Lessons learned from the CQC and the scrutiny experience in England based on evaluation of recent reports: A joint report for the Care Inspectorate and Healthcare Improvement Scotland

The scrutiny landscape in Scotland

A number of bodies contribute to the scrutiny landscape for the health and social care sector in Scotland. In addition to the Care Inspectorate and Healthcare Improvement Scotland (HIS), these include:

- Audit Scotland
- Education Scotland
- Mental Welfare Commission
- Scottish Housing Regulator
- Scottish Children's Reporter Administration
- Workforce and professional regulators

There has been a drive in recent years to reform and streamline public services in general, and the scrutiny landscape in particular, based on a collaborative culture of joint working between public sector bodies and scrutiny partners.

The Crerar Review (2007) recommended that five principles should govern the application and use of external scrutiny – independence; public focus; proportionality; transparency; and accountability.

The Christie Commission (2011) warned that the public service system was often "fragmented, complex and opaque, hampering the joint working between organisations which we consider to be essential." It stressed that addressing these issues would require a "fundamental overhaul of the relationships within and between those institutions and agencies – public, third sector and private – responsible for designing and delivering public services."

The Public Services Reform (Scotland) Act 2010 includes a Duty of Cooperation. The regulation, audit and inspection activities of scrutiny bodies should be co-ordinated to be efficient, effective and economical for all those involved.

The Care Inspectorate, HIS and other scrutiny bodies are currently working together to develop a more joined up approach to inspection. A multi-disciplinary approach to the scrutiny and improvement of children's services is currently being developed by the Care Inspectorate, while a similar approach to the inspection of adult services will be piloted later this year. This new approach will be supported by new relationships with NHS partners, the Scottish Social Services Council (SSSC), other scrutiny bodies, local authorities, delivery partners, people who use services and their carers and

the wider public, ensuring that each understands their role and responsibilities within scrutiny and improvement.

The recommendations in this report, based on analysis of the operation and accountability of the CQC, also support the wider principles of the Crerar Review and the Christie Commission:

- a focus on joint working between scrutiny partners
- better use of resources
- the importance of engagement
- improved accountability and transparency
- better long-term strategic planning
- enhanced performance reporting and data gathering; and
- a focus on outcomes and prevention through encouraging improvement and innovation.

Background

Scrutiny in England has recently faced a number of high-profile challenges. These include abuse highlighted by BBC 'Panorama' at Winterbourne View Hospital – a private hospital for people with learning disabilities; the financial collapse of Southern Cross, previously the largest care home provider in the UK; and the independent and public inquiries into the operation of the commissioning, supervisory and regulatory bodies responsible for scrutiny and quality assurance of the Mid-Staffordshire NHS Foundation Trust.

In addition to the above there have been several reports into the care of vulnerable groups, including recent reports from the King's Fund and the Commission on Dignity in Care for Older People.

The Care Quality Commission (CQC) has come under particular criticism in its first three years of operation with four major reports into its operation, performance and governance:

- National Audit Office – The Care Quality Commission: Regulating the quality and safety of health and adult social care (National Audit Office, 2011)
- House of Commons Health Committee: Annual accountability hearing with the Care Quality Commission (House of Commons, 2011)
- House of Commons Committee of Public Accounts: The Care Quality Commission: Regulating the quality and safety of health and adult social care (House of Commons, 2012)
- Performance and Capability Review: Care Quality Commission (Department of Health, 2012)

In Scotland, following the death of a resident at the Elsie Inglis care home, and concerns regarding the financial collapse of Southern Cross, the Scottish Parliament's Health & Sport Committee held an Inquiry into the Regulation of

Care for Older People, which both the Care Inspectorate and HIS and other partners and agencies gave evidence to.

Although the Committee concluded that “the current regulatory system is sufficiently rigorous to identify care services for older people which are failing to deliver high quality care”, it made a number of recommendations to the Care Inspectorate calling for:

Complaints

- Guidance for care staff in relation to "whistleblowing"
- Support and guidance from the Care Inspectorate to help ensure service providers have effective complaints procedures

Involvement

- More to be done to encourage involvement of people using care services in the inspection regime, including use of independent advocacy where appropriate

Grading

- Action to improve consistency of inspection gradings

Healthcare

- Guidance and information on psychoactive medications, working alongside the Mental Welfare Commission for Scotland and other interested parties
- Enhanced engagement of healthcare professionals in the inspection process

Risk

- Independent research and evaluation of the Care Inspectorate's risk assessment tool, including the self-assessment system.

Commenting on the willingness of the Care Inspectorate and HIS to work more closely together, the Committee concluded that early action should include the introduction of joint inspections of care pathways, including clinical care in the community and the inspection of social care for older people in NHS acute services.

The Committee suggested this would be facilitated by a review of the National Care Standards, alongside establishing a single point of entry for complaints about integrated services.

Purpose

The purpose of this report is to advise the Care Inspectorate and HIS Board and Executive Team members of a series of key messages, issues and recommendations that have emerged from a number of reports on the CQC and the health and social care sector in England. This will ensure that both the Care Inspectorate and HIS can learn any lessons from action taken in England and, where relevant, take mitigative action to reduce risks and therefore improve the quality of care for people in Scotland.

The recommendations in this report will also support and help to inform the delivery of Care Inspectorate and HIS's corporate outcomes and objectives.

Introduction

The Department of Health noted in its Performance and Capability Review that high profile cases had brought the CQC into "sharp focus" and the "negative public profile had seriously challenged confidence in its role". Although the Health & Sport Committee's Inquiry found the regulatory system in Scotland to be "sufficiently rigorous", the Inquiry highlighted improvements that the Care Inspectorate and, to a lesser extent, HIS should undertake. By reviewing criticisms made of the CQC in particular, and the wider health and social care environment in general, we can learn lessons for improving our own work processes.

Criticisms of the operation and governance of the CQC can be split into a number of distinct areas:

- new scrutiny models and managing expectations of key stakeholders
- strategic planning and focus
- leadership and organisational culture
- public reporting
- risk assessment and management of risk
- quality assurance
- delivering the scrutiny model

In each section the key messages will be outlined and where appropriate any issues of relevance identified for the Care Inspectorate and HIS. Recommendations will enable both bodies to reduce risk, learn from the CQC and where appropriate take action. There may also be implications for the wider scrutiny landscape in Scotland.

New scrutiny models and managing expectations of key stakeholders

The health and social care system in England underwent significant change in 2009 when the CQC was launched as the regulator of both health and adult social care.

The National Audit Office (NAO) notes that the considerable change created disruption and additional work for providers, and confusion for the public. It also criticised the CQC for:

- Not communicating effectively
- A lack of clarity among providers and commissioners about the CQC's role in relation to quality assurance
- Inconsistency in provision of advice and information.

The Department of Health highlighted similar issues, noting the CQC's external communications to be "mixed", with the result that its roles and responsibilities were often misunderstood. Providers also expressed frustration about the regulator's record on engagement.

It recommended the CQC:

- Be more proactive and systematic in understanding the expectations of stakeholders and demonstrating that it is a learning organisation
- Take the lead in working more closely with other scrutiny bodies within the health and social care sector to increase joint effectiveness and reduce burden on providers.

The CQC has since improved its communications with a new website launched in October 2011. Separate sections for providers and the public have helped to manage expectations of the scrutiny body and avoid unnecessary confusion.

Although the establishment of the Care Inspectorate and HIS did not integrate the regulation of health and social care, change was still considerable. It will be important for both bodies to continue to ensure alignment of their roles and separate responsibilities; and communicate their key messages in a clear and consistent way in language which is appropriate for each audience. This will ensure that the following stakeholders understand the roles, responsibilities and limitations of the scrutiny bodies:

- people who use services, patients and their families
- the wider public
- carers
- scrutiny partners
- NHS partners
- MSPs and the Scottish Government
- commissioners
- local authorities
- umbrella bodies
- service providers
- workforce and professional regulators
- police and fire and rescue services.

The Public Services Reform (Scotland) Act 2010 places a Duty of User Focus on the Care Inspectorate and HIS, setting out a framework of what is expected. Both bodies ensure that these expectations are met by involving people who use care services and patients using health services, their carers and the wider public in all aspects of their work. Engagement with people who use services and their carers helps to encourage continuous improvement in scrutiny practice, informing new scrutiny models and assessing quality of care or patient experience.

HIS works to ensure that NHS boards and independent healthcare services provide healthcare that is responsive to individual personal preferences, needs and values, ensuring that patient and carer values guide all clinical decisions. It also ensures that there is meaningful involvement of patients and the public by the NHS in Scotland. It has published a User Involvement and Person Centredness Strategy which outlines a number of priorities in this area, including how it will work with the Care Inspectorate.

The Care Inspectorate has recently published its Involving People, Improving Services Plan, which sets out its continued commitment to involve people who have experience of using care and social work services and carers in its work. In order to address the Duty of User Focus, it stresses that it will need to be an organisation that:

- Thinks creatively about involving people who use scrutinised services in order that they can express their views about the services they receive and want
- Is not only influenced in its day to day activities by the feedback of people who use care services and carers but works alongside them in different ways to produce the best results.

It is important to remember that primary responsibility for improving services lies with the organisations that provide them. However, a core role of HIS is to support health care providers in Scotland to deliver high quality, evidence based, safe, effective and person centred care, while also developing a work programme to support Scottish Government priorities. Widespread and common themes arising from scrutiny reports may require a coordinated improvement response.

The role of the scrutiny bodies is to inspect, verify, support improvement and enforce when necessary. Professor Crerar stated that external scrutiny could be a catalyst for improvement where it influences the behaviour and culture of providers, leading to improvements in the way that services are delivered so that people who use services enjoy a better quality of life as a result of excellent accessible services.

A number of reports critical of the CQC acknowledge this. The Department of Health:

- Found that the CQC was often held responsible for poor provision that was not directly in its control

- Noted that public expectations could be “unrealistically high”.

The NAO found that there was a gap between what the public and providers expected of the CQC and what it could achieve as a scrutiny body.
It is important to note that in addition to its national health care scrutiny function, HIS unlike the CQC has an important role in supporting the improvement of healthcare. Maintaining the balance between objective scrutiny of services and support for improvement will create both tensions and opportunities which have not arisen in any previous report. It will be important for HIS (and other scrutiny partners) to capture the learning from this unique set of responsibilities.

Managing the expectations of key stakeholders is crucial. Parallels can be drawn here in Scotland. No scrutiny body can be expected to provide 100% assurance all of the time – it will never be possible, or is it appropriate, for inspectors to be in social and healthcare settings 24 hours a day to check whether people using care services and patients are receiving good quality care. There will always be risks to be managed and mitigated by everyone who has responsibility for commissioning, delivering and scrutinising health and social care. Success in this area will depend on the level of risk that the Scottish Government and the Care Inspectorate and HIS Boards are willing to tolerate in scrutinising health, care and social work services. This is an issue that was highlighted during the Inquiry into the Regulation of Care for Older People.

Recommendation 1

The Care Inspectorate and HIS should continue to communicate their key messages in a clear and consistent way to explain their respective roles and responsibilities. This will contribute to key stakeholders’ understanding and awareness, helping to manage expectations. Both bodies should have a plan in place for external communications.

Recommendation 2

The Care Inspectorate and HIS should ensure that their websites, as the first point of contact for many stakeholders continue to provide clear, consistent and up to date information and advice. This will mean that people using and choosing care services and accessing health services, are aware of their rights and the quality they can expect; who to contact when the quality is not good enough or they have a concern; and that they have access to the most up-to-date information to make informed choices. To assist in this, both bodies could also consider separate sections for the public and providers.

Recommendation 3

The Care Inspectorate should progress plans to undertake a stakeholder survey, and HIS should consider a similar study, to find out how stakeholders view the organisations. This would provide a baseline for measuring objectives. The survey would also be useful in assessing how clear stakeholders are on the roles and responsibilities of the scrutiny bodies.

Consideration could also be given to the way in which the stakeholder survey may provide an opportunity for stakeholders to play a part in the design and implementation of realistic and relevant scrutiny and inspection processes.

Recommendation 4

Building on the new approach to the inspection of children's services and plans for joint inspection of adult services, the Care Inspectorate and HIS should continue to work with scrutiny partners where possible to join together scrutiny processes and share information. This will mean that delivery partners experience more efficient scrutiny and the public, using health or care services and their carers, will receive stronger assurance as a result of more cohesive scrutiny. It will also ensure universal coverage of our respective scrutiny functions and consistency of approach, avoiding confusion and helping to manage public expectations.

This recommendation should also be read in conjunction with recommendation 19 on triangulation of information.

Recommendation 5

The Public Services Reform (Scotland) Act 2010 sets out a Duty of User Focus for all scrutiny bodies. The Care Inspectorate and HIS should continue to work with scrutiny partners to develop a common approach to observing this duty.

Recommendation 6

The Care Inspectorate should advance plans for the creation of a dedicated research/policy hub to signpost best practice. This will assist in making the Care Inspectorate a key source for news and policy developments within the Scottish social care and social work sectors.

HIS should continue to promote its participation network as a vehicle to share good practice and develop new approaches. This will contribute to building its reputation as a centre of excellence for healthcare quality improvement. The NHS Scotland Quality Improvement Hub, which provides easy access to Quality Improvement (QI) tools and techniques, will also play a role in this.

Recommendation 7

The Care Inspectorate and HIS should use a variety of innovative methods to encourage two-way communication with key stakeholders, including the wider public and people who use services and their carers. This should include the use of social media tools including Facebook and Twitter; presence at external events; and hosting engagement events on key topic areas or areas of their work.

Strategic planning, focus and governance

The CQC was strongly criticised in a number of reports for its lack of focus, strategic direction and for failing to set clear measures of success.

The NAO stated that the CQC had not made clear what success in delivering its priorities would look like, although noted that the definition of this would depend to some extent on the level of risk the CQC and the Department of Health were prepared to tolerate in regulating health and social care. It warned: "A clear understanding of risk appetite should be central to decisions about resourcing and priorities."

Other reports highlighted:

- A lack of clarity from the CQC and the Department of Health around what success would look like. It was noted that this made it difficult to know whether the CQC had the resources it required to operate effectively. (Public Accounts Committee)
- Confusion about the extent to which the CQC's role goes beyond regulating against the minimum standards into wider quality improvement. (Public Accounts Committee)
- The need for the CQC to be clear on how it carries out its functions within the system. It was suggested that it take "greater opportunities to contribute as a 'thought leader' on quality and quality improvement." (Department of Health)

Improvement is key to the work of the Care Inspectorate and fundamental to the role of HIS. One of the Care Inspectorate's corporate objectives is that national policy is influenced and informed by scrutiny, improvement and innovative practice; while one of the core purposes of HIS is to support health care providers in Scotland to deliver high quality evidence based, safe, effective and person centred care. A strategic objective is to influence national policies to improve the quality of healthcare. This is an important role and both bodies should be proactive in highlighting both excellent and poor care, supporting continuous improvement in services and in healthcare practice.

The Care Inspectorate's draft Public Reporting Strategy outlines an intention to undertake performance reporting in the media, highlighting both good or innovative practice within the sector and where care services are failing to deliver acceptable levels of quality. This should be welcomed. The creation of a multi-disciplinary team to encourage improvement and disseminate best practice should also assist in this.

Recommendation 8

The Care Inspectorate and HIS Boards and Executive Teams should be clear about the vision going forward for the organisation. Both bodies should ensure that long-term strategic plans are in place, including greater

transparency around resource allocation decisions and governance arrangements.

Recommendation 9

The Care Inspectorate and HIS should be 'thought leaders' in driving improvement and highlighting best practice across the health and social care sector. This in turn should influence national priorities and policy.

Recommendation 10

The Care Inspectorate should progress its Public Reporting Strategy – proactively highlighting both excellent and poor care in the media. This will help to encourage improvement across the social care sector.

Leadership and organisational culture

The CQC was criticised in a number of reports for its poor leadership. The Public Accounts Committee warned that the CQC was "poorly governed and led" stressing that it was "overly focussed on reputation management at the expense of transparency and accountability."

The NAO suggested that staff morale was low, having been negatively affected by inconsistencies in pay and conditions, with staff doing the same job on different pay scales.

The Department of Health raised similar issues, suggesting that:

- The Board should provide greater challenge to the executive team on current performance and take a longer term view to anticipate future changes
- The Board must have the correct mix of skills and capability
- Capability at executive level should be strengthened with greater strategic capability and wider sector-specific expertise.

HIS has an important role in building capacity and capability for improvement. With its strategic partners it provides a range of education and learning opportunities, including development programmes designed to build improvement skills and identifying the Board and leadership role for improvement.

Recommendation 11

The Care Inspectorate and HIS Chairs and Chief Executives should ensure that the Board and Executive Team continue to have the correct mix of skills and capability to set and deliver corporate objectives and execute good governance.

Public reporting

A number of reports criticised the CQC's performance reporting, noting that while it reports what it does, it does not measure the quality or impact of its work. It was suggested that performance measures should:

- Include compliance activity and registration, but also measures of quality of service, such as complaints, and outcome measures, such as rates of improvement. (Department of Health)
- Go further than activity-based indicators and cover issues of quality, timeliness and cost. (National Audit Office)

The CQC has recently begun publishing on its website information about how well it is performing against the targets it has set in different areas of its work. The targets, as set out in the business plan, relate to registration, monitoring compliance, enforcement and customer service (including work in answering high priority calls and dealing with complaints). This takes the form of a scorecard.

The Care Inspectorate has developed a number of Key Performance Indicators (KPIs) to measure progress in meeting a number of key outcomes. These include that the Care Inspectorate performs effectively and efficiently as an independent, scrutiny and improvement body and works well in partnership with other bodies. It is also developing quality indicators (QIs) to complement its performance assessment processes and make sure that the quality of its work is reporting alongside the quantity.

HIS has outlined a number of objectives for 2012-13. These are set in the context of its corporate work and show how well it will support the delivery of safe, effective and person-centred health and care, and contribute to an appropriate infrastructure to enable quality improvement. A priority for improvement capability is the need for service level understanding of measurement for improvement.

Recommendation 12

The Care Inspectorate and HIS should ensure that key performance indicators or objectives measure quality and impact in addition to quantitative, activity-based measures.

Recommendation 13

The Care Inspectorate and HIS should improve the ways in which they make public their ongoing performance in meeting targets and delivering better outcomes for those using health and social care services.

Risk assessment and management of risk

A number of reports critical of the CQC highlight the need for inspectors having access to accurate and timely information about providers to make informed judgements about risk.

Witnesses at the Mid-Staffordshire NHS Foundation Trust Inquiry referred to the role of the CQC and its predecessors, focusing on:

- The lack of proactive assurance or 'triangulation' of information
- The perceived over-reliance on self-assessment by trusts and other NHS organisations.

The Inquiry recommended that the Department of Health investigate the commissioning, supervisory and regulatory bodies. Areas of inquiry recommended included:

- the methods of monitoring used
- the auditing of information relied on
- whether there is a requirement for a greater emphasis on inspection over self-reporting.

The NAO noted that the CQC had a systematic approach to assessing risk, but the effectiveness of the approach in practice depended on good quality data. This was not always found to be available, which made risk assessment more difficult.

The Care Inspectorate recognises the importance of intelligence to inform risk and has developed an Intelligence Framework and a Risk Framework. This will ensure that the right people receive the right information at the right time.

In a number of reports whistleblowing is highlighted as a key source of information in detecting poor quality or unsafe care. The Report from the Commission on Dignity in Care for Older People, called for a "culture of personal responsibility". It recommended that professionally registered staff should challenge poor care as soon as they "see any shortcomings".
The CQC was widely criticised for failing to act promptly on information received from a member of staff at Winterbourne View Hospital. Since abuse was uncovered by BBC Panorama, the CQC has strengthened its practice in this area.

It has created a dedicated team at its Customer Service Centre. Whistleblowing concerns are monitored to make sure they are followed up and the information provided is included in regional risk registers. The registers list providers where 'major concerns' have been identified.

Recommendation 14

The Care Inspectorate and HIS should ensure that staff have the capacity and capability – time, skills and access – to receive the right information at the right time.

Recommendation 15

The Care Inspectorate and HIS must work with scrutiny partners and other public bodies that have an interest in health and social care, to align and share intelligence where that will protect people, identify risk, and streamline how information is collected. This will help to reduce duplication of information collection, reduce the burden on providers and maximise the available intelligence about health and social care.

Recommendation 16

The Care Inspectorate should continue to work with other scrutiny partners in developing validated self-evaluation models that involve a number of disciplines, including health colleagues. A new model of self-evaluation will contribute to the shared risk assessment process and reduce duplication across scrutiny bodies in future.

Recommendation 17

HIS should continue to evaluate its self-assessment model based on the current quality improvement measures and guidance that promote good practice.

Recommendation 18

The Care Inspectorate should regularly review its risk assessment processes to ensure they are as effective as possible. This should include evaluation of risk tools. The development of the forthcoming Risk Framework will assist in this.

Recommendation 19

The Care Inspectorate and HIS should consider how best to further incorporate the views of the public, people using care or health services and staff, including whistleblowers, in making decisions on where to inspect. This will allow for triangulation alongside other sources of qualitative information.

Recommendation 20

The Care Inspectorate and HIS should build on existing NHS and SSSC guidance for staff on whistleblowing. Both bodies should also consider the creation of a dedicated whistleblowing team. All concerns should be taken seriously and followed up. Information should be included as part of the risk assessment process if appropriate.

Recommendation 21

It is the responsibility of all health and social care professionals to raise concerns if they recognise evidence of failure of professional standards. Care Inspectorate and HIS inspections should ensure that the culture of each provider organisation or acute setting recognises and respects this professional obligation and supports the confidentiality of staff when they choose to raise concerns.

Quality assurance

The CQC has been heavily criticised for inconsistency in practice and decision making between its inspectors. Indeed the CQC's own internal auditors found that differences in approach were leading to inconsistencies within and between regions (March 2011).

The Department of Health:

- Suggested the CQC needed to ensure clear and consistent communication from the centre to the regions
- Criticised growing inspector caseloads
- Highlighted the need to ensure access to clinical and sector expertise during inspection
- Recommended greater coherence between the centre of the CQC and its operational frontline, specifically with the locally based inspection teams.

Other reports raised similar issues, with the NAO noting that differences in approach were leading to inconsistencies within and between regions.

The Public Accounts Committee was particularly critical, noting evidence that inspectors:

- Were responsible for large and varied portfolios of providers
- Had not been given enough training and support to fully understand what constitutes good quality care in sectors where they have no experience.
- Showed a lack of consistency in judgement
- Judgements were not subject to a robust assurance system
- Work was judged against activity levels rather than quality.

It recommended that the CQC provide training and guidance to inspectors that specifically addresses the risk of inconsistent judgements in inspections and enforcement. The Health Committee agreed, stressing that judgement on risk could only be exercised if the CQC provided a clear framework and guidance.

The CQC was also criticised for not providing information about the sector in a way that gave the public a clear indication of the state of care at a national, regional or local level. The Public Accounts Committee noted disappointment that the CQC no longer awarded star ratings, stressing that these grades had previously helped the public choose between providers.

The CQC has since worked to address these issues with the publication of a quarterly 'Market Report' – a report highlighting trends in health and social care services in England. This allows the public to see how the different sectors the CQC regulates are performing and which areas are causing concern.

It is vital that the Care Inspectorate and HIS continue to influence alignment of scrutiny policy and practice, working together to ensure completeness of inspection cover and consistency of scrutiny approach.

Recommendation 22

The Care Inspectorate and HIS should consider the publication of regular 'state of the nation reports' and whenever possible share intelligence from reports. This would provide clear information for the public on the state of care across the country and identify where improvement is required. This would also be helpful for Ministers in setting national policy and priorities.

Recommendation 23

The Care Inspectorate and HIS should ensure that information on services and inspection findings are well publicised and current. Both bodies should use social media and other proactive methods such as RSA feeds to report this information to the public.

Recommendation 24

The Care Inspectorate should continue to use a grading system and publish the results of grading regularly. It should work with other scrutiny bodies to make sure that the language and grading system used are consistent and are therefore more easily understood by people who use the service, their carers and the public.

Recommendation 25

The Care Inspectorate should ensure that appropriate information is provided in easily accessible form to its inspection staff in order to ensure consistency of inspection policy and practice.

Recommendation 26

The Care Inspectorate and HIS should continue to develop their quality assurance processes to reassure the public that no matter where they are in the country they will get the same quality of inspection. This should include

internal quality assurance such as peer or management review of performance.

The creation of a National Inspection Team within the Care Inspectorate will also assist in this. It will promote greater consistency of approach and improve the rigour of its work. It will also allow the organisation to build up expertise, facilitate support for staff within teams and better develop and share best practice.

Recommendation 27

The Care Inspectorate and HIS should continue to support staff in developing their skills to allow them to fulfil the responsibilities of their role. This must include training in areas such as quality of decision making, evidence gathering, risk analysis and report writing. This will help to ensure consistency in practice between inspectors and across the country.

Recommendation 28

It is essential that national inspection planning is progressed. The Care Inspectorate should ensure it has a system in place for allocating inspectors work based on evidence from a recent diary exercise to more accurately plan the time taken for inspection. This must include appropriate time allocations for different service types based on risk and size, scope or location to help manage inspectors' workloads.

Recommendation 29

The Care Inspectorate and HIS should regularly review their skills matrix for recruitment to ensure that the workforce has the correct balance of skills and experience.

Delivering the scrutiny model

Reports into the failings of the CQC made a number of criticisms of how the scrutiny model is delivered.

The House of Commons Health Committee stressed that low staffing ratios can have such an "exceptional impact" on the quality of care that monitoring these is an essential part of ensuring quality outcomes. It called on the CQC to develop a mechanism whereby it can keep a closer track of staffing ratios in private care homes.

This was an area raised but not yet addressed during the Inquiry into the Regulation of Care for Older People. The Care Inspectorate is currently supporting the work of the Joint Improvement Team (JIT) for a care home staffing model, although it is important to note that responsibility for staffing ratios lies with the employer and not the scrutiny body.

The King's Fund report into the care of frail older people with complex needs (2012) recommended that national organisations, such as the CQC, limit the

volume and frequency of detailed instructions and guidance issued to health and social care providers because it can distract senior leaders from their task and confuse the picture in organisations. The aim should be to set guiding principles, not rules, and to emphasise the responsibility of senior leaders and clinicians to deliver better outcomes for patients and staff. It also suggested national leaders create and disseminate good practice examples and case studies.

The Commission on Dignity in Care for Older People:

- Recommended that the regulatory system place as much emphasis on securing dignity in care as it does on financial and clinical outcomes
- Called on the CQC to work with all partners to develop a clear rating scheme, based on the quality standards in social care to be set by NICE; and for commissioners to notify the CQC when they have concerns that a hospital or care home provider is failing to deliver dignified care
- Noted a lack of "reliable" data on the abuse of older people in the health and social care system
- Called for organisations to have a "common understanding of what constitutes abuse and a consistent approach to recording it"
- Stressed the need for a "consistent understanding across the care system of what dignified care means"
- Recommended that commissioners, providers and regulators across health and social care use the new quality standard for patient experience from NICE to provide consistency when defining and measuring performance
- Further recommended that commissioners of care home services incorporate dignity into all their standards and requirements.

Recommendation 30

The Care Inspectorate should consider the work of JIT on the development of a care home staffing model.

Recommendation 31

The Care Inspectorate and HIS should ensure that dignity and rights continue to be guiding principles of inspection and quality of care. This should be reflected in submissions to the forthcoming review of the National Care Standards.

Recommendation 32

Scrutiny partners should work together to agree a common understanding of what constitutes abuse, across all settings in health and social care, and a consistent approach to recording and sharing information on this.

Recommendation 33

Scrutiny partners should work together to agree a common standard to measure dignified care – this will provide consistency when defining and measuring delivery. This should build on existing standards including the principles of the National Care Standards, the Dementia Standards and NHS standards, including the Clinical Standards for Older People in Acute Care. The work of the Scottish Human Rights Commission should also be considered.

Conclusion

It is important to note that many of the above recommendations build on the existing direction of travel for both organisations. However, while there is much we do well in Scotland, it is imperative that we do not become complacent. By learning valuable lessons from the problems faced by the CQC in particular, and the wider health and social care environment in general, we can ensure that the Care Inspectorate and HIS avoid some of the potential pitfalls our equivalent bodies have faced.

The following actions taken from analysis of the operation and accountability of the CQC can support and help inform the Care Inspectorate and HIS in delivery of their corporate outcomes and objectives.

Care Inspectorate

Outcome 1: The quality of services in Scotland is improving

This outcome could be supported by:

- service providers and staff understand the quality of services they are expected to provide and the standards they will be scrutinised against
- championing best practice and contributing as a thought leader in health and social care
- proactive public reporting
- more frequent reporting on the state of care across the country
- key performance indicators and objectives based on quality and impact
- intelligence sharing between public bodies leading to more efficient scrutiny
- staff receiving the right information at the right time
- correct skills mix within workforce
- enhancing the skills, knowledge and understanding of inspection staff
- better quality assurance

- joint working with scrutiny partners

Outcome 2: People understand the quality of services they should expect and have a good experience of services centred on their needs, rights and risks

This outcome could be supported by:

- improved two-way communication with key stakeholders
- providing clear, consistent and current information
- proactive public reporting
- more frequent reporting on the state of care across the country
- increasing the public profile of the Care Inspectorate
- key performance indicators and objectives based on quality and impact
- championing best practice and contributing as a thought leader in health and social care

Outcome 3: The Care Inspectorate performs effectively and efficiently as an independent, scrutiny and improvement body and works well in partnership with other bodies

This outcome could be supported by:

- staff receiving the right information at the right time
- correct skills mix within workforce
- improved two-way communication with staff
- key performance indicators and objectives based on quality and impact
- intelligence sharing between public bodies leading to more efficient scrutiny
- improved consistency in approach to inspection
- enhancing the skills, knowledge and understanding of inspection staff
- clear focus and vision going forward
- better quality assurance
- improved governance and leadership
- joint working with scrutiny partners
- correct mix of skills and capability within the Board and Executive Team
- following a common approach to the Duty of User Focus

HIS

Support innovation and improvement in the delivery of high quality healthcare planned and designed with the patients their families and the public at the centre of everything we do

This objective could be supported by:

- improved two-way communication with key stakeholders
- increasing the public profile of HIS
- following a common approach to the Duty of User Focus
- resource site for examples of good practice and resources to support local improvement action

Provide assurance of the safety and quality of healthcare services to the people who use them and to the public in Scotland through risk-based proportionate scrutiny of those services

This objective could be supported by:

- staff receiving the right information at the right time
- correct skills mix within workforce
- improved two-way communication with staff
- key performance indicators and objectives based on quality and impact
- intelligence sharing between public bodies leading to more efficient scrutiny
- joint working with scrutiny partners
- improved consistency in approach to inspection
- enhancing the skills, knowledge and understanding of inspection staff
- better quality assurance

Provide authoritative, evidence-based advice and guidance on high quality treatment and care, and best practice in public engagement

This objective could be supported by:

- improved two-way communication with key stakeholders
- championing best practice and contributing as a thought leader in health care
- intelligence sharing between public bodies leading to more efficient scrutiny
- following a common approach to the Duty of User Focus

Influence national policies to improve the quality of healthcare

This objective could be supported by:

- providing clear, consistent and current information
- proactive public reporting
- more frequent reporting on the state of care across the country
- championing best practice and contributing as a thought leader in health care
- improved two-way communication with key stakeholders

Appendix

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