Joint inspection of adult services



Integration and outcomes

Record Review Template – Working Guidance v1.2

25 August 2023

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| **Record Review Guidance Joint Inspection of Adult Services-Mental Health**  Link to record review template: [JIAS\_Record\_review\_templatev1.1.docx](https://careinspectoratecloud.sharepoint.com/:w:/r/sites/StrategicScrutiny/Strategic%20Scrutiny%20Documents/Current_Scrutiny_Activity/Adults/Methodology/FINAL-DOCS_Mental_Health/06.Review%20of%20%20Records/JIAS_Record_review_templatev1.1.docx?d=wd613154122be4145b453068c0d29db55&csf=1&web=1&e=K13EPo)  **Guidance**  The record review process aims to gather evidence of integrated practice and processes at the frontline. Integrated practice and processes mean that both health and social work/social care must be involved. The template is designed to scrutinise integrated practice and processes rather than single agency involvement. The record review is undertaken to gain an overview of integrated practice and an understanding of integration. It is not the aim to audit details of the files and decide on particular aspects of practice in partnerships but to gain insight into how agencies and partners work together to achieve good outcomes for individuals.  For quality assurance purposes, where members of the inspection team have not worked together using this template before, at least one record should be read by all inspectors to ensure consistency of responses.  Please read the guidance carefully, however, these notes are designed to complement, not replace, your professional judgement. Please focus on practice in the last two years only, to ensure our findings are relevant and helpful.    **General Approach**  The bundle of health and social care records provided for each person in the review of records sample should contain information from the health and social care services they have received in the last 2 years. This means that each person in the sample could be at very different stages. Some may have entered the health and social care system within the last 2 years and information on their initial referral and assessment may be available, but their care, support and treatment may not yet have been reviewed. Some may have been receiving support for a number of years and as such the circumstances of the initial referral and assessment may not be clear.  This means that the way you answer the questions needs to vary according to each individual’s history and circumstances, guided by the available evidence.  There is no one size fits all approach, but it can be helpful to think about the following:   * We want to base our answers on evidence of integrated practice or the lack of integrated practice in the care, support and treatment that has had a significant impact on the person’s current outcomes.  These may be the most recent episodes, but they might not be.  Effective early intervention and prevention 18 months ago might be extremely important even if it is not evident in the current assessment/review because it is no longer relevant.  A comprehensive integrated initial response may have become less effective if reviews have been missed or have been undertaken by services working in isolation from each other. * There is no single way of identifying the most relevant evidence.  Individual inspectors will develop their own approach to gaining the necessary information which may be dependent on how the information has been provided.      * It is important to have a copy of this guidance to refer to as you go and also to make notes against relevant sections as you identify evidence.  The smart survey requires questions to be answered in a particular order so making notes can save time and effort because the evidence will probably not be organised in the same order (of course these notes need to be kept secure and will be important to ensure that they are appropriately destroyed at the end of the inspection). Please be aware that if you answer ‘no’ to question 7.1.1 “Is there an unpaid carer who provides care and support to the person?” the survey template will assume you have finished and close the survey down, so you’ll no longer be able to return to other questions. So you shouldn’t answer no to that question until you’re sure you’ve completed the rest of the questions. * Using “N/A” and “not known from the file bundle.”  There is not always evidence to allow you to answer the question positively or negatively.  If, in your professional opinion, something is not relevant to the person’s needs and circumstances use the N/A option.  If there is clearly no evidence of something that in your professional opinion should have been done, select the “No.”  If there is some ambiguity in the evidence which means that you cannot clearly say that something did or did not take place, select “not known from the file bundle.”   **Ratings Guidance**  Throughout the recording tool you will be asked to give a rating for certain aspects of work or practice. Professional judgment is essential in assessing the correct rating. There will be some guidance points to consider when deciding on the rating.:   |  | | --- | | **Excellent** – An evaluation of excellent will indicate that there is agreement with all the statements where they are appropriate. All the areas are very strong. People are likely to experience excellent outcomes. There are a number of features above the normal standard of practice and these aspects together should ensure an extremely high-quality experience for the person (and any other people as appropriate, including an unpaid carer). A rating of excellent indicates clear evidence of an outstanding level of professional competence across all agencies/services. | | **Very good** – An evaluation of very good will indicate that there is agreement with all the statements where they are appropriate. There are no weak areas and there are areas of real strength. People are likely to experience very good outcomes. Practice is of a high standard and should demonstrate professional competence which exceeds an acceptable level across all agencies/services. | | **Good** – An evaluation of good will indicate that there is agreement with all the statements where they are appropriate. There are a few weaker areas which could be strengthened. People are likely to experience generally good outcomes. Practice is of a good standard in most aspects and should still demonstrate an entirely acceptable level of professional competence across most agencies/services. | | **Adequate** – An evaluation of adequate will indicate that there is agreement with most of the statements where they are appropriate but there are some areas of weakness. These weaker areas have, or are likely to have, reduced the quality of the person’s experience and outcomes. A rating of adequate should demonstrate a basic level of competence and practice could be strengthened.  It could also indicate a good level of competence in some agencies/services but a poorer level in others. | | **Weak**–. An evaluation of weak will indicate that there is a lack of agreement with more than half of the statements where they are appropriate.  Some key areas are weak.  The person’s experiences and outcomes are likely to be generally poor. There is a lack of professional competence in key areas and agencies/services are not working together effectively. | | **Unsatisfactory**–An evaluation of unsatisfactory will indicate that there is agreement with only a minority of the statements where they are appropriate. There are major weaknesses.  The person’s outcomes are likely to be significantly poor. Practice is compromised and/or there may be a serious risk to the wellbeing or safety of the person (or other people) due to one or more of the following: key professionals demonstrate a lack of professional competence; services are not working effectively together; critical resources are not made available; insufficient attention has been given to key areas | | |
| SECTION 1 - GENERAL INFORMATION | |
| In this section we are gathering basic information on the file reader and the records being reviewed. This should be readily available in the file bundle paperwork. | |
| SECTION 2 - FILE BUNDLE | |
| The file bundle for each person will contain episodes and/or on-going involvement from both health and social care/social work over the past 2 years.  The files/records contained within the file bundle will therefore potentially differ dependent on which professionals, services or integrated teams have been involved and what the person’s individual needs are.    For example, a person receiving rehab/reablement within a community setting may have an NHS OT (Occupational Therapy), MH nurse, rehab support worker, care staff and social worker. Whereas a person with on-going support/care at home may have a community MH nurse, MHO (Mental Health Officer), and Care at home staff involved.    We encourage the partnership to include records/files from providers where these are available, as good integrated practice should involve them as partners, if they are part of the person’s care and support. Providers can be from the third and independent sector or in-house services within the partnership.    If you have a file that does not clearly fit into those listed, record it as other and specify what it is. | |
| SECTION 3 - INTEGRATED TEAM ROUND THE PERSON | |
| This section looks at the way the team works and whether it is integrated. Working in an integrated way may or may not be supported by integrated systems. It should be expected that integrated working will be evident where there are integrated systems in place however, professionals can still be working in an integrated way without those specific integrated systems. We are looking at how staff communicate, share information and work with other professionals to attain the desired outcomes of the person. | |
| 3.1 | Are there any formally integrated teams working with the person? |
| Integrated teams will normally consist of NHS and local authority staff but may also include third sector/ voluntary/ independent sector staff. The team name/ function should be identifiable from the letter headings, signatures or joined paperwork.    If it is unclear that third sector/ voluntary/ independent sector staff are formal team members, please tick and note in “other – please specify”    If teams have several components such as community mental health and community rehab, tick all that apply.  If there is no evidence of any integrated team tick no. | |
| 3.2 | Is there evidence that different professionals understand what each other does? (i.e., professional role, duties, and statutory responsibilities)? |
| The integrated team round the person may include commissioned services from the third/ independent or voluntary sector. Team members should be cognisant of the role and responsibility of other professions working with the person and when to call upon other teams' members to assist with health and care needs. | |
| 3.3 | Is there evidence of shared values, purpose, language, and mutual respect across partnership staff working with the person? |
| These questions give the record reviewer opportunity to comment on any evidence about the culture of the integrated team.   There should be a shared language and understanding among the team. Professionals should be respectful of one another’s roles in meeting the needs of the person.    Where professionals continue to work in silos, for example, there may be evidence of a “them and us” culture or lack of respect evident through “blaming” apparent in the notes. There may be differences in approach e.g., a deficit-based approach rather than strengths based. There may be expectations which differ around service provision e.g., formal day care rather than a connecting with community approach. | |
| 3.4 | Is there evidence of effective information sharing? |
| Do the records show professions sharing information effectively to reach the desired outcomes for the person? Are all members of the team sharing information to achieve optimum outcomes for the person? This may be through formal processes such as shared recording systems, or less formally through regular discussion. | |
| 3.5 | Are there any people/ roles who should be working as part of the integrated team round the person who are not doing so? |
| This can include professions who should be involved with the care and health needs of the person and/ or professionals who are working in an isolated, siloed way which leads to unnecessary duplication or delay. In some cases peripheral services such as housing, police, SFR, or environmental health could also be considered as part of the integrated team. | |
| 3.6 | Are you able to identify a key worker from the person’s records? |
| The key worker is the person who co-ordinates the person’s care and support, is the single point of contact for family and the person and organises the reviews. Key worker may not be the term used by all partnerships and the role may be referred to as care co-ordinator, lead professional or some other term. But the role should be identifiable from the records. | |
| 3.8 | Rate the quality of integrated practice in achieving good outcomes for people |
| Use the ratings guidance at the start of this template to rate the quality of the integrated practice overall considering the following points:   * Collaborative approach * Regularly jointly reviewed * Signed off appropriately by each relevant service * Views of carer and person are visible in documents for all services * Shared outcomes focussed approach * Effective communication and information sharing between professionals * Timeous referrals to other professionals | |

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| SECTION 4 - KEY PROCESSES | | |
| **4.1** | Access | |
| This section is about how the person accessed health and social work/care advice, support, and services.    Integration offers partnerships opportunities to develop more streamlined pathways for people to request help, rather than navigate what may feel like a complex and confusing system.  In an integrated landscape there is likely to be a range of ways a person might enter the system.    For example, there may be a stated “no wrong door approach” where any single point of access within health and social care services quickly and efficiently links people to the service responses that are appropriate for them. The Partnership may offer hubs in local communities where people can drop in and receive advice and sign posting in relation to prevention and early intervention. This may be staffed by the voluntary sector with health and social care staff providing clinics as required. HSCPs (Health and Social Care Partnerships) may have an integrated single point of contact via a contact centre which may have some professional staff in the team. Locality teams may have integrated duty systems with both nurses and social workers able to respond to inquiries.    When a person has an initial conversation about their needs, the professional(s) they are talking to should engage in a “good conversation” which focuses on personal outcomes - what matters to the person and what they want to achieve. The professional(s) should support the person to talk about assets and strengths and move away from a conversation about requesting formal service delivery (i.e., “I’m phoning because I want a home help) | | |
| **4.1.1** | Where did the person access the system? | |
| This is asking where the person first accessed the mental health system. This information may not be available from the file bundle if the person accessed the system more than two years previously, in which case choose N/A. | | |
| **4.1.2** | To what extent did the person have a seamless experience of accessing services? | |
| Consider to what extent there is evidence that:   * The first service to engage with the person involved other services as required, or supported the person to access them if this was more appropriate. The person didn’t have to seek out and contact services for themself. * The person was supported to provide as much relevant information as possible in one conversation, with minimal duplication at other stages. * The person’s information was shared between services so that they didn’t have to repeat what they’d already said. * Services only asked for additional information that hadn’t already been given and that was needed to allow them to fulfil their function. * There were minimal delays caused by having to access health and care services separately. | | |
| **4.1.3** | Rate the overall effectiveness of the access process. | |
| Use the ratings guidance at the start of this document. Effectiveness of access rating should encompass the following:     * The person was able to access the services that were right for them * The person was able to access the services they needed in a place which was right for them * the person was able to access the services they needed at the time that was right for them * The process reduced complexity from the person’s point of view * The person was supported to access the services they needed * The process was completely or mostly seamless (refer to answer for 4.1.2) * There was evidence of a “good conversation” * There was an effective immediate response to urgent need (if required) * There were no false starts with an inappropriate service. * The person was accepted the first time by the services they needed. * It is likely that the person or their representative was clear about the services they needed * It is likely that the person or their representative was clear about what would happen next. | | |
| **4.1.4** | Please note any other additional comments on access. |
| Free text box for any comments of note. | | |
| **4.2 Early Intervention and Prevention** | | |
| **4.2.1** | Is there evidence of any early interventions or preventative activities being offered? | |
| Mental illness cannot always be prevented but some symptoms may be alleviated by self-care techniques and general lifestyle changes. This may include peer support, sleep hygiene, avoiding drugs and alcohol and social prescribing when people are referred to community-based services to improve physical and mental wellbeing. These services can be groups for gardening, healthy eating, and different activities as well as therapeutic groups such as a cognitive behaviour group or psychoeducational group. | | |
| **4.2.2** | Were the activities offered timeously? | |
| Please use professional judgment to assess the timing of early intervention and preventative activities. Were they made available at the point the person needed and would gain most benefit from them? | | |
| **4.2.3** | How would you rate the overall effectiveness of early intervention or prevention activities? | |
| Use the ratings guidance at the start of this document. Effectiveness of early intervention and prevention activities rating should encompass the following:   * Comprehensive steps taken to implement an anticipatory, early intervention/prevention (EIP) approach * Coordinated effort to support the person to access activities in their community * Health, care, and social-economic risk factors considered * Assessment of risks to health and well-being is comprehensive and contributed to by a range of professionals. * Interventions and activities that are put in place are tailored to reducing (further) harm, more serious ill health, poverty and poor-quality living conditions, loneliness. Health screening and early intervention appointments e.g., befriending, money advice, physiotherapy, occupational therapy, peer support networks, as appropriate * Activities are tailored to the person and those close to them such as their unpaid carer and immediate family. * Activities support self-management * People are listened to and treated with dignity. * Good coordination avoids lengthy delays in EIP activities. | | |

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| 4.2.4 | Please note any additional comments on early intervention and prevention | |
| Free text box for any comments of note. | | |
| **4.3 Rehabilitation, reablement and intermediate care** | | |
| **4.3.1** | Has the person received any time limited intervention to help regain or improve their wellbeing or functioning? | |
| This will include interventions and activities that support a person living with a mental illness to live as well as they can in their community. It may include counselling, Distress Brief Intervention, online Cognitive Behaviour Therapy, peer group support, support to attend social activities or other such interventions. It may also include physical rehabilitation activities if appropriate. If there has been no requirement for rehabilitation, reablement or intermediate care, choose N/A | | |
| **4.3.2** | Is the approach to reablement/ rehabilitation: | |
| The file bundle may have a rehab/ reablement/ recovery plan or this could be inherent within care/support plans. Please identify the extent to which the approach is shared between agencies. | | |
| **4.3.3** | Rate the overall effectiveness of integrated rehabilitation, reablement and intermediate health and social care | |
| Use the ratings guidance at the start of this document and consider the following:   * Increases independence. * A person-centred approach based on agreed goals considering the needs, preferences, priorities and circumstances of the person and their carer(s).  It should reflect everything that is important to them, relationships, activities, and their spirituality. * Includes physical, psychological, and social assessment. * Interventions which address physical, psychological, and social factors. * Is multidisciplinary and where appropriate multiagency. * Communication and coordination between relevant teams and services. * Outcomes focused to improve health, wellbeing, and independent living * Appropriate aids and assistance to support safety, self-management * Any legal limitations or considerations * Medications and side effects | | |
| **4.3.4** | Please note any additional comments of rehabilitation, reablement or recovery care: | |
| Free text box for any comments of note. | | |
| **4.4 Assessment** | | |
| **4.4.1** | Have assessments been provided in the person’s records? | |
| The assessments can be from any professional involved in supporting the person’s health and care needs and assisting them to achieve their objectives. If the person first approached the HSCP longer than 2 years ago this information may not be included in the file bundle. In this case you should choose N/A. | | |
| **4.4.2** | How long did the person wait for an assessment from point of approaching the HSCP for help? | |
| The length of time should be estimated from when the person first approached the HSCP (including primary care) to the point where the initial assessment(s) were complete, eligibility criteria applied (if relevant) and a care plan was ready to commence in relation to needs which were critical to the person’s outcomes. | | |
| **4.4.3** | Was the assessment- | |
| There may be profession specific assessments in the file bundle as well as shared assessment. Please identify the extent to which the assessment is shared between agencies | | |
| **4.4.4** | Please rate the effectiveness of the collaborative approach to assessment across the HSCP | |
| Use the ratings guidance at the start of this document. Rating effectiveness will include:   * The right professionals becoming involved at the right time. Understanding of the professional roles across the HSCP * No unnecessary delays in initiating assessment or protracted process in completing assessment * Minimal “hand-offs “across professionals/services * Effective information sharing and shared documents (as relevant) * Regular communication focussed on a shared understanding of the person’s personal outcomes * Shared approaches to working with the person e.g., strengths based * Avoiding duplication in information gathering from the person * The person and their carer are at the centre of the collaborative team approach to assessment * Seeking common understanding of people’s desired outcomes, priorities, preferences, and choices. * A common approach to assessing risks and risk enablement. | | |
| **4.4.5** | Please note any additional comments on the collaborative assessment approach. | |
| Free text box for any comments of note. | | |
| **4.5 Planning for care, support, and treatment** | | |
| **4.5.1** | Have care, support and treatment plans been provided in the person’s records? | |
| These can be integrated plans or from individual professionals. | | |
| **4.5.2** | Is the Care/ Support/Treatment plan: | |
| Please identify the extent to which the plan is shared between agencies | | |
| **4.5.3** | Where appropriate, were options of self-directed support discussed and promoted with the person | |
| Does the file include any record of the SDS (Self Directed Support) options being discussed with the individual and is the outcome of that discussion recorded? This could be in any part of the file bundle. | | |
| **4.5.4** | Were treatment and health interventions discussed, explained and options offered where relevant? | |
| Is there any record in the file bundle of a discussion about options and choices about treatment and care? | | |
| **4.5.5** | Is there evidence of the person being supported to use strategies to support self-management of their condition | |
| Does the file contain any evidence of the person receiving advice, assistance and/or instruction in how to use strategies to manage their mental health condition? There are numerous options for strategies from someone taking a walk when feeling anxious to the use of medication. The strategies should be identified as being suitable for the issues experiences by the person. | | |
| **4.5.6** | Is there an up to date and meaningful future care plan in place which all partners are aware of? | |
| This may also be called an advance statement outlining preferences for treatment, medications and where the person would rather be treated if possible. | | |
| **4.5.7** | Is there a multi-agency contingency/ emergency plan in place and known to the **person** and all team members? | |
| Note that this may be in the carers section of the file bundle as part of the Carers Support Plan | | |
| **4.5.8** | Have risk assessments been provided in the person’s records? | |
| The risk assessment may be part of the assessment or outcomes document and may not be a stand-alone document. The risk assessment document may also be part of a review document or for a Care Programme approach document. | | |
| **4.5.9 Are the risk assessments** | | |
| There may be individual, shared or coordinated risk assessments. These may be in various sections of the file bundle. There may be input from community resources and other non-funded support. You should consider risk management and enablement to be fully integrated if it is based on a defined and/or agreed approach to how services/staff work together to deliver a common and coordinated approach to risk management and risk enablement.    You should consider risk management and enablement to be co-ordinated/shared if there is evidence of communication and information sharing to ensure that the person’s needs risks are managed in a coordinated way, but this is not delivered according to a defined or agreed approach. | | |
| **4.5.10** | Rate the Quality of the integrated care, support, and treatment planning | | |
| Use the ratings guidance at the start of this document and consider the extent to which planning includes:   * Participation by all relevant services/professionals/agencies * A focus on what the person would like to achieve with their care and support, their goals, and aspirations for the future. * What is important to the person about how they live their life now: what they enjoy doing, their interests, likes and dislikes, who is important to them, who they like to see, and their preferred routines. * Details of key life events and dates to assist with chronological orientation, avoiding purely deficit-based events * How best to support and involve the person in decision-making. * Essential information and contingencies for continuity of care and emergencies. * Roles and responsibilities so that the person receives coordinated care and support to meet their needs. * Where a person lacks capacity to express their choices, how their families and others who are interested in their welfare have been consulted and the attempts to engage with the person. * What outcome the person wants, and any other options considered. * The associated benefits and risks of each option. * A risk enablement approach. | | |
| **4.5.11** | | **Please note any additional comments on planning care, treatment and support** |
| Free text box for any comments of note. | | |
| **4.6 Service Delivery** | | |
| **4.6.1** | Were service providers included as partners with HSCP assessment staff and the person in planning service delivery? | |
| Is there evidence in the file of service providers attending planning meetings or being present during assessments for support. Were service providers consulted with prior to a care, support and treatment plan being devised? These may be third sector/ voluntary/ independent/ private providers. | | |
| **4.6.2** | Is there evidence that information sharing across the integrated team (assessors and providers) is effective? | |
| **Always** – all information about the person’s personal outcomes, preferences and plan was shared across all the team timeously all the time. This contributed to excellent outcomes for the person.    **Often** – identified outcomes, preferences, and plan were shared often. This contributed to very good outcomes for the person.    **Sometimes–** identified outcomes, preferences and plan were sometimes shared. This led to opportunities for better outcomes for the person being missed.    **Rarely –** Very few updates or pieces of information about the person were shared leading to poorer outcomes.    **Never** – There appears to be no information sharing between assessors and providers. This led to higher risks and inadequate outcomes. | | |
| **4.6.3** | Are Community supports part of the support plan? | |
| Examples of these may be faith or worship groups, leisure centres, peer groups, community clubs, befrienders, peer support, organised activities. Where you assess that such involvement would be beneficial and desired by the person, note whether or not it is included in the plan. It may be that the person does not want or would not benefit from community involvement due to the personal factors. In this case, choose N/A | | |
| **4.6.4** | Was there any delay in providing formal services? | |
| Does the file give any indication in delays of service provision once it was agreed this was required. This can be from health or social care. This question focuses on the provision of services **after** the assessment and planning stages. Providers should be considered as part of the formal services which includes support and care and treatment. If there were delays, please say in which service. | | |
| **4.6.5** | Please note any additional comments on service delivery. | |
| Free text box for any comments of note. Please note the length of delays. | | |
| **4.7 Unplanned care, support, and treatment** | | |
| **4.7.1** | If there is a change of circumstances requiring an emergency response, is there a timely and coordinated multi agency response? | |
| If such circumstances have arisen in the past 2 years, use your professional judgement to decide if a timely and integrated response was provided, If either factor was missing, choose no and explain your choice at 4.7.4. If such a situation has not arisen, choose N/A. | | |
| **4.7.2** | Does the integrated response prevent emergency respite or hospital admission? | |
| If the emergency is due to acute illness, hospital admission is likely to be the most appropriate response. If, in your judgement, this is the case, choose N/A. However, if the change of circumstances is due to other social or situational factors, and you consider that appropriate interventions could have prevented admission or emergency respite, answer the question. Whilst sometimes a range of factors will affect the outcome and it may not clear to what extent the intervention itself prevented admission, use your professional judgement to decide on balance whether the intervention was a significant factor. | | |
| **4.7.3.** | Rate the effectiveness of the integrated emergency response | |
| Use the ratings guidance at the start of this document and consider:   * Multi-agency/ multi-professional input * Fast response * Co-ordinated response * Timely service delivery * Person centred and strengths based * Inclusive of carer * Effective communication pathways across hospital teams and community * Working collaboratively to bring about a timely discharge i.e., as soon as the person is medically fit * Shared discharge or aftercare plan * Emergency contacts and/or discharge pack provided * Shared personal outcomes plan * Shared understanding and acceptance of risk | | |
| 4.7.4 | Please note any additional comments on unplanned care, support, and treatment. | |
| Free text box for any comments of note. | | |
| **4.8 Reviews** | | |
| **4.8.1** | Have reviews been provided in the person’s records? | |
| These can be integrated or single agency. If, in your opinion, there should not be any reviews in the pack (for example, because the person hasn’t been receiving services for long enough, choose N/A). However, if there are no reviews and you think there should be, pick no. | | |
| **4.8.2** | Are the reviews: | |
| Please identify the extent to which reviews are shared between agencies. There may be reviews in the file that are individual reviews that take account of the overall care, support, and treatment plan. These should be considered to be co-ordinated or shared. There may be some shared reviews (for example in relation to the care programming approach) but others that are single agency (for example from a housing support provider). In this case you should pick ‘mixed’. | | |
| **4.8.3** | Did reviews take place frequently enough to respond to the person’s needs and circumstances? | |
| Social work services commonly seek to review at least annually, and registered care providers have a statutory obligation to undertake reviews every 6 months. These are broad guidelines, but more frequent reviews may be required if the person's needs change or are very complex. Reviews of health care and treatment may depend on clinical judgement. In your professional opinion, do reviews appear to have taken place frequently enough? There are statutory guidelines for reviews under the Mental Health (Care and Treatment Act) and the Adults with Incapacity Act. We are not inspecting the legislative process so cannot comment on the statutory timescale of those reviews but are looking at the needs of the person and the review structure to meet those needs. There may also be Care Programme Approach paperwork which should have reviews included. | | |
| **4.8.4** | Are formal services adjusted as the person becomes more or less independent and/ or outcomes are achieved? | |
| Does the file contain evidence of changes to care and support provision because of the review? | | |
| **4.8.5** | Were appropriate arrangements put in place for the person and their carer (if appropriate) to be involved in the review? | |
| You should consider:   * Were the person and carer informed of the review and was it at a suitable time to attend? * Were any transport or escort needs met? * Did they get support to prepare for the review and understand what would happen at it? * Were they supported and encouraged to share their views? * If they could not attend in person, was there a way for their views to be represented? * Any other arrangements that were required to support meaningful involvement. | | |
| **4.8.6** | How would you rate the overall effectiveness of the integrated reviews? | |
| Use the ratings guidance at the start of this document and consider:   * The review was timely, considering the person’s needs and circumstances * The person and their carer were at the centre of the collaborative approach to reviewing their needs, priorities, and preferences. * The review facilitated timely new or adjusted responses to the person, or their carers needs if this was required. * The right professionals were involved * No unnecessary delays in initiating the review or protracted process in its completion * Minimal “hand-offs “across professionals/services of challenges or risks. * Effective information sharing and shared documents (as relevant) * A shared understanding of the person’s personal outcomes, their feedback, or changes. * Shared approaches to working with the person e.g., strengths based * Avoiding duplication in information gathering from the person * A renewed common understanding of people’s desired outcomes, priorities, preferences, and choices. * A shared approach to risk and risk enablement * Progress can be seen based on review action plans by relevant professionals | | |
| **4.8.7** | Please note any other comments on reviews. | |
| Free text box for any comments of note. | | | |
| **4.9 Incapacity** | | |
| **4.9.1** | Is there evidence that the person lacks capacity? | |
| In your professional opinion, is there any information in any of the records you have read that indicates that the person may lack capacity? | | |
| **4.9.2** | Please comment on the effectiveness of the process for responding to incapacity. | |
| Doctors have the principal responsibility for the formal assessment of capacity in relation to money management and personal welfare decisions under the Adults with Incapacity Act, although it is considered good practice to consult the wider multi-disciplinary team round the person and involve advocacy. There is no one all-purpose test for incapacity. The principles of maximising capacity should always be considered in the first instance with alternative communication aids used to assist the person. There should be a clear and timely referral process for a capacity assessment with explanation of the medical condition along with the reasons for the request, including the decision(s)to be made. An AWI (Adults with Incapacity) Section 47 Capacity Assessments often completed in hospital only relates to consent to medical treatment and cannot be used for financial and welfare decision.  In your answer, you should consider:   * How concerns about capacity were identified, considered and appropriately shared * Whether action was taken to investigate potential incapacity at the right time? * How the person and their family and/or unpaid carers were provided with information about and supported during the process? * How quickly the process was started? * How quickly the assessment was completed? * Were the right people and services consulted? * Was the outcome shared timeously with all relevant parties?   . | | |

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| SECTION 5 - COVID -19 RESPONSE | |
| **5.1.1** | Has the person experienced any significant impacts as a result of the Covid 19 pandemic? |
| The impacts should be within the last 2 years and should relate to the person’s wellbeing and to their care and treatment | |

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| SECTION 6 - NATIONAL HEALTH AND WELLBEING OUTCOMES  Central to the record reader’s professional judgement should be any indicators of how integrated services have impacted on the person’s life. Consideration should be given to following questions based on the “what people can expect” statements set out within the national health and wellbeing outcomes framework.    Taking account of the available evidence, can you be reasonably confident of answering “yes” to the questions for each outcome, on the balance of probabilities. You should give greater weighting to any recorded feedback from the supported person than any other evidence or judgements by other professionals.  **Completely** – based on the evidence across the whole file bundle, you are reasonably confident of answering “yes” to all the questions for this outcome (yes to all of the questions all, all the time).    **Mostly** – based on the evidence across the whole file bundle, you are reasonably confident of answering “yes” to most of the questions for this outcome (yes to more than half of the questions all of the time or yes to all of questions some of the time)    **Partly** – based on the evidence across the whole file bundle, you are reasonably confident of answering “yes” to half or less than half of the questions (yes to half or less of the questions all of the time or yes to more than half some of the time)    **Not at all** - based on the evidence across the whole file bundle, you are reasonably confident of answering “no” to all the questions for this outcome (no to all the questions all the time).    Not known – based on the evidence across the whole file bundle, you cannot assess the outcome with reasonable confidence. | | |
| **6.1.1.** | Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer | |
| * Is the person supported to look after their own health and wellbeing? * Is the person able to live a healthy life for as long as possible? * Is the person able to access information? | | |
| **6.1.2** | Outcome 2: People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting. | |
| * Is the person able to live as independently as possible for as long as they wish? * Are community-based services available to the person? * Can the person engage with and participate in their community (if this is desirable and appropriate)? | | |
| **6.1.3** | Outcome 3: People who use health and social care services have positive experiences of those services, and have their dignity respected. | |
| * Is the person’s privacy respected? * Is it likely that the person has positive experiences of services? * Are the person’s views listened to? * Is the person treated as a person by the people doing the work – we develop a relationship that helps us to work well together? * Are services and supports reliable and responsive to what the person says? | | |
| **6.1.4** | Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use services. | |
| * Is the person supported to do the things that matter most to them? * Do services and support help the person to reduce and manage the symptoms that they are concerned about? * Are the services the person is using continuously improving? * Do the services the person uses improve their quality of life? | | |
| **6.1.5** | Outcome5: Health and social care services contribute to reducing health inequalities. | |
| * Is the person able to access the health and social care services they need in their local community? * Support and services are available to the person? * Are the person’s individual circumstances considered? | | |
| **6.1.6** | | Outcome 7: People who use health and social care services are safe from harm. |
| * Is the person safe and protected from abuse and harm? * Do the supports and services protect the person from harm? * Are the person’s choices respected in making decisions about keeping them safe from harm? | | |

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| SECTION 7 - UNPAID CARERS | |
| **Assessment and Support** | |
| **7.1.1** | Is there an unpaid carer who provides care and support to the person? |
| **PLEASE NOTE THAT IF YOU ANSWER NO TO THIS QUESTION THE TEMPLATE WILL ASSUME THAT YOU HAVE FINISHED THE SURVEY AND WILL CLOSE – WHICH MEANS YOU CANNOT GO BACK TO ANY OTHER QUESTIONS. SO DON’T SAY NO HERE UNLESS YOU’RE SURE THE REST OF THE TEMPLATE IS COMPLETED!**  The unpaid carer is not commissioned by an agency to provide the support but is informal in their role. Note that an unpaid carer may be paid for some aspects of care and support by an SDS option but continue to provide additional unpaid support to the person. | |
| **7.1.2** | Has the carer been offered an Adult Carer Support Plan? |
| There should be indication in the notes as to whether the carer has been offered an Adult Carer assessment and support plan even if this has been conducted by another agency. | |
| **7.1.3** | Has the carer accepted the offer of an Adult Carer Support Plan? |
| The notes should indicate if someone has turned it down | |
| **7.1.4** | Has an Adult Carer Support Plan been completed? |
| The Adult Carer Support Plan should be in the file bundle but may have been completed by another agency and kept on their records with recommendations of support given to the commissioning agency. | |
| **7.1.5** | **Rate the quality of the adult carer support plan** |
| Use the ratings guidance at the start of this document and consider:   * No unnecessary delay in offering and completing of the support plan * Avoiding duplication in information gathering from the person * Person centred - describing the carer’s personal circumstances and the nature and extent of the care they provide or intend to provide * Impacts - identifying impacts of caring on the carer’s well-being and day-to-day life * Health - identifying any physical, mental or emotional health issues * Planning for emergencies * Planning for the future care of the person they care for * Outcome focussed - describing what would improve their lives and allow them to have a life alongside caring e.g. paid work, study, training, leisure, relationships and social activities * Strengths based assessment and support * Needs - what support they need to help in their caring role and to achieve their personal outcomes * A support plan describing how needs which meet the local eligibility criteria will be met   OR   * Signposting to advice, information, carer centres or assisting with putting in place an emergency plan, if needs do not meet eligibility criteria. | |
| **7.1.6.** | Please detail which supports the carer was provided with or signposted to |
| There is the option to detail any support provided not included on the list. | |
| **7.1.7** | Were self-directed support options discussed? |
| Where appropriate the SDS options should have been discussed and the details of that discussion been recorded in the file bundle. The outcome of that discussion, giving the carers’ choices, should be clearly noted.  In circumstances where the carer is not eligible to receive social care services in their own right, please choose N/A. | |
| **7.1.8** | Is there an emergency support plan in place should the carer be unable to continue in their caring role? |
| An emergency support plan for a carer is good practice and can be compiled by anyone in the integrated team. It should include details of what will happen if the carer is unable to continue in their role and involve both the carer and the person in the formation of the support plan. | |
| **7.2 Carers Outcomes** | |
| **7.2** | Outcome 6: People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health. |
| See guidance on outcomes for person at **section 6**  The ‘what can we expect’ statements for outcome 6 are:   * The carer can get the support they need to keep on with their caring role for as long as they want to do that * The carer is happy with the quality of their life and the life of the person they care for * The carer can look after their own health and wellbeing | |

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| **7.3 Integrated team around the person** | |
| **7.3.1** | Is there evidence that the unpaid carer is regarded as an integral member of the team around the person? |
| The unpaid carer should be included in assessments, reviews, case conferences and care and support planning. They should be copied into meeting invites, care and support plans and review notes. (This will apply on the assumption that the person consents or the carer has an active role via legislation such as Power of Attorney). | |
| **7.3.2:** | If the person isn’t regarded as an integral part of the team is this because? |
| There should be a statement in the file to indicate the reasons why the carer is not part of the integral team. This can be the decision of the person or the choice of the carer, amongst other reasons. If there is no specific reason given, you should use your professional judgement to identify the reason or choose not known. | |
| **7.3.3** | Please rate the effectiveness of the integrated response to the unpaid carer. |
| Use the ratings guidance at the start of this document and consider:  Was the carer support plan offered and completed timeously?  Was there a focus on what the carer needed to have a good quality of life and continue in their caring role?  Was the carer signposted to or provided with the information, advice and support that hey needed. Was this reviewed on a regular basis?  Did the team check with the person if they wanted to include unpaid carer in all correspondence and meetings?  Did the team check on the legal status (if any) of the unpaid carer to verify their right to be involved?  Did the carer get included in all correspondence regarding the persons care and treatment?  Did the carer get invited to meetings and reviews concerning the persons care and treatment?  Was the carer asked to give their views on the care and treatment at reviews and meetings?  Was the role provided by the carer acknowledged during planning and review meetings  Were all members of the team around the person aware of the unpaid carer and their role | |
| **7.4.1 Please describe any impacts on the carer** **as a result of the Covid 19 pandemic** | |
| Please comment on any impact described or noted in the file bundle. This may not be in the file bundle as it should only hold records from preceding 2 years. | |
| **7.5. Please note any additional comments on integrated practice with carer(s):** | |
| Free text box for any comments of note. | |