care inspectorate

A quality framework for support services (not care at home)

For use in self-evaluation, scrutiny and improvement support

October 2019

HAPPY TO TRANSLATE

Changes to our inspection

We are developing new approaches to scrutiny. We want to make sure that inspections and our other scrutiny work are strongly focused on assessing the extent to which people experience wellbeing, and on understanding the difference care and support makes to their lives. Since 1 April 2018, the **Health and Social Care Standards** have been used across Scotland. They have been developed by Scottish Government to describe what people should experience from a wide range of care and support services. They are relevant not just for individual care services, but across local partnerships. The Care Inspectorate's expectation is that they will be used in planning, commissioning, assessment and in delivering care and support. We will use them to inform the decisions we make about care quality. This means that we are changing how we inspect care and support. From 2018, on an incremental basis, we have been rolling out a revised methodology for inspecting care and support services.

The changes build on approaches we have introduced in the past three years: an emphasis on experiences and outcomes; proportionate approaches in services that perform well; shorter inspection reports; and a focus on supporting improvement in quality. The core of the new approach is a quality framework that sets out the elements that will help us answer key questions about the difference care is making to people and the quality and effectiveness of the things that contribute to those differences. The primary purpose of a quality framework is to support services to evaluate their own performance. The same framework is then used by inspectors to provide independent assurance about the quality of care and support. By setting out what we expect to see in high-quality care and support provision, we can also help support improvement. Using a framework in this way develops a shared understanding of what constitutes good care and support.

It also supports openness and transparency in the inspection process. In developing this framework, we have involved both people who experience or have experienced care and those who provide care and support. It is based on the approach used by the European Foundation for Quality Management, specifically the EFQM Excellence Model, which is a quality tool widely used across sectors and countries. We have adapted the model for use in care settings and have used the new Health and Social Care Standards to illustrate the quality we expect to see. Our frameworks are tested and evaluated to hear the views of people experiencing care, their carers and care providers. This helps us refine the framework and the way we will use it.

How is the framework structured?

The quality framework is framed around six key questions (see the table on page 8 of this document). The first of these is:

- How well do we support people's wellbeing?

To try and understand what contributes to wellbeing, there are four further key questions:

- How good is our leadership?
- How good is our staff team?
- How good is our setting?
- How well is care and support planned?

Under each key question, there is a small number of quality indicators. These have been developed to help answer the key questions. Each quality indicator has a small number of key areas, short bullet points that make clear the areas of practice covered.

Under each quality indicator, we have provided quality illustrations of these key areas at two levels on the six-point scale used in inspections. The illustrations are the link to the Health and Social Care Standards and are drawn from the expectations set out in the Standards. They describe what we might expect to see in a care service that is operating at a 'very good' level of quality, and what we might see in a service that is operating at a 'weak' level of quality. These illustrations are not a definitive description of care and support provision but are designed to help care services and inspectors evaluate the quality indicators, using the framework.

The final key question is:

- What is our overall capacity for improvement?

This requires a global judgement based on evidence and evaluations from all other key areas. The judgement is a forward-looking assessment, but also takes account of contextual factors that might influence an organisation's capacity to improve the quality of the service in the future. Such factors might include changes of senior staff, plans to restructure, or significant changes in funding. We think this is an important question to ask as part of self-evaluation.

In each quality indicator, we have included a scrutiny and improvement toolbox. This includes examples of the scrutiny actions that we may use in evaluating the quality of provision. It also contains links to key practice documents that we think will help care services in their own improvement journey.

How will this quality framework be used on inspections?

The quality framework will be used by inspectors in place of the older approach of 'inspecting against themes and statements'. Inspectors will look at a selection of the quality indicators. Which and how many quality indicators will depend on the type of inspection, the quality of the service, the intelligence we hold about the service, and risk factors that we may identify, but it is likely that we will always inspect Quality Indicators 1.1, 1.2, 1.3 as well as 5.1. We will

use the quality illustrations, which are based on the Health and Social Care Standards, in our professional evaluations about the care and support we see.

One of the quality indicators, 1.4, looks beyond the practice of an individual care service and introduces elements about the impact of planning, assessment and commissioning on people experiencing care. This is important because these practices impact on people's experiences and the extent to which they experience wellbeing. This quality indicator may help us during an inspection to find information or intelligence that is relevant to practices in commissioning partnerships, but our overall inspection evaluations (grades) will reflect the impact and practice of the care service itself.

We will provide an overall evaluation for each of the key questions we inspect, using the six point scale from unsatisfactory (1) to excellent (6). This will be derived from the specific quality indicators that we inspect. Where we inspect one quality indicator per key question, the evaluation for that quality indicator will be the evaluation for the key question. Where we inspect more than one quality indicator per key question, the overall evaluation for the key question will be the lower of the quality indicators for that specific key question, recognising that there is a key element of practice that makes the overall key question no better than this evaluation.

How will we use the six-point scale?

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

6	Excellent	Outstanding or sector leading
5	Very Good	Major strengths
4	Good	Important strengths, with some areas for improvement
3	Adequate	Strengths just outweigh weaknesses
2	Weak	Important weaknesses – priority action required
1	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. While

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 while addressing those elements that are not contributing to positive experiences and outcomes for people.

An evaluation of **weak** will apply to performance in which strengths can be identified but these are outweighed or compromised by significant weaknesses. The weaknesses, either individually or when added together, substantially affect peoples' experiences or outcomes. Without improvement as a matter of priority, the welfare or safety of people may be compromised, or their critical needs not met. Weak performance requires action in the form of structured and planned improvement by the provider or partnership with a mechanism to demonstrate clearly that sustainable improvements have been made.

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

How can this quality framework be used by care services?

The framework is primarily designed to support care services in self-evaluation. We are working with care services and sector-wide bodies to build the capacity for self-evaluation, based on this framework. We have published "Self-evaluation for improvement – your guide". The guide is available **here.**

Self-evaluation is a core part of assuring quality and supporting improvement. The process of self-evaluation, as part of a wider quality assurance approach, requires a cycle of activity based round answering three questions:

- **How are we doing?**

This is the key to knowing whether you are doing the right things and that, as a result, people are experiencing high quality, safe and compassionate care and support that meets their needs, rights and choices.

- **How do we know?**

Answering the question 'how we are doing' must be done based on robust evidence. The quality indicators in this document, along with the views of people experiencing care and support and their carers, can help you to evaluate how you are doing. You should also take into account performance data collected nationally or by your service.

- **What are we going to do now?**

Understanding how well your service is performing should help you see what is working well and what needs to be improved. From that, you should be able to develop and prioritise plans for improvement based on effective practice, guidance, research, testing, and available improvement support. You can find out more about the Model for Improvement and tools to support your improvements on the Care Inspectorate's Hub.

Using this quality framework can help provide an effective structure around self-evaluation.

The diagram below summarises the approach:

Irrespective of our role as the national scrutiny and improvement body, care providers will want to satisfy themselves, their stakeholders, funders, boards and committees that they are providing high quality services. We believe this quality framework is a helpful way of supporting care and support services to assess their performance against our expectations of outcomes for people, outwith an inspection and as part your own quality assurance. We are promoting this approach as we believe it adds value and we consider it important that care and support providers do not take actions merely to satisfy the inspection process.

The quality indicator framework

Key question 1: How well do we support people's wellbeing?	Key question 2: How good is our leadership?	Key question 3: How good is our staff team?	Key question 4: How good is our setting?	Key question 5: How well is our care planned?
1.1. People experience compassion, dignity and respect	**2.1.** Vision and values positively inform practice	**3.1.** Staff have been recruited well	**4.1.** People benefit from high quality facilities	**5.1.** Assessment and care planning reflects people's outcomes and wishes
1.2. People get the most out of life	**2.2.** Quality assurance and improvement is led well	**3.2.** Staff have the right knowledge, competence and development to care for and support people	**4.2.** The setting promotes and enables people's independence	**5.2.** Carers, friends and family members are encouraged to be involved
1.3. People's health benefits from their care and support	**2.3.** Leaders collaborate to support people	**3.3.** Staffing levels are right and staff work well together		
1.4. People are getting the right service for them	**2.4.** Staff are led well			
Key question 6: What is the overall capacity for improvement?				

This registration category covers a wide variety of service types providing a range of different supports, including support provided to children and young people. This framework covers outcomes for people across the whole range of registered support services that are not care at home. Care at home and housing support services will be covered by their own quality framework.

In order to identify outcomes that are relevant to the service, you should consider the aims and objectives of the service when looking at the quality illustrations and evaluating it using the quality indicators and key questions.

The term 'people' has been used throughout this document to include children and young people as well as adults.

Key question 1:
How well do we support people's wellbeing?

This key question has four quality indicators associated with it.

They are:
1.1. People experience compassion, dignity and respect
1.2. People get the most out of life
1.3. People's health benefits from their care and support
1.4. People are getting the right service for them

Quality indicator 1.1: People experience compassion, dignity and respect

Key areas include the extent to which people experience:

- compassion
- dignity and respect for their rights as an individual
- help to uphold their rights as a citizen free from discrimination.

Quality illustrations	
Very good	**Weak**
People experience care and support with compassion because there are warm, encouraging, positive relationships between staff and people making use of the service, which helps people to achieve their individual outcomes. People feel respected and listened to because their wishes and preferences are used to shape how they are supported, including if they wish to decline an aspect of their support. People experience support that promotes their identity, independence, dignity, privacy and choice. They feel connected within communities. They are enabled to maintain and develop relationships with the people around them, which gives them a sense of belonging.	People's views and preferences are not actively sought when planning and delivering care and support. People's views and preferences are not reflected in daily practice. Care and support is delivered around routines and tasks with little regard for individual needs and wishes. The rights of people in making choices and maintaining their independence, for example, freedom of movement, are not promoted and a risk averse approach is prevalent. Staff interact with people in ways that are impersonal or abrupt. People feel isolated or excluded from their communities and others.

People's rights are respected. They are treated fairly and staff actively challenge any form of discrimination. Where people's independence, choice and control are restricted, they are well informed about this and legal arrangements and appropriate supports are in place. Restrictions are kept to a minimum and carried out sensitively. Where some people's behaviour is seen as disruptive to others as a result of cognitive impairment or other condition, staff provide sensitive support to reduce the impact on other people. People's wellbeing and sense of worth is enhanced by staff who are knowledgeable about and value diversity	There is a limited range of opportunities for everyone to be involved in decisions about the service. Where views are gathered, people still feel they are not listened to and there is little evidence to show how their views have been taken into account. Restrictions placed on people's choice or independence are not designed to benefit the individual, or are not linked to risk.
People are well informed about their citizenship rights, including voting. They are actively supported to understand and exercise these rights. Staff demonstrate the principles of the Health and Social Care Standards in their day-to-day practice. People are involved in decisions about the service in ways that are meaningful to them. People feel empowered because their voice is heard, including opportunities to use independent advocacy.	Staff are unclear about the purpose of obtaining consent, or do not actively seek consent from people or their representatives. Staff do not know about the Health and Social Care Standards, or they are not clear about how the principles should inform their practice. People may experience stigma, or feel as though they are judged or not valued because of their circumstances.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• Carry out a SOFI 2 observation (where appropriate). • Observe practice and interactions. • Review how the confidentiality policy, procedure and practice is managed, such as whether all information is held confidentially and maintained by staff including during discussions. • Discussion with: - people who are using the service - relatives, friends and visitors - staff. • Examine review / meeting minutes, action plans and evidence change in practice. • Examine advocacy links and support for people and if advocates are available, speak with them. • Examine how policies, procedures and practice ensure that people are not subject to discrimination based on protected characteristics including disability, gender, age, sexuality. • Examine policies, procedures and practice for restriction of liberty. • Identify how communication support tools are used in gathering people's views and decision making.	The Health and Social Care Standards: **www.newcarestandards.scot** Rights, Risks and Limits to Freedom, and Human Rights in Mental Health Services, Covert Medication, Working with the AWI Act, Decisions about Technology. All from the Mental Welfare Commission: **www.mwcscot.org.uk/publications/good-practice-guides** Information from the Scottish Human Rights Commission: **www.scottishhumanrights.com** World Health Organisation – QualityRights: Human Rights and Recovery in mental health: **https://www.who.int/mental_health/policy/quality_rights/guidance_training_tools/en/** SCLD – Using scrutiny to drive outcomes and associated resources: **https://www.scld.org.uk/what-we-do/policy-issues/health-social-care-scrutiny/using-scrutiny-to-drive-outcomes/** Scottish Recovery Consortium: **https://www.scottishrecoveryconsortium.org/** Guidance for care providers in Scotland using CCTV **https://hub.careinspectorate.com/media/1515/guidance-for-care-providers-in-scotland-using-cctv-in-their-services.pdf**

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
	Charter for Involvement: **https://arcscotland.org.uk/involvement/charter-for-involvement/** 7 Golden Rules for Participation and other rights information (Children and Young People's Commissioner Scotland): **https://www.cypcs.org.uk/rights**

How are we doing?

How do we know that?

What do we plan to do next?

Quality indicator 1.2: People get the most out of life

Key areas include the extent to which people:

- make decisions and choices about how they spend their time
- are supported to achieve their wishes and aspirations
- feel safe and are protected but have the opportunity to take informed risks.

Quality illustrations	
Very good	**Weak**
People are recognised as experts on their own experiences, needs and wishes. This means they are fully involved in decisions about their care and support that affect them. People can choose how they spend their time and benefit from maintaining and developing their interests and what matters to them. People are supported to build their aspirations and confidence to have a strong sense of their own identity and wellbeing. Staff use their knowledge of the impact of people's health condition or diagnosis when supporting people with this. In a group setting, staff are proactive and use their skills to sustain the involvement of everyone, ensuring both individual and group outcomes are met.	People experience care and support at a basic level, focused on tasks and routines, that does not treat people as individuals entitled to personalised care. The quality of people's experience is negatively affected because staff do not know the person or use their personal plan to enhance both the care provided and their social interactions. There is a lack of recognition of people's interests, culture or past life, including sexuality, spirituality or important relationships, with little acknowledgement of the importance of this for each person. Where specific programmes are offered as part of people's support, sessions are regularly cancelled due to poor planning or because the necessary trained staff are not available.
People are enabled to get the most out of life with options to maintain, develop and explore their interests and skills, which may include education and accredited learning, employment and leisure. People are able to explore opportunities to connect with their communities in creative and imaginative ways.	The service does not provide appropriate structure or stimulation to enable people to have a sense of purpose and direction. Opportunities for meaningful activity are sparse. Choices are limited and people's aspirations are restricted by assumptions of what is safe or possible.

Social bonds are strengthened because people are supported to build and maintain meaningful relationships with others. Contributions and achievements are recognised by others, which has a positive impact on people's confidence and self-esteem.	Staff show an ambivalent attitude to supporting people to become involved in their community. People who communicate in different ways are disadvantaged because staff lack the skills and/or resources to respond appropriately. People's confidence suffers because they have limited chances to be socially active or are not given the support they need to participate. They have low expectations for themselves and their aspirations and achievements are not encouraged.
People feel safe and staff demonstrate a clear understanding of their responsibilities to protect people from harm, neglect, abuse, bullying and exploitation. Measures are in place to prevent this happening and people are confident that if they identify concerns, the open and supportive culture within the service ensures that they are responded to appropriately. People are enabled to develop an understanding of risk. Their right to make choices and take informed personal risk is part of the language and culture of the service. People have confidence that staff have the skills and understanding to support them to exercise these rights where appropriate, enabling ambitious and aspirational choices.	People may not be safe, or may not feel safe and staff are unclear of their role in identifying and reporting concerns about the safety and wellbeing of people. Appropriate assessments, supports and referrals may not be made. Harm may be ignored or not identified. Staff may participate in or accept poor practice without considering the impact on people's emotional wellbeing and dignity. The culture makes it hard to report poor practice, which may lead to people being at risk of unsafe care and support.
People regularly have fun and are able to get involved in a wide range of activities and interests. They have regular opportunities that promote their creativity, including through the arts. People are enabled to develop a sense of fairness and learn to cooperate with others.	People have limited opportunity to get involved in activities and lack purpose and direction as a result. New experiences are rare, and people don't get the encouragement and support they need to be active.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• Carry out a SOFI 2 (where appropriate). • Observe staff practice and interactions. • Discussion with: - people who are using the service - relatives, friends and visitors if available - staff. • Review meeting minutes and action plans for people, relatives and staff. • Review how personal plans are informing care and evidencing change through daily recording and reviews. • Look at how people spend their time, how this relates to their identified outcomes and any policies that relate to this. • Review adult and child protection procedures, training, knowledge and referrals made. • Look at how the service implements national guidance and best practice in child protection, including child sexual exploitation	The Keys to Life: **https://keystolife.info** Autism Strategy for Scotland: **http://www.autismstrategyscotland.org.uk/** Good Communication Standards **https://www.rcslt.org/speech-and-language-therapy/inclusive-communication-overview** Scottish Recovery Network – Peer Support: **https://scottishrecovery.net/wp-content/uploads/2011/09/srn_exe_form.pdf** Wellness Recovery Action Plan: **http://mentalhealthrecovery.com/** Information on supporting people with complex needs and sight loss: **https://www.rnib.org.uk/professionals-social-care-professionals/complex-needs-social-care** Information resources on person-centred practice: **http://helensandersonassociates.co.uk/person-centred-practice/** Disability Rights UK – doing sports differently: **https://www.disabilityrightsuk.org/doing-sport-differently** Jenny's Diary – supporting conversations about dementia with people who have a learning disability: **http://www.learningdisabilityanddementia.org/jennys-diary.html**

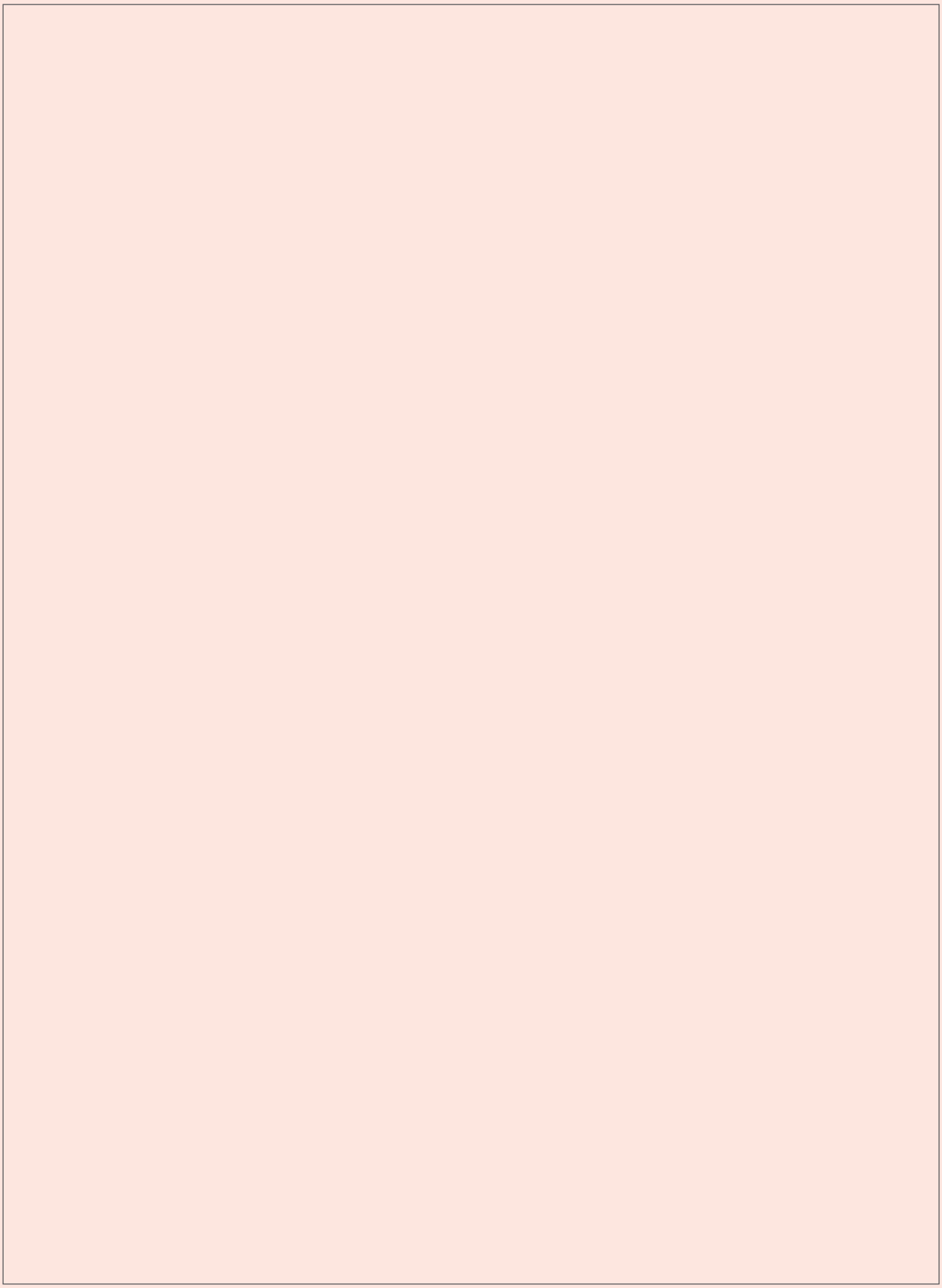
Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
	Promoting excellence in dementia care (includes people with a learning disability and dementia): http://www.sssc.uk.com/workforce-development/supporting-your-development/promoting-excellence-in-dementia-care See Hear – framework for meeting the needs of people with a sensory impairment: https://www.gov.scot/publications/see-hear/ Care about physical activity: https://hub.careinspectorate.com/how-we-support-improvement/care-inspectorate-programmes-and-publications/careabout-physical-activity/ Arts in Care: https://hub.careinspectorate.com/how-we-support-improvement/care-inspectorate-programmes-and-publications/arts-in-care/ National Guidance for Child Protection in Scotland (Scottish Government): https://www.gov.scot/publications/national-guidance-child-protection-scotland/

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
	Child Sexual Exploitation: Definition and Practitioner Briefing Paper (Scottish Government): **https://www.gov.scot/publications/child-sexual-exploitation-definition-practitioner-briefing-paper/** Practice Guide: supporting professionals to meet the needs of young people with learning disabilities who experience, or are at risk of, child sexual exploitation **https://www.childrenssociety.org.uk/what-we-do/resources-and-publications/unprotected-overprotected-meeting-the-needs-of-young-people** National Guidance for Child Protection in Scotland: additional notes for practitioners: protecting disabled children from abuse and neglect (Scottish Government): **https://www.gov.scot/publications/national-guidance-child-protection-scotland-2014-additional-notes-practitioners-protecting-disabled-children-abuse-neglect/** General standards for neurological care and support 2019 **http://www.healthcareimprovementscotland.org/our_work/standards_and_guidelines/stnds/neurological_care_standards.aspx**

How are we doing?

How do we know that?

What do we plan to do next?



Quality indicator 1.3: People's health benefits from their care and support

Key areas include the extent to which people experience:

- care and support based on relevant evidence, guidance, best practice and standards
- the right healthcare from the right person at the right time
- food and drink that meets their needs and wishes.

Quality illustrations	
Very good	**Weak**
Staff in the service understand their role in supporting people's access to healthcare and addressing health inequalities, even where the role of the service in this is minor. This includes ensuring that relevant information is shared with the right people. People are fully involved in making decisions about their physical and emotional wellbeing through their personal plans, including long-term and life-limiting conditions. Staff employ creative approaches to promoting and supporting people's choices. People have control of their own health and wellbeing by using any necessary technology and other specialist equipment. People are enabled to make informed health and lifestyle choices that contribute to positive physical and mental health.	Staff working in the service may lack understanding about supporting people's physical and emotional wellbeing, so opportunities to intervene and improve people's health are missed. People's wellbeing may be compromised because they are not supported to obtain appropriate health assessments. The support that people receive, and how they spend their time has limited links to health promotion, recovery and/or harm reduction. There is limited access to equipment and technology and its use is often focused on assisting staff rather than on enabling people to have more control over their life. Staff in the service do not fully understand their contribution to helping reduce health inequality.

People have as much control as possible over their medication and benefit from a robust medication management system that adheres to good practice guidance. People benefit from support to access community healthcare and treatment from competent trained practitioners, including prevention and early detection interventions. People are well informed about their treatment or intervention because information about treatment options, rehabilitation programmes or interventions is available in a format that is right for them. This helps to ensure that people experience treatments or interventions that are safe and effective. People experience a range of opportunities that contribute to health education, including sexual wellbeing and sleep health.	People may not always receive the right medication or treatment at the right time, with the potential to affect their physical and emotional wellbeing. The use of 'as required' medication may not be clearly laid out or in line with good practice guidance. Where people's medication needs to be given covertly, or the person does not have capacity to consent, the relevant legal powers, consent and processes are not in place. Support to enable people to access appropriate healthcare in their community may be limited. Even where there is access to healthcare professionals, people's healthcare needs are not consistently followed through. This may result in people experiencing reactive or disjointed care and support, which could impact on their physical and emotional health. People only access physical, mental or sexual health education in response to specific issues, rather than as part of the service's ethos of health promotion.
People's wellbeing is supported because the service promotes a healthy attitude to food and drink. If meals are provided as part of the service, people are able to enjoy healthy meals or snacks and drinks that reflect their cultural and dietary needs and preferences, including fresh fruit and vegetables. People can enjoy their food in an unhurried, relaxed atmosphere. People benefit from a wide range of aids and have the required support to enjoy their meals.	Options for meals, snacks and drinks do not always reflect people's cultural and dietary needs. People often do not enjoy their meals and do not always receive the right support to help them eat the best diet for them. There are limited methods used to help people make choices at mealtimes resulting in others often making the choices for them. Staff may control access to food and drink without professional rationale, and as a result people may not be able to eat or drink when they want or need to.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• Carry out a SOFI 2 observation (where appropriate). • Observe care and support at mealtimes if relevant. • Examine how people are supported to identify and monitor their health needs. • Review how personal plans are used to promote people's health, including specific plans to support people with for example, epilepsy or behaviour support plans. • Examine daily recordings to see how people's goals are set and reviewed and progress is measured. • Discussions with people, staff, and relatives and carers. • Key areas for adults experiencing life-limiting conditions that must be looked at are skin care, nutrition (including special diets, weight loss, fluid intake), medication, where people are fed using PEG. • Speak with other professionals who provide support to the service or individual. Contact and seek views of other professionals as appropriate.	Safe Administration of Medication: Modules 1-3 (Scottish Social Services Council): **http://learn.sssc.uk.com/sam/** Safe and Secure handling of medicines: **https://www.rpharms.com/recognition/setting-professional-standards/safe-and-secure-handling-of-medicines** Notifications about controlled drugs: guidance for providers, 2015: **https://www.careinspectorate.com/images/documents/2611/Records%20that%20all%20registered%20care%20services%20(except%20childminding)%20must%20keep%20and%20guidance%20on%20notification%20reporting%20(V6).pdf** SCLD Healthy Eating Healthy Living Pack: **https://www.scld.org.uk/healthy-eating-healthy-living-pack/** Supporting psychological wellbeing in adults with learning disabilities – an educational framework on psychological interventions **https://www.nes.scot.nhs.uk/media/4148312/LDFramworkPDF.pdf** Autism Hospital Passport: **https://www.autism.org.uk/about/health/hospital-passport.aspx** BBV Sexual Health Framework 2015-2020: **https://www.gov.scot/publications/sexual-health-blood-borne-virus-framework-2015-2020-update/#res484414** 'Transforming Psychological Trauma: A Knowledge and Skills Framework for the Scottish Workforce': **https://www.nes.scot.nhs.uk/media/3971582/nationaltraumatrainingframework.pdf**

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
	Rights, respect and recovery: alcohol and drug treatment strategy: **https://www.gov.scot/publications/rights-respect-recovery/** Quality Principles - Standard Expectations of care and support in drug and alcohol services: **https://www.gov.scot/publications/quality-principles-standard-expectations-care-support-drug-alcohol-services/** Alcohol Related Brain Damage: **https://www.mwcscot.org.uk/sites/default/files/2019-06/arbd_gpg.pdf** Mental Health Strategy for Scotland: **https://www.gov.scot/publications/mental-health-strategy-2017-2027/** Holding Safely: A Guide for Residential Child Care Practitioners and Managers about Restraining Children and Young People (SIRCC): **https://www.celcis.org/files/7914/3878/4811/holding-safely-2005.pdf**

How are we doing?

How do we know that?

What do we plan to do next?

Quality indicator 1.4: People are getting the right service for them

Key areas include the extent to which people:

- are fully involved in the professional assessment of their holistic needs
- can choose the care and support they need and want
- experience high quality care and support as result of planning, commissioning and contracting arrangements that work well.

Quality illustrations	
Very good	**Weak**
The care and support that people are experiencing is right for them and based on their outcomes, rights and choices. People are involved in a comprehensive assessment of their needs in a meaningful way and this has informed the care and support they experience. Where relevant, the assessment involves other people, families, friends and professionals to help shape the decision about the suitability of the service. People and professionals are involved in reviewing the assessment. Staff working in the service understand their role and contribution to ensuring the assessment is comprehensive, even where their role is minor.	People have limited or no involvement in their assessment and review processes. There may be limited involvement of other relevant people, including professionals to help shape the decision about the suitability of the service. The assessment process does not fully capture people's current outcomes or take account of their future needs and preferences.
People have been able to choose the care and support they want, based on their assessed needs and outcomes. People are involved in planned reviews of their support to determine whether the care and support meets their outcomes. Where there are identified changes to their support needs, appropriate measures are taken to address these.	The commissioned service that people are experiencing does not meet their needs, rights or choices. People's choices about their care and support are limited or undermined by pressure on resources. Decisions about their care and support arrangements are made for people without appropriate legal powers or without taking into account the principles of relevant legislation.

People benefit from strong links between the provider and the health and social care partnership to ensure that current and future care and support needs are met and planned for. If the person's support needs change so that the current support service is no longer appropriate, there is a co-ordinated and planned approach to look at suitable alternative support that takes account of their wishes and preferences.	Planned reviews may not involve the right individuals and as a result people's support needs are not fully met. There may be significant delays in responding to people's changing needs. If someone is using a service that doesn't fully meet their needs, there may be a lack of a coordinated and planned approach to look at alternative care and support taking account of their wishes and preferences.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• SOFI 2 observation. • Observation of staff practice and interactions. • Discussions with people, staff, relatives and carers and other professionals. • Review notes and action plans. • Personal plans. • Meeting minutes and action plans people, staff and relatives. • Advocacy links and discussion with advocacy providers. • Policy or procedure for accessing other services.	Understanding Personal Outcomes, from the Scottish Social Services Council: **https://www.sssc.uk.com/supporting-the-workforce/self-directed-support-and-integration/personal-outcomes/** Supported Decision Making, from the Mental Welfare Commission **https://www.mwcscot.org.uk/publications/good-practice-guides/** Principles of Good Transitions 3 (Scottish Transitions Forum), including the autism and life shortening conditions supplements, can be found at: **https://scottishtransitions.org.uk/summary-download/**

How are we doing?

How do we know that?

What do we plan to do next?

How well do we support people's wellbeing?

Quality indicator 1.1

Action

Responsibility

Achieved by

Sign off by

Quality indicator 1.2

Action

Responsibility

Achieved by

Sign off by

Quality indicator 1.3

Action

Responsibility

Achieved by

Sign off by

Quality indicator 1.4

Action

Responsibility

Achieved by

Sign off by

Key question 2:
How good is our leadership?

This key question has four quality indicators associated with it.

They are:
2.1. Vision and values positively inform practice
2.2. Quality assurance and improvement is led well
2.3. Leaders collaborate to support people
2.4. Staff are led well

Quality indicator 2.1: Vision and values inform practice

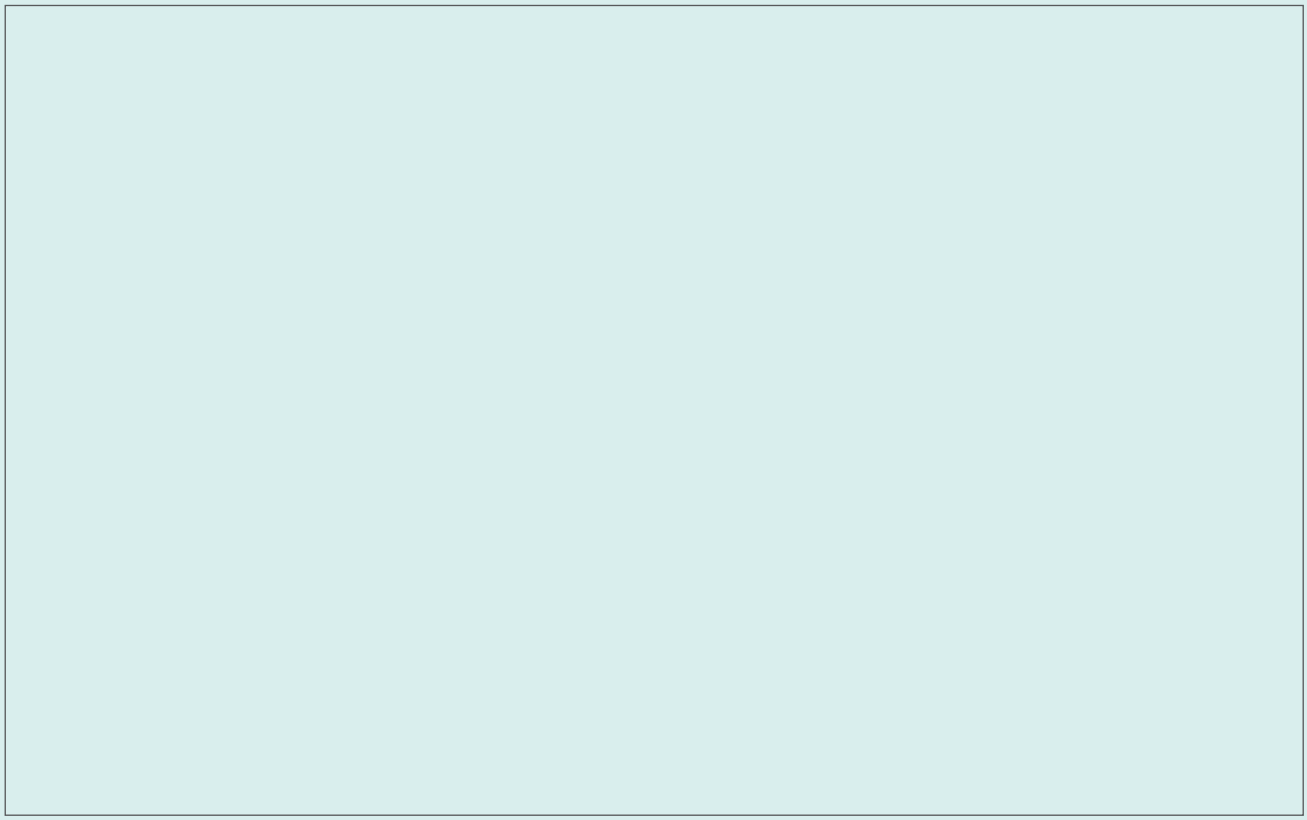
Key areas include the extent to which:

- vision, values, aims and objectives are clear and inform practice
- innovation is supported
- leaders lead by example and role model positive behaviour.

Quality illustrations	
Very good	**Weak**
There is a clear vision that is inspiring and promotes equality and inclusion for all. Leaders are aspirational, actively seeking to achieve the best possible outcome for people and this is shaped by people's views and needs. The aims and objectives of the service inform the care and support and how people experience this.	The vision is unclear; it lacks clarity, collective ownership and does not focus sufficiently on improving outcomes. There is no, or limited, evidence that equality and inclusion are embedded either within policies, procedures and plans or from observing staff practice. Staff's awareness or knowledge of the vision, values and aims are minimal and do not inform practice.
The culture encourages creative contributions from staff and people using the service. Staff are empowered to innovate and provide person-led care and support, fostering a culture of positive risk-taking. Learning from this is shared, including when things go wrong. In the spirit of genuine partnership, all relevant plans, policies and procedures reflect a supportive and inclusive approach. Leaders and staff recognise the importance of an individual's human rights and choices, and embrace the vision, values and aims to support these being met.	Where improvements are needed, there is limited innovative thinking and staff do not feel confident in contributing to or implementing improvement. Staff may not think creatively about how to change practice in order to support people to meet their outcomes and they may be unable or unwilling to tailor care and support for individuals.
Collective leadership is evident, with capacity for leadership being built at all levels. Leaders ensure that the culture is supportive, inclusive and respectful and they confidently steer the service through challenges where necessary. Leaders are visible role models as they guide the strategic direction and the pace of change.	People using the service, their relatives and staff do not have confidence in leaders. Leaders are not visible role models, and not well known to staff or people who use the service and their relatives. Their leadership may lack energy, visibility and effectiveness.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• Observation of practice and interactions. • Quality assurance of relevant policies, procedures, records and outcomes. • Discussion with people, staff, relatives and other professionals. • Meeting minutes and action plans. • Examining how people quality assure what they do. • Looking at improvement plans.	Supervision guidance – Scottish Social Services Council: **www.stepintoleadership.info/supervision.html** Steps into leadership – Scottish Social Services Council: **www.stepintoleadership.info/**

How are we doing?



How do we know that?

What do we plan to do next?

Quality indicator 2.2: Quality assurance and improvement is led well

Key areas include the extent to which:

- quality assurance, including self evaluation and improvement plans, drive change and improvement where necessary
- leaders are responsive to feedback and use learning to improve
- leaders have the skills and capacity to oversee improvement.

Quality illustrations	
Very good	**Weak**
Staff continually evaluate people's experiences to ensure that, as far as possible, people who are using the service are provided with the right care and support in the right place to meet their outcomes. People are well informed about any changes implemented, and their views have been heard and taken into account. Leaders empower others to become involved in comprehensive quality assurance systems and activities, including self-evaluation, promoting responsibility and accountability. This leads to the development of an ongoing improvement plan that details the future direction of the service. This is well managed, with research and good practice documents being used to benchmark measurable outcomes.	There are some systems in place to monitor aspects of service delivery however, there is confusion and a lack of clarity regarding roles and responsibilities. Quality assurance processes, including self-evaluation and improvement plans, are largely ineffective. The approaches taken are not sufficiently detailed to demonstrate the impact of any planned improvement. There is little effective evaluation of people's experiences to ensure that they are supported to meet their outcomes. The lack of individualised support and limited aspirations to help people get the most out of life have a detrimental effect on people's overall wellbeing.

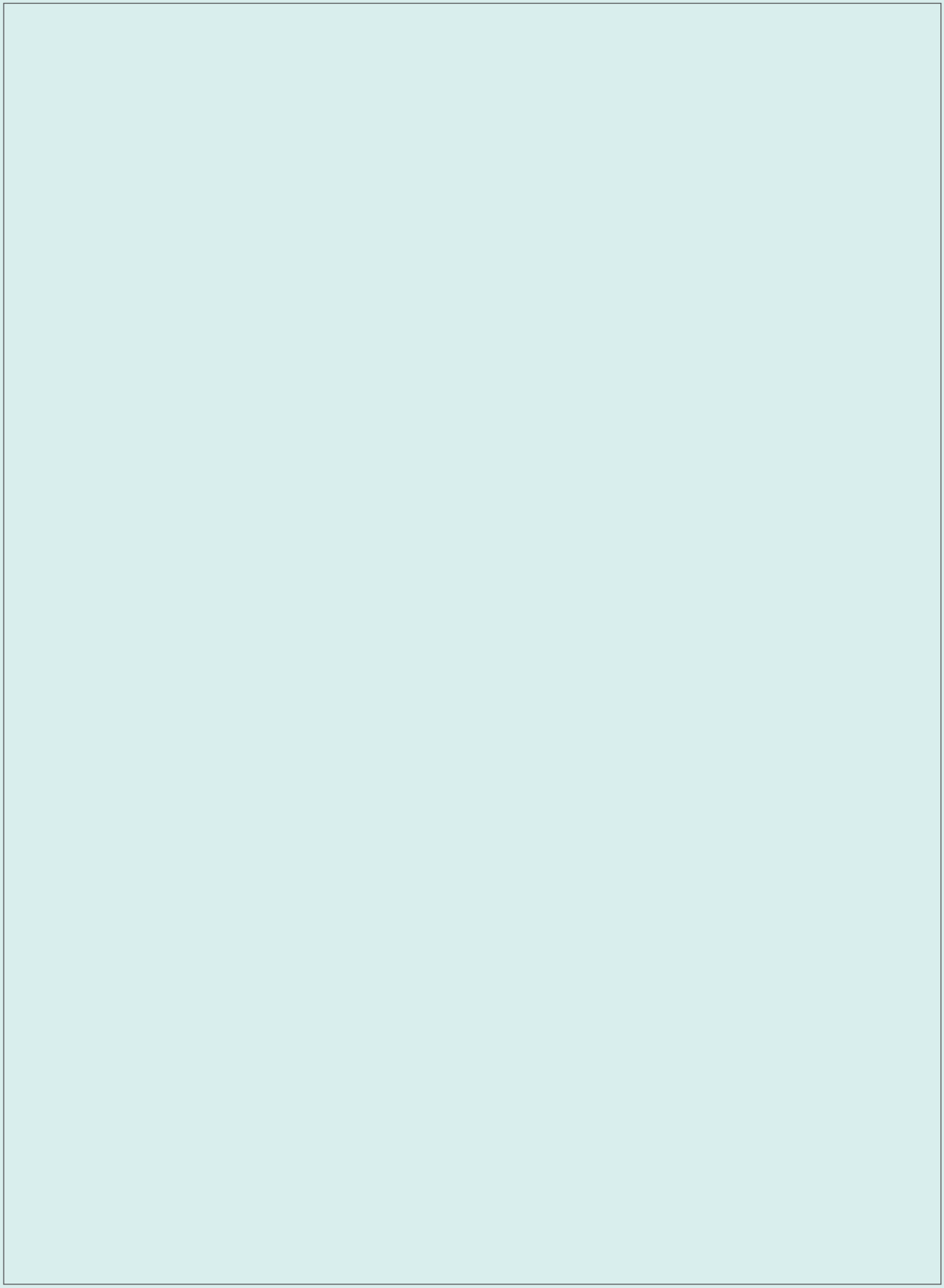
People are confident giving feedback and raising any concerns because they know leaders will act quickly and use the information to help improve the service. Where things go wrong with a person's care or support or their human rights are not respected, leaders offer a meaningful apology and learn from mistakes. Leaders understand how the Duty of Candour will impact on their care and support. Leaders use learning from complaints to improve the quality of care and support. People are supported to understand the standards they should expect from their care and support and are encouraged to be involved in evaluating the quality of the service provided.	Leaders do not use success as a catalyst to implement further improvements. They may fail to motivate staff and others to participate in robust quality assurance processes and systems. The lack of information regarding the rationale and need for improvement may inhibit change. Changes may happen as the result of crisis management rather than through effective quality assurance and self-evaluation. People are either unclear how to raise concerns or make a complaint, or do not feel supported to do so. Complaints and concerns may not drive meaningful change when they could or should. Where things do go wrong, leaders may be defensive and unwilling to learn from mistakes.
Leaders demonstrate a clear understanding about what needs to improve and what should remain, and they ensure that the outcomes and wishes of people who are using the service are the primary drivers for change. Leaders at all levels have a clear understanding of their role in directing and supporting improvement activities, and where to obtain support and guidance. The pace of change reflects the improvements needed.	There is insufficient capacity and skill to support improvement activities effectively and to embed changes in practice. The pace of change may be too slow because leaders focus on responding to day-to-day issues.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• Discussion with people, staff and relatives. • Review minutes of meetings and action plans for people, staff and relatives. • Quality assurance of relevant policies, procedures, records and outcomes. • Look at the improvement plan. • Review accident and incident records, audits and outcomes. • Look at complaint and concerns records, audits and outcome. • Understand how the service gathers feedback and takes action, including how this is built into induction and supervision. • Analysis and evaluations from participation methods and activities.	The Model for Improvement and associated resources: **http://hub.careinspectorate.com/improvement/** Duty of Candour guidance: **https://www.careinspectorate.com/index.php/duty-of-candour** National Occupational Standards (NOS) **http://learn.sssc.uk.com/nos/about.html** Learning from adverse events through reporting and review: A national framework for Scotland 2015: **http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/management_of_adverse_events/national_framework.aspx**

How are we doing?

How do we know that?

What do we plan to do next?



Quality indicator 2.3: Leaders collaborate to support people

Key areas include the extent to which:

- leaders understand the key roles of other partners and their responsibilities
- services work in partnership with others to secure the best outcomes for people
- leaders oversee effective transitions for people.

Quality illustrations	
Very good	**Weak**
Leaders overcome barriers to enable people to gain real control over their care and support. A culture of joint responsibility and decision-making helps to create a positive climate. This takes into account each person's whole life including their physical, mental, cultural, emotional and spiritual needs. Because leaders have a sound knowledge of the key roles and responsibilities of partner agencies, they quickly identify when to involve them. Partner or multi-agency working is supported by a clear strategy to facilitate working together so that people get the right support from the right organisation when they need it. Leaders are confident in working across boundaries to support people and ensure they experience high quality care and support. Leaders recognise the benefits of sharing ideas and practice, not just within the service, but further afield to.	Leaders do not ensure that care and support is provided in collaboration with people, their families and the wider community. There is a lack of understanding of the roles that others from external organisations have that may benefit or provide additional support for people. There is a lack of a clear strategy and guidance to inform a collaborative approach. Leaders are not able, knowledgeable or confident at accessing local pathways for people. They may not work effectively with other organisations or know how to obtain specialist support when needed.

Where people are supported by more than one organisation, they benefit from organisations working together, sharing information promptly and appropriately, and working to coordinate care and support so that people experience consistency and continuity. Where information is being shared between agencies for specific purposes, consent is sought first (except where there is a serious risk of harm).	Leaders may not be confident at learning from other organisations to improve the services they provide, or be willing to work with them. There is a lack of clarity about when to contact other organisations to help support outcomes for people. Information about people is not shared when it is appropriate to do so and will lead to improvements in people's care and support. Where information is shared, consent may not have been obtained from the person or their representative.
Leaders ensure that the processes for starting to use the service are person-centred. Leaders ensure that commissioned services are delivered efficiently and effectively. They will monitor the success and effectiveness of working with partner providers and other agencies. When people are moving on from the service, leaders contribute to the clear processes that support the person with this.	Silo working may impact negatively on people's experiences of health and social care in the service. Leaders have not put in place clear systems or processes that support people to start using the service or to move on to make use of other care and support.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• Look at the procedures, practice and experience of people who are using the service for the first time. • Discussion with people, staff and relatives. • Observe practice and interactions. • Look at the information sharing policy and practice. • Look at arrangements for multi-agency working and how these benefit people. • Examine links the service has to local resources and how these are used and accessed.	Steps into leadership – Scottish Social Services Council **http://www.stepintoleadership.info** General Data Protection Regulation (GDPR) guidance: **https://www.gov.uk/government/publications/guide-to-the-general-data-protection-regulation**

How are we doing?

How do we know that?

What do we plan to do next?

Quality indicator 2.4: Staff are led well

Key areas include the extent to which:

- leaders at all levels make effective decisions about staff and resources
- leaders at all levels empower staff to support people
- leadership is having a positive impact on staff.

Quality illustrations	
Very good	**Weak**
Leaders engage meaningfully with staff, people who are using the service, their families and the wider community, taking a collaborative approach to planning and delivering care and support. This means leaders are skilled at identifying and delivering the appropriate type and level of resources needed to provide high-quality care and support now and in the future. They intervene at the earliest opportunity to ensure that people experience high-quality care and support. Where relevant, registered nurses are empowered to play a key role in leading nursing care, including working with other staff and supporting all staff in delivering high-quality care. This results in robust systems of care with clear lines of responsibility and professional accountability including clinical governance.	Leaders lack the skills and knowledge to anticipate the type and level of resources needed for people. This has a detrimental impact and fails to prevent difficulties arising and escalating. Leaders do not identify potential barriers that impact on people, which may mean that adults who are using the service have little influence on decisions that relate to their care and support. There is a lack of vision and creativity in identifying services that may support meeting the unique outcomes for each person.

Leaders model a team approach by acknowledging, encouraging and appreciating efforts, contributions and expertise, while instilling a 'safe-to-challenge' culture. They listen to others and respect different perspectives. They recognise that people are often best placed to identify their own outcomes and encourage staff to support this approach. Leaders recognise the importance of sharing ideas in a relaxed and supportive environment and work hard to tackle inequalities, encouraging equality of opportunity both among the staff and people living in the service. They use successes to act as a catalyst to implement further improvements in the quality and outcomes for individuals.	Staff are not empowered to help identify solutions for the benefit of people who are using the service. Communication and direction is lacking and the approach to improvement is not sufficiently detailed. The rationale for change is not always clear to staff, impacting negatively on people's experiences. Leaders may fail to engage or energise staff leading to confusion and a lack of clarity of roles and responsibilities. Equality and inclusion are not embedded within policies, procedures and plans. There is a lack of understanding that staff at all levels have an important role to play in delivering high-quality care and support.
Leaders adapt their leadership style to help motivate staff to deliver high-quality care and support. A good work-life balance is encouraged at all times, which impacts positively on staff and people who are using the service.	Opportunities to use initiative, take responsibility and influence change are limited. Staff seldom adopt leadership roles. There is no, or limited, evidence that professional learning is linked to organisational priorities. Silo working exists and little attempt is made to address this.

Scrutiny and improvement toolbox

Scrutiny and improvement support actions	Key improvement resources
• Observe practice and interactions. • Discussion with people, staff and relatives. • Interview manager. • Look at the quality assurance policy, procedure, practice and outcomes. • Look at how staff training records, appraisals, supervision and deployment. • Review the improvement plan.	Step into leadership - Scottish Social Services Council: www.stepintoleadership.info

How are we doing?

How do we know that?

What do we plan to do next?

How good is our leadership?

Quality indicator 2.1

Action

Responsibility

Achieved by

Sign off by

Quality indicator 2.2

Action

Responsibility

Achieved by

Sign off by

Quality indicator 2.3

Action

Responsibility

Achieved by

Sign off by

Quality indicator 2.4

Action

Responsibility

Achieved by

Sign off by

Key question 3:
How good is our staff team?

This key question has three quality indicators associated with it.

They are:
3.1. Staff have been recruited well
3.2. Staff have the right knowledge, competence and development to care for and support people
3.3. Staffing levels and mix meet people's needs, with staff working well together

Quality indicator 3.1: Staff have been recruited well

Key areas include the extent to which:

- people benefit from safer recruitment principles being used
- recruitment and induction reflects outcomes for people experiencing care
- induction is tailored to the training needs of the individual staff member and role.

Quality illustrations	
Very good	**Weak**
Staff are recruited in a way that has been informed by all aspects of safer recruitment guidance, including a strong emphasis on values-based recruitment. The process is well organised and documented so that core elements of the procedure are followed consistently. People using the service have opportunities and the necessary support to be involved in the process in a meaningful way that takes their views into account, including in recruitment decisions. Staff do not start work until all pre-employment checks have been concluded and relevant mandatory training has been completed. There is a clear link between the needs of people and the skills and experience of the staff being recruited. A range of supports is in place to encourage staff retention.	There is insufficient attention paid to understanding why safer recruitment is important. Key elements of processes may be ignored, for example exploring gaps in employment records or checking that references come from a previous employer. Even where good recruitment policies are written, they may not be thoroughly implemented consistently, for example only one reference is obtained and staff start to work alone before their membership of the Protection of Vulnerable Groups scheme has been confirmed. The service may not fully understand the skill set and experience it needs to provide high-quality care and support for the people who are using the service.

The induction is thorough and has been developed to enable staff to support the outcomes of people in the particular setting. This includes an emphasis on implementing the Health and Social Care Standards as underpinning values for all care and support. There is a clear plan as to what is included and how this will be delivered with sufficient time to ensure that staff can understand all the information and what is expected of them. During the induction period, feedback is sought from people using the service to help evaluate staff members' values, communication and development needs.	The values and motivation of potential staff may not have been explored as part of the recruitment process, and may not inform recruitment decisions. Staff start work before they have sufficient knowledge and skills. They may receive no induction, it may be brief and patchy or there may be too much covered too quickly for it to be effective. New staff may only have the opportunity for a minimum period of shadowing and there is limited structure for additional discussions about their learning needs, either through supervision or a mentor.
Throughout the recruitment process, individual learning needs and styles are taken into account. There is likely to be a range of learning styles, for example the opportunity for face-to-face discussion and shadowing of more experienced staff. Staff are clear about their roles and responsibilities, with written information they can refer to and a named member of staff for support. Staff are clear about their conditions of employment and the arrangements for ongoing supervision and appraisal. There is additional supervision in the first few months to discuss any learning needs or issues.	The induction may be generic, have not been reviewed recently, or may not include effective input about the Health and Social Care Standards.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• Look at the recruitment policy and procedure. • Review the analysis of staff skills required. • Look at interview records. • Examine how fitness checks are undertaken. • Review relevant HR or personnel files. • Look at the induction policy, procedure and practice. • Look at staff job descriptions and roles. • Discussion with people, staff and relatives.	Scottish Social Services Council and the Care Inspectorate, Safer Recruitment Through Better Recruitment: **http://hub.careinspectorate.com/knowledge/safer-recruitment** The national health and social care workforce plan: part two **https://www.nes.scot.nhs.uk/media/4076403/Item%2010b%20National%20Health%20and%20Social%20Care%20Workforce%20Plan%20Part%202%202018-01-24.pdf**

How are we doing?

How do we know that?

What do we plan to do next?

Quality indicator 3.2: Staff have the right competence and development to support people

Key areas include the extent to which:

- staff competence and practice supports improving outcomes for people
- staff development supports improving outcomes for people
- staff practice is supported and improved through effective supervision and appraisal.

Quality illustrations	
Very good	**Weak**
Staff competence is regularly assessed to ensure that learning and development supports better outcomes for people. This means that people are being supported by staff who understand and are sensitive to their needs and wishes because a range of learning and support measures is in place. There is a clear structure of learning for each role within the service. This includes values, the Health and Social Care Standards and any applicable codes of practice and conduct, as well as specific areas of practice.	Arrangements for assessing ongoing competence are sporadic, with little encouragement for reflection on how learning needs will be met or how this might improve practice and outcomes for people. Staff may be registered with relevant professional bodies but do not fully understand their responsibilities for continuous professional development or how they can fulfil this. They may lack confidence or support in taking responsibility for their own learning and development.

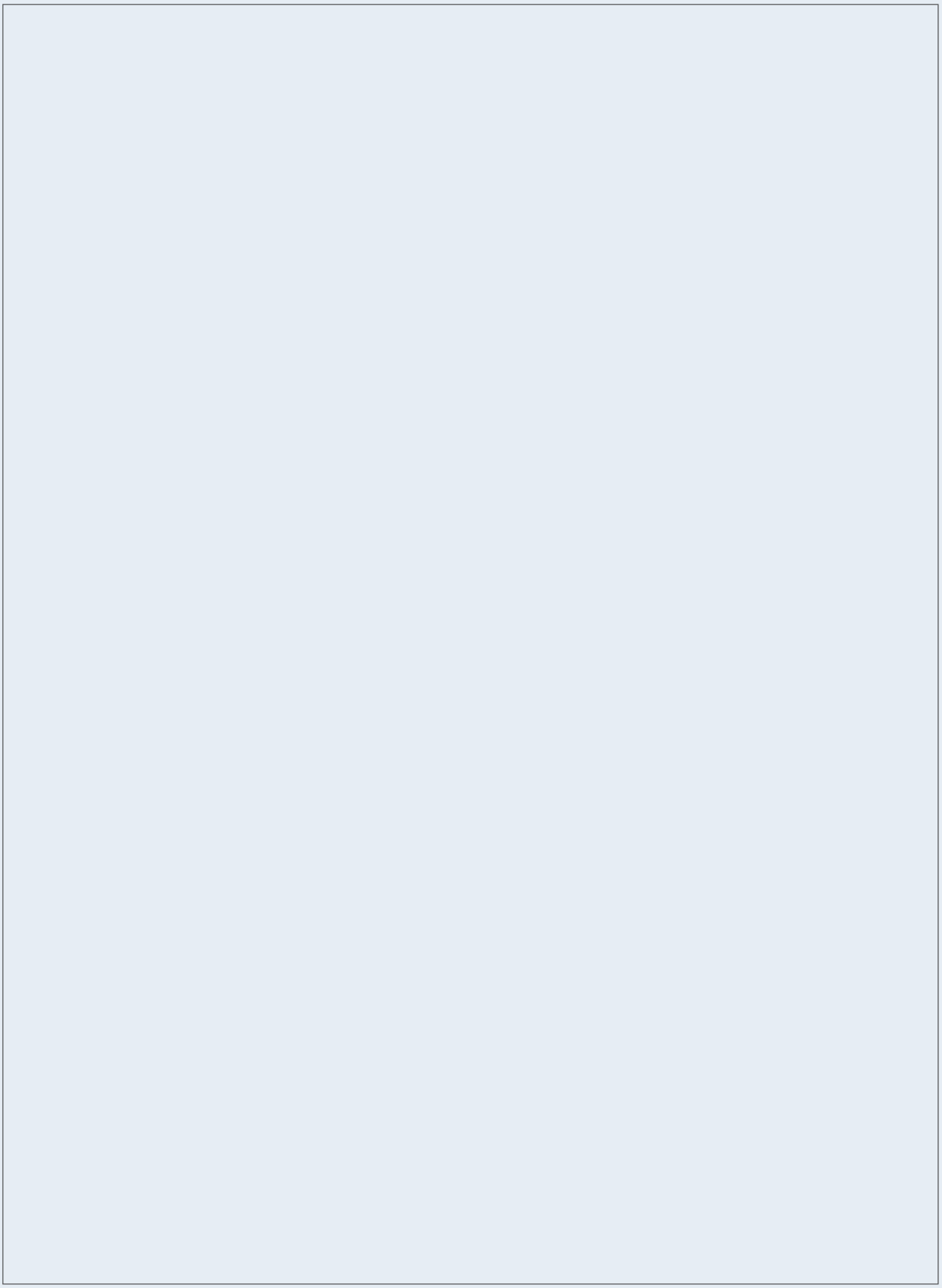
Learning opportunities are developed to support meeting outcomes for people who are using the service based on evidence and best practice guidance. This is regularly analysed, with new training planned as people's needs change. People who use the service are involved in staff development and learning, if this is what they want. There is a range of approaches to suit different learning styles and it is evident that all staff have access to training and have their own learning plan that identifies development needs and how these will be met. Staff are confident about where to find best practice guidance and advice on how they can support people. There is a learning culture embedded within the service, which includes reflective practice. Staff are comfortable acknowledging their learning needs, challenging poor practice and they are confident these will be addressed.	Training is basic and restricted to set topics, often with little mention of values and codes and their importance to inform good care and support. The plan for training is static and may not reflect the needs of people who are using the service. Training is regarded as an event rather than ongoing learning. There is little access to best practice guidance or opportunity for further discussions to ensure knowledge is consolidated and embedded into practice. There is no effective training analysis for the service or individual staff. The training plan and records are incomplete or held in a format that does not allow the identification of priorities.
Regular supervision and appraisal are used constructively and staff value them. There are clear records of learning being planned and undertaken that inform what is provided for each member of staff. Staff are aware of their responsibilities for continuous professional development to meet any registration requirements, they have support to achieve this and they keep a record. The views of people who are supported by staff are used to give staff feedback and are included in supervision and appraisal.	Supervision may not take place or is so limited that there is no opportunity to reflect on skills, knowledge and learning. Staff may also consider that if they have completed all the training, they have no other learning needs. Where learning needs are identified, the systems for ensuring that these are met are insufficiently robust, resulting in gaps in knowledge remaining unfilled.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• Observation of staff practice. • Discussion with people using the service, staff and relatives. • Mandatory training for different grades of staff. • Training needs analysis and training plan. • Staff development plan and outcome. • Staff supervision and appraisal.	Achieving effective supervision – IRISS insight: **https://www.iriss.org.uk/resources/insights/achieving-effective-supervision** Frequently asked questions about SSSC registration: **https://www.sssc.uk.com/knowledgebase/article/KA-01130/en-us** Employer responsibilities–supporting staff with registration: **https://www.sssc.uk.com/registration/employer-responsibilities/** Supporting psychological wellbeing in adults with learning disabilities – an educational framework on psychological interventions **https://www.nes.scot.nhs.uk/media/4148312/LDFramworkPDF.pdf** Framework for continuous learning (SSSC) **http://www.continuouslearningframework.com/**

How are we doing?

How do we know that?

What do we plan to do next?



Quality indicator 3.3: Staffing levels are right and staff work well together

Key areas include the extent to which:

- the skill mix, numbers and deployment of staff meet the needs of people
- there is an effective process for assessing how many staff hours are needed
- staff are flexible and support each other to work as a team to benefit people.

Quality illustrations	
Very good	**Weak**
Because the staff in the service understand the needs of the people using it, the right number of staff with the right skills are working at all times to support people's outcomes. Staff have time to provide care and support with compassion and engage in meaningful conversations and interactions with people. Staff are clear about their roles and are deployed effectively. Staff help each other by being flexible in response to changing situations to ensure care and support is consistent and stable. People can have a say in who provides their care and support.	The numbers of staff are minimal and sometimes insufficient to meet fully the needs of people using the service. Staff work under pressure and some aspects of care and support may be skipped or missed, affecting outcomes for people. People using or visiting the service perceive staff to be rushed. When matching staff to work with individuals using the service, limited importance is placed on staff skills, experience and personality to help people build successful relationships and work well together.
The numbers and skill mix of staff are determined by a process of continuous assessment, featuring a range of measures and linked to quality assurance. This includes taking account of the acuity and complexity of people's needs, circumstances and outcomes. Feedback from all parties contributes to this and any dependency assessment takes account of the premises layout, where applicable. This includes how best to deploy staff to support keyworking and high-quality support with good continuity of care.	The number of staff hours deployed is relatively static, with infrequent reviews and not adjusted to meet changing needs. There may be a dependency assessment but this is not translated into staff hours and no other measures or feedback are used to determine what staff time is required. There may be an over-reliance on agency staff, which leads to people experiencing a lack of consistency and stability in how their care and support is provided, and limits their ability to build a trusting relationship with staff members.

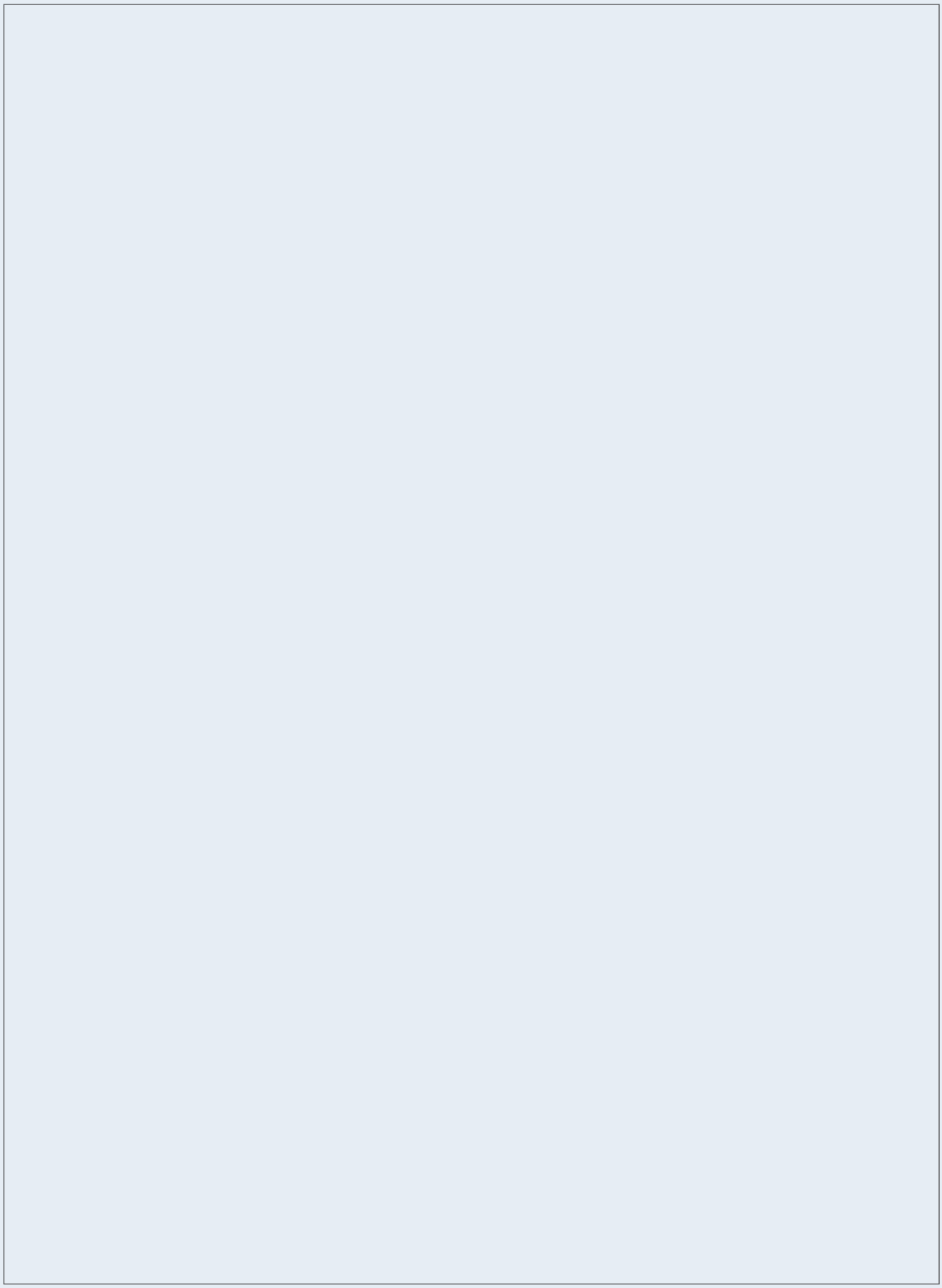
People using the service and staff benefit from a warm atmosphere because there are good working relationships. There is effective communication between staff, with opportunities for discussion about their work and how best to improve outcomes for people. Motivated staff and good team working mean that staff spend as much time as possible with people. Staff are confident in building positive interactions and relationships. Staff who are not involved in providing direct care and support to people understand their contribution to the overall quality of the service and know they play an important role in building a staff team.	The pressure on staff leads them to stick to their designated tasks because there is no capacity to respond to other demands. Despite staff members' best efforts, care and support is basic with little time for speaking with people or supporting them to maintain interests. Communication and team building may suffer due to lack of time and this affects staff motivation.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• Carry out a SOFI 2 observation. • Observe practice and interaction. • Look at the staff rota and deployment. • Examine staff roles and duties. • Look at any dependency assessment tools used. • Discussion with people who use the service, staff and relatives. • Look at the care and support plans and assessments of people and how this informs staffing. • Interview other relevant professionals.	Records that all registered care services (except childminding) must keep and guidance on notification reporting (Care Inspectorate): **https://www.careinspectorate.com/images/documents/2611/Records%20that%20all%20registered%20care%20services%20(except%20childminding)%20must%20keep%20and%20guidance%20on%20notification%20reporting%20(V6).pdf**

How are we doing?

How do we know that?

What do we plan to do next?



How good is our staff team?

Quality indicator 3.1

Action

Responsibility

Achieved by

Sign off by

Quality indicator 3.2

Action

Responsibility

Achieved by

Sign off by

Quality indicator 3.3

Action

Responsibility

Achieved by

Sign off by

Key question 4: How good is our setting?

This key question has two quality indicators associated with it.

They are:
4.1. People benefit from high-quality facilities [where the service is buildings-based]
4.2. The setting promotes people's independence and inclusion

Quality indicator 4.1: People benefit from high quality facilities

Key areas include the extent to which:

- the layout of the setting supprts people's outcomes
- people can influence how the setting is used
- the setting is comfortable, safe and well maintained.

Quality illustrations	
Very good	**Weak**
The setting has been designed or adapted for high-quality care and support and reflects the intended function and purpose of the service. People can choose to use quiet or communal areas, and have opportunities for privacy when they want. The building is right for the number of people using it. People benefit from an environment with plenty of natural light, fresh air and sufficient space to meet their needs and wishes. The environment is well suited to how people will spend their time there and gives them the message that they are valued. The design of the setting contributes to people developing relationships, with space to spend time in small groups as well as larger functions.	The layout or how the setting is organised may compromise people's ability to use the setting for its intended purpose. The setting does not offer enough space or different places where people can spend their time. There may be few opportunities for people to experience a quiet environment when they need to. Spaces are not used for their designated purpose due to poor planning or poor housekeeping. There is limited flexible space, which means that people lack the opportunity to develop friendships. Staff do not identify changing needs for equipment or facilities. People do not have the equipment that best meets their needs or the equipment is not available when needed.
People are involved in decisions about the layout of the setting where possible, and can influence how the space is used. People feel they are listened to and that their views count.	There is a bureaucratic or risk-averse approach to the way the setting is designed, managed or furnished, reducing people's ability to contribute to decision-making about the setting.
The environment is clean, tidy and well looked after.	The environment may not be clean and there may be a lack of attention to standards of decoration and the quality of furniture, which may be deteriorating or shabby.

People are confident that risk assessments of community activities reflect their outcomes and ensure that facilities are safe and suitable for them to use. There are arrangements in operation for maintenance of the premises and the equipment to ensure people are safe. The building promotes people's safety. Robust infection control measures are in place and food safety is promoted in settings where food is prepared or provided.	Risk-averse practice creates an imbalance between maintaining safety and security and supporting people's freedom and independence. Systems for the ongoing maintenance of the environment and equipment are either not organised or not followed, which may place people at risk. Some equipment may not be fully functioning or may break down regularly.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• Carry out a SOFI 2 observation (where appropriate). • Observe practice and interactions. • Observe the environment • Review maintenance records. • Discussion with people, staff and relatives.	Living in the Community: Housing design for adults with autism: **https://www.rca.ac.uk/research-innovation/helen-hamlyn-centre/research-projects/2010-projects/living-community-housing-design-adults-autism/** Care Inspectorate, Building Better Care Homes: **http://www.careinspectorate.com/images/documents/4293/Building%20better%20care%20homes%20for%20adults%202017.pdf** Preventing infection in care: **https://www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/healthcare-associated-infections/training-resources/preventing-infection-in-care.aspx** Health and Safety Executive information: **http://www.hse.gov.uk/pubns/hsis6.pdf** The King's Fund: **https://www.kingsfund.org.uk/projects/enhancing-healing-environment/ehe-design-dementia**

How are we doing?

How do we know that?

What do we plan to do next?

Quality indicator 4.2: The setting promotes people's independence and inclusion

Key areas include the extent to which:

- the setting promotes people's independence
- people are included in their communities
- the setting enables people to thrive and develop.

Quality illustrations	
Very good	**Weak**
The culture of the service is welcoming to visitors and everyone who uses the service. The setting supports a focus on people's abilities and assets. All aspects of the setting promote independence, with flexible facilities, control of lighting, heating, ventilation and security. This promotes comfort and encourages people to be active and move around as much as possible. They can independently access all parts of the premises they use. People benefit from a setting that is right for them. They have the equipment that best meets their needs and is provided when required.	The service lacks, or has limited ways of supporting, the inclusion of parents, relatives and friends in its development. The setting limits independence and this affects people by restricting their movement or by increasing their dependence on staff. This may also curtail people's choices about where they spend their time. Internal facilities and fittings may also restrict people's choices and comfort in their daily life, such as unsuitable equipment. This may include communication technology, reassessing how space is used or items to help people with new experiences or interests.
The service's setting and location supports people to be active members of their community, reducing the risk of isolation. People are supported to keep connected to their communities. Staff use their knowledge of the local community landscape to signpost and support people's involvement. People are empowered to make their communities more inclusive.	The service is isolated, or the culture in the service is insular, with limited links to the local community. Visitors might feel unwelcome. The location of the setting, or transport links, may enable access to the local community and amenities however people are not routinely supported where appropriate to access these.

There are strong links with the local community that encourage the growth of informal support networks. People benefit from this in a variety of ways including: meeting new people, cross-generational relationships, links that support individual interests, and introducing different ideas and experiences.	People may be less able to benefit from a wide range of relationships or membership of groups and networks. Barriers to using community resources may not be identified or addressed. The importance of people's visibility in and contribution to their community is not understood.
The setting's design enables people to get the most out of life, including promoting and enhancing positive relationships with their peers.	There is limited flexible space for promoting peer relationships or a sense of community.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• Carry out a SOFI 2 observation (where appropriate). • Observe the environment, looking at movement for people around building, and equipment that enables people to be as independent as they want. • Observe people experiencing the environment. • Consider the areas for people to prepare drinks and snacks. • Look at information on local resources for use by people. • Consider the links and access to the community. • Consider how staff support people to keep in touch with important people to them.	Learning Disabilities and Behaviour that Challenges: Service Design and Delivery (NICE): **https://hub.careinspectorate.com/media/1545/learning-disabilities-and-behaviour-that-challenges-service-design-and.pdf**

How are we doing?

How do we know that?

What do we plan to do next?

How good is our setting?

Quality indicator 4.1

Action

Responsibility

Achieved by

Sign off by

Quality indicator 4.2

Action

Responsibility

Achieved by

Sign off by

Key question 5:
How well is our care and support planned?

This key question has two quality indicators associated with it.

They are:
5.1. Assessment and care planning reflects people's outcomes and wishes
5.2. Families and carers are encouraged to be involved

Quality indicator 5.1: Assessment and care planning reflects peoples' outcomes and wishes

Key areas include the extent to which:

- leaders and staff use care and support plans to deliver care and support effectively
- care plans are reviewed and updated regularly, and as people's outcomes change.
- people are involved in directing and leading their own care and support

Quality illustrations	
Very good	**Weak**
People benefit from dynamic, innovative and aspirational care and support planning that consistently informs all aspects of the care and support they experience. People and, where relevant, their families, are fully involved in developing their personal plans. Strong leadership, staff competence, meaningful involvement and embedded quality assurance and improvement processes support this happening. Care and support planning maximises people's capacity and ability to make choices. This includes the potential for people to reduce the support they receive or change their care setting. Where support services are crisis-based or provide very short-term support to people, safety plans are based on identifying warning signs, immediate risks and how to reduce these to stay safe, including coping strategies and who can help.	Personal plans are basic or static documents and are not routinely used to inform staff practice and approaches to care and support. They may be kept in an inaccessible place, or do not reflect the care and support experienced by people who use the service. People may not know whether they have a personal plan, or it may be in a format that is not meaningful to them. The standard of care and support planning is inconsistent and is not supported by strong leadership, staff competence and quality assurance processes. Personal plans focus entirely on people's needs or a deficit-led approach rather than building an enabling approach based on assets or outcomes.

People benefit from personal plans that are regularly reviewed, evaluated and updated involving relevant professionals (including independent advocacy) and take account of good practice and their own individual preferences and wishes. People are helped to live well right to the end of life by making it clear to others what is important to them and their wishes for the future. There is a range of methods used to ensure that people are able to lead and direct the development and review of their personal plans in a meaningful way.	Multi-disciplinary professional involvement in the care planning and review process may be limited. People may not benefit from professional advice because this is not taken account of in the care planning and review process. Personal plans do not reflect up-to-date good practice guidance. Care reviews may not be carried out in line with legislation. Where people are supported in crisis, Staff are unable to respond flexibilly when they identify what is and is not working for the person.
Where people are not able fully to express their wishes and preferences, individuals who are important to them or have legal authority are involved in shaping and directing the care and support plans. Advocacy support has been sought where appropriate. Staff understand the planning process and can support people to navigate this, maximising their involvement. Supporting legal documentation is in place to ensure this is being done in a way that protects and upholds people's rights. Risk assessments and safety plans are used to enable people rather than restrict people's actions or activities. People are fully involved in decisions about their current and future care and support needs. Their plans and wishes for their life in the future are also fully taken account of. Where appropriate, this involves the use of anticipatory (advanced) personal plans.	People may not be involved or have limited involvement in their care and support planning and review process and therefore do not consistently experience care and support in line with their wishes and preferences. Where people are not able fully to express their wishes and preferences, relevant individuals important to them are not involved, or have limited involvement, in the care planning and review process. Supporting legal documentation may not be in place. The culture within the service can be defined as risk averse, and directly reduces people's quality of life and experiences as a result of over-protective attitudes and practice. Risk assessments appear punitive or designed to prioritise protecting the organisation rather than keeping people safe. Outcomes and aspirations for individuals may be limited by low expectations of people who are involved in assessing and planning their care and support.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• Carry out a SOFI 2 observation (where appropriate). • Observe practice and interaction. • Review personal plans, daily recording notes. • Examine review minutes and action records. • Discussion with people, staff and relatives	HIS guidance on anticipatory care planning: **https://ihub.scot/anticipatory-care-planning-toolkit/** Power of attorney guide: **https://www.mwcscot.org.uk/media/241253/poa_leaflet_care_homes.pdf** Mental Welfare Commission guidance on personal plans **https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf** Mental Welfare Commission guidance on advance statements: **https://www.mwcscot.org.uk/media/128044/advance_statement_guidancesep2018revision.pdf** MWC good practice guide - supported decision making **https://www.mwcscot.org.uk/publications/good-practice-guides/** Scottish Independent Advocacy Alliance – companion guides **https://www.siaa.org.uk/publications-category/companionguide/** Think local act personal – personalised care and support planning tool **https://www.thinklocalactpersonal.org.uk/Latest/Making-it-Real-how-to-do-personalised-care-and-support/**

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
	Children and Young People (Scotland) Act 2014, asp 8: **http://www.legislation.gov.uk/asp/2014/8/contents** Understanding Personal Outcomes (Scottish Social Services Council): **https://www.sssc.uk.com/knowledgebase/article/KA-02701/en-us** Person-centred support planning information– Helen Sanderson: **http://helensandersonassociates.co.uk/person-centred-practice/care-support-planning/**

How are we doing?

How do we know that?

What do we plan to do next?

Quality indicator 5.2: Carers, friends and family members are encouraged to be involved

Key areas include the extent to which:

- carers, friends and family members are encouraged to be involved and work in partnership with the service
- the views of carers and family members are heard and meaningfully considered.

Quality illustrations	
Very good	**Weak**
There is a supportive and inclusive approach to involving all carers and family members in the delivery of care and support if this is important to the person using the service. Where family members have learning or communication difficulties or where English is their second language, they are appropriately supported to be able to express their views fully. Leaders engage meaningfully with people and, with consent, their families. Leaders take a collaborative approach to ensure that they have a thorough understanding of people's views, wishes and expectations. The service understands that the right of family members to be involved in care and decision-making hinges on the consent of the individual, and that the wishes and best interests of the person using the service must be taken into account. Where there are disagreements, these are responded to sensitively and a shared way forward is sought. Where guardianship or power of attorney are in place, staff are clear which legal powers are relevant, and fully involve and consult with the guardian.	Leaders either seldom engage with the families of people, or fail to do so in a meaningful way. There are limited ways for friends or family to be involved and these are often one-way or tokenistic. The views of friends and family are not effectively heard by leaders, resulting in a limited understanding of their views, wishes and expectations. There is little evidence of changes being made to how care and support is provided as a result of this involvement. Where people are the subject of guardianship or powers of attorney, the staff in the service don't fully recognise or understand what this means, or where decision-making powers lie. Leaders are not clear when someone lacks capacity to consent, or how to proceed if this is the case. Low expectations or over-protective attitudes from some family members are allowed to define the extent of people's ambition or outcomes.

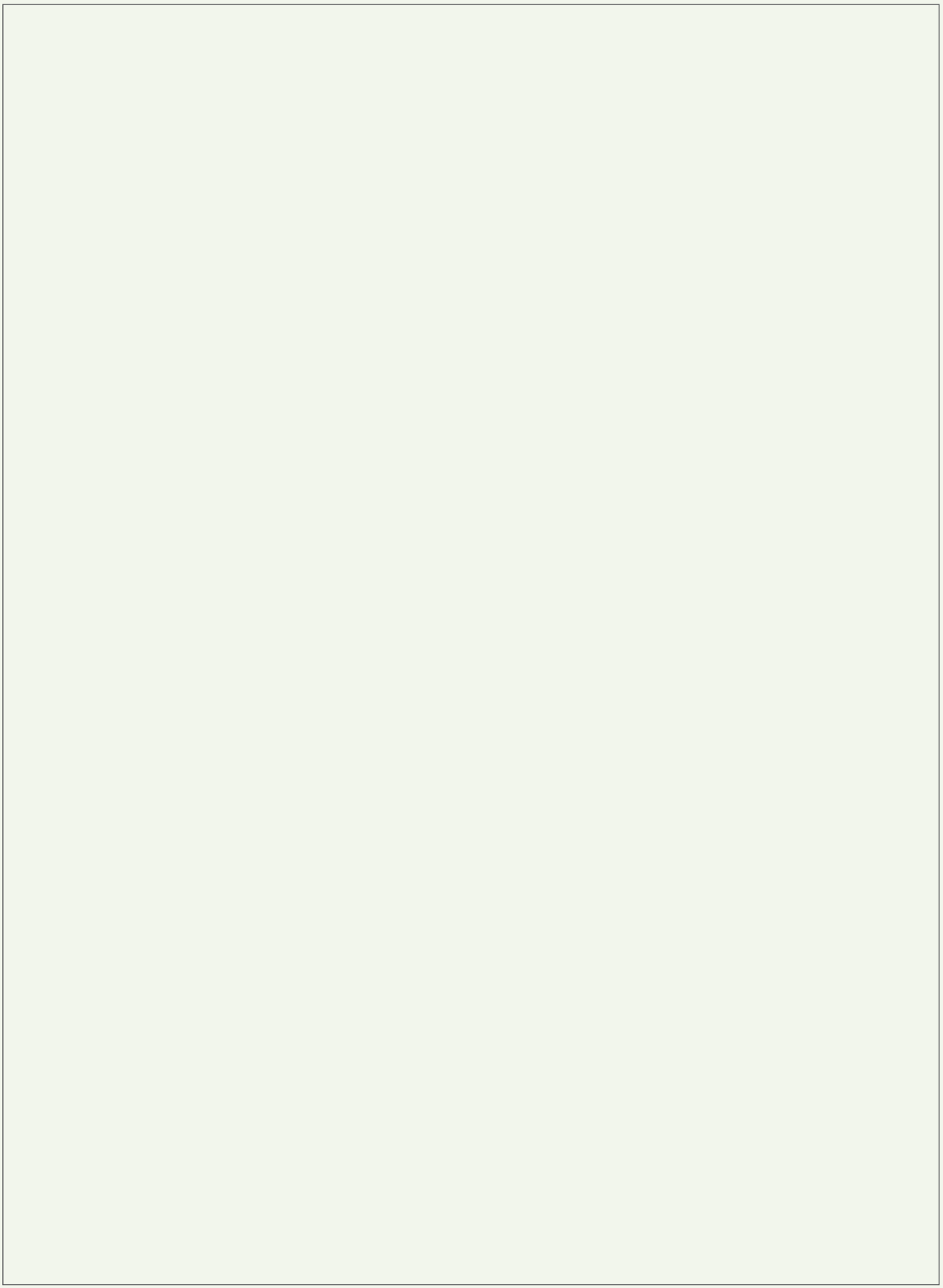
The service is led in a way that is strongly influenced by the people who use it, with the opportunity for family members, friends and carers where appropriate to be involved in a variety of ways. The views, choices and wishes of people who use the service, and their family members, inform changes in how care and support is provided, even where that challenges previous approaches. If the person using the service agrees, family members have the opportunity to be involved in making recruitment decisions in a meaningful way. The staff working in the service understand the complexities of family relationships and can provide support to people to try to reconnect with friends or family where these relationships have broken down. Staff understand the value of positive peer support in providing support and improving outcomes for people.	People and their families have no or limited opportunity to be involved in making recruitment decisions, or their wishes carry little weight in decision making. Information about people using the service is shared with their family members, friends or carers without appropriate consent. Leaders lack knowledge about informed consent. Leaders don't recognise the value of support provided by individuals who are important to the person using the service.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• Observations of practice and interactions. • Discussion with people, staff and relatives. • Care and support plans. • Personal plan review and action plan minutes. • Meeting minutes and action plans for people, staff and relatives. • Systems for acting on feedback, including complaints.	Carers Act: **https://www2.gov.scot/Topics/Health/Support-Social-Care/Unpaid-Carers/Implementation** Equal Partners in Care: **http://www.knowledge.scot.nhs.uk/home/portals-and-topics/equal-partners-in-care/about-equal-partners-in-care.aspx** Carers Trust: Triangle of care Carers included **https://professionals.carers.org/working-mental-health-carers/triangle-care-mental-health** Mental Welfare Commission – Carers and Confidentiality good practice guide. **https://www.mwcscot.org.uk/publications/good-practice-guides/**

How are we doing?

How do we know that?

What do we plan to do next?



How well is our care and support planned?

Quality indicator 5.1

Action

Responsibility

Achieved by

Sign off by

Quality indicator 5.2

Action

Responsibility

Achieved by

Sign off by

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