited. Some community care team and care at home frontline staff viewed self-directed support processes, other than option three, as cumbersome. This contributed to a reluctance to engage with more flexible, outcomes-focused approaches. Most people preferred the local authority to manage services under option three. However, our case file reading indicated that self-directed support was discussed and offered in just over half of the cases. Carer awareness of self-directed support was low, with only a few reporting meaningful discussions about available options.

Independent and third sector care at home providers expressed interest in expanding self-directed support choice, but were constrained by the care at home framework. Self-directed support information from organisations such as Self-Directed Support Forth Valley and the carer's centre was highly valued, yet the overall availability of clear, accessible information remained insufficient. A recently approved (June 2025) self-directed support policy, co-produced by a multi-agency working group, was yet to be fully implemented.

Key area 7: Strategic and operational performance

Summary

The partnership performed well in the levels of care at home service delivery and the quality of care across services. Delivery on other key Scottish Government integration indicators, such as hospital emergency admissions, readmissions and delayed discharges, was much less positive. Investments in telecare and assessment processes showed progress, but care system flow and financial pressures persisted. These contributed to stalled redesign efforts.

Performance monitoring and management were improving, with better data use and operational tools enhancing management oversight. However, qualitative and outcome data was not routinely prepared or analysed. This limited the use of performance management for self-evaluation and service development.

Care at home commissioning delivered generally positive outcomes, with most people reporting good experiences. However, a significant minority of people did not experience positive experiences. While many carers were supported, a substantial number had unmet needs. Overall, services promoted independence and wellbeing, though support for unpaid carers was inconsistent.

Evaluation: Good

7.1 Care at home services' performance

Partnership performance

The partnership made significant efforts to adopt whole-system integrated health and social care approaches. As such, it invested substantially in care at home services. Falkirk ranked among the highest in Scotland for levels of care at home provision across all age groups. Improvements had been made in reducing waiting times for assessments and service delivery. A care package review programme was underway to better target services. Notably, the partnership performed above the national average on the proportion of adults with intensive care needs receiving care at home, and the proportion of care services evaluated as good or better by the Care Inspectorate.

As part of this inspection, 27 regulatory care inspections were conducted across in-house and commissioned care at home services operating in the partnership area. These services supported the vast majority of care at home recipients.

All inspections rated services as generally good or better across key quality themes, such as care planning, wellbeing support, leadership, and staffing. This reflected a consistently high standard of care delivery.

Despite these commendable efforts, the partnership was underperforming in system-wide health and social care as measured by the Scottish Government's core integration indicators. Improvements such as reducing the levels of emergency hospital admissions and readmissions, reducing the number of people delayed awaiting a hospital discharge or the length of their hospital stays had not materialised.

Performance monitoring

There was an improving picture of how the partnership was using its performance data. There was a shift to ensuring that the right data was being sought and used. Plans were underway to revise the performance management framework to enable more robust monitoring and reporting. Benchmarking activities, including engagement with the Local Government Best Value Network, were informing strategic planning and commissioning.

IT tools contained a wealth of operational management information. This enhanced the partnership's management's oversight of service delivery. Performance reports were clear, trend-focused, and incorporated both national and local indicators, and these were routinely reviewed to address any emerging issues. An annual performance report included interpretative commentary. A quarterly complaints and feedback report was produced. A SMART care at home improvement plan was in place and progressing well.

However, performance reporting remained limited in its capture of qualitative and outcome-focused data. While people's outcomes were assessed through care planning processes, these were not systematically analysed to inform service development. There was a recognition among managers and staff of the need to better evidence the impact of services on personal outcomes. Additionally, performance data was not consistently used to guide self-evaluation priorities. Enhancing performance frameworks to include qualitative and outcome-based indicators would strengthen the partnership's improvement approach.

7.2 People's and carers' outcomes

People experienced generally positive wellbeing outcomes as a result of the partnership's commissioning arrangements for care at home services. Most people had good or better experiences. The partnership had a good suite of outcome-focused assessment, care planning, and review tools, which were used consistently. However, there was limited evidence of routine analysis of this data to inform strategic reporting on outcomes.

Overall, the quality of staff practice in achieving positive outcomes was good or better in most cases. However, a notable minority did not experience positive outcomes. While many carers were well supported to maintain their own health and wellbeing and sustain their caring roles, a substantial proportion had unmet support needs.

Our case file reading analysis indicated that most people were supported to maintain and improve their health and wellbeing, and live in good health for longer. Nearly all people, including those with complex needs, were enabled to live independently at home or in a homely setting. People's experiences of social care services were largely positive, with people's dignity consistently respected. Care at home services were generally effective in maintaining or improving quality of life. Support for unpaid carers was more variable. While some were well supported, nearly half experienced only partial support in managing the impact of their caring role. People's and carers' outcomes, as assessed from the records we read, are shown in Figure 7 below.

Figure 7: National health and wellbeing outcomes

Statement	Completely	Mostly	Partly	Not at all	Not known
Are able to live independently and at home or in a homely setting	54%	37%	7%	2%	0%
Social care services are centred on helping to maintain or improve the quality of life of people	42%	44%	10%	2%	2%
People have positive experiences of social care	39%	44%	14%	0%	3%
Look after and improve their own health and wellbeing and live in good health for longer	14%	61%	25%	0%	0%
Carers are supported to look after their own health and wellbeing	8%	26%	45%	0%	21%

Conclusions

Falkirk Health and Social Care Partnership's commissioning arrangements for care at home services were effective and contributed to good outcomes for almost all people. The partnership had a good understanding of the local care at home market, and this supported strategic investment decisions. Personalised care planning and the involvement of people and carers alongside multi-disciplinary teamwork were a success story for the partnership. Effective performance management systems supported a collaborative working culture that existed across the partnership.

There were some areas for improvement. These included improving access to self-directed support options, enhancing carers' assessments, support planning and access to services. Development work was needed to strengthen the continuity of care arrangements after a hospital discharge. The pace of transformational change to address the significant financial and strategic challenges that the partnership faced needed to be accelerated.

Next steps

Falkirk Health and social care partnership should prepare an improvement plan. Prioritised actions will be required to ensure that people's and carers' needs are met and their wellbeing improved more consistently. The Care Inspectorate, through its link inspector, will monitor progress. We will discuss with the partnership the scale and nature of the improvements required, how it intends to make the necessary improvements and what support they will seek .

Appendix 1 - Inspection methodology

The inspection took place between April 2025 and September 2025. Our methodology included:

- reviewing publicly available data (for example, from Public Health Scotland) and intelligence held by the Care Inspectorate
- reviewing a self-evaluation position statement provided by the partnership;
- reviewing documentary evidence submitted by the partnership
- undertaking a staff survey of care at home service providers operating in the Falkirk health and social care partnership area, with 201 responses
- undertaking a survey of care at home service providers' managers operating in the Falkirk health and social care partnership area with 8 responses
- undertaking 27 regulatory care inspections of care at home service providers operating in the Falkirk health and social care partnership area. These delivered care at home to the vast majority of the people receiving services commissioned internally or externally, by Falkirk Health and Social Care Partnership
- analysing 370 responses from care service questionnaires (staff) in regulatory care inspections of care at home service providers operating in the Falkirk health and social care partnership area
- analysing 434 responses from care service questionnaires (people and carers) in regulatory care inspections of care at home service providers operating in the Falkirk health and social care partnership area
- analysing additional specific survey information requested from regulated care at home service providers operating in the Falkirk health and social care partnership area (26 services) and across Scotland (118 services);
- reading 59 sampled people's case files
- undertaking 20 focus groups and interviews with a total of 80 frontline staff
- holding 17 meetings with a total of 22 senior leaders and managers
- participating in 8 discussions with a total of 22 people and carers.

Appendix 2: Explanation of terms

Term	Meaning
Adult carer support plan	Under the Carers (Scotland) Act, every carer has a right to a personal plan that identifies what is important to them and how they can be supported to continue caring and look after their own health. This is called an adult carer support plan. Adult carer support plans are required to include plans for how the cared-for person's needs will be met in the future, including when the carer is no longer able to provide support.
Capacity	Capacity is the maximum amount of care, support or treatment that day service or individual member of staff can provide.
Care and clinical governance	The process that health and social care services follow to make sure they are providing safe, effective and person-led care, support and treatment.
Care at home	Also known as home care or domiciliary care, is a form of support provided to people in their own homes. It aims to help people live independently and securely by offering personal and practical assistance. This can include help with daily tasks like bathing, dressing, and eating, as well as support with housework, shopping, and medication reminders.
Carer	An unpaid carer of an adult person.
Carers' centre	Carers' centres are independent charities that provide information and practical support to unpaid carers. These are people who, without payment, provide help and support to a relative, friend or neighbour who can't manage without that help. Carers' centres are sometimes funded by health and social care partnerships to provide support.
Commissioning	Commissioning is the process by which social work and social care services are planned, put in place, paid for and monitored to ensure they are delivering what they are expected to.
Complex needs	People have complex needs if they require a high level of support with many aspects of their daily lives and rely on a range of health and social care services.
Contract Management	Contract management is the process that local authorities use to ensure that services they purchase from other organisations are of a good standard and are delivering at the expected level.
Coordinate	Organising different practitioners or services to work together effectively to meet all of a person's needs.
Core suite of integration indicators	These are indicators, published by Public Health Scotland, to measure what health and social care integration is delivering.

Term	Meaning
Early intervention	Early intervention is about doing something that aims to stop the development of a problem or difficulty that is beginning to emerge before it gets worse.
European Foundation for Quality Management	Management model for improving operational performance, managing change and driving sustainable transformation. It is a comprehensive model that can be applied to any organisation, regardless of its size or sector.
Eligibility criteria	Eligibility criteria are used by social work to determine whether a person has needs that require a social care service to be provided.
Good conversations	Conversations that take place between people, carers and staff. These conversations allow an understanding to develop of what is important to and for people and carers on their terms. This allows the identification of desired personal outcomes for the carer.
Health and social care integration	Health and social care integration is the Scottish Government's approach to improving care and support for people by making health and social care services work together so that they are seamless from the point of view of the people who use them.
Health and social care partnership	Health and social care partnerships are set up to deliver the integration of health and social care in Scotland. They are made up of integration authorities, local authorities, local NHS boards and third and independent sector organisations.
Independent sector	Non-statutory organisations providing services that may or may not be for profit.
Integrated services	Services that work together in a joined-up way, resulting in a seamless experience for people who use them.
Integration Joint Board	A statutory body made up of members of the health board and local authority, along with other designated members. It is responsible for the planning and delivery of health and social care services.
Localities	Agreed sub-areas within a health and social care partnership area. The partnership should make sure it understands and responds to the different needs of people in different localities.
Mixed economy	A system where services are provided by a blend of public (government-funded), private (for-profit and non-profit) organisations, and informal (family and community) sources.

Term	Meaning
National health and wellbeing outcomes	Standards set out in Scottish legislation that explain what people should expect to get from health and social care integration.
Outcomes	The difference that is made in the end by an activity or action. In health and social care terms, the difference that a service or activity makes to someone's life.
Performance Indicators	Measures that are used to evaluate how well organisations are doing in relation to a particular target or objective. For example, the Scottish Government uses national performance indicators to understand how well health and social care partnerships are achieving good health and wellbeing outcomes for people.
Person-led	This means putting the person at the centre of a situation so that their circumstances and wishes are what determine how they are helped.
Prevention	In health and social care services, prevention is about activities that help to stop people becoming ill or disabled, or to prevent illness or disability from becoming worse.
Procurement	The process that health and social care partnerships use to enter into contracts with services to provide care or support to people.
Reablement/ rehabilitation	The process of helping a person return to good health, or to the best health that they can achieve.
Respite care	Temporary care that is provided for someone with health and social care needs, usually to provide a break for the person or their carer. Respite care is often provided in a residential setting, but can also be provided via short breaks for the person and/or their unpaid carers.
Scrutiny	The process of carefully examining something (for example a process, policy, or service) to gather information about it.
Self-directed support	A way of providing support that means people are given choice and control over what kind of support they get. It starts with a good conversation with social work and social care staff about what personal outcomes an individual wants to achieve. There are four options available for arranging support. 1. Option one: a direct payment where the person purchases their own support. 2. Option two: the person chooses the service and the provider, and the health and social care partnership organises the support for them.

Term	Meaning
	3. Option three: the health and social care partnership identifies and arranges the support. 4. Option four: a combination of the options.
Service providers	Organisations that provide services, such as residential care, care at home, day services or activities.
Short breaks	Opportunities for people who need care and support and/or their unpaid carers to have a break. Its main purpose is to give the unpaid carer a rest from the routine of caring.
SMART	SMART criteria is a framework for setting effective goals. It stands for Specific, Measurable, Achievable, Relevant, and Time-bound. By making goals clear, quantifiable, realistic, aligned with broader purposes, and given a deadline, individuals and organisations can improve their chances of success and maintain focus throughout the goal-setting process.
Social care	Social care means all forms of personal and practical support for adults who need extra support. It describes services and other types of help, such as care and support at home, day services, respite care and residential care.
Social work	Social work provides a wide range of services. These include care services for adults, services for children and families and criminal justice services, including the supervision and rehabilitation of offenders. The statutory framework for social work services covers many different pieces of legislation. The Social Work (Scotland) Act 1968 is the key legislation and places the responsibility for these services with local authorities. For example, social work service practice includes social workers' and occupational therapists' involvement in assessment, care planning and management functions.
Strategic needs assessment	A process to assess the current and future health, care and wellbeing needs of the community in order to inform planning and decision-making.
Telecare	Telecare is the use of technology to provide health and social care to people in their own homes. It can include communication systems, alarms and monitoring of health status and symptoms.
Third sector	Organisations providing services that are not private or statutory. The term is often used to refer to voluntary organisations but can also refer to community organisations or social enterprise organisations.

Term	Meaning
Workforce plan	A plan that sets out the current and future needs for staff in the organisation, and how those needs will be met.

Appendix 3 - Six-point evaluation scale

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

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

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

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

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

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

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

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

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

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