care inspectorate

Scrutiny and Assurance Directorate Strategy

HAPPY TO TRANSLATE

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Scrutiny and Assurance Directorate Strategy

Foreword

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

All our work in the Scrutiny and Assurance Directorate is aligned to the four strategic outcomes of our Corporate Plan 2022-2025.

- High-quality care for all
- Improving outcomes for all
- Everyone's rights are respected and realised
- Our people are skilled, confident and well-supported to carry out their roles

In support of this, the Scrutiny and Assurance Directorate's overarching aim is to ensure as far as possible the safety, protection and wellbeing of people and promoting and ensuring safe care that upholds and protects human rights. The health and wellbeing of our own staff remains a priority.

We will continue to focus our efforts on doing all that we can through our various scrutiny approaches to provide independent assurance about the care, protection, and wellbeing of people taking account of learning during the Covid-19 pandemic, current pressures on services and, where necessary, support services to make improvements.

We provide public assurance primarily through the reports that we publish and raising awareness of the actions we have taken in response to how well services are performing, particularly those poorer performing services. We believe this helps people who use care services, their families or carers, communities and the public in general to have confidence in what we do and that we will act promptly, appropriately and effectively to address any concerns about poor quality care.

We believe that scrutiny and improvement support are not mutually exclusive. Our approaches to inspection and scrutiny are designed to support services to improve by signposting good practice, providing professional advice and encouraging the sharing of experience and good practice. We believe that through every single contact, visit or inspection by our inspectors we are supporting services to improve as well as providing the necessary independent assurance about the quality of care, thereby discharging our responsibility and general duty of furthering improvement in the quality of social services, (Section 44(1)(b) of the Public Service Reform 2010 Act). This enables services to adapt, learn and improve practice. We will continue to take this approach and work closely with our colleagues in the Strategy and Improvement Directorate, and where necessary and appropriate our scrutiny and delivery partners, to share our scrutiny findings to enable them to provide targeted improvement support.

Given the breadth of our work in the Scrutiny and Assurance Directorate, we will continue to take account of a wide range of current and emerging policies, in particular considering at an early stage the possible implications of new policies and those being developed or reviewed.

The Covid-19 pandemic continues to be a key feature of policy discussion, both in terms of the ongoing challenges it represents and the reflection and learning that is taking place, as well the ongoing public inquiry into the pandemic response in Scotland. The pandemic has had a significant impact on services and those experiencing and providing care that we will continue to reflect on and take account of that and any further learning that is identified.

Plans for a National Care Service will be at the forefront of our work over the next few years and beyond. We will support this in a number of different ways, for example in the provision of scrutiny evidence, through providing professional advice and guidance and in developing our scrutiny approaches. We will also take account of any recommendations arising from the Independent Review of Inspection, Scrutiny and Regulation (IRISR) across social care support services, announced by the Scottish Government on Friday 23 September 2022. This review, which arises from a recommendation of the Feeley Review (2021), is chaired by Dame Sue Bruce. We view it positively and are committed to engaging with it in that way.

We will demonstrate our commitment to keeping The Promise to Scotland's children and young people.

We will do so by continuing to strengthen inspection methodology and inspectors' development to ensure we listen to children and young people and focus attention on what is of greatest importance to them.

We are committing to amplifying children's voices and to further developing collaborative approaches to support improvements where they are needed. More information about The Promise can be found in our Corporate Plan 2022-25.

Other key policy developments include:

- education reform, as it relates to the work we do in ELC and how we work more collaboratively with Education Scotland and the new Education Inspectorate
- continued expansion of ELC for one and two-year-olds and school-aged childcare
- ongoing work to establish the Barnahus ('Bairns Hoose') model in this parliamentary session
- The Children's Care and Justice Bill
- The Scottish Mental Health Review Final Report (2022).

We will continue to be flexible and responsive to the changing landscape and keep the priorities we set under constant review and be mindful that we are uniquely positioned to provide real-time intelligence on services and the experiences of people who use them.

We will continue to focus on evaluating experiences and outcomes to ensure the best possible outcomes for people, their carers, families and communities.

We will continue to work collaboratively with colleagues throughout the Care Inspectorate and with a wide range of organisations and bodies.

We will undoubtedly face many challenges as we move forward, but the professionalism, determination and commitment that our staff are known for, and have demonstrated emphatically over the past three years during the Covid-19 pandemic, help us to support services and each other and provide the necessary public assurance and protection that is so critically important.

Kevin Mitchell
Executive Director of Scrutiny and Assurance

Section 1 –Mission, Values, and Principles

Mission and values

Our Mission

Our Mission is to provide public assurance about the quality of care, social work and early learning services, promote innovation and support continuous improvement. We will take action where experiences and outcomes are poor.

Our Values

Our values are at the heart of all that we do.

Person-centred:
we will put people*, compassion and kindness at the heart of everything we do.

Fair:
we will act fairly and consistently, be transparent and treat everyone equally.

Respectful:
we will be respectful in all that we do.

*infants, children, young people, adults and older people

Integrity:
we will be impartial and act to improve care for all those in Scotland.

Efficient:
we will provide the best possible quality and public value from our work.

Equality:
we will promote and advance equality, diversity and inclusion in all our work and interactions.

In delivering our scrutiny and assurance work we will demonstrate these values by:

- working hard to develop and maintain professional relationships with all, promoting and supporting dialogue with our delivery and scrutiny partners
- taking seriously our position as an independent scrutiny body, being open, honest, balanced, and fair in our dealings with people
- taking time to explain to people what we are doing and why, what we find, and using our scrutiny evidence to support our decision-making
- being professional and courteous in all that we do, listening carefully to the views of others, even when we don't necessarily agree
- using our knowledge and understanding of care and social work to highlight and help tackle inequalities and promote better outcomes for people
- using public funds wisely, efficiently, and effectively
- admitting when we don't get things right, and apologising if we get things wrong
- trying to reach a resolution when people are unhappy with any aspect of our work or directing them to the appropriate recourse when we cannot.

Principles

The underpinning principle of all our work is enshrined in our vision '…for world class social care and social work in Scotland, where everyone in every community, experiences **high-quality care**, support and learning, tailored to their rights, needs and wishes..' and in our mission to '…provide public assurance about the **quality of social care**, social work and early learning services …'

Our primary focus will always be on the quality of care people receive and their experience of that. Where care is not as good as it should be, we will do what we can to support services to make improvement.

In developing our approaches, we take account of the relevant legislation and policy including:

- the Public Service Reform (Scotland) Act 2010
- the Health and Social Care Standards (Scottish Government, 2017)
- the Crerar Review: the report of the independent review of regulation, audit, inspection and complaints handling of public services in Scotland (Scottish Government, 2007)
- the Better Regulation Taskforce
- the Scottish Regulators' Strategic Code of Practice (Scottish Government, 2015).

The following principles and approaches will underpin all our work.

- We remain committed to ensuring our activities are **targeted**, **proportionate**, **intelligence-led,** and **risk-based**.
- We will increasingly use **data, information and intelligence** to plan scrutiny interventions designed to provide independent public assurance, improve the quality of life for people who experience care and help support quality improvement and **human rights-based care**.
- The **involvement of people** who experience care, and their families and carers will be central to all that we do.
- We will focus on **reducing inequalities and working collaboratively** based on the principles outlined in the Christie report on public service reform, people, prevention; partnership; and performance (Report on the future delivery of public services by the commission chaired by Dr Campbell Christie (Scottish Government, 2011).
- Through our work, we support the drive to **empower communities and enable public services to be agile and flexible**, and design and deliver services based on need and what works well.
- Through **responsive regulation,** we will continuously develop our approaches to ensure regulation and inspection are powerful tools to improve outcomes for people experiencing care.
- We will **assess risk,** use **professional judgement** and be proportionate in our response and actions.
- We will deliver all our work with a high level of **professionalism** and with staff who have the requisite **skills, knowledge and experience** to do it well.
- We have in place **good governance** to ensure the work we do is to a high standard.

Section 2 – Scrutiny and assurance directorate

Who are we and what do we do?

The Care Inspectorate is the independent scrutiny and improvement support body for social care and social work services in Scotland.

Our directorate provides that independent assurance and supports improvement across integrated health and social care, social work, early learning and childcare and justice social work. We have responsibility for regulating and inspecting almost 12,000 care services and lead responsibility for the scrutiny of services for children, justice and protection. We also carry out joint inspections of integrated health and care services and services for adults.

We also has a statutory duty to deal with complaints about registered care services. In our directorate we currently deal with around 6,000 complaints each year. We are uniquely positioned to report on the impact of strategic level planning and commissioning at a service level, and on the experiences of, and outcomes for, people who use services and their families and carers.

We also play a significant role in supporting improvements in the quality of care, and reducing health and social inequalities, in Scotland. Within section 44(1)(b) of the Public Services Reform (Scotland) Act 2010, we have a general duty of furthering improvement in the quality of social services. We also have general duty to ensure that good practice in the provision of social services is identified, publicised and promoted (Section 45(5)).

We play a key role in influencing and advising on the development, implementation and review of national policy, including, for example, the expansion of funded early learning and childcare, the integration of health and social care and public protection and in time through the creation of a National Care Service.

Regulated care service profile

38 adoption services

71 adult placement services

3,886 childminders

17 childcare agencies

3,559 day care of children services

59 fostering services

5 offender accommodation services

62 school care accommodation services

5 secure accommodation services

1,058 housing support services

1,392 care home services

- 255 Adults
- 336 Children and young people
- 801 Older people

121 nurse agencies

1,489 support services

- 1,095 Care at home
- 394 Other than care at home (adult daycare services)

We also carry out scrutiny, assurance and improvement activity for social work services, including joint inspections with partners across services for:

- children and young people
- adults
- older people
- justice services

Across

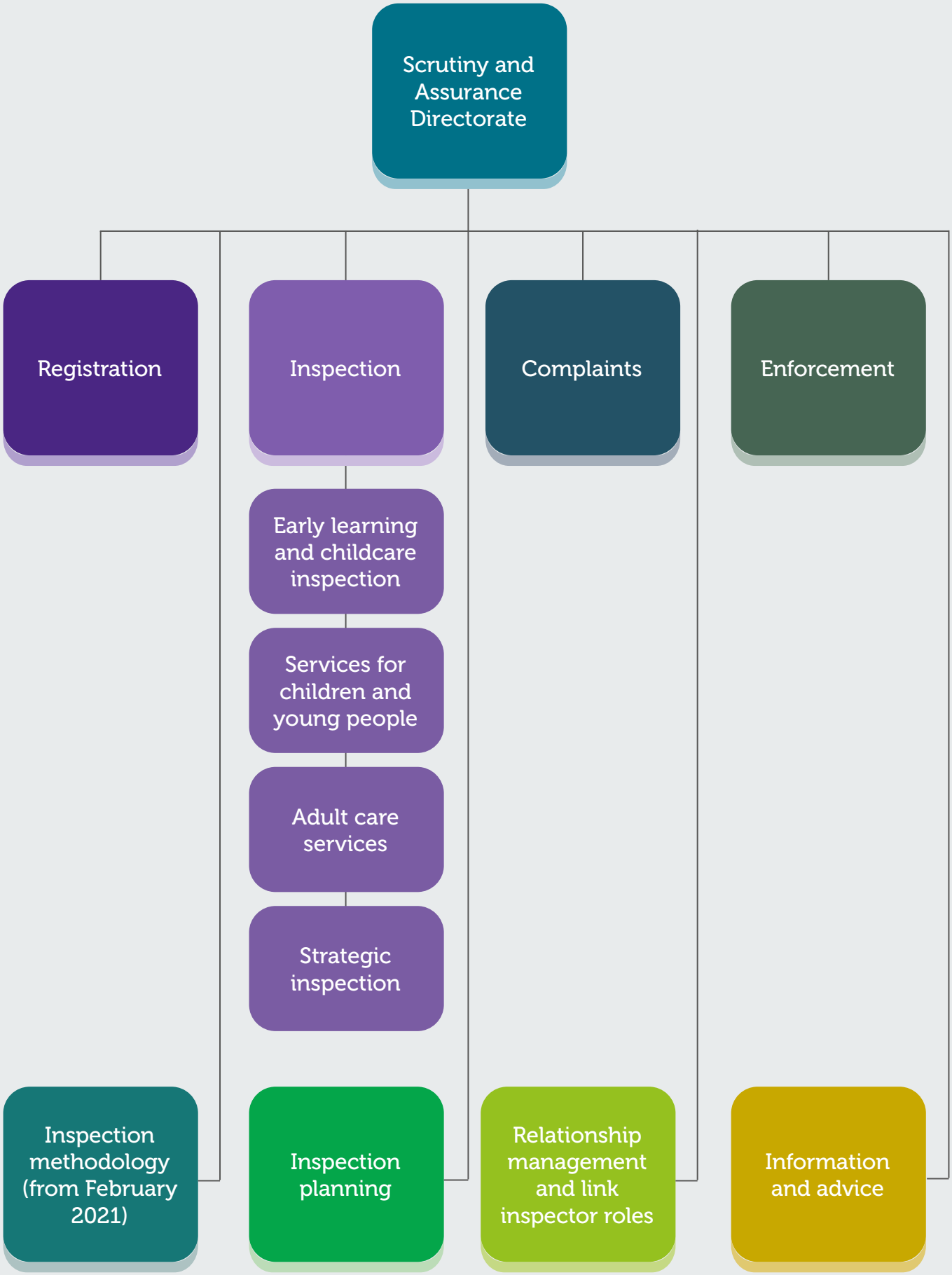
32 local authorities

31 integration authorities

Current partners in our strategic joint inspection programmes include

- Healthcare Improvement Scotland
- His Majesty's Inspectorate of Constabulary in Scotland
- Education Scotland
- His Majesty's Inspectorate for Prisons in Scotland

Directorate structure



Leadership team: roles and responsibilities

The directorate is led by the Executive Director of Scrutiny and Assurance who is responsible for the overall leadership, direction and development of strategic inspection, all regulated care scrutiny and regulation activities. They ensure we meet our responsibilities to inspect and improve the quality of care in Scotland in a collaborative way, as defined by the Public Services Reform Act 2010 and other relevant legislation.

The Executive Director of Scrutiny and Assurance is supported by four chief inspectors:

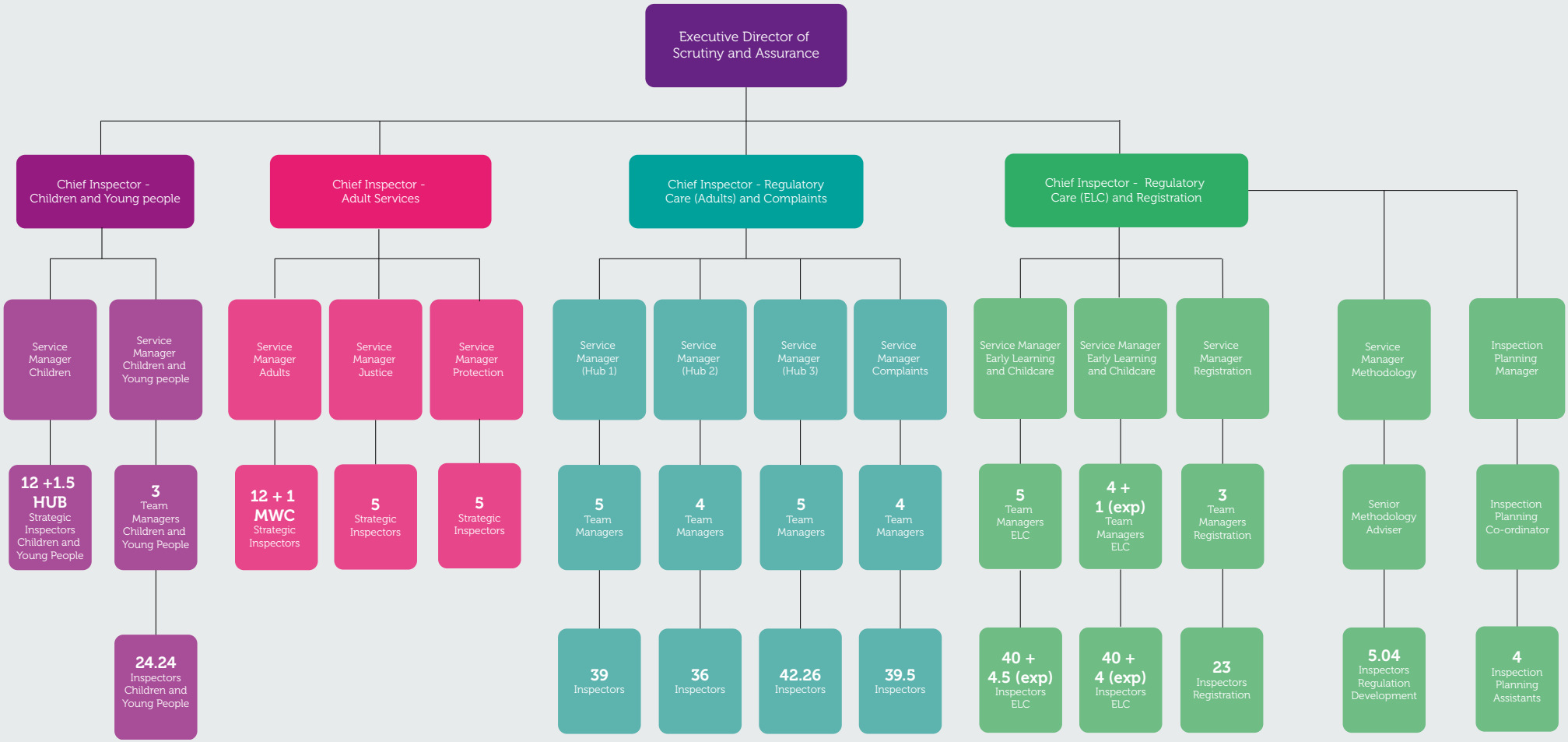
- Chief Inspector (Regulated Care – Adults and Complaints)
- Chief Inspector (Regulated Care – ELC and Registration)
- Chief Inspector (Strategic Scrutiny Adult Services)
- Chief Inspector (Strategic Security, C&YP and Regulated Care C&YP)

Our Directorate

We employ around 640 staff (FTE) of which 392 (FTE) or 61% are in the scrutiny and assurance directorate with remaining spread across the other three directorates / support functions. Of the 392 (FTE) staff in the scrutiny and assurance directorate there are around 294 (FTE) care service inspectors, including in our complaints and registration teams, and 36 (FTE) strategic inspectors.

Our inspectors are qualified professionals who have substantial experience of the services they inspect. We have inspectors from a range of relevant professional backgrounds, social workers, nurses, allied health professionals, teachers and former managers of regulated care services, all of whom are registered with the appropriate professional regulator. Inspectors also receive additional training in regulation, scrutiny and improvement. Inspectors are registered as 'authorised officers' and undertake the Professional Development Award in Scrutiny and Improvement. The award is a postgraduate level qualification approved by the Scottish Qualifications Authority.

Scrutiny and Assurance structure chart



The journey so far

Section 3 - Functions

Registration

Any person who wishes to provide a care service must apply to register that service. We must consider the application against the statutory test for registration which is set out in Section 60(3) of the 2010 Act; whether the Care Inspectorate is satisfied that the requirements of applicable regulations made under the 2010 Act and of any other enactment which appears to the Care Inspectorate to be relevant, will be complied with. Prior to submitting an application for registration, an applicant can ask for pre-registration application advice and support, which we encourage them to do.

We may grant or refuse a registration and if granting registration, may do so subject to conditions as we think fit (Section 60(2) of the 2010 Act), for example, as to the number of people who may be cared for, parts of the building which may or may not be used in the provision of the service. It is unusual for a registration to be granted without conditions of some kind. Once a service is registered us, a provider can apply to vary their conditions of registration, for example to increase the numbers of people being cared for in the service. We take a risk-based approach when registering services or assessing applications to vary conditions. This will include consideration of the regulatory history of a service or provider and intelligence gathered from other sources. We will use this information to support our decision-making process.

It is an offence to operate a care service without being registered. Where we receive information that a service is potentially operating without being registered to do so, the registration team will assess this information and if required send a report to the Procurator Fiscal to consider prosecution.

The registration function is led by the chief inspector (regulatory care - ELC and registration).

Inspection

For those services that we have registered, regulated care services, we carry out inspections at an individual service level across early learning and childcare services, services for children and young people and adults.

We also carry out strategic inspections of the work done by multi-agency partnerships, such as health and social care partnerships, child, adult and public protection committees and drug and alcohol partnerships. We mostly carry out these inspections jointly with other inspection bodies.

Early learning and childcare

The scrutiny and inspection of early learning and childcare (ELC) services, which includes childminders, daycare of children (playgroups, nurseries, family centres, school-aged childcare) and childcare agencies is led and overseen by the chief inspector (regulatory care – ELC and registration).

The ELC provision in Scotland incorporates the Scottish Government funded ELC provision of 1,140 hours for all 3 and 4-year-olds and eligible 2-year-olds, and also the additional state funded provision and the provision funded by parents in the private and voluntary settings. The team also have responsibility for the inspection of childcare agencies.

The Scottish Government have continued to extend their commitment to ELC to make Scotland the best place in the world to grow up. During this session of parliament, funded provision will be extended to one-year olds with a further commitment to enhance school aged childcare across Scotland.

Where a service provides funded ELC, they may also be inspected by Education Scotland. If both organisations intend to inspect the same service within an 18-month period, both organisations work collaboratively and will undertake the inspection on a shared basis.

Services for Children and Young People

A range of services for care experienced children and young people is inspected by three teams led by the Chief Inspector (Strategic scrutiny C&YP and regulated care C&YP). Services include:

- care homes for children and young people
- secure care
- foster care and adoption agencies
- adult placement services where these are caring for young people up to the age of 26 years in continuing care
- housing support services for young people, including care leavers.

The team also inspect some specialist provision for families, such as refuges for women and children fleeing domestic abuse. The team also carries out inspections of schoolcare accommodation services, sometimes working in conjunction with colleagues from Education Scotland, who are accountable for inspecting school provision.

Adult Care Services

The scrutiny and inspection of adult care services covers a range of services provided to adults in the community. This includes specialist services such as:

- justice services
- services for older people
- services for adults with disabilities, drugs and alcohol services and homelessness services.
- care homes,
- care at home
- housing support
- day services
- support services
- nurse agencies.

The work is led and overseen by the Chief Inspector (Regulated care – adults and complaints).

Adult care covers all adults who are in receipt of a registered care service in Scotland and includes those living with disability, dementia, mental health, homelessness or who require support to live their daily lives.

Strategic Inspection

The 2010 Act gives us powers to inspect any social service or combination of social services, or the organisation or coordination of any social services, relating to the whole or any part of Scotland. In addition, Section 115 of the 2010 Act details powers to carry out joint inspections with other bodies and report to Scottish Ministers on our findings. These inspections are carried out by strategic inspectors based in four teams, leading respectively on:

- scrutiny of services for children and young people
- integrated health and care services and services for adults
- justice services
- protection.

Strategic inspection is carried out in an increasingly complex landscape. Since 2016 services for adults have been the responsibility of health and social care partnerships (HSCPs) who share a common purpose of delivering better health and wellbeing outcomes for the people of Scotland. However, there is no standard model for delivery and commissioning of children's social work services and justice social work services. In some areas HSCPs have been delegated responsibility, while in others, they remain the responsibility of the local authority.

Our strategic inspectors also scrutinise and support improvement in the work of multi-agency partnerships, such as community planning partnerships, child, adult and public protection committees and drug and alcohol partnerships. We work collaboratively with other scrutiny bodies to carry out strategic scrutiny activity. We usually lead or co-lead inspection programmes, but sometimes contribute as guest inspectors to programmes on one-off pieces of work led by another organisation, such as His Majesty's Inspectorate of Prisons for Scotland (HMIPS).

Strategic inspections need to be both informed by, and responsive to, what we learn about the quality and sufficiency of registered care services locally and nationally. Strategic inspections also reach into important service areas which are not regulated or inspected elsewhere, but which have a very significant impact on the experience of people and their families and tell us about the difference that intervention is making to their lives. This includes the practice of social workers and other staff in local area teams and services, such as aftercare, addictions, community payback, unpaid work services.

We also has specific responsibilities around a number of serious incidents in social work, such as reviewing the deaths of looked after children, criminal justice social work serious incidents, and learning reviews for children and adults (formerly known as initial and significant case reviews).

Complaints

We have a statutory duty to deal with complaints about registered care services (ELC, children and young people and adult services) (s.79 of the 2010 Act) which is unique in health and social care regulation. The complaints function is led by the Chief Inspector (Regulatory care – adults and complaints).

Our complaints handling procedure was revised in November 2017 and is designed to be open, transparent, risk based and focused on peoples' experiences. We aim to resolve simple matters quickly and focus our attention on more serious issues. This approach is based on complaint handling guidance from the Scottish Public Services Ombudsman, in its Model Complaints Handling Procedure. The aim of this model is to standardise and streamline complaints handling procedures. The model complaint handling procedure shows that concerns are best resolved as close to the point of service delivery as possible.

In 2021/22, we received 5,595 complaints about care services. The number of complaints we deal with has risen year on year from 2011 when we dealt with 2,800 complaints.

This general increase in the numbers we received may indicate greater awareness of our complaints process and a greater awareness amongst people about the standards of care they and others should expect. Despite this increase, there has been no overall reduction in the quality of care across services in Scotland.

All complaints are assessed for any protection issues and where these are identified we make immediate referral to the Police Scotland and social work departments, as appropriate. We ensure we update the case holding inspector of all protection referrals made to enable them to follow these up.

We use a risk assessment process that takes into account what else we know about the service, including intelligence logged from previous complaints, to help us decide how to proceed and what action we need to take to achieve the best outcome for people experiencing care. Before we act on a complaint, we assess it to ensure that it falls within our remit to investigate, and that we have enough information to understand the substance of it. If there is any reason we cannot proceed, the complaint is revoked which means no further action is taken. All revoked complaints are still shared with the inspector of the service as intelligence.

Complaints are a valuable source of intelligence about how a care service is performing, even those that we do not investigate or are out with our remit. It provides a voice to people to ask for support to change the care they or those important to them receive. It enables staff to raise concerns where these have not been acted on with the manager or provider of a service and meets our obligations in whistleblowing legislation. It enables inspection colleagues to use the intelligence to target resources.

Enforcement action (care services)

Enforcement is a powerful and necessary element of regulation. It is central to our aim of protecting people who use services and bringing about improvement in the quality of care services. The 2010 Act gives us legal powers to take **enforcement action** where necessary to protect people's safety and wellbeing.

Three types of formal enforcement action are available to us under the Public Services Reform (Scotland) Act 2010 (the Act). These are:

- condition notices
- improvement notices and cancellation of registration where they are not complied with
- emergency proceedings – for conditions and cancellation of registration

In broad terms, this means we can change existing conditions of registration or impose new conditions. We can also serve an improvement notice on a service to require it to improve within a set timescale. If the service does not make these improvements, we can cancel their registration. We also have the power to make an application to the sheriff court for the cancellation of the registration of a care service, if any person would otherwise be at serious risk to their life, health or wellbeing.

There are also a number of offences created under the Act and associated regulations and we may, from time to time, require considering reporting such offences. This is not of itself 'enforcement', but there may be instances where we become aware of a provider committing an offence and may need to consider reporting it to the Procurator Fiscal, potentially along with enforcement action being taken.

We carried out a review of our enforcement policy in 2019 and later included learning from enforcement during the pandemic. The new enforcement procedure is based on the identification of risk and the Early Indicators of Harm by Hull University. Our senior leadership team agreed the new policy and procedure on 13 April 2022.

When we take enforcement action the inspector identifies the risks to people and action required, which our legal team reviews and agrees. Enforcement procedures can end up in court and our staff must give statements and provide evidence in court.

When we take enforcement action, we must work with other agencies, including health and social care partners, education departments and chief social work officers to ensure people are safe. We carry out monitoring of the service and outcomes for people as well as supporting improvement. We put in place a clear monitoring and improvement plan, agreed with the service and partners.

We must also decide on referrals we make to other agencies and regulators as part of our enforcement action. This may include referrals to Police Scotland to consider prosecution under wilful neglect legislation, child and adult protection referrals to social work and referrals to regulators of professional staff, including the Nursing and Midwifery Council (NMC) or Scottish Social Services Council (SSSC).

As part of our new procedures all teams will have a risk register which identifies those services we must monitor closely. Each service will have detailed chronologies and clear monitoring plan in place.

Inspection methodology

The Scrutiny and Assurance Directorate took over the responsibility for methodology from the Strategy and Improvement Directorate in February 2021. We use the term 'methodology' to describe how we gather evidence and how we support inspectors to make judgments and decisions on the evidence gathered, linked to outcomes for people who use services. It is an important driver to achieving consistency and innovation in our scrutiny and assurance activities, whilst recognising the unique nature of each service type.

The role of the methodology team is to coordinate the development and enhancement of scrutiny and assurance approaches, and to develop and support the implementation of new approaches. This means putting in place frameworks, tools, training and guidance to support our inspectors. The team also have a key role in ensuring that our scrutiny practices evolve to meet the changing health and social care landscape.

The Covid-19 pandemic accelerated some of these changes, so too have the various independent reviews of care, for example, The Promise, The Independent Review of Adult Social Care and Education Reform for ELC. In time these will see further impact on the delivery of social work and social care services and consequently on how we scrutinise services.

The methodology team will continue to have lead responsibility for inspection procedures which will be reviewed and updated annually, and our quality assurance processes.

The methodology team is committed to taking a collaborative approach to developing methodologies and approaches. In section 112 of the Public Services Reform (Scotland) Act 2010, we have a duty of **user focus** to involve people who use services in the design and delivery of our scrutiny functions. Our inspection volunteers, including young inspection volunteers, have an important role to play in this.

Our methodologies will always be centred on the views and experiences of the people who use services, reflecting their quality of life. Our role and commitment is to continue to ensure that the people using services are at the heart of what we do.

The methodology team works across the directorate and the work is overseen by the four chief inspectors.

Inspection planning

We must carry out **inspections** of social services in accordance with an inspection plan agreed with Scottish Ministers (Sections 53 and 54 of the 2010 Act). The plan must be kept under review and may from time to time be reviewed, with the approval of Scottish Ministers. In addition, Scottish Ministers may request that we inspect specific social services, services in the whole of Scotland or any part of it, specified services in the whole or any part of Scotland, or services provided to a particular individual or individuals, as may be specified. We must comply with such a request (Section 55 of the 2010 Act).

When inspecting a care service we take account of relevant legislation, particularly The Social Care and Social Work Improvement Scotland (Requirements of Care Services) Regulations 2011 (SSI 2011/210) and the Health and Social Care Standards (2017).

The planning team generate an annual inspection plan which takes account of risk based, targeted and proportionate criteria to identify which care services will be inspected by whom and when. As part of this process the planning team consider any collaboration with other scrutiny partners, for example Education Scotland or Health Improvement Scotland, within the inspection plan.

Risk is dynamic, therefore the plan is kept under regular review throughout the year and is amended to take account of new information, or when particular risks are identified. This allows for prioritisation and re-prioritisation of services for inspection on a weekly and monthly basis. As such, planned inspections may be brought forward or put back according to identified risk and intelligence.

The planning team support the collation, management and analysis of data in relation to how inspection staff are deployed to support workforce planning through the development, maintenance and oversight of the capacity management tools. Analysis of the information is used to support capacity management at an individual, team, specialist area and national level. This supports managers to make informed and evidence-led decisions around what work is allocated to whom and maximises overall efficiency.

The planning team is led by the Chief Inspector (Regulated Care – ELC and Registration), supported by a planning manager, planning co-ordinator, four planning assistants and one business support officer.

The planning team also work with strategic support officers to ensure the complex work of planning strategic inspections is completed sufficiently early each year to allow our scrutiny partners to plan their own resourcing and deliver on their commitments to the joint inspection programmes. This is particularly challenging as the scheduling of joint inspections needs to take account of competing priorities across a number of different scrutiny partners.

Relationship manager and link inspector

We allocate to each integration authority, health and social care partnership and local authority a relationship manager and a link inspector. They link with social work and health and social care partnership colleagues about practice and quality issues in services. They work with social work leaders and managers and social work teams. They support commissioning, contracts and quality assurance staff where there are quality issues with services, or where they are seeking advice on possible options for future developments for services that may need to be registered.

The relationship manager for each health and social care partnership area manages a team of inspectors of the care services in that area. This relationship manager liaises with partnership colleagues on service provision and quality, emerging issues and intelligence about areas for improvement that informs local planning and commissioning of services. During the pandemic, relationship managers enhanced the sharing of our intelligence and decision-making processes. Through membership of the local oversight groups, they meet with partnerships on a regular basis.

The link inspector works closely with local strategic leadership teams supporting quality improvement and focusing primarily on the performance of social work services, public protection processes, identifying and sharing good practice, and providing advice. This can include understanding the impact of commissioning decisions and highlighting and sharing good commissioning practice. The relationship manager works closely with the link inspector to ensure we retain an overview of social work and social care services within the context of wider strategic issues and risks for the partnership and to support the partnership in understanding these to inform and support improvement.

Some larger providers of care services are also allocated a relationship manager to facilitate regular contact and sharing of intelligence across the providers' services. We meet to discuss the intelligence on findings from scrutiny, provider governance and to support quality improvement in the provider's organisation.

We will continue to develop these roles in coming years.

Information and advice

We also has a statutory duty in relation to the provision of **information and advice**. We must provide information to the public about the availability and quality of social services (Section 51(1) of the 2010 Act). We do that primarily through our website and the publication of inspection reports. We must provide, when asked to do so, advice to Scottish Ministers (Section 51(3)(a) of the 2010 Act). We must also, when asked to do so, provide advice to:

- those who provide, or may seek to provide social services
- people or groups who represent those who use, or are eligible to use, social services
- people or groups who represent those who care for those who use, or are eligible to use, social services
- local authorities
- health bodies
- integration joint boards established under Section 9(2) of the Public Bodies (Joint Working) (Scotland) Act 2014
- people or groups as may be prescribed. (Section 51(3)(b) of the 2010 Act).

We will continue to play a pivotal role in discharging this responsibility together with our responses to Scottish Government consultations, using the evidence from our inspections wherever possible, which makes our contributions more compelling.

Section 4 – The foundations for our scrutiny

The Health and Social Care Standards

The Health and Social Care Standards are published by the Scottish Government and set out the standards of care that people using care services should expect. They are focussed on the experiences of people and their outcomes and apply across health and social care. They aim to ensure that people experiencing care are treated with dignity and respect and their basic human rights are upheld. They also aim to drive improvement, promote flexibility and encourage innovation in how people are cared for and supported. We began to take account of these in our inspections and in the registration of services from 1 April 2018. The Standards do not replace or remove the need to comply with legislation, which sets out requirements for the provision of services. The Standards are intended to be used to complement relevant legislation and best practice that support care services to ensure high quality care and continuous improvement. Current best practice guidance can be found on our corporate website and The Hub. All our quality frameworks are underpinned by the Health and Social Care Standards.

Quality frameworks

We publish quality frameworks for different services and different care settings. The frameworks are informed by the European Foundation for Quality Management (EFQM) model which focusses on key outcomes, stakeholder needs, delivery of services, management, leadership and capacity for improvement. They firmly focus on experiences and outcomes for people, take account of the Health and Social Care Standards and promote human rights-based care. The primary purpose of the quality frameworks is to support services to self-evaluate and make improvements. The frameworks outline quality indicators that sit under a series of key questions. Each quality indicator has related illustrations describing what very good and weak practice looks like. Our inspectors also use the same frameworks to make judgments and evaluate the quality of care during inspections, which helps achieve greater consistency and supports an open, transparent and collaborative inspection process .

We will continue to develop and update our quality frameworks in line with any changes to the policy or scrutiny landscape and use these as a key part of our scrutiny work.

Self-evaluation for improvement

We believe external scrutiny is best applied in conjunction with robust, evidence-based self-evaluation for improvement that is carried out by those providing care. This means managers and leaders considering their own evidence about the extent to which their services are meeting people's needs, rights and wishes

We will continue to strengthen our approaches to self-evaluation, ensuring it is core to our scrutiny. We will recognise when services do this well, principally through proportionality of inspection. We will share good practice to promote learning and improvement.

Core assurances (regulated care services)

In the same way that we do not expect services to self-evaluate themselves against the whole quality framework at once, neither do we inspect services against the whole framework at each inspection. Instead, we aim to take a **targeted**, **proportionate, intelligence-led** and **risk-based approach**. However, we do have 'core assurances' which are the things inspectors will look at on every inspection.

Experience has taught us that when things go wrong in care services, they often relate to key areas. Theory and inquiries undertaken when care goes wrong has highlighted the areas that are important to monitor because these can be identified as early indicators of concern to people using services (Scottish Government 2014, Hull University 2012, Francis Report 2013, Wardhaugh and Wilding 1993). These are the key areas considered during the registration process, and policies and procedures relating to them must be in place before a service is registered.

Because we know, and research tells us, that these key areas are essential to a service being safe, we have called them 'core assurances'. This checklist of core assurances highlights what inspectors must look at on inspection. They help guide providers on the areas that are important to people's safety and wellbeing. The core assurances span the entire framework, covering elements of several different quality indicators. If we have any concerns arising from our assessment of a particular core assurance, we may decide to focus in on a specific quality indicator.

Evaluating / grading

Once we have carried out our inspections of care services, we evaluate quality themes using a six-point scale:

- excellent (grade 6)
- very good (grade 5)
- good (grade 4)
- adequate (grade 3)
- weak (grade 2)
- unsatisfactory (grade 1).

We use an evaluation tool and our quality frameworks to help us make these evaluations and describe what we find during our inspections.

A similar approach is used in our strategic inspections.

Section 5 - Approaches

Focussing on experiences and outcomes for people, their carers, families and communities

We are continually strengthening our focus on experiences and outcomes for people, their carers, families and communities. Ensuring that scrutiny primarily focuses on **evaluating experiences, outcomes and impact,** rather than a disproportionate emphasis on checking inputs, is a central feature of our scrutiny and assurance business model.

Responsive regulation

In recent years **responsive regulation** has been a key feature of our approach. This is a well-researched, evidence-based approach to regulation. Responsive regulation underpins the methodology we use to inspect to ensure it is evidence- based. Responsive regulation ensures we understand those we regulate, and we tailor our response based on the outcomes for people and the behaviours of those we regulate, rather than simply checking compliance with a policy or procedure. It requires skill and expertise from those who regulate to not only make professional evaluations but to understand the context of the issues and the response of those regulated.

Responsive regulation is described as:
'...An ethical and fair culture, whether within an organisation or in a regulatory enforcement regime, has to be seen to respond to problems and wrongdoing by distinguishing between people who are basically trying to do the right thing and those who are not ...' (Hodges, 2016).

In all that we do we must focus on outcomes for people and those important to them. Responsive regulation takes account of this and has a focus on the experience and impact on individuals supporting improvement. Responsive regulation is based on intelligence, outcomes and the capacity to improve of those regulated.

Scottish Regulators' Strategic Code of Practice

In discharging our regulatory functions, we must have regard to the Scottish Regulators' Strategic Code of Practice (2015). The code requires regulatory functions to be exercised in accordance with the principles of better regulation, considering economic and business factors appropriately. The better regulation principles are that regulatory functions should be exercised in a way that is **transparent**, **accountable**, **proportionate**, **consistent** and **targeted,** only where necessary.

As required by the code, we will adopt the following high-level approaches.

- A positive enabling approach in pursuing outcomes that contribute to sustainable economic growth.
- In pursuing our core regulatory remit, be aware of other interests, including relevant community and business interests, taking business factors appropriately and proportionately into account in their decision-making processes, and protecting public health and safety.
- Adopt risk and evidence-based protocols which help target action where it's needed and help to ensure the achievement of measurable outcomes.
- Develop effective relationships with those we regulate and have clear two-way communication in place.

- Tailor our approach depending on the nature of the sector we are regulating and the desired outcomes. This includes a commitment to advice and support for those who seek to comply, allied with robust and effective enforcement when justified.
- Recognise, in our policies and practice, a commitment to the five principles of better regulation: regulation should be **transparent, accountable, consistent, proportionate** and **targeted** only where needed.
- Pursue continuous improvement in regulatory practice based on the principles of better regulation.

As highlighted in the Code, nothing above should be interpreted as a justification for non-compliance or a signal that we will tolerate that. For example, we will not allow the promotion of economic growth to prevail over the safety, health or wellbeing of people receiving care services. In other words, the safety and protection and wellbeing of people is paramount.

Collaborative working

We recognise the critical importance of collaborative working internally with our colleagues and with all our scrutiny and delivery partners.

We will continue to work in partnership with our scrutiny and delivery partners. We will also continue to work collaboratively with the Scottish Government, HSCPs, local authorities, health boards, public health, providers' umbrella organisations and care services.

We are also members of the Sharing Intelligence for Health and Care Group, which is a mechanism that enables seven national agencies to share, consider, and respond to intelligence about care systems across Scotland (in particular NHS boards).

Intelligence and risk

During the pandemic, we have strengthened our intelligence gathering. The importance we attach to the development of this intelligence-led, risk-based approach was already increasing at pace before the pandemic as a fundamental strand of our **business model** as outlined in our Corporate Plan 2019-22.

In line with our business model, we have revisited our cycles of inspection and for all well-performing services we will choose different types of scrutiny, assurance, or quality improvement intervention relative to the individual service and how it is performing. This means the specific focus, breadth and depth of each intervention will be driven by the risk profile for that service type and the specific information and intelligence we hold about individual services, including past performance and robust self-evaluation.

We believe approaches that are risk-based, outcome-focused, proportionate, and intelligence-led will provide the strongest assurance and protection for people and have the greatest impact on improving the quality of care. In this context, the value of scrutiny is realised by the extent to which inspectors add value to care services and local partnerships through a cycle of self-evaluation, scrutiny and improvement support, or regulatory action where required. Robust, evidence-based scrutiny acts as a diagnostic tool and key driver for improvement in the quality of care. In turn, this supports the safety, protection and wellbeing of people, with additional improvement support resources being deployed as indicated by initial scrutiny.

Risk assessment document/Scrutiny assessment tool

Responsiveness in our scrutiny of care services is closely linked to **proportionality** and **targeting,** with **risk assessment** playing a crucial role in determining our inspection approach. We do this by using a scrutiny assessment tool (SAT) for each service. In simple terms it is a way for us to assess which services are in greatest need of a scrutiny and/or improvement support intervention, which can mean an inspection. It could mean other action such as a visit or contact to check something. It should not be confused with grades awarded following an inspection, which are based on the evidence gathered during and inspection and outlined in an inspection report.

The SAT has been developed as a tool to identify early possibility service failure. The SAT is based on the University of Hull's early indicators of concern (University of Hull, 2012).

The SAT involves a dynamic process of gathering information and intelligence about individual care services, including complaints we receive about services and notifications services make to us, as well as the outcomes from inspections and information we receive from others, including from the various oversight groups in health and social care partnerships. We also incorporate what is reported to us about adult support and protection or child protection concerns, incidents within services, change of manager and note any marked deviation/variation from national trends for that particular service type, for instance, on complaint, medication administration /errors etc.

A services overall regulatory history, how they respond to complaints and our assessment of their capacity to make improvements is another consideration. It requires professional assessment and oversight from inspectors.

Minimum frequency of inspection

As signalled by our business model outlined in our Corporate Plan 2019-2022, we have moved away from a cyclical approach to inspection, recognising that there are better ways to provide assurance and make the best use of our finite resources. This means that instead of inspecting services on a fixed frequency basis, we determine when we inspect and what we inspect, relative to a dynamic risk assessment. Some better performing services will not be inspected as frequently as they were previously. This allows us to spend more time supporting poorer performing services or those where specific risks are identified.

We are empowered to design our own approaches to furthering improvements in social services, including in designing what constitutes an inspection. The 2010 Act describes a very wide range of 'purposes' for which an inspection may take place, and these include:

a. reviewing and evaluating the effectiveness of the provision of the services
b. encouraging improvement in the provision of those services
c. enabling consideration as to the need for any recommendations to be prepared as to any such improvement
d. investigating any incident, event or cause for concern
e. enabling consideration as to the need for enforcement action
f. reviewing and evaluating the extent to which a social service is complying with the integration delivery principles and contributing to achieving the national health and wellbeing outcomes.

It might be argued that there is a contradiction between a cyclical approach and one which is truly intelligence-led. However, moving forward our Board wishes to establish an ideal period between inspection. To do so, we would need much more sophisticated resource modelling and IT capability to determine what is possible within our current resources, as well as for managing, recording and reporting different scrutiny and improvement support interventions. Work on resource modelling is underway and led by our customer and corporate services directorate and this will also be supported by our digital transformation strategy.

Notifications

In terms of the Regulation of Care (Requirements as to Care Services) (Scotland) Regulations 2002 (SSI 202/114), all providers are required to maintain certain records and notify certain things to us. This includes death, illness or other events (Regulation 21). These are commonly referred to as 'Notifications' and are usually submitted to us electronically on our 'eForms' system. They are reviewed, assessed and acted upon in a variety of different ways by inspectors and team managers which may include following up with services and others, which can sometimes be resource intensive. With these we may also identify child and adult protection matters that need onward referral to police / social work services.

In 2021 we received in excess of 324,000 notifications compared to around 71,000 in 2017 representing almost a 500% increase. It will be noted from the table below that the number of notifications received increased substantially during the period of the Covid-19 pandemic. Additional notifications around deaths, staffing and outbreaks in care services accounted for most of the increase.

Number of notifications submitted by services, by year and notification type, 01 April 2017 to 31 March 2022

Notification Type	Number of notifications submitted in 2017-18, up to 31st March 2018	Number of notifications submitted in 2018-19, up to 31st March 2019	Number of notifications submitted in 2019-20, up to 31st March 2020	Number of notifications submitted in 2020-21, up to 31st March 2021	Number of notifications submitted in 2021-22, up to 31st March 2022
Total	71,713	75,698	92,525	343,784	453,831
Total minus Covid related notifications	71,713	75,698	84,785	88,940	82,929

Guidance on records that all registered care services must keep and guidance on notification reporting is published on our website. Our inspectors follow these up by contacting the service providing advice or guidance as necessary. Our risk assessment process also takes account of the notifications we receive.

Performance reporting

Our performance will be reported to senior managers and the Board in accordance with our Performance Measurement Framework 2022-2025, a summary of which can be accessed on our website.

Conclusion

As we move forward this strategy will support the key priorities outlined in our Corporate Plan 2020-2025 in particular:

- we will continue to build upon our flexible, risk and intelligence-led approach to ensure our scrutiny, assurance and quality improvement support activity is risk-based, proportionate and intelligence-led
- we will scrutinise and support local authorities and partnerships to ensure that that those accessing services can do so when and where they need to, and their support meets their individual needs.
- we will develop our enforcement work and by seeking to implement further powers to strengthen our enforcement action to enable us to act more swiftly when required. This will improve the health and wellbeing of those experiencing care
- we will collaborate with and support services to continually improve through robust and thorough self-evaluation
- we will promote and share an understanding of what those experiencing care have a right to expect according to their rights, needs and wishes.

We are absolutely committed to a flexible and response approach to all our scrutiny and assurance work that takes account of the changing policy and practice landscape. Therefore, we will keep this strategy document under regular review to take account of any changes, in particular those arising from the implementation of a National Care Service and the Independent Review of Inspection, Scrutiny and Regulation (IRISR) by Dame Sue Bruce.

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