



## Triennial Review – Further Actions

**Report to:** Policy Committee  
**Date:** 11 November 2015  
**Report by:** Rami Okasha, Acting Director of Strategic Development  
**Report No:** P-26-2015  
**Agenda Item:** 14

### **PURPOSE OF REPORT**

To advise members of actions and thinking arising from the Triennial Review.

### **RECOMMENDATIONS**

That the Policy Committee:

1. Notes this paper and reflects on the issues raised when considering the scrutiny and improvement plan for 2016/17.

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**Version Control and Consultation Recording Form**

Version	Consultation	Manager	Brief Description of Changes	Date
1.0	Senior Management	ET		22.10.15
	Legal Services			
	Resources Directorate			
	Committee Consultation (where appropriate)			
	Partnership Forum Consultation (where appropriate)			
<p><b>Equality Impact Assessment</b></p> <p>To be completed when submitting a new or updated policy (guidance, practice or procedure) for approval.</p>				
Policy Title:				
Date of Initial Assessment:				
EIA Carried Out		YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	
If yes, please attach the accompanying EIA and briefly outline the equality and diversity implications of this policy.				
If no, you are confirming that this policy will have no negative impact on people with a protected characteristic and a full Equality Impact Assessment is not required.		Name: R Okasha Position: Acting Director of Strategic Development		
Authorised by Director	Name: R Okasha	Date: 27 October 2015		

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## 1.0 BACKGROUND

The Care Inspectorate published its triennial review, 'Inspecting and improving care and social work in Scotland', in August 2015. The last Policy Committee, and the most recent Board, received a presentation on the key findings of the report and discussed them.

It was agreed that the learning from the report was valuable, and should be used to influence our scrutiny and improvement work in future. Key operational colleagues have worked with the authors of the review to identify learning points which can be applied now, and ones where further consideration is needed.

This report presents some emerging issues around the triennial review and identifies where some improvements can be made as a result.

## 2.0 REACTION TO THE REPORT

The reaction to the report has generally been positive. Contacts within the sector have remarked on the findings, and the report has clearly influenced ministerial thinking. The Cabinet Secretary for Health, Wellbeing and Sport mention on the report at the Care Inspectorate staff conference thus:

the report is a detailed and informative overview of the Inspectorate's findings over its first three years of operation which evidences the hard work and dedication of everyone within the organisation. I would like to take this opportunity to thank those involved in the development and publication of this report... It was encouraging to read in the triennial report that progress has been made in improving social care services in Scotland, and across various types of services. However the report also identified several challenges and areas for improvement which shows there is still work to do.

The Cabinet Secretary for Education and Lifelong Learning cited the triennial reviews as an influence in her thinking about child protection. In her address to the International Federation of Social Workers conference in Edinburgh in September 2015, she said:

we need to ask - are we 'good enough' at joining up all the actions public services can and should take to prevent children becoming vulnerable in the first place? I don't think so. And my view is reinforced by the findings of the Care Inspectorate's recent triennial review. While it found that there are considerable strengths and positives in Scotland's child protection system, there are substantive issues for us to address.

The triennial review was also cited in the ministerial update report on the Brock

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report and on the National Action Plan to Tackle Child Sexual Exploitation, published in October 2015.

Policy colleagues within Scottish Government, including in the office of the chief social work advisor, have been particularly interested in the review and are seeking to ensure that the findings are discussed at the next network meeting of chief social work officers.

### **3.0 IMPLICATION FOR FUTURE CARE INSPECTORATE WORK**

Initial discussions about the next steps for the Care Inspectorate were had between the acting directors of strategic development and inspection, and key scrutiny and intelligence colleagues, in October 2015. This identified that the lessons from the triennial review fell into four main categories:

- lessons for future reports of this nature
- lessons for data collection and analysis
- lessons for how we apply scrutiny
- lessons for how we support improvement.

### **4.0 LESSONS FOR FUTURE REPORTS OF THIS NATURE**

Significant reflection has been had on determining whether the resources used to develop the triennial review were justified by the final product. While the report was produced within existing resources, there was a major opportunity cost in terms of all the other work that was not prioritised as a result. The principal inputs were the significant period of time devoted by two strategic inspectors who acted as the authors of the report, the generation, interrogation and analysis of data and editing and verifying statistical content by the intelligence team, and extensive editing and case study illustration by the head of quality and improvement.

A significant factor identified was the length of time between the raw data collection (from April 2011 to 31 March 2014) and the publication date (in August 2015). Serious consideration needs to be given to an alternative approach to future reports. It might be that more focused and more frequent reports are better able to inform emerging policy better. The acting head of quality and improvement and the strategic communications manager are currently working on bringing forward a future publications plan which will allow some of these decisions to be explored further. A decision on whether or not a future piece of work should take the same form should be informed by the views of stakeholders.

### **5.0 LESSONS FOR DATA COLLECTION AND ANALYSIS**

Generally, data collected by the Care Inspectorate is collated by service type.

This is understandable and necessary from a regulatory perspective. The triennial review data was broken down not just by service type, but by age and

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stage. This more accurately reflects the way individuals may use a web of often complex services, some of which we regulate and some of which we don't. The wide range of service types within a category of registration was challenging. For example, day care of children services includes nurseries, playgroups, breakfast clubs, holiday clubs, and out of school clubs. Support services include care at home services and day centres for adults.

In the long term, consideration will need to be given to the way data is collected by the Care Inspectorate. This will be particularly important if the current registration categories in the Public Service Reform (Scotland) Act 2010 are relaxed, giving rise to more innovative types of registerable services which cater to a range of service user groups.

In the medium term, there are two areas for improvement around data collection, but it should be noted that both may require significant ICT developments. First, we currently do not have a way of tracking the subject matter of requirements. We can tell how many requirements have been made at inspection about a particular quality statement, but examination of requirements about a particular issue requires manual reading of the requirement text itself. Requirements made at complaints are recorded separately from requirements made at inspection. This is an area where further work is required and which would allow us to identify themes and trends more clearly.

Second, we could improve the information we collect about complaints. Currently, approximately a quarter of complaints are classified as being about general health and welfare. Improvements to the recording categories could be considered as part of our review of our complaints process which is on-going.

The triennial review also highlighted the need for more clarity about how information is generated and presented on a provider, local authority or hub basis. A review of the role of contact managers and the link inspector will support this work and is currently being taken forward by the inspection directorate. The proposal to create intelligence profiles is being taken forward by the strategic development directorate as part of the Review of Scrutiny and Improvement.

### **6.0 LESSONS FOR HOW WE APPLY SCRUTINY**

The scrutiny evidence base in the triennial review is significant: we undertook over 30,000 inspections, complaint investigations, registrations and variations during the period of the review. A number of key areas have arisen which will be considered as we develop our methodology and refine our working practices.

The ability to make effective judgements about participation and about self-evaluation was identified as an important area for reflection. We need to be clearer about what quality looks like in both of these areas, and be specific by service type: quality participation in day care of children service may be very

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different than quality participation in a care home for older people. It is also important to ensure that we have a clear link between scrutiny of what we see and the subsequent impact on people using the service.

Revised national care standards will paint a clearer picture about what quality provision looks like across a key range of service types and practices. Our methodology review will begin to develop a judgement framework for inspectors, showing more clearly how decisions about grading is made by service type, and supporting consistency. The authors have suggested that we consider specifically the threshold for 'excellent', which will be undertaken as part of our review of scrutiny and improvement.

The review found evidence about care at home services being of a high quality based on our current approach and existing national care standards, but raised important questions about what quality should look like in a changing era of care at home, and what sufficiency of provision looks like. This is an area which straddles both our regulated care service inspections and our strategic scrutiny. This will be important areas to expand and refine our thinking on as we develop new methodologies at both levels of scrutiny.

At present, we provide scrutiny of an individual service and strategic scrutiny of the provision of services for young people and for adults. Improving the link between both approaches will be crucial for improving the way in which we scrutinise a care journey. We need to build an approach which recognises that some of the services used by people using a care services will not be services we regulate. Within the bounds of our responsibilities, and in co-operation with other scrutiny partners, we need to begin to think about the health and education experiences of people using care services. Our inspection focus areas around the Keys to Life has begun to address some of these issues, in that the IFA looks at the access that people with a learning disability resident in a care home have to health services. As new approaches are developed for our joint inspections and our regulated care service inspections, it will be essential to build more coherence around them. A common set of national care standards, underpinning all our scrutiny work, will help. We are currently considering whether we can plan regulated service inspections in places where a joint inspection is due to happen, but it is not yet clear whether this approach would be practicable.

The findings of the triennial review highlight the difference in scrutiny information we have between child protection and adult protection. This may, in fact, reflect a (wrongly) perceived importance of the former over the latter, but is an indication that we need to be much clearer about how we collect evidence and provide scrutiny of the handling of adult protection concerns at a service and strategic level. Some improvement will be made through centralising the ASP and CP referrals we make through our ICT system, which will allow us to capture trends and patterns, and from our nascent child and adult protection procedure. More thinking is needed, however, in the role that adult support and protection scrutiny plays in our strategic inspection, and the role that we can play through link inspectors around support and constructive challenge to

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partnerships and adult protection committees.

The triennial review notes (p119) that ‘there is no national data set to measure the progress of local authorities in providing options for self-directed support’. The speaks also to a wider issue about the role the Care Inspectorate could play in supporting informed choice around self-directed support. It is proposed that further work in relation to both scrutiny and supporting informed choice is explored further during 2016/17.

## **7.0 LESSONS FOR HOW WE SUPPORT IMPROVEMENT**

The evidence base from the triennial review has identified a number of areas where the Care Inspectorate could support improvement. These will need to be planned carefully and built into the scrutiny and improvement timetable for 2016/17 in order to be resourced. In many of these areas, it will be necessary to work with a wide range of other partners.

Within care services for older people, the triennial review identified concerns about medicines management and nutrition and hydration. The health improvement team is currently working to review and publish care triggers about these issues for inspectors to use in scrutiny work. Further improvement resources in these areas can be developed, including the development of dedicated pages on The Hub signposting to materials produced by the Care Inspectorate and other agencies. The health improvement team is also looking at how it works with Scottish Care, and other umbrella bodies, to support direct development in services, with a focus on smaller independent care homes where improvement may be less readily available from other sources.

The triennial review also identified a number of social work practices where the Care Inspectorate may be able to support improvement. The use of chronologies in social work (and also in some cases to support care planning) is an important area where observed practice is mixed. The Social Work Inspection Agency, before it merged to form the Care Inspectorate in April 2011, published a practice guide on effective use of chronologies in 2010, noting that they ‘have become one of the most talked about and least understood tools in modern social work practice’. Consideration should be given to devoting resources to update this practice guide in conjunction with Social Work Scotland and supporting its roll out across partnerships.

An important related issue is improving practice around the assessment of needs. The quality of assessment impacts significantly on the nature, quantity and quality of care that is subsequently provided to people who need it. The triennial review notes (p118) that ‘there is room for continued improvement and consistency in the quality of assessments of risk and need, decision making and planning for individual children and young people’ and (p124) that there was ‘variation in the assessment and management of risk’ to vulnerable adults.

The triennial review identifies, in a number of areas, the variation around the relative preparedness of partnerships for integration, and the need for

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partnerships to jointly measure and demonstrate the impact of their work. This suggests that there is scope for the Care Inspectorate to work with others to develop improvement resources and interventions which support strategic joint commissioning to focus clearly on the impact on outcomes for people, including in relation to children's services. This will be apposite ahead of the Care Inspectorate and Healthcare Improvement Scotland's new responsibilities around strategic commissioning from April 2017.

## **8.0 FURTHER WORK**

This report sets out some initial thinking that the Care Inspectorate needs to do at a corporate and strategic level. There is significant learning to be had from the triennial review at the level of individual inspector and team practice. In some cases, issues identified in the triennial review might lend themselves as suitable for inclusion in the inspection guidance for inspectors for next year, but in other cases further professional discussion and reflection is needed.

It has therefore been agreed that the triennial review will be discussed by expert groups and teams to promote professional reflection around the detailed findings, in order to ensure that individual practice builds on the findings of the review.

## **9.0 RESOURCE IMPLICATIONS**

Any resource implications arising from the discussions in this paper will need to be costed and planned using existing decision-making arrangements, including the scrutiny and improvement plan for 2016/17.

## **10.0 BENEFITS FOR PEOPLE WHO USE SERVICES AND THEIR CARERS**

Ensuring that the Care Inspectorate uses the findings from the triennial review will help us meet our statutory responsibility of furthering improvement in social services. The changes discussed here for our intelligence, scrutiny and improvement work will have material impact on people using services and their carers.

## **11.0 CONCLUSION**

The Policy Committee is invited to discuss the issues raised here.

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