If inspection is the enemy of improvement, someone's not doing it right: towards an outcome-focused model of scrutiny and improvement in care

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There is significant debate in the improvement community about whether inspection impedes improvement. Older inspection approaches risk impeding innovation by measuring success in terms of compliance with an orthodox set of processes: this is checking inputs. Modern forms of scrutiny, which examine the impact of care on people's experiences and outcomes, support innovation and can help drive improvement.

Social care and social work scrutiny in Scotland is moving from compliance to an improvement-focused approach which provides assurance about care quality. There are two elements of change: a greater methodological emphasis on evaluating the quality of people's experiences and outcomes, and a new set of national care standards. This 'Scottish model' may help provide a theoretical framework to resolve past tensions between scrutiny and improvement. Modern scrutiny can become an important tool in the quality toolbox.

Background

Scotland's National Performance Framework embeds outcomes as the measuring link between government policy aims and public service delivery. This drives the growth of improvement science in public services and, therefore, the need for regulatory bodies to provide assurance and support improvement. In this way, quality becomes about outcomes for people, not just about achieving targets.

The Care Inspectorate (formally Social Care and Social Work Improvement Scotland) is the independent scrutiny body for social care and social work in Scotland. It has a statutory duty to support improvement, and uses diagnostic tools to identify where this is needed. All providers of social care and children's services must be registered with it. It applies strategic scrutiny to local authorities and other commissioning and co-ordinating bodies. Some of these scrutiny interventions are joint inspections with health, police and education inspectorates. Each year, inspectors undertake about 7,500 inspections of care delivery sites, and 6-12 large-scale joint inspections of local areas. About 2000 complaints from people experiencing care and their relatives are investigated annually.

Change 1: Shifting the focus

In 2014/15, the Care Inspectorate began major changes to inspection methodology for care delivery sites. Now inspections are planned using an intelligence-led approach, with more proportionate scrutiny where concerns are low.

- Previous approaches of checking inputs and policies were eschewed in favour of examining experiences and outcomes. This involves more discussions with people using care, including where communication needs are high. A tool developed by the University of Bradford, the Short Observational Framework for Inspection, helps record the quality of interaction in a structured and evidence-rich way.

- Inspectors are encouraged to focus on personal outcomes. Previously, any time a care service was in breach of a regulation, inspectors made a formal requirement. Now inspectors focus on the impact (or potential impact) of the care on people's experiences and person outcomes, and what improvement support is required.

- Previously, where care services identified weaknesses through self-evaluation, inspectors would treat this as a failing. Now, where care leaders have identified that they have improvement needs, and there is a robust plan in place, inspectors see this as a management strength. This shifts the scrutiny relationship from compliance to being improvement-supporting. Frankness is incentivised and candour is encouraged. Robust, evidence-based self evaluation helps local leaders take ownership for their own improvement journey.

- Previously, a specialists in pharmacy, tissue viability, continence, nutrition, and palliative care supported inspectors to identify poor quality provision. Now, these specialists support care providers and managers use improvement methodologies to improve care. In addition, the Care Inspectorate and Healthcare Improvement Scotland work together to lead specific tests of change in care services.

This is a major cultural shift and still underway. Inspectors are working in new ways, with an improvement focus, and care services are negotiating new regulatory relationships. The percentage of care managers that felt quality would improve as result of their inspection rose from 93% in 2013 and 2014 to 98% in 2015 and 2016.

At the same time, methodology for the strategic inspection of care co-ordination has continued to evolve. Most services are now delivered on a partnership basis, so inspectors look holistically at how well services are working together to meet the needs of vulnerable people, rather than working in silos. The core of a strategic inspection is a set of collaborative self-evaluation tools for local partnerships to assess their own performance against quality indicators, supporting openness and transparency.

The EFQM approach places emphasis on the outcomes for people, the quality of the leadership, and key processes. This becomes one part of three lines of assurance: managers are responsible for leading and delivering care, local partnerships self-evaluate their own performance and impact, and inspectors offer assurance about the quality of provision, or alert chief executives and senior officers where practice is not leading to positive outcomes.

Case study: helping senior leaders understand areas for improvement
Inspectors visited a health and social care partnership in a large city. The partnership had undertaken robust, evidence-based self-evaluation across a number of quality indicators. Inspectors examined how quickly and how well adult safeguarding concerns were followed up. Inspectors alerted chief officers to serious concerns about potentially poor outcomes for vulnerable adults. As a result, chief officers took decisive action to change care for adults at risk of harm, and put in place quality assurance measures to evidence that the changes led to improvement.

Change 2: New national care standards

Scotland's first national care standards were introduced in 2002, with 26 standards for different social care types, and over 2,400 statements, focussed on inputs. In 2015, the Care Inspectorate and Healthcare Improvement Scotland were commissioned to develop new standards for all healthcare and social care. With major public input, five core principles were agreed: dignity and respect, compassion, responsive care and support, be included, and personal wellbeing. Five main standards followed, with under 200 statements. They are underpinned by human rights and wellbeing principles. Public consultation showed overwhelming support. These will form the basis of future inspections, but are not solely for scrutiny. They are explicitly designed to support improvement, in three ways.

- First, they are person-led. Virtually all the statements start with "I experience…" or "I am…". They locate quality firmly through the lens of the person experiencing care. This is empowering for people who may be in unfamiliar or distressing environments, and is designed to ensure care professionals reflect on their practice from the perspective of the person. This person-led approach is a well understood tenet of improvement activity.

- Second, they are outcome-focused, describing what the consequence of good care should be, not how it should be delivered. Detailed and technical inputs about staff ratios and nutritional intake are replaced by outcome indicators. For example, a previous descriptor about the minimum size of a care home room is replaced by a new descriptor which states "I have enough physical space to meet my needs and wishes". This allows care leaders, along with the person, to decide what the right size is – and on inspection, explain how and why they came to that decision.

- Third, the outcomes are decoupled from settings. Instead of separate standards for care homes, hospitals, children's services, there is a common set of outcomes across all care. The standards are relevant for planning, commissioning, assessment and care delivery. This is to allow coherence and improvement activity at every level.

Inputs characteristic of good care will continue to be described in guidance, practice notes and peer-reviewed research. The assessment of quality, however, becomes whether the experience and outcomes for people is positive. This radical approach means inspectors cannot rely on lists of policies and inputs to check, and practitioners cannot assume their inspections will be positive just by following processes. Practitioners are released to creatively solve problems and innovate to improve. The new standards are designed to practitioners to plan, do, study, act. Inspectors no longer see whether something is done 'correctly', but instead ask 'how successful is this change in improving experiences and outcomes for people?'.

These changes are happening now in Scotland. The new standards will be in place from summer 2017. Scrutiny bodies have structured programmes in place to incorporate the standards in inspection and improvement activity from 2018 onwards. Over time, a common set of standards across care will allow people to understand what they should experience, and practitioners to devise innovative and high-quality ways of ensuring they do.

Uniting two disciplines and practice communities?

This 'Scottish model' of social care scrutiny and improvement (Fig. 1) is designed to improve care quality. Quality is assessed by the extent to which care supports positive outcomes, not compliance. Intelligence-led scrutiny, based on robust self-evaluation by care leaders, informs evidence-led improvement activity. Scrutiny becomes a diagnostic tool which evidences to the public, and care leaders, what is working well and what needs to improve. Inspectors can take regulatory action where care is failing, but this is a last resort.

This modern form of scrutiny does not mandate how improvement must take place – that is owned by local care leaders. The model provides independent evidence on whether improvement activity has been successful.

There is therefore an important need to expand our concept of evidence-led improvement to include scrutiny evidence which tests the quality of experience and outcomes, as well as research evidence which tests the efficacy of an intervention itself. Combined, there is potential for a powerful evidence base to help care improve.

Finally...

This paper presents a model of practice (Fig. 2), not a conclusion. Are the approaches here proven? No, but they are happening now, and the emergent evidence is encouraging. Further evaluation is needed to understand how this theoretical framework can best be implemented successfully, and to test its application beyond social care and social work. Scotland's world-class scrutiny and improvement approaches, along with a radical set of new quality standards, provide a potentially exciting framework for uniting the improvement and scrutiny communities in a common purpose: the triple aim of making care better, safer, and more efficient.

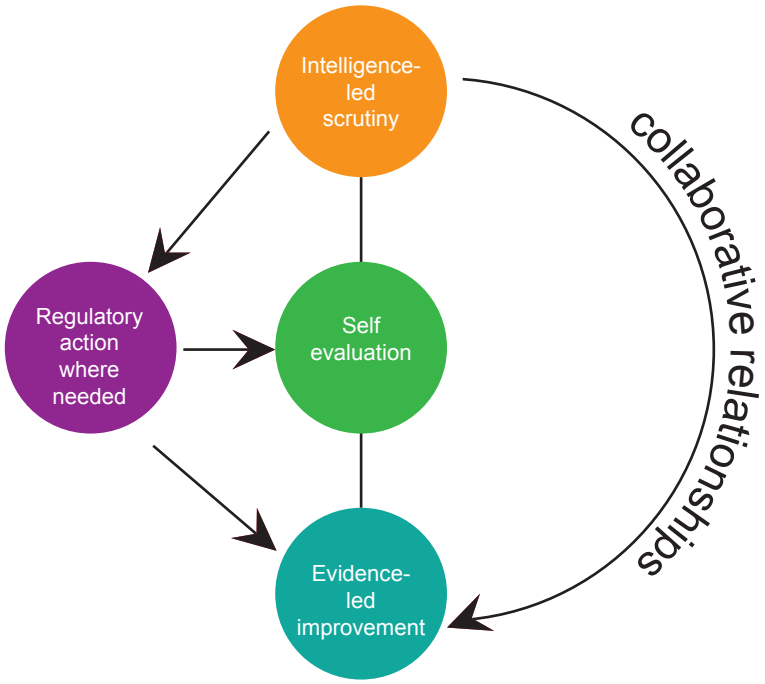

Fig 1. The Scottish model of social care scrutiny

Regulation	Scrutiny
Inspectors discover information	Care leaders self evaluate
Focus on inputs	Focus on outcomes/potential outcomes
Inspectors check processes	Inspectors examine experiences first
Specialists identify deficiencies	Specialists share knowledge
Leaders told what to do	Leaders understand the improvement needed
Power relationships	Collaborative relationships

Fig 2. The shift from compliance to improvement support

With many thanks to the many colleagues who have developed this model and given their time to review this paper.

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