

# Scotland's Health and Social Care Standards

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## Abstract

**Scotland's new Health and Social Care Standards mark a radical departure from traditional frameworks used to measure quality of care. Provider inputs for different types of services are replaced by one set of outcomes-based standards, which describe what people should expect whichever part of the health and social care system they are experiencing. Rather than technical rules, the Scottish care standards focus on the importance of relationships and trust for care to have a positive impact on people's health and wellbeing. For the first time, integrated statutory standards across health, social work and social care articulate an individual's right to compassion and meaningful involvement in decisions about their care.**

**The factors that influenced the Scottish model are examined in this paper, including the development of social and healthcare policy, academic knowledge and inspection practice. The paper also explores the far-reaching implications of the new standards for the future of care and care scrutiny.**

## Introduction

In 2002 the Scottish Parliament introduced the first National Care Standards (NCS), which consisted of 23 sets of standards for different types of registered social care and independent healthcare. Responsibility for implementation had been passed from local authorities to the Care Commission, the newly established national care regulator and predecessor body to the Care Inspectorate. In April this year, Scotland's new Health and Social Care Standards ('the Standards') came into force and replaced the previous NCS. Under the Public Sector Reform (Scotland) Act 2010, the Care Inspectorate and courts hearing appeals must take the Standards into account in making any decision.

The Standards are ground-breaking in that they introduce one set of standards to cover the whole care system, health care as well as social care. They also adopt a radical person-led approach, which focusses on human rights and wellbeing, and they are entirely written in the first person. For the first time, statutory national standards set out in some detail what human rights and wellbeing look and feel like for someone, irrespective of which part of health and social care they happen to be experiencing. The model turns the traditional regulatory framework on its head by looking at standards from the perspective of a citizen experiencing care, rather than minimum requirements for a professional provider to meet.

The Standards mark a fundamental shift in Scotland's policy and practice for care. The Care Inspectorate and Healthcare Improvement Scotland, which jointly led the review of the standards on behalf of Scottish Government, are currently redesigning their scrutiny and improvement methodology for health and social care in order to take

them into account. The level of interest in the new Standards is considerable, including from scrutiny bodies and governments across the globe. In this paper, the Care Inspectorate's Strategic Lead for the Standards explores how the Scottish model was developed and what it means for the future of care.

## Why one set of standards?

The previous NCS only applied to individually registered and regulated social care services, such as a care home, a nursery or independent healthcare service like a hospice. This meant that most of the care system, including the National Health Service (NHS) and social work provision, was not covered. The Standards are therefore a vehicle for the long journey to integrate health and social care, aligned with the creation of Integrated Joint Boards pursuant to the Public Bodies (Joint Working) (Scotland) Act 2014. Co-ordinating the domains of health and social care in order to provide a more seamless, efficient and effective service for the public has long been one of the holy grails of public policy, which has recently been given a statutory footing in Scotland.

The limitations of the previous framework are illustrated by the scrutiny of domiciliary care, with care at home agencies having their own set of NCS and annual inspections. However, how these services were planned, commissioned, procured and chosen was excluded, so inspections against the NCS only told part of the story. Inspectors could award high grades to a service that delivered its contracted duties to people well, while at the same time finding that task-focussed commissioning practice was failing to meet the needs of the same people. The care at home staff and provider might be complying with the technical terms of the local authority contract, but this did not necessarily mean that someone was experiencing high quality care.

The Care Inspectorate inherited different scrutiny models, with service level regulation of social care from the Care Commission and strategic level inspection of local authorities and health boards from the Social Work Inspection Agency and Her Majesty's Inspectorate of Education's child protection unit. 'Scrutiny' as a term encompasses the different models of service regulation and strategic inspection. The NCS review therefore provided the opportunity for more integrated and comprehensive standards to be created and for the best aspects of different inspection traditions to be retained and blended. As well as the NCS and the Quality Indicators used for strategic inspection, the review drew upon the shared knowledge built up by the range of inspection and improvement bodies that comprise the scrutiny landscape. Differences in standards and methodology deployed by Audit Scotland, Education Scotland, the Mental Welfare Commission, the Housing Regulator and Quality Scotland for example, all contributed to the review. Similarly, there was useful learning from other jurisdictions, including the

recent review of inspection frameworks carried out by Ofsted and the Care Quality Commission.

The review was also able to draw and build on wider policy drivers and developments. For example, since 2002 aims, standards and targets across health and social policy had generally evolved from traditional provider inputs and outputs to consumer outcomes. Key landmarks in this evolution included the Scottish Government's National Health and Wellbeing Outcomes<sup>1</sup>, the National Outcomes and Standards For Social Work Services in the Criminal Justice System<sup>2</sup> and Sir Harry Burns' recent Review of Targets and Indicators for Health and Social Care in Scotland<sup>3</sup>. Similarly, the increasing use of the European Foundation for Quality Management's (EFQM) Excellence Model ([www.efqm.org](http://www.efqm.org)) and the prominence of improvement science approaches across care influenced the new Standards.

## Connecting the messy joins

In addition to health and social care integration, having one set of standards promotes a more joined-up approach from everyone involved in the business of providing care. Greater integration and collaboration is needed across multiple professional silos, which includes traditional divides between the statutory, private and voluntary sectors as well as between education and childcare. Collectively, if we are to promote and secure the best experiences and outcomes for people regardless of which part of the complex system they access, we need to share and agree what we want to achieve. Understanding and navigating through the maze of different structures and services is complex and a whole professional infrastructure is funded just to help the public with this. Often the lack of coordination between the different moving parts of the care system is most keenly felt and understood by people with complex needs, such as a homeless person or someone with learning disabilities coming of age and entering the different world of adult care.

Where care systems have failed, often with tragic consequences, enquiries usually identify the need for different staff and professionals to work across boundaries and share information. For social work, this might concern child protection, such as the Caleb Ness enquiry<sup>4</sup>, or adults with learning disabilities, such as the Miss X report<sup>5</sup>. For health, this might concern a hospital, such as in Mid Staffordshire<sup>6</sup>. For social care, this might involve care homes for children, such as the Shaw Review<sup>7</sup>, or care at home, such as the Panorama investigation<sup>8</sup>. A common finding is that professionals from different disciplines worked too much in isolation and need to communicate and collaborate more. The Christie Commission<sup>9</sup> highlighted the need for public services to improve partnership working across the board and it is often the messy joins between services and professional silos that require improvement for care to have the greatest impact on people's outcomes.

Introducing a common set of standards will not in itself solve the complex and wide-ranging problems regarding professionals working together. At the same time, adopting a common framework that puts the interests of people first and identifies partnership working as a fundamental

factor to achieve this, is an important step. The Standards include the following statements promoting multidisciplinary collaboration:

"If I am supported and cared for by a team or more than one organisation, this is well coordinated so that I experience consistency and continuity." (HSCS 4.17)

"I benefit from different organisations working together and sharing information about me promptly where appropriate, and I understand how my privacy and confidentiality are respected." (HSCS 4.18)

The Standards offer a common language and understanding that reaches across professional silos and speaks to all stakeholders. The benefits of blurring professional boundaries reflects one of the main findings of the Scottish Government's 21st Century Review of Social Work<sup>10</sup>.

## People before provision

Defining quality through the lens of the person experiencing care rather than from the perspective of services or professional structures has other advantages. It enables a generally more flexible approach to regulation. For example, the 23 sets of NCS reflected the most common service types at the turn of the century and since then provision has changed considerably, with more care provided at home and as part of the local community. If the review had adopted the same approach, different sets of standards would have been developed reflecting the most common settings at the present time. But who knows how services will develop over the next 20 years to meet people's needs and wishes? Moving away from fixed service-based standards and describing what people should experience irrespective of the setting allows for more flexibility that supports improvement and future innovation. Previously, if a rural community wanted to establish a single organisation to meet its small population's diverse care and support needs, multiple registrations and standards for the different service types would have been required.

Moving away from settings-based standards allows more flexibility and proportionality in how care is regulated, which reflects the findings of national reviews regarding regulation more widely. Both the Hampton Report<sup>11</sup> and the Crerar Review<sup>12</sup> recommended less rigidity in how statutory regulation was applied. More recently the idea of creating a 'regulatory sandbox', in which providers and regulators can explore more flexible options outwith the normal regulatory restrictions, is gaining traction and promising a more responsive form of regulation that supports innovation and improvement<sup>13</sup>.

## From checking inputs to assessing outcomes

The new Standards replace traditional compliance measures, all those tangible inputs such as records, procedures and health and safety that providers must meet, with statements which directly address people's experiences and outcomes. While black-and-white inputs might be easy to measure, evidence shows that

they are not the most reliable indicators of high quality care and can sometimes lead to negative consequences rather than service improvement. A service that needs to tighten up its record keeping, policies or procedures for example, might at the same time be providing compassionate care, involving people and upholding their rights. Similarly, another service might have very effective systems for maintaining inputs, but the atmosphere and relationships lack warmth, empathy and people having a say in how care is provided. The NCS and the Care Commission's framework meant that inspectors made formal recommendations for services to comply with the technical inputs, while being constrained from assessing and reporting directly on what really makes a difference to people's outcomes.

The consistent message from people experiencing care is that human relationships, kindness and trusting staff and organisations are the key indicators of quality. The Care Inspectorate works with a team of people with first-hand knowledge of care, who actively participate in inspecting services alongside inspectors as experts by experience, and they support this view. The Care Inspectorate's analysis of the cumulative evidence from the tens of thousands of inspections it has carried out since it was established, reinforces this finding. This evidence is backed up by research such as the Compassionate Frome Project ([www.communitycatalysts.com](http://www.communitycatalysts.com)), which tested between 2013 and 2016 what happened when GPs changed prescribing practice to include human contact and community involvement. From 2013-2016, while emergency hospital admission rates for Somerset as a whole rose by 29%, in Frome they dropped by 17%.

Superseding proxy indicators with more direct and meaningful indicators for people follows a general direction of travel. For the Standards, a seminal framework was Getting It Right For Every Child<sup>14</sup> and its wellbeing indicators for children to be safe, healthy, achieving, nurtured, active, respected, responsible and included. The Standards of Care for Dementia in Scotland<sup>15</sup>, with their detailed descriptions of how an individual's poor care experience gets better, were also key.

Adopting such outcome-based standards does not mean that tangible inputs no longer have a role in scrutiny and there will be circumstances where regulators need to ensure compliance with minimum measures. However cyclical inspection has proven that almost all registered services are already complying and it adds limited public value to keep routinely checking these same inputs. Deploying precious public resources in a targeted and proportionate manner, as recommended by the Crerar Review, is also supported by academic experts such as Malcolm Sparrow<sup>16</sup>. He challenged regulators to stop routinely cleaning streets that were already clean and use their powers more flexibly to lever positive change. Moving away from a 'one size fits all' approach allows for what Walshe<sup>17</sup> calls 'responsive regulation', in which regulators can draw flexibly from a range of tools to meet the specific circumstances presented by each provider. Using intelligence and data with greater sophistication will allow scrutiny bodies to become much more responsive in the future, including anticipatory regulation. In order to support innovation, Armstrong and Rae<sup>18</sup> argue that regulation should be advisory, adaptive and anticipatory. Alongside

a more flexible approach to registration using regulatory sandboxes, the digital era provides the opportunity for a more sophisticated evidence-based deployment of resources. For example, the Behavioural Insight Team at Downing Street's 'Nudge Unit' recently highlighted ([www.behaviouralinsights.co.uk](http://www.behaviouralinsights.co.uk)) that analysing prescribing practice and patient comments on the 'Choices' website led to a 95% accuracy prediction of which GP practices performed poorly.

Extensive public consultation confirmed overwhelming support for basing the standards on human rights, compassion, involvement and wellbeing rather than safety, policies or procedures. The Standards are therefore underpinned by the following principles: Dignity and respect, Compassion, Be included, Responsive care and support and Wellbeing. The factors influencing each principle are considered below and the implications for the scrutiny of care explored.

### 'Dignity and respect' – aye, rights

Basing the Standards on human rights and wellbeing reflects an overall rise in expectations across the public discourse since 2002. The NCS reflected a residual position, setting out the information about rights that care providers were expected to issue to people, while the new Standards adopt a proactive position, with providers expected to work alongside people and stand up for their rights. The Standards therefore open with the following statements:

**"I am accepted and valued whatever my needs, ability, gender, age, faith, mental health status, race, background or sexual orientation." (HSCS 1.1)**

**"My human rights are protected and promoted and I experience no discrimination." (HSCS 1.2)**

The Human Rights Act (1998) consolidated and extended previous legal protection and the United Nations Conventions both on the Rights of the Child (1992) and on the Rights of Persons with Disabilities (2006) are also referenced in Scottish law. A proactive approach to upholding rights in Scotland has been promoted by the Scottish Human Rights Commission (SHRC), which produced the FAIR guide on rights-based decision making ([www.scottishhumanrights.com](http://www.scottishhumanrights.com)).

The care sector has been particularly active regarding human rights since 2002 and organisations led by people with learning disabilities have taken a leading role in claiming their rights. The United Nations Convention on the Rights of Persons with Disabilities enshrines the social model of disability, with articles covering the rights to accessibility and participation in decision making. In Scotland, the Independent Living Movement has been (and remains) instrumental in producing policies, such as Keys to Life<sup>19</sup>, and legislation in the form of the radical Social Care (Self-directed Support) (Scotland) Act 2013, which is designed to empower people to take control of decisions affecting their life.

In 2010 the SHRC produced Care About Rights<sup>20</sup> in partnership with the Care Commission, Scottish Care

(representing private adult social care providers) and Age Scotland (representing older people). The Mental Welfare Commission for Scotland's focus on rights of individuals within the mental health system and their 'Rights, risks and limits to freedom'<sup>21</sup> good practice guide similarly influenced the review. It was having the SHRC alongside as an active partner however that really helped the review show what human rights mean for someone experiencing care.

### 'Compassion' – what's love got to do with it?

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With relationships being at the heart of quality, the Standards deliberately highlight the softer side of care rather than hard tangibles with statements such as:

"I can build a trusting relationship with the person supporting and caring for me in a way that we both feel comfortable with." (HSCS 3.8)

"I experience warmth, kindness and compassion in how I am supported and cared for, including physical comfort when appropriate for me and the person supporting and caring for me." (HSCS 3.9)

The NCS were silent on physical touch and this probably contributed to the pervasive myth, which seemed to sweep across the whole of the care sector, that touch was something to be feared rather than embraced. Fuelled by professional defensiveness in reaction to the litany of inquiries into institutional abuse, this led to the baby being thrown out with the bathwater. Suzanne Zeedyk ([www.suzannezeedyk.com](http://www.suzannezeedyk.com)) has highlighted the harmful unintended consequences of this myth for young children. Similarly, the organisation Who Cares? Scotland, led by young people looked after by local authorities, has been instrumental in busting this myth. Care experienced young people who had been through the system demanded the right to care based on love and trust rather than rules and a risk-averse approach. This informed the following statements:

"I have agreed clear expectations with people about how we behave towards each other, and these are respected." (HSCS 3.3)

"As a child or young person I feel valued, loved and secure." (HSCS 3.10)

The importance of people experiencing kindness and compassion from organisations as well as from individual carers is reflected in the Standards and this is extended to cover staff:

"I experience care and support where all people are respected and valued." (HSCS 4.3)

### 'Be included' – power to the people

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With personal autonomy and the ability to control one's life being so central to health, happiness and wellbeing, many statements describe what this principle means in practice and one of the five headings used for the Standards is:

"I am fully involved in all decisions about my care and support."

The NCS reflected expectations from the last century, with providers being encouraged to consult but ultimately not to share power with people. Involving people was seen as good practice rather than a required entitlement and was frequently peripheral to core decision making, such as consulting on décor or menus. Shared rights and responsibility for decision making about one's own care, as well as participating in aspects of the way that a service is provided, therefore permeate the new Standards. The review tried to move from tokenism to genuine empowerment and to give substance to outcomes-focused statements like:

"I am recognised as an expert in my own experiences, needs and wishes." (HSCS 1.9)

"I can control my own care and support if this is what I want." (HSCS 2.1)

"My views will always be sought and my choices respected, including when I have reduced capacity to fully make my own decisions." (HSCS 2.11)

This reflects rising expectations regarding involvement and participation broadly across the public domain in Scotland. The Community Empowerment (Scotland) Act 2015 and its associated National Standards for Community Engagement<sup>22</sup> were important milestones, as was the SHRC's PANEL (Participation, Accountability, Non-discrimination and equality, Empowerment and Legal) approach. The idea of collective leadership, co-producing new services with communities and harnessing existing community assets has been generating widespread interest and support. The Commons Movement is starting to consider health and wellbeing and Nesta, an influential UK based innovation foundation, is promoting People Powered Health for developing new models of care for people with long term conditions ([www.nesta.org.uk](http://www.nesta.org.uk)).

Within social care and social work, Self-directed Support and Buurtzorg have both been influential. Buurtzorg's model of care from the Netherlands takes respect for the independence and autonomy of the individual client as its starting point to lead to the development of self-managing teams providing care ([www.buurtzorg.com](http://www.buurtzorg.com)).

The professionals involved in the review knew the theory, but it was not until organisations led by as well as representing people experiencing care got meaningfully engaged in the drafting process that the Standards started to walk the talk of co-production. Organisations such as Inclusion Scotland, Who Cares? Scotland and the Scottish Older People's Assembly helped not just with tone but also content, and brought the personal experience of people to the heart of national policy-making.

### 'Responsive care and support' – adapting to changing circumstances

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Being sensitive and responsive to the changing needs and wishes of individuals is identified as a key principle, covering both the statutory duty of local authorities and

health boards for assessing needs and planning services as well as the contracted service provider. The onus on all professionals to work together to ensure that care is consistent and stable is increasingly important with more pressure and volatility across the system:

“My care and support is provided in a planned and safe way, including if there is an emergency or unexpected event.” (HSCS 4.14)

“I experience stability in my care and support from people who know my needs, choices and wishes, even if there are changes in the service or organisation.” (HSCS 4.15)

A potential downside of relationship-based standards is that responsibility can be perceived as falling entirely to individual practitioners and services. Recent major care failures, not least the collapse of the UK largest care home provider, Southern Cross, serve as salutary reminders that organisations as well as individuals need to be sensitive and responsive. Consequently the Standards are clear with regard to corporate accountability. As a regulator the Care Inspectorate recognises that concerns manifesting at an individual service level are often symptomatic of a wider corporate culture and practice. Diagnosing and raising concerns upstream could prevent people experiencing these downstream.

Organisational responsiveness and the role of leadership in ensuring that corporate aims and vision are actually being experienced by people is of course nothing new to the business world. The Standards take into account the European Foundation for Quality Management (EFQM) Excellence Model ([www.efqm.com](http://www.efqm.com)), which is widely used across a range of sectors, including care. EFQM provides a framework for identifying what enables positive results to be experienced by customers and how this can be measured, which follows a continuous stream of knowledge from Total Quality Management through to the Best Value duties placed on local councils by central government under the Local Government in Scotland Act 2003.

### ‘Wellbeing’ – Getting It Right For Every Person

The holistic approach of the new Standards recognises that many factors contribute to overall wellbeing and positive outcomes, including how individuals feel about and own the care process. Take eating and drinking as an example of a common component of providing high quality care. Rather than a series of technical inputs regarding nutrition and hygiene, the Standards cut to the chase and focus on the impact of eating and drinking on wellbeing:

“I can choose suitably presented and healthy meals and snacks, including fresh fruit and vegetables, and participate in menu planning.” (HSCS 1.33)

“I can enjoy unhurried snack and meal times in as relaxed an atmosphere as possible.” (HSCS 1.35)

“If appropriate, I can choose to make my own meals, snacks and drinks, with support if I need it, and can choose to grow, cook and eat my own food where possible.” (HSCS 1.38)

The Standards also take a risk-benefit approach to safety and move away from the traditional risk-averse approach, which resulted in people experiencing unnecessary restrictions in formal care settings. This recognises that many risks can be safely managed and that people experiencing care are as entitled as the general population to take risks:

“I make informed choices and decisions about the risks I take in my daily life and am encouraged to take positive risks which enhance the quality of my life.” (HSCS 2.24)

### What gets measured gets done

Setting national standards that shift the focus so comprehensively onto the unfamiliar territory of personal experience and human relations challenges the whole care sector, and not least scrutiny bodies. How can such woolly concepts of compassion, empowerment and wellbeing be objectively assessed? Although the task is undoubtedly more nuanced and complex, it is easy to forget that social work, social care and healthcare are all ‘people professions’. How people feel and relate to professionals lie at the heart of their professional expertise.

The Care Inspectorate and Healthcare Improvement Scotland employ inspectors from these professional backgrounds because of those softer skills rather than simply health and safety or any other technical knowledge. Scotland’s longitudinal research project tracking a large cohort of children, Growing Up in Scotland<sup>23</sup>, indicates that assessing the softer side of care is more relevant than other more tangible measures. The study found that the quality of care and support in day care services, as evidenced by the grades awarded by the Care Inspectorate for one of four inspection themes, has a measurable impact on children’s outcomes, particularly the critical language and communication skills. The Quality of Care and Support theme covered the quality of staff to child interaction and it is significant that there was no equivalent correlation to outcomes for the other themes of Quality of Environment, Quality of Staffing or Quality of Management and Leadership.

The Care Inspectorate and Healthcare Improvement Scotland are already embracing the cultural shift from a checklist mentality to making professional judgements based on observation, discourse and self-evaluation. Inspections now involve less forensic examination of paperwork in the offices of service managers and more observation where care happens, whether this is a hospital ward, nursery playroom, a care home lounge or increasingly people’s own homes. A range of validated tools to support observation, such as SOFI (Short Observational Framework for Inspection) developed in 2006 by the Care Quality Commission and the University of Bradford ([www.bradford.ac.uk](http://www.bradford.ac.uk)), are available to support this development and inspectors are being trained in using these tools.

## What's the bottom line?

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The Standards herald a change of regulatory culture, moving away from policing all services to comply with a baseline to a more collaborative approach in order to support each service improve as much as possible. While minimum inputs, such as space and staffing ratios, are still available for regulatory action when outcomes for people are poor or potentially poor, the Standards deliberately avoid stating these. With regulated care expanding inexorably, focussing on the bottom line tends to become a self-fulfilling prophecy, with the minimum measures becoming the norm as more services are planned and registered. This also defines the regulatory role, limiting it to what Day, Klein and Redmayne's study, as discussed in Stanley and Reed, characterises as:

*"policing versus consultancy (for example, enforcement versus partnership); rules versus discretion; and stringency versus accommodation (characterised by a pedantic, trivialising approach to regulation rather than understanding the complexity...)." <sup>24</sup>*

By describing what the consequence of high quality care should be, not how it should be delivered, the Standards change the nature of inspection from seeing whether something is done 'correctly' to asking 'how successful is this in improving experiences and outcomes for people?' It allows inspection to be used as a tool for identifying what needs to improve as well as for prescriptive rules-based compliance. The new Standards are designed to help all service providers creatively solve problems and deliver effective care through innovation. When the Care Inspectorate was established its statutory duties were widened to include supporting improvement in addition to regulation, as reflected in its formal title 'Social Care and Social Work Improvement Scotland'. With this expanded remit, the Care Inspectorate can work more in partnership with services in a collaborative way developing improvement relationships, providing advice and support without formal regulation. The Care Inspectorate also develops improvement resources which supports the whole sector to know what they need to do to improve. This reflects the spread of improvement science as a specific discipline with its own methodology (Plan, Do, Study, Act), emanating from Harvard University and adopted by NHS Scotland with the Institute for Healthcare Improvement.

## Whose standards are they anyway?

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Ownership of the NCS was confined to a relatively small number of people in the business of regulating and being regulated. Inspection was largely a closed transaction between the inspector and manager of a registered service. And at its worst it could be a tetchy transaction at that, with heated nit-picking over finer technical points. In contrast these Standards are designed to be owned by everyone, including people commissioning services, staff, and most importantly people directly experiencing care and their families. They herald a shift from a transactional to a transformational model for care standards.

However, implementing the Standards is relatively easy in regulated services using the lever of inspection compared

to the majority of care provision, which is unregulated. Increasingly organisations run a combination of registered and non-registered services and the Standards can equally be used for internal quality assurance as external inspection. Walshe argues that standards and scrutiny should ideally blend the strengths of internal quality assurance and external inspection. The Care Inspectorate is developing quality indicator frameworks to help implement the Standards for specific settings, which are designed to be used for self-evaluation and inspection. Many organisations are also already using the Standards as an accessible tool with staff, volunteers and people experiencing their services in order to improve care and plan service development. In addition to direct care provision whether registered or not, they are also relevant for the spectrum of organisations making up the wider care system, including educational establishments, training providers, workforce regulators, advocacy, advice and helpline services.

Organisations representing the voice of people experiencing care helped the professional silos overcome differences in jargon and create genuinely accessible and meaningful Standards. By describing what to expect, they are for people to use as an entitlement for their often complex journey or pathway through the care system. Just as care experienced people were involved in producing the Standards, it is intended that this voice is equally prominent in how they are implemented and made a reality.

## So what?

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The Standards open up the possibility of creating a more holistic and effective scrutiny model, one which diagnoses where and what improvements are needed on a strategic as well as service level. They have been designed to assess the quality of an individual's experience and for care to be seen through this lens irrespective of which aspect of care is being scrutinised. Consequently this perspective is applied to a specific service, the organisation providing the service and to the statutory bodies responsible for assessing needs and planning, commissioning and procuring services.

As well as being aspirational and supporting continuous improvement, the Standards ask bigger societal questions of the care sector, with statements such as:

*"I am supported to be emotionally resilient, have a strong sense of my own identity and wellbeing, and address any experiences of trauma or neglect."* (HSCS 1.29)

*"I am empowered and enabled to be as independent and as in control of my life as I want and can be."* (HSCS 2.2)

*"The organisations that support and care for me help tackle health and social inequalities."* (HSCS 4.2)

Recent research into Adverse Childhood Experiences (ACEs) and the film 'Resilience' has confirmed that Scotland's persistent problems regarding health and wellbeing are caused by deep-seated trauma. Evidence regarding the effect of ACEs in Scotland is set out powerfully in Carol Craig's 'Hiding in Plain Sight' <sup>25</sup>.

Historically one of the telling cultural traits of social care regulation has been division and conflict. Regulators tend not to be trusted, regarded “as a sinister force that imposes regulations, increases administrative burdens and hands out penalties” according to Professor Leistikow of the Dutch Health and Youth Care Inspectorate<sup>26</sup>. Professor Leistikow talks about the benefits to be gained for the whole of health and social care by regulators investing in building trust and improving relationships with the regulated. In order to address wider problems of health and social inequality and overcome the legacy of ACES, there needs to be less conflict and more co-operation between all the players. We all need to be reading from the same page and these Standards are intended to at least get us reading from the same book. Creating common standards also opens up the possibility of creating a common currency of knowledge and intelligence between all the constituent parts of existing scrutiny. In addition to horizontal integration across external inspectorates for health, social work and social care, there could be vertical integration with the range of internal audit and quality assurance frameworks used by provider organisations.

Another traditional characteristic of regulation is that it is politicised, with the cyclical swinging between greater regulation and deregulation often described as a pendulum. Rather than gauging which way these Standards swing, instead they can be seen as building on the traditional regulatory role. Regulation as a type of market licensing still has its place, but inspection as a scrutiny tool can do so much more. Regulation is an essential part of creating a ‘level playing field’ for social care and these Standards contribute to extending the field across the whole of care. However, in order to improve the care system and the actual quality of people’s experience, it is not enough to just oversee a level playing field. Scrutiny bodies need to be part of the game and collaborating with people planning, commissioning, providing and experiencing care to help achieve long term and extensive improvement.

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