



Independent Review of Inspection, Scrutiny and Regulation of Social Care in Scotland



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1. Foreword



In 2022, I accepted an invitation from Kevin Stewart MSP, Minister for Mental Wellbeing and Social Care, to become the Independent Chair of a Review of Inspection, Scrutiny, and Regulation of Social Care in Scotland (IRISR). I welcomed the appointment of Stuart Currie as Vice Chair, who has been a real asset to the Review and, amongst other things, has led on our extensive programme of engagement.

As a result of changes within government, I welcome the opportunity to present the findings of the Review to Maree Todd MSP, Minister for Mental Wellbeing, Social Care and Sport.

In undertaking this Review of Inspection, Scrutiny, and Regulation of Social Care in Scotland (IRISR), no assumptions were made about what the Review would find or would recommend. We recognised that the present system of inspection, scrutiny, and regulation has been in place for two decades and in that time there has been a great deal of incremental change in social care support. This includes partnership working, pressures in the system and, of overarching importance, recognition of the importance of the views and expectations of those receiving social care support services.

Organisations and individuals are working diligently whilst under considerable pressure in a social care landscape that is complex, congested and at times inconsistent in terms of accessibility and quality. The Review has heard that some positive changes have been made in inspection, scrutiny, and regulation however, recurring feedback from the frontline of service delivery asked where the difference was being made.

It is clear that the social care support sector often struggles to secure and retain a stable and sufficient workforce, the importance of which, in supporting improvement, is a theme that ran through all our discussions. Whilst workforce issues were not of themselves central to our remit, the Review believed this to be an issue of such underpinning importance that we do make comment in the following report.

The appetite for engagement and change has been striking. There is a palpable sense that the Review provides a real opportunity to support an inspection and regulatory system that works better for those using and providing social care support services and that puts human rights and fairness at the very centre. The difference will be made in protecting people, in ensuring that people receive the quality services they deserve, in services being helped to improve, and above all, in ensuring improved personal outcomes for those being supported and cared for.

While resourcing was considered important, there is a keen awareness of the need to understand how existing resources are used effectively to deliver the best possible outcomes for people. As our discussions have developed, contributors and participants have come forward with constructive ideas and views on how things can change and develop for the better.

In recent years, several reviews have identified the need for change across the social care and wider support landscape. This Review has drawn upon and builds upon the prior work and findings including 'The Promise', 'The Independent Review of Adult Social Care in Scotland', 'Putting Learners at the Centre' and 'Trust and Respect'. The recommendations of this Review are set out across five themes and are firmly informed by the evidence that has been gathered. They are driven by a commitment to equality and human rights and by putting the cared for at the heart of our considerations.

An implementation gap has been identified and progress needs to be accelerated. The recommendations lay out clearly what the Review thinks needs to be done to close that gap. Here is an opportunity to take the recommendations and make the difference that people delivering support and being supported across the sector are looking for. Now is the time for action.

I would like to thank all those who contributed to the Review. People have been extremely generous with their time and their views. The Review has heard from people with lived experience of social care support services and their relatives, from service providers across social care, from those delivering regulation and scrutiny, and from professionals bringing a wide range of perspectives and contexts. I would like to thank those who served on the Independent Review Panel and the Practitioner and Stakeholder Panel, all of whom gave generously of their time and their frank, challenging and open contributions to our discussions.

I would also like to take this opportunity to thank the Review Secretariat for their diligence and Vice Chair, Stuart Currie, whose knowledge, experience and commitment has been extremely valuable throughout.



Sue Bruce

Dame Sue Bruce
Independent Chair

2. Executive Summary



In September 2022, the Scottish Government announced an Independent Review of Inspection, Scrutiny, and Regulation of Social Care in Scotland (IRISR). Dame Sue Bruce was appointed as the Chair of the IRISR with Mr Stuart Currie as the Vice Chair. Biographies of both the Chair and Vice Chair are shown at Appendix A.

No assumptions were made about what the Review would find or would recommend, but it was recognised that the present system of inspection, scrutiny, and regulation has been in place for two decades. In that time there has been a great deal of incremental change in the social care landscape, in partnership working, in pressures in the system and, of overarching importance, in recognising the importance of the views and expectations of those receiving social care support services.

In recent years, a number of reviews have identified the need for change across the social care and wider support landscape. This Review has drawn upon and builds on this earlier work and their findings. All those involved in this Review have been clear that now is the time for action, with this and the many prior reviews providing both evidence and recommendations to support action.

Hearing the views and experiences of all individuals, including seldom heard voices, was paramount in this Review. It was important that the Review's recommendations were informed by listening to and learning from people, particularly those who work in and use social care support services as well as other linked services such as housing support, addiction services and community health.

The work of the Review was supported by two advisory panels, the Independent Review Panel and the Practitioner and Stakeholder Panel. Both panels included people with lived and living experience and provided expert knowledge, guidance and support in the making of the Review recommendations.

In addition to the Panel meetings, the Chair and the Vice Chair hosted in excess of 30 meetings with professional subject matter experts across the sector, to inform the Review.

Theme 1 – a person centred approach

Inspection, scrutiny, and regulation of social care support must fundamentally be about people. How inspection, scrutiny and regulation are operationalised and experienced should ensure not only the provision of safe and high-quality care and support, but also that people are treated with respect, involved in decision making about their lives and are fully informed about the support they can expect.

The Review heard from people who receive social care support, and from those who work in the sector, that they want a system of inspection, scrutiny, and regulation where the rights of people with lived and living experience are understood and upheld, strong professional relationships are built, there is meaningful and inclusive involvement processes and information is clear and accessible to all.

The recommendations made under this theme are:

1. It is recommended that inspection, scrutiny, and regulatory bodies consistently apply a human rights-based approach that places people at the centre of the process.
2. It is recommended that matters of trust, respect, relationships, ethos and culture be placed at the heart of inspection, scrutiny, and regulation and should be reflected in reports.
3. It is recommended that inspection, scrutiny, and regulatory bodies must set out clearly in their annual report how they have led and cultivated a culture of openness and trust.
4. It is recommended that inspection, scrutiny, and regulatory bodies make appropriate arrangements to engage people with lived and living experience in co-designing engagement tools and developing the inspection and regulatory frameworks.
5. It is recommended that a strengthened system be put in place for people to have a **formal** role as lay inspectors in the process of inspection, scrutiny, and regulation, including young people with care experience. An appropriate level of remuneration should be made available.
6. It is recommended that inspection bodies' approach to engagement must be flexible, inclusive and appropriate. This includes allowing sufficient time for responses to be made and making suitable arrangements for conversations to take place with individuals, family members and staff, ensuring consistency and accessible information is available.
7. It is recommended that independent advocacy is available for people to help them to exercise their rights, and when necessary, to provide support to navigate complaints and any escalation processes.

Theme 2 – what needs to be inspected, scrutinised, and regulated?

Inspection, scrutiny, and regulation is an essential element of providing protection and safety for those who use social care support services. It is a way of giving assurance to families, friends and unpaid carers that their loved one is in receipt of good services, and it provides evidence to those commissioning and delivering care.

Evidence provided to the Review identified a range of services not currently subject to inspection, scrutiny, and regulation. It also heard that there are gaps in the regulation of some staff groups working in social care support services.

The recommendations made under this theme are:

8. It is recommended that a co-produced and bespoke scheme of registration for Personal Assistants (PAs) which recognises their skills and role, and opens up access to training and development, should be developed. Such a scheme would **expressly** seek not to create barriers, and through co-production, would create positive opportunities for both the Personal Assistant and their employer.
9. It is recommended that there should be a universal requirement to obtain registration with a regulatory body for all social care support staff appropriate to their role and setting, and that this should be a condition upon joining the social care workforce.
10. It is recommended that inspection, scrutiny, and regulation should be extended to areas not part of the current system, including agencies who provide social care support staff, to help drive continuous improvement and deliver better outcomes.
11. It is recommended that further development of stronger links between regulatory bodies across all areas within and out with the borders of Scotland should be established to ensure better regulation, transparency and accountability of providers of social care support services.
12. It is recommended that best practice from other nations' regulatory landscape is explored and considered with a view to enhancing transparency and accountability, particularly in relation to there being a named, accountable link to registration, inspection, and local employees.
13. It is recommended that the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 be reviewed to ensure consistent, effective and comprehensive applicability of the fit and proper person provisions across social care support services in Scotland.
14. It is recommended that Scottish Ministers make appropriate arrangements for market oversight and sustainability in the social care sector.
15. It is recommended that the list of care service types and set of corresponding definitions as set out in Schedule 12 of the Public Services Reform (Scotland) Act 2010, are assessed for fitness for purpose.

Theme 3 – how should inspection, scrutiny, and regulation be carried out?

The Review heard consistently that a more streamlined system of inspection, scrutiny, and regulation is needed to reduce duplication, increase consistency, be inclusive of all services, and to support the delivery of high-quality services. Inspection and scrutiny can be the catalyst for improvement and is widely recognised by providers, commissioners and regulators as critical for the delivery of safe, agile and effective community health and social care support services.

The recommendations made under this theme are:

16. It is recommended that inspection, scrutiny, and regulation processes more fully take account of an individual's experience of service delivery and their overall care journey to understand, follow and evaluate the person's social care support experience over time and their impacts.
17. It is recommended that clear and accessible information about the agencies and their roles, responsibilities and accountabilities is provided for all those who require social care support services.
18. It is recommended that Scottish Government work with the regulators to clarify roles and responsibilities between organisations to streamline inspection activity, remove repeat inspections by different agencies and to reduce duplication and omission. This should include reviewing how joint inspections are currently carried out, encouraging more partnership working and joint inspections, and greater involvement of people in receipt of social care support in inspection, scrutiny, and regulation.
19. It is recommended that inspectors and regulators, whilst fulfilling their statutory duty to identify shortcomings in improvement, should also place equal weight on identifying good practice, innovation and improvement across the sector.
20. It is recommended that an emphasis on outcomes and continuous improvement becomes a central focus of inspection, scrutiny, and regulation.
21. It is recommended that the Scottish Government updates and clarifies its expectations regarding the National Performance Framework (NPF) in relation to publicly funded delivery bodies, particularly with respect to outcomes for social care support services.
22. It is recommended that there should be a duty on the regulator/inspector to work more closely with the provider on agreeing action plans and timescales for continuous improvement recommendations that are additional to regulatory requirements and improvement notices.
23. It is recommended that Scottish Ministers should review legislation to ensure that regulatory bodies have adequate enforcement powers.

24. It is recommended that a duty to self-report should be reviewed to ensure that self-reporting is inherently linked to continuous improvement, whilst also ensuring the regulatory bodies have appropriate powers to act when issues are identified.
25. It is recommended that there is clear and accessible public information about how to raise a concern and systems of complaints. Those systems of complaints should be easy to use, have accessible detail about routes of escalation with clearly defined outcomes that can include redress for people.
26. It is recommended that the Scottish Government should make arrangements to ensure appropriate oversight of regulatory provision of social care support and consider whether there should be separate arrangements put in place for Scotland, in this respect.

Theme 4 - how will we know systems are working?

When people and their families need to access social care support, particularly for the first time, it can be a life-changing experience, involving bringing new people and routines into an individual's life. This often means having to understand a lot of information to inform decisions about what might work best for the person and their family. It also often requires placing a significant amount of trust in services, professionals and regulators. For some it can be a worrying time whilst for others it can be reassuring, offering up new opportunities.

As part of the Review, it was important to explore how we know systems are working by speaking to people about issues related to informed decision making, digital technologies, data collection and supporting good practice.

The recommendations made under this theme are:

27. It is recommended that qualitative measures should be co-designed by the regulatory agencies and people with lived and living experience to ensure that they include elements of services that are important to people.
28. It is recommended that the sharing of data is examined, with the people at the centre of the process having access to their own data in formats that facilitate their understanding of it in order to support decision making and their involvement in this. This data should also be utilised for service planning and improvement, both strategic and operational.
29. It is recommended that data is utilised for social care planning and individuals, and their advocates have access to this to inform their choices.
30. It is recommended that the type of data collected, and its purpose, is reviewed to ensure that the right data is collected for the right reasons, with a focus on data supporting performance management and service improvement.

31. It is recommended that a more tailored and contextualised approach is developed to how GDPR is used and interpreted within the regulatory landscape. It is also recommended that an Information Governance (IG) group is established to support the effective and proper use of information and engagement with IG experts.
32. It is recommended that there is a 'duty to co-operate' placed upon service providers to share data appropriately and, equally upon regulatory bodies to work together to avoid duplication in their requests for information.
33. It is recommended that a review of the Health and Social Care Standards takes place to ensure they are based on human rights, ethical commissioning and are outcomes focused. The Standards should be the basis on which social care support services are inspected, scrutinised and regulated.

Theme 5 – how will systems of inspection, scrutiny, and regulation support the workforce?

One of the key aims of this Review is to identify and set out recommendations to help ensure inspection, scrutiny, and regulation works towards making the system better for everyone, including for those who work to deliver social care support. The Review was keen to understand views on how current support systems and arrangements for the workforce might be improved, built upon and further strengthened, for the benefit of all.

The recommendations made under this theme are:

34. It is recommended that Scottish Ministers should review the powers of intervention and enforcement currently in place, where providers fail to meet workforce registration obligations or fail to follow the codes of conduct and consideration be given as to where powers of enforcement should lie.
35. It is recommended that regulators and providers examine ways in which the workforce can become more actively involved in the inspection process, on a basis of mutual trust and respect.
36. It is recommended that Scottish Ministers align the social care workforce in a coherent model, based on fair work, to support the sustainability of the workforce and to help drive continuous improvement.
37. It is recommended that Scottish Ministers should review the sufficiency, quality and availability of resources for training, development and improvement.
38. It is recommended that steps are taken to ensure that nationally recognised qualifications that reflect the skills required to work in the social care sector are developed and are portable across the social care sector.

3. Background



What is social care support?

Social care support services are about providing people with the support and assistance they need to lead a full and active life.

The social care support sector is large and as diverse as the people it assists. Figures from the [Insights in Social Care: Statistics for Scotland](#) show there are approximately 14,000 registered services across Scotland providing social care support to an estimated 200,000 people of all ages (1 in 25 of the population) each year. Over 200,000 people are part of the social care support workforce in Scotland, and 167,600 are part of the [Scottish Social Services Council Register](#).

Social care support is delivered in a variety of settings, including people's own homes, their local communities and care homes, by a mixed economy of public sector and independent services. Social care support is one part of a wider system, that includes Social Work Services, Housing, Third Sector, Children's Services, Early Learning and Childcare provision and Community Health.

Why an Independent Review of Inspection, Scrutiny, and Regulation?

Robust inspection, scrutiny, and regulation has a crucial part to play in ensuring that people experience high-quality care and support which makes a positive impact on their lives, based on their needs, rights and choices.

The terms 'inspection', 'scrutiny', and 'regulation' are frequently used interchangeably. For definitions to use in this Review we looked first to [The Crerar Review: The Report of the Independent Review of Regulation, Audit, Inspection and Complaints Handling of Public Services in Scotland](#). The Crerar Review defined regulation and inspection as:

Regulation focuses on providing a licence to operate, enforcement of legislation and regulations and monitoring the quality of services provided. Regulation may also include elements of service inspection and can be designed to drive up quality as well as to enforce standards. To this definition we would add that as well as enforcing standards, regulation in the context of this Review may include assessing performance against agreed themes, for example, for thematic inspections.

Inspection is periodic, targeted scrutiny of specific services, to check whether they are meeting national and local performance standards, legislative and professional requirements and the needs of service users.

Scrutiny The Review acknowledges that this can mean different things to different people and organisations. As set out in the Scottish Commission for Learning Disability Report – [Using scrutiny to drive outcomes: Improving quality of life for people with learning disabilities](#), it also happens in different ways – for example, through involving people in decisions about planning and delivering services, through citizen-led scrutiny, through internal review and challenge, and through external scrutiny and investigation. In this Review we have deliberately adopted a broad definition of scrutiny.

Our national regulators play a critical role in assuring consistent and high standards of social care support. However, the current system has been in place over the last 20 years, during which time the social care support landscape and skills requirements of the workforce have changed.

The [Independent Review of Adult Social Care in Scotland](#) (IRASC) reported hearing a range of views on current arrangements for inspection and regulation. Examples of good practice, where inspection was based on genuine dialogue and a focus on improvement, were described, but the IRASC was told that often too much attention was placed on process and not enough on individuals' experience of care and support. In addition, the IRASC also heard the view that there was an accountability gap at a national and local level and that there is not meaningful joint inspection of health and social care support services. The IRASC also raised important questions around how to deliver improvement.

The conclusions of IRASC are consistent with a growing body of evidence from recent reviews that highlight some of the challenges with current systems including, [The Promise](#), [The Scottish Drugs Deaths Taskforce Final Report](#), [Changing Lives](#), and 'The Muir Review', [Putting Learners at the Centre: Towards a Future Vision for Scottish Education](#).

Although these reviews vary in their focus on children and care, adult social care, drug deaths and education, common themes include:

- the need to focus on putting people and relationships above processes;
- a need to focus on improvement; and
- challenges with data collection and sharing.

A key recommendation from the IRASC was the creation of a National Care Service (NCS). The IRASC stated:



We need a National Care Service to achieve the consistency that people deserve, to drive national improvements where they are required, to ensure strategic integration with the National Health Service, to set national standards, terms and conditions, and to bring national oversight and accountability to a vital part of Scotland's social fabric.

The Scottish Government's vision for the NCS is for everyone to have access to consistently high-quality social care support across Scotland, whenever they might need it. It is intended to provide services that are co-designed with people who access and deliver care and support, respecting, protecting, and fulfilling their human rights.

The National Care Service (Scotland) Bill was introduced to Parliament in June 2022. If approved by Parliament, it would represent one of the most ambitious public services reforms in generations, having significant implications for how social care services are commissioned, delivered, and governed in Scotland. The Bill proposes some limited changes in the powers of the Care Inspectorate and Healthcare Improvement Scotland but raises important questions in how regulation and improvement will operate and be strengthened under the NCS.

It was in this evolving context that, in September 2022, Scottish Ministers announced an Independent Review of Inspection, Scrutiny, and Regulation (IRISR) would look at how social care support services are regulated and inspected across Scotland.

The terms of reference for the IRISR were to:

- make recommendations as to how inspection, scrutiny, and regulation of social care, and linked services, have a basis in human rights and trauma informed practice, is inclusive of people with lived and living experience and how best to ensure continuous improvement is standard practice;
- consider what the inspection, scrutiny, and regulation of social care, and linked services landscape needs to look like to ensure it meets the requirements of the National Care Service (NCS);
- consider how any new arrangements will meet the needs of and interface with services that are not part of the NCS;
- ensure that any new approach to inspection, scrutiny, and regulation of social care, and linked services is future proofed and flexible;
- consider what data will be needed for regulation and improvement and how data sharing can be improved, standardised and tied into wider work considering the data requirements for the NCS in line with the [UK General Data Protection Regulation \(UK GDPR\)](#);
- be inclusive of wide-ranging engagement with stakeholders including people with lived and living experience, and unpaid carers;
- consider if there is a need for an independent scrutiny body for inspection and regulation of social care and support services in Scotland similar to that of the Professional Standards Authority in England or otherwise, taking account of the reserved nature of professional regulation of the clinical professions; and
- complete the Independent Review and publish findings and make such recommendations deemed appropriate across all considered areas and any other recommendations considered appropriate, in accessible formats.

It is important to note at the outset that this Review supports a human rights-based approach to inspection, scrutiny, and regulation and explores this in more detail in subsequent chapters. The Review is clear that the [PANEL Principles](#) of Participation, Accountability, Non-Discrimination, Empowerment and Legality are ones that should underpin systems. The Review acknowledges that barriers exist for some groups accessing social care support services and taking a human rights-based approach empowers people to know and access their rights.

How does inspection, scrutiny and regulation currently work?

The legislative foundation of inspection is provided by the [Public Services Reform \(Scotland\) Act 2010](#) which has its origins in the [Regulation of Care \(Scotland\) Act 2001](#). The main aim of the Regulation of Care (Scotland) Act 2001 was to improve standards of social care services and the Act established the Scottish Commission for the Regulation of Care and the [Scottish Social Services Council](#) (SSSC).

The inspection, scrutiny, and regulation of social care support services in Scotland is predominantly carried out by three main bodies.

[Care Inspectorate](#) (CI) is a non-departmental public body (NDPB) and is the national regulator for care services in Scotland. The CI provides independent public assurance about the quality of social care, social work, and early learning services. It is responsible for the registration and regulation of care services (including childcare services) in Scotland and its role is to scrutinise, inspect and support improvement in services to ensure the quality of care meets high standards.

The CI inspects each of the circa 14,000 registered care services in Scotland, higher-risk services are inspected more often. The CI also works with other scrutiny bodies to look at how local authorities, community planning partnerships and health and social care partnerships are delivering a range of services in their communities.

[Scottish Social Services Council](#) (SSSC) is like the CI, a NDPB and acts as the independent professional regulator for social workers, social care and early learning and childcare practitioners. It sets standards for their practice, conduct, training and education, and by supporting their continuous professional development. Where people fall below the standards, the SSSC will investigate their fitness to practise and take action accordingly.

[Healthcare Improvement Scotland](#) (HIS) is a Health Body. Its broad remit and general statutory duties are to further improve the quality of health and social care through evidence, scrutiny, public participation, redesign of services, and inspecting any service provided under the health service. HIS duties include the regulation of independent hospitals and clinics. HIS are also responsible for providing information to the public about the availability and quality of services under the health service. This includes providing advice to current

and prospective providers, users, carers and Local Authorities regarding health services. Where a service provided under the health service and social services are provided by virtue of an integration scheme approved in the [Public Bodies \(Joint Working\) \(Scotland\) Act 2014](#), HIS may inspect the planning, organisation or coordination of those services.

Although HIS is the inspection and improvement body for health, it does carry out a number of strategic and thematic inspections with the CI, for example, inspections of Health and Social Care Partnerships and, with His Majesty's Inspectorate of Constabulary Scotland (HMICS), of Adult Support and Protection services.

Whilst not a regulator, the Mental Welfare Commission (MWC) has responsibilities to ensure people with a mental illness, or learning disability, and those that lack capacity, have their human rights upheld. The MWC carry out their statutory duties by focusing on five main areas of work. They are visiting people, monitoring the Acts, investigations, giving information and advice, and influencing and challenging. The MWC has wide powers to raise matters of general concern with a range of bodies, including the CI, as well as a duty to raise any particular service concerns.

The Regulation of Care Act (Scotland) Act 2001 sets out the statutory functions of the role of the SSSC in the registration and regulation of social care workers. The SSSC have [Codes of Practice for Social Service Workers and Employers](#) that set out the behaviours and values expected of social service workers and their employers. If either party does not meet the standards in the codes of practice, the SSSC can take action.

The healthcare workforce is registered with different professional regulators, such as the General Medical Council and the Nursing and Midwifery Council, and do not fall under the same system as social care support. The regulation of the majority of healthcare professional groups is reserved, though new groups of healthcare professionals and those regulated since the [Scotland Act 1998](#) is devolved to the Scottish Parliament. In practice there is a four-nations commitment to ensuring regulation is consistent UK-wide.

The roles in the social care support sector that currently do not require to be registered are also explored in more detail under Theme 2 (page 39).

In the chapters that follow, the Review works on the underlying principle that future arrangements for inspection, scrutiny, and regulation must work constructively for everyone who uses or who delivers social care support.

The [Professional Standards Authority for Health and Social Care](#) (PSA) oversees the nine statutory bodies that regulate health professionals in the United Kingdom and social care in England. It includes the principles, which the Review would support, that regulation should aim to be Proportionate, Consistent, Targeted, Transparent, Accountable and Agile.

Scotland needs a system of inspection, scrutiny, and regulation that is focused on the type of social care support and wider sector that people want to see, embedded in human rights. It needs to be able to reflect the changing roles of the workforce, for example, the move towards hybrid models of working. There is an identified need to address long-standing and well documented issues along with exploring how inspection, scrutiny, and regulation can best contribute to improving outcomes for people.

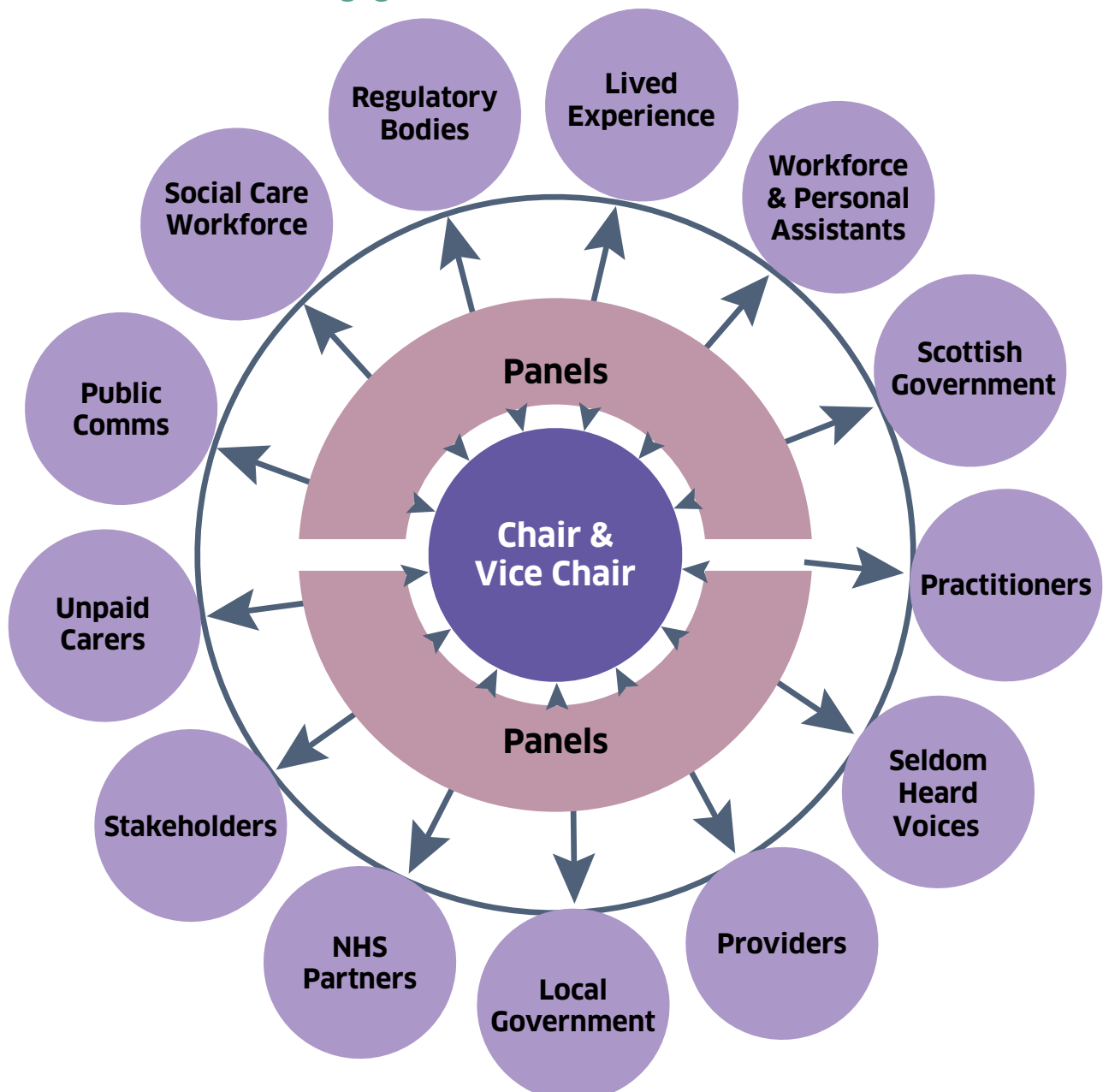
4. Listening and Learning



Hearing the views and experiences of all individuals, including seldom heard voices, was paramount in this Review. It was critical that the Review’s recommendations were informed by listening to and learning from people, particularly those who work in and use social care support services as well as other linked services such as housing support, addiction services and community health.

The Review has benefitted from open and honest engagement by individuals from the outset and participants have come forward with constructive ideas and views on how things can change and be developed for the better. It is also important to stress that we heard many examples of where things worked well, and of how people and services were supported to make and sustain improvements.

Who did the Review engage with?



To offer as much opportunity for involvement with the Review as possible, an engagement programme took place between October 2022 and January 2023. This consisted of two main elements: a call for evidence and a series of engagement events. Both elements of the programme focused on five key themes:

- Theme 1 - a person-centred approach.
- Theme 2 - what needs to be inspected, scrutinised, and regulated?
- Theme 3 - how should inspection, scrutiny, and regulation be carried out?
- Theme 4 - how will we know systems are working?
- Theme 5 - how will systems of inspection, scrutiny, and regulation support the workforce?

Call for evidence

The call for evidence was launched on 24 October 2022 and ran until 13 January 2023. Details of the call for evidence were shared widely across the social care support sector and other linked services. Responses to the call for evidence were submitted using the consultation platform Citizen Space.

To ensure all of the information gathered as part of the call for evidence and engagement events was thoroughly and independently analysed, Why Research was commissioned (through an open tendering process) to undertake the consultation analysis. The 'Independent Review of Inspection, Scrutiny, and Regulation (IRISR) Call for Evidence Analysis Report' sets out the findings across the five themes in detail, and was critical in informing the recommendations set out in this report.

A total of 100 responses were received, 60 were from organisations and 40 from individuals. A list of all those organisations that submitted a response to the call for evidence is included in Appendix 1 of the [analysis report](#). Respondents were assigned to particular groupings to allow analysis of any differences or commonalities across or within the various types of organisations and individuals that responded. The following table provides the profile of those who responded to the call for evidence.

Table 1: Respondent profile: call for evidence

	Respondent sub-group
Advocacy	3
Health & Social Care Partnerships (HSCP) / Local authority	8
Regulator	5
Representative body	28
Providers of social care support	10
Other	6
Total organisations	60
Individuals	40
Total respondents	100

Engagement events

Twenty engagement events were held across Scotland, led by the Vice Chair. In-person events were hosted in Orkney, Inverness, Borders, Glasgow, Edinburgh, Kirriemuir, and Ballater, with the remaining events held virtually.

The virtual meetings enabled people from across Scotland to attend which meant there was representation from different geographical locations.

In total the engagement events were attended by 149 people. As the following table shows this included a wide range of providers of social care support, representative bodies, regulators, local authorities, advocacy organisations, individuals, and others.

Table 2: Respondent profile: engagement events

	Respondent sub-group
Advocacy	4
Health and Social Care Partnerships (HSCP) / Local authority	17
Regulator	8
Representative body	24
Organisations providing social care support	38
Other	39
Total organisations	130
Individuals	19
Total respondents	149

In order to maximise opportunities for people to contribute via engagement sessions, a number of bespoke events were facilitated by members of the Practitioner and Stakeholder Panel, and the Vice Chair responded to requests for individual conversations. In addition, the Chair and Vice-Chair held a number of meetings with the regulators to gather their perspectives of what currently worked well and where they saw current challenges.

Findings from the analysis report are considered under each of the subsequent Themes but key findings identified by Why Research include:

- ensuring that people with lived and living experience are able to share their knowledge and thus contribute to inspection and regulation processes. To do this, it is vital that people are involved in decision making, and at the centre of systems of inspection, scrutiny, and regulation;
- a majority of respondents felt there are services not currently subject to inspection, scrutiny, and regulation that should be;
- if something goes wrong in a service respondents wished to see a clear procedure for reporting the problems, particularly for people receiving social care support;
- there were also calls for all people involved with providing social care support to have a role in improvements;
- it was seen as important to involve people receiving social care support and their families in co-designing inspection, scrutiny, and regulation processes;

- there were also calls to ensure that training for the social care support workforce provides people with the skills needed to perform their roles effectively; and
- creating a culture change so that inspection, scrutiny, and regulation is seen as an opportunity to reflect on challenges, successes and learning; it was felt that a greater focus on the positives was needed.

Advisory panels

The work of the Review was supported by two advisory panels, the Independent Review Panel and the Practitioner and Stakeholder Panel, both of which included people with lived and living experience.

The [Independent Review Panel](#) (IRP) consisted of nine individuals who were appointed as well-recognised experts in a number of fields relevant to the Review. This included academic research, public mental health, health care regulation, housing, criminal justice, children's services, community health, governance, social work and equality and advocacy across the public sector. Membership of the IRP can be found in Appendix A.

The [Practitioner and Stakeholder Panel](#) (PSP) included representatives from a large number of organisations and groups across the sector. The PSP was made up of 29 organisations and groups, including Social Work Scotland, Scottish Care, Convention of Scottish Local Authorities (CoSLA), Coalition of Care and Support Providers in Scotland (CCPS), Centre for Excellence for Children's Care and Protection, People-Led Policy Panel, Community Justice Scotland, Scottish Trade Union Congress, and Coalition of Carers in Scotland. Membership of the PSP can be found in Appendix B.

Both panels provided expert knowledge, guidance and support in the making of the Review recommendations.

Subject matter expert meetings

The Chair and the Vice Chair hosted in excess of 30 meetings with professional subject matter experts across the sector, to inform the Review. A full list of who they met with can be found in Appendix C.

5. Theme 1 - A person-centred approach




Inspection, scrutiny, and regulation of social care support must fundamentally be about people. How inspection and regulation are operationalised and experienced should ensure not only the provision of safe and high-quality care and support but also that people are treated with respect, involved in decisions about their lives, and are fully informed about the support they can expect.

The Review heard from people who receive social care support, and who work in the sector, that they want a system of inspection, scrutiny, and regulation where the rights of people with lived and living experience are understood and upheld, strong professional relationships are built, there is meaningful and inclusive involvement in inspection processes, and information is clear and accessible to all.

Current systems of inspection, scrutiny, and regulation are complex and sometimes duplicative and that can make them challenging for people to navigate and to participate in. Recent reviews, including [The Promise](#), 'The Muir Review', [Putting Learners at the Centre: Towards a Future Vision for Scottish Education](#) and the [Independent Review of Adult Social Care in Scotland](#), have found that regulatory systems and inspection processes often do not pay enough attention to individuals' experiences or the issues that matter most to them. IRASC sent a particularly strong message that there should be a requirement to demonstrate how human rights are understood and acted upon and this Review very much endorses that view:

“ ... there is not meaningful joint inspection of health and social care support services ... too much attention is paid to procedural and process issues and not enough to individuals' experience of care and how social care connects people with their communities.

This Review recognises that a rights-based approach is built into some key social care legislation. For example, Self-Directed Support (SDS) is one of the main ways in which social care support is delivered in Scotland. The [Social Care \(Self-Directed Support\) \(Scotland\) Act 2013](#) sets out that anyone who accesses social care support should be able to do so in a way that supports their human rights, dignity, and ability to take part in the life of their communities. However, despite progress being made in ensuring that services are inclusive, the evidence report [Self Directed Support and Personal Outcomes](#) by the Equality and Human Rights Commission Scotland, published in July 2022, states:

 **Self-Directed Support users who shared certain protected characteristics experienced inequality in accessing Self-Directed Support and being able to achieve their personal outcomes.**

The affirmation of equality and human rights in the social care support sector should be intentional, evidential, and accountable. From the evidence considered by the Review, inspection, scrutiny, and regulation currently are more process-led than outcomes-led.

The Review heard that methodology and reporting does not sufficiently concentrate on what difference social care support services make to people's lives. A human rights-based approach can help to address this.

The Review notes that the Scottish Government recognises and promotes the importance of taking a human rights-based approach across a range of public duties, including the provision of social care support. Scottish Government is currently consulting on a [Human Rights Bill](#), which proposes incorporating, a range of economic, social, cultural and environmental rights into Scots law for the first time, within the limits of devolved competence. The Bill will seek to place duties on public bodies to first ensure these rights are central to everything they do, and after a period of implementation, to ensure they comply with the rights. Furthermore, the Bill will aim to ensure public bodies take account of the rights contained in treaties tackling discrimination against women, disabled people and people and groups who experience racism, and do so in a way that delivers the rights without discrimination. The Bill will also enable people to seek justice where their rights are not upheld – through improving access to justice.

PANEL principles & human rights

One of the key questions the Review considered was how to ensure that people with lived and living experience of care and support services are able to contribute to inspection, scrutiny, and regulation. In support of its commitment to a human rights-based approach, the Review adopted the PANEL (Participation, Accountability, Non-Discrimination and Equality, Empowerment and Legality) principles to ensure that feedback gathered throughout the Review was translated into responsive and person-centred recommendations.

PANEL principles are one way of understanding what a human rights-based approach means in practice:

Panel Principles

Participation

People should be involved in decisions that affect their rights.



Accountability

There should be monitoring of how people's rights are being affected, as well as remedies when things go wrong.

Non-discrimination

Nobody should be treated unfairly because of their age, gender, ethnicity, disability, religion or belief, sexual orientation or gender identity. People who face the biggest barriers to realising their rights should be prioritised when it comes to taking action.



Empowerment

Everyone should understand their rights and be fully supported to take part in developing policy and practices which affect their lives.

Legality

Approaches should be grounded in the legal rights that are set out in domestic and/or international law.



Throughout the engagement phase, individuals signalled their support for using PANEL principles in inspection, scrutiny, and regulation. The Review also heard that there is a need to ensure that there is a clearer understanding of what human rights are and how they can be fully embedded in organisational and inspection processes.

Person-centred & person-led

In line with the PANEL principles, the Review asked people what they felt person centred inspection, scrutiny, and regulation processes should look like.

Language is important and the Review recognises that terms like person-centred and person-led, although often used interchangeably, have slightly different meanings to people.

The Review's understanding of these terms is:

- a 'person-centred' approach might be described as ensuring the person in receipt of social care support is at the centre of all that happens. It places people and their families/unpaid carers at the centre of decision making, treating them as experts in their own care and support needs, working alongside professionals to get the best outcome; and
- a 'person-led' approach might be described as a person and their families/unpaid carers making their own decisions relating to their social care support. It involves empowering people to be able to lead on, and actively participate in decisions about their social care support, acknowledging they are the most important voice in the decision-making process.

Some of those participating in the engagement events were of the view that a 'person-centred' approach can create a dynamic where social care professionals encircle an individual and their family, in some instances leading to the focus being on inter-professional issues, rather than the person and what matters to them. Others felt a 'person-led' approach is more empowering and was their preferred term to use.

The Review also heard that for some people there was a preference to see an approach in line with the [Getting it Right for Every Child](#) 'GIRFEC practice model' where the system comes together behind the person, with the individual taking the lead. The Review is aware of work underway by Scottish Government on developing [Getting it Right for Everyone](#) (GIRFE). This is an approach that focuses on individual care needs. Taking a GIRFE approach ensures that every person is empowered and involved in multi-disciplinary decision making and the support available to them.

Throughout this Review, reference is made to a person-centred approach (as illustrated below). The Review understands this to mean that people's preferences, needs and values guide decisions, leading to care and support that is respectful of and responsive to them.



In the report by Why Research, it says:

“ Having people with lived experience involved in all aspects of inspection, scrutiny, and regulation will encourage good practice through its very nature. People with lived experience can create clear guidance on how to conduct inspections and encourage best practice.

The Review acknowledges that there are some circumstances where a person's choices may be limited. For example, they may be living with dementia or a mental health issue that limits their decision-making capacity, they may be a young child or there may be matters relating to public safety. Nonetheless, the PANEL principles can still be applied to their involvement in the processes of inspection, scrutiny and regulation.

The Review recognises that all of the agencies involved in inspection, scrutiny, and regulation make efforts to take a human rights-based approach and involve people in their processes. For example, the [Health and Social Care Standards](#), which were co-created and have a basis in human rights, underpin inspections by both the Care Inspectorate and Healthcare Improvement Scotland. The SSSC's commitment to equality, diversity, inclusion, and human rights, is stated on their website.

Notwithstanding this, however, the Review heard consistently that people did not feel current processes were inclusive or based on human rights. A response from a representative body to the call for evidence stated:

“ Inspection and quality assurance have lost the focus on the child and place greater emphasis on good documentation than good practice.

The Review found that there is a gap between intention and what is often experienced, and the system needs to be re-balanced to focus on human rights as opposed to process. In order to address this, the following recommendation is made:

Recommendation 1 – It is recommended that inspection, scrutiny, and regulatory bodies consistently apply a human rights-based approach that places people at the centre of the process.

What to expect from inspection, scrutiny, and regulation

People expressed a range of views and suggestions regarding what works well in relation to inspection, scrutiny, and regulation and what could work better.

The Review heard that knowledgeable and skilled inspectors and regulators are valued by people and the importance of building good relationships was emphasised. Having consistent inspection approaches by staff was also highlighted as something people and services found beneficial but differing approaches to inspection by different agencies for the same services was deemed negative.

There was a range of views as to whether it was helpful to have advance notice of inspections taking place. Some felt an advantage of providing advance notice of an inspection is that it would allow people and their families/unpaid carers the opportunity to be more fully involved in the process and to ensure they are able to provide feedback in the way that works best for them. This was felt to be important if someone has a disability or requires translation services or other aids to communication. However, others felt an inspection without notice might provide a more candid impression of a service.

The Review recognises the value of both types of inspection. It is vitally important that both announced and unannounced inspections are retained and that an improved culture of openness and trust is fostered leading to better outcomes for individuals. To ensure that inspection, scrutiny, and regulation builds an improved culture ethos of trust and respect, in line with the PANEL principles, the Review recommends the following:


Recommendation 2 – It is recommended that matters of trust, respect, relationships, ethos and culture be placed at the heart of inspection, scrutiny, and regulation and should be reflected in reports.

Recommendation 3 – It is recommended that inspection, scrutiny, and regulatory bodies must set out clearly in their annual report how they have led and cultivated a culture of openness and trust.

Accessible and inclusive approaches


Throughout the Review a clear theme emerged about the importance of regulatory and inspection bodies involving people with lived and living experience and their families/unpaid carers in all aspects of inspection, scrutiny, and regulation. This includes the planning of inspection and regulatory activity as well as operational delivery. An open approach to involving people in decision making was emphasised, along with a focus on ensuring engagement is meaningful and accessible to all. Key to this was a need to see that participation in the inspection process could lead to positive action, change and improvement.

One illustrative comment from the call for evidence was:

 **The people who use our services (who responded to this consultation) were passionate about the need to be involved. They felt they should not only be involved at point of inspection but more generally in the making of rules which services are assessed against.**

The Review heard that there are duties in current legislation to involve people in the design and delivery of scrutiny functions, under [s.112 of the Public Services Reform \(Scotland\) Act 2010](#).

Each of the inspection and regulatory bodies currently involve people in the work they do. For example, in the [Care Inspectorate Corporate Plan 2022](#) it states:

 **We will build upon our work to encourage and facilitate feedback from those experiencing care and their communities and review our methods of engagement to allow more to have their say.**

The plan outlines their 'Volunteer Programme' which offers opportunities for experienced volunteer inspectors to be involved in inspections. As well as this, volunteers make contributions to the wider work of the organisation. For instance, they co-design the CI's strategic inspection methodologies and sit on the recruitment panels for interviews.

HIS have set up a Strategic Stakeholder Advisory Group to support their work. This group provides strategic advice for all the work they carry out across the organisation within the integration landscape. In order to provide such advice, the group have adopted a broad definition of any strategic issue that may be impacting on the achievement of the vision for health and social care integration, which is:

“ Ensuring better care and support for people where users of health and social care services can expect to be listened to, to be involved in deciding upon the care they receive and to be an active participant in how it is delivered. This will result in better outcomes for people, enabling them to enjoy better health and wellbeing within their homes and communities. (HIS website)

The SSSC has recently published [Involving People - Our Engagement Strategy and Framework 2023-2026](#). This sets out:

“ Our intention to take a people-led approach to the design of our services and to work collaboratively with anyone who has an interest in our work.

In acknowledging all of the above work, the Review heard that people did not feel they had the opportunity to be involved in the processes of inspection, scrutiny, and regulation, that often they did not understand how the process worked or what opportunities they had to share their views.

A similar finding was reported in the [Scottish Mental Health Law Review - Final Report](#) that despite a duty in the Public Services Reform (Scotland) Act 2010 to:

“ ... secure continuous improvement in ... the involvement of users of scrutinised services in the design and delivery of scrutiny functions’ (Section 112), the user voice in scrutiny appears weak.

The Review was made aware of one model which was felt to be worthy of further exploration namely [Scottish Housing Regulator's](#) (SHR) system of appointing Tenant Advisors.

The SHR recruits tenants of Registered Social Landlords (RSLs) and Local Authorities as volunteers to participate in the regulation work of the SHR, there are 12 members appointed for a 3-year period. Tenant Advisors come from all walks of life, but are not employed by the SHR. This means that they are able to provide a unique and independent perspective on landlords, and the work of the SHR. Tenant Advisors are involved in various projects and may act as mystery shoppers, review publications, or gather views from other service users.

This collaborative and participative approach to regulation mirrors the person-centred focus people have told the Review they want to see embedded across inspection and scrutiny processes, as highlighted in the report by Why Research:

 **Having people with lived experience involved in all aspects of inspection, regulation, and scrutiny will encourage good practice through its very nature. People with lived experience can create clear guidance on how to conduct inspections and encourage best practice.**

In order to address the gap in the involvement and equity of both people who use and work in social care support and linked services, the following recommendations are made:

Recommendation 4 - It is recommended that inspection, scrutiny, and regulatory bodies make appropriate arrangements to engage people with lived and living experience in co-designing engagement tools and developing the inspection and regulatory frameworks.


Recommendation 5 - It is recommended that a strengthened system be put in place for people to have a formal role as lay inspectors in the process of inspection, scrutiny, and regulation, including young people with care experience. An appropriate level of remuneration should be made available.

Communication and information

A number of approaches to communication and information sharing were highlighted to the Review in response to the question about how inspection and scrutiny processes could be more person-centred in how they communicate with people. It is evident that people want to be well informed about inspection processes and outcomes, with information that is easy to understand, available at the right time and in the right format. It is also clear that people really value inclusive conversations and the opportunity to build good relationships.

The Review acknowledges that the inspection and regulatory bodies do take steps to ensure accessibility of information. The Review found that overall, the accessibility of information and good communication around process was not always being achieved however, the Review is also aware there are attempts to assess the impact and quality of communication between staff and care home residents.

One suggestion from the call for evidence was:

 **Ensure inspectors are able to access a range of communication tools used by those with communication differences and difficulties or ensure that where appropriate/required supported individuals receive support from those who know their preferred communication style well throughout the inspection process. Listen to the voice of the team around the supported person as they are often the experts in translating methods of communication. Provide easy read information to providers and supported individuals on the purpose of inspection and how people can contribute to the process.**

Other suggestions for how communication could be improved included:

- not underestimating the value of speaking ‘face-to-face’ and participating in other forms of engagement including citizen’s committees, focus groups and workshops;
- the use of pre-inspection reports, social media platforms, surveys and online tools while ensuring that alternative options and support are available to people who might need them; and
- improved and more accessible information about the rights of those who use care and support services and inspection outcomes and processes.

To ensure accessible information is available and good communication is achieved the following recommendation is made:

Recommendation 6 – It is recommended that inspection bodies’ approach to engagement must be flexible, inclusive and appropriate. This includes allowing sufficient time for responses to be made and making suitable arrangements for conversations to take place with individuals, family members and staff, ensuring consistency and accessible information is available.

To participate in the processes of inspection, scrutiny, and regulation some people in receipt of social care support may need additional assistance. This may be because they have needs that change their capacity, require specific support with communication or that families/unpaid carers have limitations on their own time or are feeling under pressure during what can be challenging situations. Advocacy being available to those that need it would support better involvement, to ensure this support is available when required, therefore the following recommendation is made:

Recommendation 7 – It is recommended that independent advocacy is available for people to help them to exercise their rights, and when necessary, to provide support to navigate complaints and any escalation processes.

6. Theme 2 - what needs to be inspected, scrutinised, and regulated?



6. Theme 2 – what needs to be inspected, scrutinised, and regulated?

Inspection, scrutiny, and regulation is an essential element of providing protection and safety for those who use social care support services. It is a way of giving assurance, to families, friends, and unpaid carers, that their loved one is in receipt of good services, and it provides assurance and evidence of quality to those commissioning and delivering social care support.

It was important for the Review to fully understand which social care support and linked services were currently subject to inspection, scrutiny, and regulation and those who were not. The Review was also keen to explore the evidence to support extending inspection, scrutiny, and regulation to areas identified and what this would mean for people who use social care support and linked services, now and in the future, and for those who work in them. In order to do this the Review asked a number of key questions:

Do you feel there are services that are not currently subject to inspection, scrutiny, and regulation that should be? If yes, please tell us:

- a. which type of services?
- b. why you think they should be inspected/scrutinised/regulated?
- c. who should be responsible for this?

Current arrangements for inspection, scrutiny, and regulation

The Care Inspectorate, Healthcare Improvement Scotland and the Scottish Social Services Council are the main organisations that inspect, scrutinise and regulate social care support services.

Evidence provided to the Review identified a range of services not currently subject to inspection, scrutiny, and regulation. It also heard that there are gaps in the regulation of some staff groups working in social care support services.

One comment shared with the Review, from a service provider was:

“ It seems incongruent that multiple care services who provide care, to often the same people, have different regulation requirements. For instance, a person may use a harm reduction service for drug use where that service may not be regulated or inspected but then that same person attends a stabilisation service which is regulated.

Gaps in staff groups

Personal Assistants

The Review heard about a number of staff groups that are not currently subject to any inspection, scrutiny, or regulation. These included social work assistants, family support workers, and community outreach groups. The most frequently discussed service – mentioned by a large minority of respondents to the call for evidence and at events – was Personal Assistants (PAs).

The current definition of a Personal Assistant agreed as part of the analysis work being undertaken by Scottish Government and the [PA Programme Board](#) to estimate the size of the workforce, is:



For the purpose of this data collection a Personal Assistant is any person directly contracted by someone in receipt of SDS Option 1 and/or Independent Living Fund Scotland in order to help them live independently. This latter person may contract one or more PAs to meet their support needs. We are aware that some people contract with PAs via other funding streams such as the Disabled Student Allowance of Student Awards Agency Scotland; the daily living component of the Adult Disability Payment or by using their personal funds.

The role of a Personal Assistant is to provide support and assistance to their employer to live a full and active life. The employer is the person requiring care and support. The work undertaken by a Personal Assistant can often be varied and may include a number of different elements, usually defined by the employer depending on their specific needs. For example, work can involve supporting a person to wash and dress as well as assisting them to take part in activities that support their wider wellbeing.

Many people in receipt of SDS use it to employ a Personal Assistant. The [Social Care \(Self-Directed Support\) \(Scotland\) Act 2013](#) has four options that people can choose from in deciding how their care and support is delivered:

- option 1 – by a direct payment from the local authority/ health and social care partnership to the supported person for the provision of support;
- option 2 – choosing what support someone wants and asking the local authority /health and social care partnership to arrange that for them;

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- option 3 – asking the local authority/health and social care partnership to make arrangements for care and support to be put in place; and
 - option 4 – a mix of Options 1, 2 or 3.

Under SDS most Personal Assistants are employed using Option 1, but they can also be employed using a payment from the [Independent Living Fund](#). The Independent Living Fund Scotland is a Non-Departmental Public Body (NDPB) sponsored by the Scottish Government and under direct Ministerial control, which provides funding and support to help disabled people in Scotland and Northern Ireland to live independently.

It is estimated that there were around 5,000 Personal Assistants providing social care support to adults in 2021. This data was compiled from Personal Assistants who were approved for a 'thank you' payment of up to £500 for their work under the first wave of the Covid-19 pandemic. The [Research Relating to Personal Assistants - Self Directed Support Scotland](#) by Scotland Excel provides a summary of the known PA workforce in 2021 providing social care support to adults who were in receipt of either [Self-Directed Support Option 1](#) or from the Independent Living Fund Scotland in 2021.

There is no requirement for Personal Assistants to register with the SSSC but some do register voluntarily. A number of people that work as PAs may already be registered with the SSSC due to the requirements of other jobs they may have.

As part of the 2021 [National Care Service consultation analysis](#) people were asked to consider whether they agreed that all Personal Assistants should be required to register centrally in the future. The majority of respondents agreed that this should become a requirement with 87% (399 of the 461 respondents) of respondents agreeing to this question.

Reasons provided by those in agreement included:

- it offers security and safeguarding of both the PA and the employer/person being supported;
- it ensures standards and pay are equal within the social care support system; and
- it allows access to support and training for the PA.

The Review's call for evidence heard similar arguments for registration, namely that:

- it would help create a consistent approach to registration for all people working within the social care support sector and provide protection for PA employers;
- it would ensure PAs had access to training and resources not currently available; and
- it would ensure that people were accountable to the SSSC codes of practice.

The Review acknowledges that there is ongoing work led by the [PA Programme Board](#) with Disclosure Scotland that is relevant in this area. In particular, changes to the Protecting Vulnerable Groups (PVG) scheme will require some people working as Personal Assistants to secure PVG membership.

Under the [Disclosure \(Scotland\) Act 2020](#), membership of the PVG scheme will become mandatory for those carrying out 'regulated roles' with children and protected adults although there are some exceptions where the activity is carried out in the course of a family relationship or personal relationship. 'Regulated roles' will replace 'regulated work' as the eligibility criteria for the PVG scheme membership.

Under [s.73 of the Disclosure \(Scotland\) Act 2020](#), Personal Assistants are required to join the PVG scheme (with the exception of someone carrying out Personal Assistant duties through a family or personal relationship). Work to implement this change from regulated work to a regulated role for the PA workforce, will be part of the transition to the new legislation which will be fully implemented in 2024.

While the Review welcomes this work, and acknowledges this is a complex and sensitive area, it wanted to explore this issue in more depth as it heard conflicting opinion on the role and desirability of registration of Personal Assistants in the evidence it received.

The Review heard a range of views related to the potential for registration being introduced for Personal Assistants. Concerns were raised that it may lead to an intrusive process that could result in the unintended consequence of regulating an individual's home. Instead of registration for PAs, it was suggested that the PA employer should be empowered and supported to be a good employer thereby improving the skills of the PA and the quality of care they deliver.

The Review was reminded of the unique relationship between the PA employer and the PA, and concern was shared that overregulation could prevent informal collaboration. Additionally, a view was highlighted that there is a difference between regulating organisations and regulation for people. Work is of equal value, skills are transferable, but the nature of the role is very different.

It was also suggested to the Review that registration could pose a risk of reducing the Personal Assistant workforce if more onerous requirements are placed upon it. Solutions suggested included a hybrid approach that could support self-registration, an option that is currently available, and that this approach might also identify Personal Assistants that have other roles in social care that are already subject to registration and therefore avoid potential duplication.

The Review recognises the work already underway in this area, including the co-production of a workplan by the PA Programme Board. The objectives of the workplan relate to the provision of support that maximises strong mutual relationships between Personal Assistants and their employers, that supports the

development of the Personal Assistant workforce, and which values and supports the employers to enable them to live a good, independent supported life.

Furthermore, as part of the implementation of the PA Programme Board work plan, there is wider work to scope out a national PA training framework, and to agree a way forward to ensure availability of training for PAs.

In revisiting one of the key aims of inspection, scrutiny, and regulation, it was felt that focusing on Personal Assistant registration would be a way to provide assurance that people employing Personal Assistants were in receipt of safe and quality services.

As such, recognising the various views on this subject, balancing the evidence heard, and bearing in mind the fundamental purpose of this Review, the following is recommended:

Recommendation 8 – It is recommended that a co-produced and bespoke scheme of registration for Personal Assistants (PAs) which recognises their skills and role, and opens up access to training and development, should be developed. Such a scheme would expressly seek to not create barriers, and through co-production, would create positive opportunities for both the Personal Assistant and their employer.

In addition to PAs, as noted previously, there are roles across social care support and linked services that are not currently required to register with the SSSC or other professional regulators.

Healthcare Support Workers

Community health services are about person and family centred care, and wellbeing support. These services provide the opportunity to access support in a range of settings including at health and care sites or agencies, in care homes or in people's own homes.


In community care, the clinical professions who work in services are all regulated by professional bodies subject to either HIS or CI inspections. An exception is [Healthcare Support Workers \(HCSWs\)](#) who are employed by the NHS but are not currently subject to registration.

In the analysis report by Why Research, respondents to the call for evidence identified community health services (e.g., nursing, healthcare assistants, and services for those with sight or hearing loss which are not included in present national arrangements), as service areas requiring further inspection, scrutiny, and regulation.

However, the Review is aware that although it is a mixed picture with varying arrangements, some form of regulation or registration is generally in place across most community health services. HIS is responsible for regulating independent

clinics, including ophthalmic hearing centres and clinics. Nurses, no matter where they are employed in UK, require to be registered with the Nursing and Midwifery Council, while Dental Nurses are registered with the British Dental Association. Additionally, employees working for organisations or charities that contract with the NHS have employment governance conditions embedded within their contractual arrangements.

Balancing the evidence shared, the Review is clear there should be a universal registration system for the whole of the social care sector. This is also consistent with findings from the NCS consultation analysis, which says:

 **There was a view that all workers in the care sector should be regulated.**

Therefore, the Review recommends:

Recommendation 9 – It is recommended that there should be a universal requirement to obtain registration with a regulatory body for all social care support staff appropriate to their role and setting and that this should be a condition upon joining the social care workforce.

Gaps in services

In addition to gaps in the registration and regulation of particular staff groups, the Review found that there are currently services in both social care support and linked services that are not currently subject to inspection, scrutiny, or regulation.

Drug and alcohol services


A significant element of drug and alcohol services are delivered as part of statutory adult healthcare and adult social work services but drug and alcohol services are not in themselves statutory ones. Alongside statutory services, there is a significant recovery community sector which operates outwith the formal treatment and recovery infrastructure.

At present there are no routine inspection, scrutiny, or regulatory arrangements in place for drug and alcohol services. The Care Inspectorate published a report in 2017 on how [Alcohol and Drug Partnerships](#) were using the 2014 Quality Principles in the delivery of services, but routine inspection or scrutiny, of the local services has not been undertaken.

The delivery of services is split between primary, secondary, acute, specialist and mental health care as well as through recovery communities and these are often delivered from community hub settings rather than in hospitals. Many alcohol and drugs services are provided under contract by third sector providers.

[The Drug and Alcohol Information System \(DAISy\)](#) is managed by Public Health Scotland and is published quarterly. Around 40% of all data on DAISy is inputted by third sector partners who would largely be outside the scope of existing scrutiny bodies. Some third sector partners could be subject to inspection, such as those who provide residential rehabilitation services from a registered care home. However, this is only a small number of the current providers.

The [Drug Deaths Taskforce Response: A Cross Government Approach](#), published in January 2023, made the recommendation that:

 **All services must be appropriately regulated, with standards and guidance developed, and should be subject to regular inspection to ensure safe, effective, accessible and high-quality services.**

Recognising the conclusions of the 'Drug Deaths Taskforce Response', the Review supports the intention that all drug and alcohol services should be appropriately regulated with standards and guidance developed.

By ensuring that all elements of drug and alcohol services are appropriately inspected, scrutinised and regulated, consistency and quality assurance are supported. It places people at the centre of the services they receive in line with the person-centred approach the Review supports and works to reduce fragmentation in the social care support services people access.

Agencies

The Review is aware that, aside from nursing care, agencies that provide social care support staff to services, are not currently subject to any regulation.

Agency staff currently need to be registered with the SSSC if they are working in a social care support role but the agencies that provide them do not. In some instances, an agency can 'introduce' carers to people who then contract direct with the carer for the provision of care. The agency that acts as the 'introducer' is currently not deemed to be a support service as the support service is considered to be the person, they provide the introduction for. As a result, the agency is currently not subject to any inspection, scrutiny, or regulation.

The Review was also made aware that, in some cases, an ongoing payment might be made to the introducer (i.e., the agency) by the recipient of the care, as a percentage of the cost of the care provided. The Review heard that there is the possibility this can result in those receiving care and their families misunderstanding the position, believing that they are receiving a regulated service.

From the analysis by Why Research, a large minority from across the broad spectrum of respondent types felt that all services should have the same level of inspection, scrutiny, and regulation, with the advantages seen to be:

- consistency of standards across the care service profession and the provision of assurance of care quality;
- providing an adequate or improved standard of care and support to vulnerable people receiving social care support; and
- driving improvements and encouraging best practice across services. This would result in more training and skills development and increased continuous professional learning (CPL) opportunities.

Considering the evidence shared, the Review is clear that for social care support and linked services, consistency is needed across inspection, scrutiny, and regulation, therefore the Review recommends:

Recommendation 10 – It is recommended that inspection, scrutiny, and regulation should be extended to areas not part of the current system, including agencies who provide social care support staff, to help drive continuous improvement and deliver better outcomes.

Cross-border placements

Cross-border placements are sometimes required for people who receive a variety of social care support services; this might include people with learning disabilities, older people or people with mental health issues. They can happen for a variety of reasons such as people requiring services that are not available close to where they live or people wanting to move to be closer to family members. They include people coming to Scotland and being placed out with Scotland. While many have successful outcomes, the Review heard evidence that in some circumstances these can be challenging and complex situations.

For the purposes of the Review the complexities in terms of children's services illustrate the issues raised.

For children and young people, a cross-border placement usually occurs when those who are subject to a care order elsewhere are placed in care settings in Scotland.

Cross-border placements of children and young people into Scottish residential care settings largely occur due to a lack of provision elsewhere. The Review heard evidence about the complexity of cross-border and long-distance placements for children and young people. We know that such placements result in children and young people being separated and distanced from their families, peers, community support networks and services. Moving children and young people, often to remote places in Scotland, can impact on the ability to plan for the child, or to maintain meaningful contact with family and other key people

in the child's life. Many children and young people are not having their rights protected due to inadequate planning, poor practice and a lack of resources during placement and cross-border moves.

It is recognised that some providers outwith Scotland will establish care businesses in Scotland and will register with the CI. However, there is currently no requirement for discussions to take place with the Health and Social Care Partnership or the local authority in whose location the placement is sited.

This means that for some local authorities there are a number of independent providers within their region, supporting individuals receiving social care support from within and outwith Scotland, about whom they have no knowledge. The Chief Social Work Officer for the local authority has a responsibility for individuals in receipt of social care support within their region at any given time, but it can be impossible to carry out this duty when they are not aware that individuals have been placed from within and outwith Scotland. The different legal systems in Scotland and England can also lead to complexities around restrictions on liberty, for example.

The CI holds responsibility for the inspection of the service once providers are registered but they have no powers or input when individuals are placed. This can be problematic if the placement breaks down and the providers are not able to fully meet the care required. When this happens, the local authority has a duty to step in and assist local providers. This has a significant impact on already pressured resources for social work services and the wider health and social care partnership.

The Review is aware of emerging good practice to improve cross-border placements. A Memorandum of Understanding has been recently drawn up between the four nations to support closer links and communication in relation to cross-border placements. There is now an arrangement for four nations meetings to take place quarterly with regulatory bodies attending some but not all of the meetings.

The Review is also aware of work being undertaken to consider whether or not legislation may be required to compel the UK government to communicate with Scottish counterparts about cross-border placements. As well as this, provision in the draft [Children \(Care and Justice\) \(Scotland\) Bill](#) is aimed at protecting vulnerable children, whilst providing the flexibility for the system of inspection, scrutiny, and regulation of cross-border placements to respond appropriately and, proportionately in the short and longer term, in ways that cohere with the wider Scottish policy and regulatory context.

The Review recognises this is a complex and sensitive area and, that work has already commenced by Scottish Government and other partners to strengthen protection for individuals in cross-border placements. There are, however, still areas that require to be addressed and the Review recognises the need for this ongoing work to be developed, and its impact measured, and therefore recommends:


Recommendation 11 – It is recommended that further development of stronger links between regulatory bodies across all areas within and out with the borders of Scotland should be established to ensure better regulation, transparency and accountability of providers of social care support services.

Gaps in accountability

Evidence gathered by the Review demonstrated that there is a dedicated and hard-working social care support sector in Scotland. However, it also identified a significant gap within the regulatory framework in terms of visibility and accountability. For example, at present, there are no statutory requirements to be licensed as a care homeowner, or to have a clear line of accountability to service users and commissioners. The Review notes that this is a significant omission in services that are involved in supporting the lives of those, often vulnerable, people who receive social care support in our communities and is a stark contrast to the many requirements for civic and other licensing regimes across Scotland.

It was suggested to the Review that there are challenges around a barring mechanism for providers who have previously been found to be unfit from registering new services. This becomes increasingly complex where the provider of the service(s) is not an individual. The Review is aware that this is a complex area, particularly as many providers are large companies with complicated organisational structures. In these cases, it can be unclear who the responsible person(s) should be.

There are helpful examples of where measures have been implemented to address similar concerns and other perceived weaknesses in regulation, in other policy areas in Scotland and in other countries. In Wales, [The Regulated Services \(Service Providers and Responsible Individuals\) \(Wales\) Regulations 2017](#) set out a duty whereby the parent company board must have a named director who is the accountable link to registration, inspection, and local employees. The legislation states:

 **The application for registration must also designate an individual as the responsible individual in respect of each place at, from or in relation to which a regulated service is to be provided. The Welsh Ministers must be satisfied that the individual is a fit and proper person to be a responsible individual and that they are eligible to be a responsible individual.**

In Wales, the introduction of fundamental standards, the fit and proper person requirement for directors and the duty of candour, were part of a wide-ranging set of changes designed to improve the regulation of health and adult social care providers. The purpose of the act was to improve accountability, enhance public confidence, and provide assurance that service users receive safe, quality care and treatment.

Scotland introduced [The Duty of Candour Procedure \(Scotland\) Regulations 2018](#) which supports the implementation of consistent responses across health and social care where there has been an unexpected or unintended incident that has resulted in harm.

The services it currently applies to are:

- support services;
- care home services;
- school care accommodation service;
- nurse agencies;
- childcare agencies;
- secure accommodation services;
- offender accommodation services;
- adoption services;
- fostering services;
- adult placement services;
- day care of children;
- housing support services; and
- social work services offered by or on behalf of local authorities.

In Scotland, [The Social Care and Social Work Improvement Scotland \(Requirements for Care Services\) Regulations 2011](#) contains detail relating to fitness of providers, which includes situations where people are not deemed to be suitable to provide a service.

Services registered with the CI are required to have a registered manager who is named on the CI Certificate of Registration. The registered manager needs to have a relevant practitioner qualification which must meet the requirements for the relevant part of the SSSC register. There is currently no requirement, however, for anyone from a parent company to be named as a responsible or accountable person.

In recognition of the gaps identified within the regulatory framework in terms of visibility and accountability, the Review recommends that:

Recommendation 12 – It is recommended that the best practice from other nations’ regulatory landscape is explored and considered with a view to enhancing transparency and accountability, particularly in relation to there being a named, accountable link to registration, inspection and local employees.

Recommendation 13 – It is recommended that The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 be reviewed to ensure consistent, effective and comprehensive applicability of the fit and proper person provisions across social care support services in Scotland.

Gaps in market oversight

The Review heard that at present there is little formal market oversight of the social care support sector. There is a lack of oversight of financial viability of services and planning on where services are located with one example being care homes opened in areas that already have sufficient bed capacity.

The IRASC proposed that the care home sector becomes a more actively managed market, with the CI taking on a new market oversight function. The intention would be to provide a long-term strategic vision, and an overview of the care home sector taking into account local needs and the balance of providers. This Review finds that further developing market oversight would enable more effective mapping of the social care support sector and would enable the identification of where specific support and action is required to ensure that outcomes for people experiencing care can be fully met.

The CI currently obtains financial information when registering new services, such as business plans, forecasts and financial declarations. However, while it may examine these materials it has no formal role in assessing financial or business viability.

In England, [s. 56\(1\) and \(2\) of the Care Act 2014](#) requires that, where the Care Quality Commission (CQC) are satisfied that a registered provider is subject to the market oversight scheme is likely to become unable to carry on a regulated activity because of likely business failure, the CQC must inform the local authorities what it thinks will be required to carry out the temporary duty to ensure continuity of care.

The NCS consultation also reported strong support for the regulator having a market oversight function with 84% of individuals and 87% of organisations responding to the question, 'Do you agree that the regulator should develop a market oversight function?'

This Review believes it is necessary to develop measures to ensure an understanding of the sustainability of social care support services in Scotland.

This would be supported by the development of a market oversight function across social care support. As part of considerations for a National Care Service, the Scottish Government has started to consider how greater market oversight can be achieved. The Review is aware of this work and considers that notwithstanding the development for the potential NCS and associated market oversight function, there is an urgency to developing this knowledge and understanding of the market that precedes the implementation of a NCS. On this basis, the Review makes the following recommendation:

Recommendation 14 – It is recommended that Scottish Ministers make appropriate arrangements for market oversight and sustainability in the social care sector.

Revisiting the definitions of care for inspection and regulation

Some of the challenges in the inspection, scrutiny, and regulatory landscape highlighted in this Review are compounded by some of the language and terminology used in the current legislation. For example, [Schedule 12 of the Public Services Reform \(Scotland\) Act 2010](#) contains a list of care service types and a set of corresponding definitions which determine which services the CI regulate and inspect. The definitions of care span several professional groups and services including, early learning and childcare services, fostering and adoption, and secure care and accommodation services for people involved in the criminal justice system.

The current definitions include ‘care at home’ and ‘housing support services’ which requires the CI to inspect each service separately when they are often provided by the same organisations to the same people.

The 2020-21 Programme for Government [Protecting Scotland, Renewing Scotland](#) included a commitment to complete a review of care service definitions contained within the Public Services Reform (Scotland) Act 2010. The Institute for Research and Innovation in Social Services (IRISS) was commissioned in 2020 to review the care service definitions and provide feedback on what challenges the current definitions pose as well as the changes the sector wants to see. [The Review of Care Service Definitions: Challenges and Recommendations \(November 2021\)](#) found that the current definitions:



... hindered person-centred care, exacerbated the current challenges of integration and created barriers between social work and social care. Stakeholders also felt the current care definitions complicated the practical operation of the SSSC Register for social care workers and further challenged professional roles in this sector.

The report also showed that the definitions posed challenges for social care support services to work both more autonomously, and with others across professions. The research further highlighted that some of the language used in the current definitions was outdated.

In recognition of the challenges experienced by the sector and the barriers that exist, as highlighted by the evidence shared with the Review, it is recommended that:

Recommendation 15 - It is recommended that the list of care service types and set of corresponding definitions as set out in Schedule 12 of the Public Services Reform (Scotland) Act 2010, are assessed for fitness for purpose.

7. Theme 3 - how should inspection, scrutiny, and regulation be carried out?



7. Theme 3 – how should inspection, scrutiny, and regulation be carried out?

The Review heard consistently that a more streamlined system of inspection, scrutiny, and regulation is needed to reduce duplication, increase consistency, be inclusive of all services, and support the delivery of high-quality services. Inspection, scrutiny, and regulation can be the catalyst for improvement and is widely recognised by providers, commissioners and regulators as critical for the delivery of safe, agile and effective community health and social care support services.

The Review wanted to understand the current challenges in how inspection, scrutiny, and regulation operates in Scotland, and what would help improvement become more routinely embedded into the work of regulators and services delivering social care support.

The Review asked a number of key questions under this theme, these were:

- Who should be responsible for undertaking inspection, scrutiny, and regulation?
- Would a system work where the same regulator inspected all services?
- Should there be different regulators for inspection and improvement?
- How can we ensure that regulation and inspection processes are underpinned by a commitment to improving services?
- Should regulation, scrutiny, and inspection have an emphasis on services continually improving? What might that look like?
- What should happen if something goes wrong in a service?
- Who should be responsible for making improvements to services?
- How do we make sure regulatory bodies are doing a good job?

Streamlining inspection and improvement

The Review heard that the current system of inspection, scrutiny, and regulation has evolved little in recent years, despite significant changes in how social care support services are delivered, not least through the introduction of Self-Directed Support.

An individual's engagement with social care support can be complex and involve interaction across multiple services over a considerable period of time. The Review was told that this sometimes fragmented journey and its impact on individuals is not always captured by current approaches to inspection. This can result in findings that accurately reflect high-quality service provision but do not necessarily capture the impact on the person at the centre of the process.

One example might be a child or young person being placed in several different services over a short space of time. Each service might be deemed to be of high quality, but the overall impact on the person of moving between services may be less positive despite each individual service acting appropriately. Examples shared with the Review about people's experiences of using social care support and linked services underline the importance of looking at how inspection processes can more fully reflect a person's journey through the social care support system.

The Review was told by some that inspection and regulation is overly complicated and that there is a lack of clarity and transparency around the roles of relevant inspection and regulatory agencies. This point was raised many times at events hosted by the Review and attended by individuals, including those with lived and living experience, who said that continuity was important for building relationships.

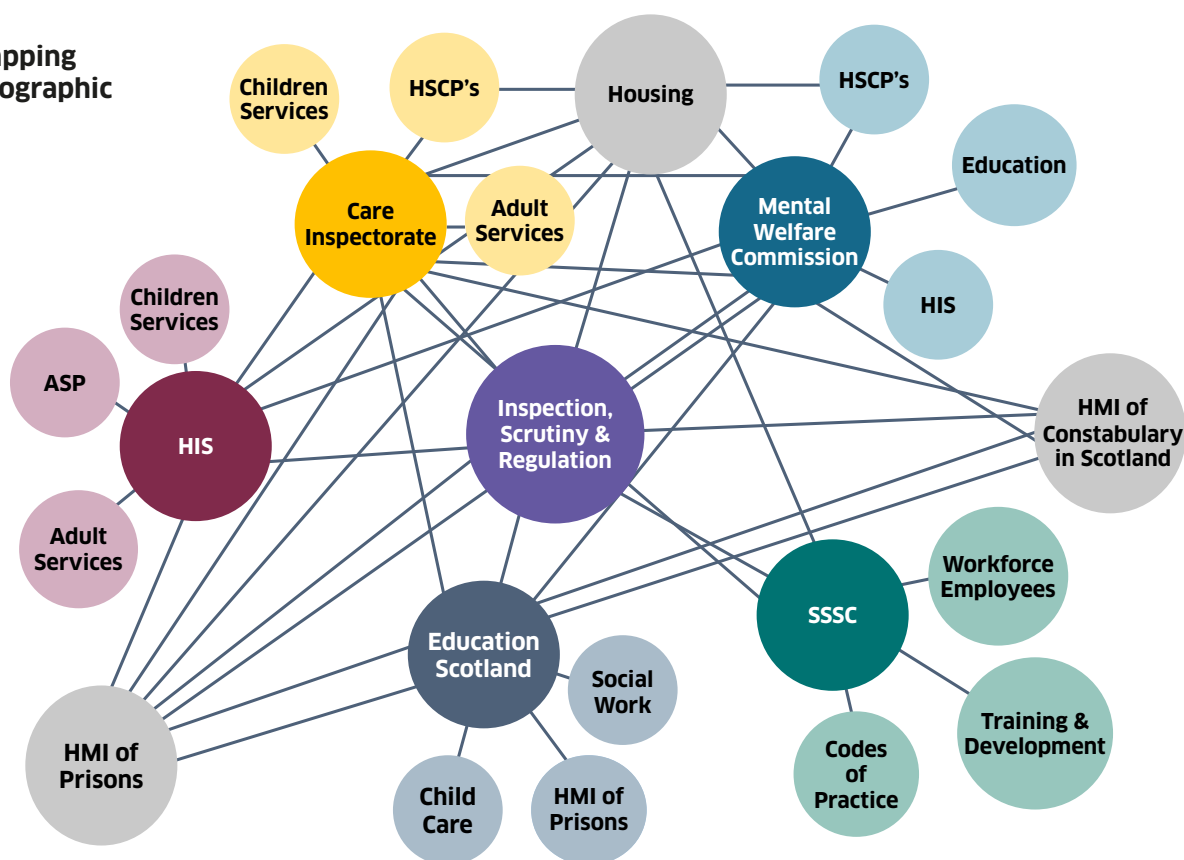
Feedback related to communication, information sharing and inclusivity were also highlighted to the Review under Theme 1, in response to the question about how inspection, scrutiny, and regulatory processes could be more person-centred. Similar concerns were raised in IRASC, which noted duplication in the information requested from services by the Care Inspectorate and local commissioners, which wastes time that could be better used to improve quality.



**... outcomes for people rather than provider
compliance with policy and process.**

To explore this further, the Review completed a high-level strategic mapping exercise (as illustrated on page 56) to understand the inspection, scrutiny, and regulatory landscape. This provided further clarity of the scale and complexity of the current system and illustrated how confusing it is, not only for the regulators and services but, more importantly, for the people and families who want to access social care support.

Mapping Infographic



To ensure that inspection, scrutiny, and regulation takes account of the wider impact of social care support on people, not just the quality of individual services, the Review recommends the following:


Recommendation 16 - It is recommended that inspection, scrutiny, and regulation processes more fully take account of an individual's experience of service delivery and their overall care journey to understand, follow and evaluate the person's social care support experience over time and their impacts.

Recommendation 17 - It is recommended that clear and accessible information about the agencies and their roles, responsibilities and accountabilities is provided for all those who require social care support services.

An example highlighted to the Review was from Early Learning and Childcare (ELC) and School Age Childcare (SAC). ELC settings are subject to inspection, scrutiny, and regulation by Education Scotland and the Care Inspectorate. The Muir Review heard that, "... there is duplication in the roles of the Care Inspectorate and HMIE within Education Scotland which was seen as particularly challenging for the ELC sector." Individuals have indicated that this is adding pressure and additional bureaucracy to the sector and impacts on recruitment and retention of the workforce.

The Review recognises that a commitment to a shared framework for ELC services has been accepted further to the [Inspection of Early Learning and Childcare and School Age Childcare Service in Scotland: Consultation Analysis \(March 2023\)](#). The shared framework is aimed at providing an integrated approach to inspection with the goal of minimising duplication and improving the quality-of-care services for children and young people.

Another example comes from the [Care Home Review - A rapid review of factors relevant to the management of COVID-19 in the care home environment in Scotland](#) published in November 2020, which found:

 **A Memorandum of Agreement is in place with HIS to undertake joint inspections with the Care Inspectorate, with HIS staff providing support for Infection Prevention Control and clinical considerations. It was clear to the Review team however that the process is not fully integrated, and that the methodologies employed, grading and reporting structures for CI and HIS differ; this brought inconsistency and challenges in agreeing applicable grades for one of the care homes in this Review.**

The Review notes that the CI produces an annual inspection plan and as part of this planning process, the CI considers any collaboration with other scrutiny bodies, for example, Education Scotland or HIS, within the plan.


A single regulator and joint inspections

[Section 115 of the 2010 Act](#) details powers for the CI to carry out joint inspections with other bodies. These inspections are carried out by strategic inspectors across four themes:

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

Strategic inspection is usually led or co-led by the CI, in conjunction with partner agencies including HIS and [His Majesty's Inspectorate of Constabulary in Scotland](#). Strategic inspection is carried out in a complex landscape and some of the issues and challenges raised can be evidenced by the examples on page 58.

Across Scotland, Phase 1 of the Adult Support and Protection Joint Inspection programme (CI, HIS, HMICS) has recently been concluded with reports from 25 HSCPs' inspections being published. The programme's intention was to provide assurance of the ongoing protection for adults at risk of harm, while managing the risk to individuals. This was done under two main quality indicators: strategic leadership, and adult support and protection processes. On the CI website it is stated:

 **We provide a rationale for the elements of adult support and protection our inspection methodology is designed to scrutinise. We say what constitutes very good adult support and protection practice, and what constitutes weak practice.**

Joint inspections also take place for children and young people at risk of harm. Inspection teams include inspectors from the CI, HIS, HMICS and Education Scotland, along with Young Inspection Volunteers, who are young people with direct experience of care or child protection services. Young inspection volunteers receive training and support and contribute to joint inspections using their knowledge and experience to help evaluate the quality and impact of partners' work.

Joint inspections can offer a more holistic approach, reflecting the multi-agency, multi-disciplinary landscape across the health and social care landscape; this can be especially true around areas of public protection. Challenges do arise with this type of inspection, including the capacity of local partnerships to engage and the co-ordination of scrutiny work across multiple partnerships (for example, when one health board area includes multiple local authorities or HSCPs).

The Review heard that inspections including thematic inspections are not consistently addressing or suggesting recommendations to resolve systemic problems. Where there are areas of weakness identified in thematic areas, wider systems challenges may be posing obstacles to improvement. If these are not considered and addressed as part of inspection outcomes, recommendations are less likely to be either acted upon or sustained. Therefore, while there are clear benefits of taking a joint inspection approach, they do not resolve some of the fundamental issues relating to inspection the Review heard about.

The Review notes that the Muir Review recommended that inspection that covers more than one area should be carried out jointly via a shared framework. Other services can impact directly on social care support such as education and learners and these may need to be considered and evaluated at the same time.

The Muir Review also recommended that a national structure is desirable, with a flexible approach tailored to individual, community, and regional needs, alongside an emphasis on collaboration and improvement. In taking forward joint inspections, it will be helpful to consider co-ordinating inspection across a number of policy areas to reduce burden on local partnerships, enable more efficient use of inspection resources, and prioritise improvement at local and national level.


The Review was also keen to understand if there were consistent views across the sector about whether having one regulator inspecting and scrutinising all services would help reduce duplication and confusion. The analysis report by Why Research found that opinion was evenly split.

Whilst the number of responses were small and many individuals and organisations did not answer this question or were unsure (including all 5 regulators who submitted evidence), a narrow majority of organisations providing a view (particularly health and social care partnerships/local authority consultees) thought a system would work with the same regulator, while a small majority of individuals did not.

The analysis report found that of those who thought the same regulator could inspect all services, the main advantage (quoted by a large minority of call for evidence consultees across all sub-groups and a point made often at events) was that:

 **this would offer a consistent or streamlined approach to regulation (e.g. over how standards are applied).**

Some respondents to the call for evidence felt that having a single regulator could result in reducing perceived inter-agency tensions and conflicts in terms of policy and data sharing. In the Why Research Analysis Report it is stated:

 **Significant minorities of a broad mix of respondents felt there would be the benefit of a reduction in inter-agency tensions and conflicts in terms of policy and data sharing.**

The introduction of a single regulator would help to avoid confusion over who is responsible for what, as the current system was viewed as overly complicated. More efficient use of resources was also highlighted by some people in favour of a single regulator.

For those who did not support a single regulator, reasons given included:

Each regulatory body has its own area of expertise and it will be therefore prove too much of a challenge to have only one regulator with the necessary spread and depth of knowledge, skills and expertise.

In having a single inspection body, the Review heard that some felt expertise would be lost, with people highlighting different organisations, services providing social care support and types of user (e.g. child and adult social care, social work services, health services) needing to be scrutinised by bodies familiar with each area's needs and priorities.

Responses submitted as part of the call for evidence and at several engagement events supported an improved partnership approach between regulators as opposed to having a single regulator.

The Review also considered if there was a preferred option between a single regulator or some other approach. The Review was conscious of the complex and evolving landscape in social care, and in inspection, scrutiny, and regulation, which is detailed at various points within this report. Merging existing bodies, or setting up one or more new ones would inevitably involve legislation, and the disruption of organisational change, as well as potential disruption to service provision as the workforce was being retrained to work in unfamiliar areas.

Evidence provided indicated some concern at the potential for disruption. The analysis report found:

A greater use of joint inspections by regulators was seen as preferable to the disruption caused by merging existing bodies, and this approach was seen to work well during the Covid pandemic.

As well as improved partnership approaches between regulators, some responses submitted suggested that these, along with joint inspections, might be an alternative to having a single regulator. It was felt this would enhance the clarity of regulatory roles, and would help promote consistency and avoid duplication and confusion.

The Review agrees with these perceptions, and considers it could also support other culture change aspects such as embedding continuous improvement, and better involvement of people who receive social care support in inspection, scrutiny, and regulation.

It would also go some way to addressing concerns about subject and specialist expertise, which would continue to sit with different bodies, and through joint and shared inspections, which would also facilitate learning across disciplines.

In light of this, the Review felt that it would be possible to implement this quickly and with fewer immediate costs than would be required with mergers or new structures. It would improve inspection, scrutiny, and regulation in the ways indicated, whilst not ruling out the creation of a single regulator at an appropriate time, particularly once a number of changes in the landscape have been planned and introduced in a strategic approach alongside the NCS.

Joint Inspections would provide a rapid response to these concerns with improvements in a number of areas, and offer flexibility during a period of widespread change in legislation, across the social care and regulatory environments.

However, the Review heard that this joined-up thinking does not always translate to areas, where more than one agency inspects services and what is required to address these issues is to strengthen and streamline the approach to partnership working; therefore, the Review recommends:

Recommendation 18 – It is recommended that Scottish Government work with the regulators to clarify roles and responsibilities between organisations to streamline inspection activity, remove repeat inspections by different agencies and to reduce duplication and omission. This should include reviewing how joint inspections are currently carried out, encouraging more partnership working and joint inspections, and greater involvement of people in receipt of social care support in inspection, scrutiny, and regulation.

Shifting the culture: regulation for improvement

The Review consistently heard about the need for a cultural shift in the sector, away from what is often seen as inspection, scrutiny, and regulation focused on identifying problems and risks, to one that recognises assets and seeks to support continuous improvement. The Review is clear that the responsibility for improvement sits across the sector, including with commissioners of services, and those providing services, and not just with regulators and improvement bodies.

A clear message from the call for evidence and engagement sessions was that a culture change was needed regards supporting and celebrating continuous improvement, and this needs to be based on mutual trust between providers, commissioners, regulators, and inspectors. Far greater emphasis on developing relationship-based practice would help to create an environment which supports learning and drives improvement across social care support services.

The Review identified a clear need to move away from a bias towards criticism to a more open approach that provides the opportunity to reflect on challenges, learning and successes. This would be aided by creating better systems to obtain feedback from the social care workforce about their experiences and, as set out earlier, for them to be more involved in the inspection processes, which in turn would support the development of good practice.

One response to the call for evidence summarised it succinctly:

 **A fundamental weakness of the current system is that it is scrutinising services, not outcomes.**


Identifying and sharing good practice

There is not currently a commonly agreed definition of good practice or a clear set of quality indicators or outcomes for social care support. There is a need to define, illustrate and share good practice, including what that looks like at practitioner level, more effectively.

It has been suggested that the development of an accessible framework that benchmarks and encourages the sharing of good practice would create more consistency across services. Feedback from the Review stated that focusing on positive and flexible examples of good practice, along with assessing the quality of service delivery, would help people receiving and delivering social care support develop a better understanding of what 'good' looks like.


Under the [Public Services Reform \(Scotland\) Act 2010](#) the CI has a duty of furthering improvement in the quality of social care services, which enables services to adapt, learn and improve practice. They have a dedicated, [Care Inspectorate Hub](#), which hosts their improvement programmes, improvement support and upcoming events.

On the CI website it is stated:


 **Our job is not just to inspect care, but help the quality improve where needed. This means we work with services and support them, offering advice, guidance and sharing good practice to help care reach the highest standards.**

A focus for HIS is to encourage and support continuous improvement in healthcare practice, and they do this by encouraging both patients and staff to challenge and change healthcare services for the better. HIS has worked with a range of partners to create an improvement resource, called the Improvement Hub (or [ihub](#) for short). This resource supports Health and Social Care Partnerships and NHS boards to improve the quality of health and social care services.

On the HIS website it is stated:

 **We work collaboratively with the staff of healthcare providers, partner organisations and the public to drive improvements which can be sustained and measured.**

The SSSC states on their website:

 **We support quality improvement (QI) learning and leadership development at all levels in the social service sector, working collectively with our partners to support these activities. The wellbeing of staff underpins effective leadership and improvement and is also a priority area of work for our team.**

The Review is also aware of a variety of initiatives that have taken a collaborative and supportive approach to improvement and the sharing of good practice. Scrutiny bodies and providers have supported improvement by hosting online resource hubs, training and networking events, and undertaking a range of partnership and pilot projects to make improvements in numerous areas, including waiting times and pain management.

An example of an effective approach is from an Early Learning and Childcare (ELC) improvement programme supported by the Care Inspectorate. The programme works to help services to meet the national standards and to help local authorities to improve ELC in their area and has provided targeted support to 214 ELC settings caring for 13,000 children.

In 2022, evaluation of the programme found positive change across 33 settings, with 31 maintaining a good standard of service delivery. Some improvement initiatives and examples of good practice may be local or smaller in scope. Where there is the potential to share more widely, scale up, or build on successful approaches, this should be explored.

Further evidence shared with the Review highlighted that inspectors having more regular visits to services as part of follow up visits, offering higher levels of support, and understanding of the ethos of organisations would result in the social care workforce and providers feeling more supported. The Review also heard strong feedback that there needs to be better visibility and accessibility of improvement support indicating that what is currently in place is not always translating into support on the ground.

In response to the evidence shared, the Review recommends:

Recommendation 19 – It is recommended that inspectors and regulators, whilst fulfilling their statutory duty to identify shortcomings in improvement, should also place equal weight on identifying good practice, innovation and improvement across the sector.

Embedding and promoting improvement

While excellent examples of good practice and improvement exist, current improvement initiatives often lack scale, are not always based on a clear evidence base and are not adequately evaluated to understand their impact and potential for roll out across the sector. The Review is therefore encouraged by the establishment of the National Improvement Framework for Adult Social Care Support and Community Health, co-chaired by the Scottish Government, CoSLA and Society of Local Authority Chief Executives and Senior Managers (SOLACE), and with the inclusion of wide representation across sectors.

The National Improvement Framework for Adult Social Care Support and Community Health is developing a national improvement framework to improve outcomes for people who use services, unpaid carers, and the workforce, through supporting clarity and consistency of action across the improvement system. It is understood that the framework will include evidence of improvement based on qualitative and quantitative data on experiences and outcomes for people.

Whilst the Review welcomes the establishing of the National Improvement Framework to help foster greater coordination and focus on improvement, the current emphasis on regulation for improvement is not sufficient and without being addressed poses significant risks to enabling a culture that focuses less on what has gone wrong to one that encourages innovation and sharing of good practice.

There is a need, for instance, for inspectors and regulators to have the necessary skills, training, qualifications, and expertise, to be supportive in improvement and improvement methodology. The Review was also told of a significant gap in local capacity to support and embed improvement activity. This holds for those commissioning, delivering and managing services. If continuous improvement is to be embedded, it is absolutely vital that the social care workforce is supported and empowered through the principles of Fair Work; this is considered in more detail in Theme 5 (page 83).

Using current inspection terms, more emphasis needs to be put on the capacity for services deemed to be “adequate” to become “good” or those that are “excellent” to maintain or exceed. Improvement should drive inspection, scrutiny, and regulation activity, though this is not to imply that immediate and effective action should not be taken to address poor practice.

The Review noted frustration from scrutiny bodies that requirements and recommendations are not always implemented. For example, a provider may make short-term improvements based on recommendations from a scrutiny body but may not maintain them. This can require repeat or additional action by the CI/regulator or partner agencies such as Health and Social Care Partnerships.

Making improvement a more integral part of the inspection and regulation process could reduce the need for additional or repeated inspection action and lead to better outcomes for people accessing social care support. The Review heard that this could be supported by regular feedback, reviews and monitoring. Examples were given such as ensuring all improvement initiatives are actioned appropriately, having an overview of performance outcomes and regular data collection and analysis.

In response to the evidence shared with the Review that continuous improvement needs to be a more integral part of the inspection and regulation process, the Review recommends:

Recommendation 20 – It is recommended that an emphasis on outcomes and continuous improvement becomes a central focus of inspection, scrutiny, and regulation.

Recommendation 21 – It is recommended that there should be a duty on the regulator/inspector to work more closely with the provider on agreeing action plans and timescales for continuous improvement recommendations that are additional to regulatory requirements and improvement notices.

The National Improvement Framework is intended to link to the Scottish Government’s [National Performance Framework](#) (NPF). The Review found that the NPF facilitated a clear understanding of Scottish Government priorities, and encouraged delivery bodies to be self-aware and self-evaluative in terms of performance, and the delivery of outcomes.

The Review also heard, however, concerns that organisational strategies and scrutiny activity, are not always aligned with or measured against the NPF, thus there was a perceived risk of focusing only on performance management at the cost of performance improvement. On balancing the evidence gathered, the Review recommends:

Recommendation 22 – It is recommended that the Scottish Government updates and clarifies its expectations regarding the National Performance Framework (NPF) in relation to publicly funded delivery bodies, particularly with respect to outcomes for social care support services.

Enforcement powers

The analysis of NCS consultation responses highlighted strong support for strengthening inspection, scrutiny, and regulation with a high number supporting additional powers for the regulator in respect of condition notices, improvement notices and cancellation of social care services.

Currently an improvement notice is issued and then a service is given time to rectify, this new power in the provision in the draft NCS Bill would support the cancellation of a service where appropriate without having to wait.

If there are concerns about a service as the main inspection agency for social care support the CI can use the following statutory measures as outlined in the [Public Services Reform \(Scotland\) Act 2010](#).

Condition notices ([s.66](#)) – A condition notice may be served to impose an additional condition or to vary an existing condition of registration enabling parameters to be placed around the operation of a care service. Details of the service provider’s right to make representations against the imposition of the condition will be provided. A separate process is available for emergency conditions where a serious risk to life, health or wellbeing exists.

Improvement Notices ([s.62](#)) – Improvement notices are issued when the Care Inspectorate considers standards have not been met, requiring the care service provider to make significant improvements by designated dates. This can escalate to cancellation of registration being proposed if the required improvements are not made.

Cancellation Notice ([s.64](#)) – Where the timescale for meeting the terms of the s.62 improvement notice has expired without compliance, the Care Inspectorate may move to giving notice of proposal to cancel registration under s.64. The service provider will be informed of the legal basis of the action and details of the service provider’s right to make written representations against cancellation will be included.

Emergency cancellation of registration ([s.65](#)) – The statutory test for emergency cancellation is predicated on “serious” risk to life, health, or wellbeing. The Care Inspectorate may apply to the sheriff at any time seeking an order to cancel a care service’s registration where it considers there is such a serious risk to people.

There are provisions laid out in s.42 in the draft NCS Bill regards stronger enforcement powers for the CI. They relate to being able to take immediate action, where necessary, rather than using the current time element for improvement notices. The new power in the draft Bill will allow the cancellation of a service where appropriate, without having to wait.

The Review notes the provision in the draft NCS Bill but is aware that this Review goes wider than the NCS alone. Other legislative challenges are noted in this report, including those relating to the definitions of care and under Theme 5 (page 83), limitations to the powers of the SSSC. In light of this the Review recommends:

Recommendation 23 – It is recommended that Scottish Ministers should review legislation to ensure that regulatory bodies have adequate enforcement powers.

Duty to self-report

The Review recognises the need for more emphasis on self-awareness and self-evaluation by service providers with the potential introduction of the ‘duty to report’.

This is consistent with other regulated sectors – for example, charities have a duty to report notifiable issues to the [Office of the Scottish Charity Regulator](#) (OSCR). This has a significant effect upon the regulated service in that the ownership of issues and empowerment associated with self-regulation can be capacity building and can reduce the balance being tipped towards it being the responsibility of an inspection or regulatory agency to find things out. It is the opinion of the Review that this approach will help to develop a culture of ‘right touch regulation’ which is proportionate to the performance of service providers.

Under [The Regulation of Care \(Requirements as to Care Services\) \(Scotland\) Regulations 2002](#) some notifiable events already have to be reported to the CI for services and staff registered with them. The CI must be told of:

- Accidents, incidents or injuries.
- Outbreak of infectious disease.
- Death of person using a care service.
- Allegations of abuse.
- Allegation of misconduct by a provider or employee.
- Criminal convictions resulting in unfitness of a manager.
- A provider becoming unfit.
- Absence of manager.
- Planned refurbishment/alteration/extension of premises.
- Change of registration details.

Social care support services have a duty under the [Regulation of Care \(Scotland\) Act 2001](#) to refer to SSSC anyone whom they have dismissed, or if the employee leaves before a disciplinary concludes, and otherwise, dismissal would have been considered or implemented, on grounds of misconduct. Service providers also have a duty under the [SSSC Codes of Practice](#) about anyone whose fitness to

practise they are concerned about, to follow SSSC's guidance on referrals. The CI will also remind employers to refer to SSSC when appropriate, or if the employer won't make the referral, then the CI will make the referral directly to the SSSC. If there is a disagreement between an employer and the Care Inspectorate on the need to report, and if due to the circumstances of a situation, it could take time to resolve, the Care Inspectorate has a mechanism in place to ensure SSSC are appropriately informed as soon as possible.

Social care support staff have responsibility under the [SSSC Codes of Practice](#) to raise issues and also have responsibilities arising from the [The Duty of Candour Procedure \(Scotland\) Regulations 2018](#). Joint guidance by the CI and SSSC can be found [here](#).

As noted earlier in the report, HIS duties include the regulation of independent hospitals and clinics. As part of their conditions of registration, services must notify HIS regards:

- Notification of IR(ME)R incident.
- Reopening of a service after a temporary closure.
- Events which threaten a service provider's ability to continue providing an independent healthcare service.
- Change of address of service or service provider.
- Introduction of controlled drugs within a service.
- Serious injury or complication to service user.
- Drug error including systematic anti-cancer therapy.
- Controlled drug incident.
- Change of name/appointment of a new manager.
- Cancellation of a service.

As can be seen from the variety of duties to report "notifiable issues" for different sectors these are broad, and can include financial and public health issues as well as deficiencies in care systems and individual care. Some further work will be necessary to identify what the range of relevant issues will be for the social care sector, therefore the Review recommends:

Recommendation 24 – It is recommended that a duty to self-report should be reviewed to ensure that self-reporting is inherently linked to continuous improvement, whilst also ensuring the regulatory bodies have appropriate powers to act when issues are identified.

Making things right

The Review heard that the current complaints system can be an exhausting and complicated process for individuals to navigate, which can have a negative impact on them. Feedback to the Review was that there should be channels available and processes in place that enable people to raise issues easily and safely.

The Review recognises the work that is ongoing by the Scottish Government in co-designing a 'Charter of Rights and Responsibilities' that is committed to embedding equality and human rights in the National Care Service. This will set out people's rights and responsibilities when accessing NCS support and provide a clear pathway to make a complaint if their rights are not met. Sections 11 and 12 of the draft NCS (Scotland) Bill place a statutory duty on Ministers to prepare and publish the Charter which, in practical terms, will raise awareness of people's specific rights and support people to assert these rights with regards to social care support.

In line with recommendation 8 (page 3) people should have access to independent advocacy support both to help them to understand their rights, and when necessary, to provide support to navigate raising concerns as well as complaints processes. The impact making complaints can have on people should also be recognised, especially when those complaints are complex or are particularly serious in nature.

Accountability regards respecting people's rights should be built-in across the system, not just via formal complaints processes. Whilst it is important to have legal remedies available it is crucial that a human rights-based approach is taken to systems of complaints and feedback.

Feedback received during the call for evidence demonstrated a view that the investigation into any concerns raised needs to be person centred, appropriate, timely and proportionate. Human rights cannot be restricted by resources or based on the level of funding services are commissioned to deliver on, human rights is a principle, a practice, and a responsibility that should be embedded into overall systems for people to raise concerns or provide feedback. There should be a culture of being expected to be taken seriously, and get appropriate action, which embeds good practice, quality social care support services, and confidence in systems.

Collating and learning from complaints was also highlighted as well as supporting services to understand what went wrong and what improved provision/what good would look like, with the importance of preventative measures noted to prevent reoccurrence. Many suggestions were made including putting remedial plans in place and the retraining of staff if required, and agencies working together to achieve solutions. The Review also heard that updating those who raised a complaint about improvements made and actions taken to rectify the situation, was something people wanted and that this does not always exist. This

would result in better outcomes for the individual and for the service. In the Why Research analysis report this is summarised as:

There were recommendations for providing and implementing solutions, along with appropriate actions and changes to solve problems. That said, respondents felt that investigations should be at an appropriate or proportionate level depending on the issue raised. Accountability was seen to be important, although there should not be a “blame” culture. A collaborative approach to problem solving with services which provide social care support was thought best where possible, along with timely remedial action. After resolution, learning reviews were strongly advocated as well as introducing preventative measures to reduce the reoccurrence of problems.

In responding to the evidence shared by individuals that there is a need to strengthen and improve the current complaints system and its focus on a human rights-based approach, the Review recommends:

Recommendation 25 – It is recommended that there is clear and accessible public information about how to raise a concern and systems of complaints. Those systems of complaints should be easy to use, have accessible detail about routes of escalation with clearly defined outcomes that can include redress for people.

Accountability - who regulates the regulator?

The Review, as part of its terms of reference, was asked to consider if there is a need for an independent scrutiny body for inspection and regulation of social care support services in Scotland similar to that of the [Professional Standards Authority](#) (PSA) in England or otherwise, taking account of the reserved nature of professional regulation of the clinical professions.

The PSA is an independent body, which is accountable to the UK Parliament. Its statutory duty is to protect the public by improving the regulation and registration of people who work in healthcare across the UK, as well as social care in England. As noted in the Background chapter, the PSA oversees the decisions of the nine statutory bodies that regulate health professionals in the UK and social care in England. The PSA also carries out annual reviews of the statutory regulators against its [Standards of Good Regulation](#).

The Scottish Government previously contributed proportional financial support for the PSA's funding; however, it is now self-funding through contributions of the statutory regulators, as well as ad hoc international work undertaken on a commercial basis. The PSA examines the decisions of Fitness to Practise (FtP) panels of the healthcare regulators across the UK and has the legal powers to refer their decisions to the High Court or Court of Session where concerns arise. The Scottish Ministers can ask the PSA for advice about professional regulation, but there is currently no body in Scotland with equivalent powers of oversight of the Scottish Social Services Council's devolved regulation of the social care services workforce.

The call for evidence and engagement events asked, "How do we make sure regulatory bodies are doing a good job?" In the analysis of the findings, it was found that a large minority from across all sub-groups thought regulators should be subject to independent scrutiny, with suggestions for an independent board of scrutiny from across social care, which would help to ensure accountability.

The Review heard that some regulators in Scotland already use the [PSA Certified Framework](#) to assess themselves. One regulator said:



We undertake an annual self-assessment of our progress using an adapted version of the PSA's Standards of Good Regulation. We also maintain regular dialogue with many of the regulators the PSA oversees such as Social Work England and the Nursing and Midwifery Council. We would welcome the opportunity to have a further discussion about the case for and role of an independent scrutiny body.

In discharging its regulatory functions, the CI must have regard to the [Scottish Regulators' Strategic Code of Practice](#). This code of practice outlines how Scottish regulators should apply regulatory principles and build good practice when setting regulations.

The Review heard about the importance of openness, transparency and communication about regulators' activities and roles. This included guidance about inspection processes, information about the complaints process, and the sharing of knowledge. Suggestions were made about performance reviews and reports, mostly in a context of self-reporting and self-assessment.

The Review also heard instances where individuals and organisations felt they had no route to redress or escalation processes in relation to decisions made by regulatory and scrutiny bodies.

On considering potential recommendations in this area, the Review is mindful that the proposed establishment of the National Social Work Agency as part of the draft NCS Bill will provide standards for social workers and as a result there will be professional oversight and scrutiny.

Other areas/linked services that are relevant to this Review have different regulators, therefore, any revised system would need to function in conjunction with these bodies. For example, the [Scottish Housing Regulator](#) (SHR) is the independent regulator of Registered Social Landlords and local authority housing services in Scotland established by the [Housing \(Scotland\) Act 2010](#). SHR's statutory objective is to safeguard and promote the interests of:

- Tenants who live in homes provided by social landlords.
- Over 120,000 homeowners who received services from social landlords.
- People and their families who experience homelessness and seek help from local authorities.
- Gypsy/Travellers who can use official sites provided by social landlords.

In setting out the various scrutiny bodies, and the role of the PSA which covers some of the UK regulatory bodies operating in Scotland, as well as providing resources which are used by bodies in Scotland, the Review considered whether or not a separate body such as the PSA was required for Scotland.

Oversight of regulation and inspection bodies is important. In light of the evolving landscape, the Review believes there should be appropriate scrutiny and, in highlighting the importance of this for individuals who receive social care support as well as service providers, wishes to ensure Scottish Government can respond quickly to developments to ensure maximum coverage. Therefore, the Review recommends:

Recommendation 26 – It is recommended that the Scottish Government should make arrangements to ensure appropriate oversight of regulatory provision of social care support and consider whether there should be separate arrangements put in place for Scotland, in this respect.

In addition to these views, the Review also considers a mechanism which ensures the independence of regulators and inspectors from Scottish Government in their operational function as essential, as is the achievement of consistency through regulation of regulators in a cost-effective way.

8. Theme 4 - how will we know systems are working?



8. Theme 4 – how will we know systems are working?

When people and their families need to access social care support, particularly for the first time, it can be a life-changing experience. It often means having to understand a lot of information to inform decisions about what might work best for the person and their family. It often requires placing a significant amount of trust in services, professionals, and regulators. For some it can be a worrying time whilst for others it can be reassuring, offering up new opportunities.

As part of the Review, it was important to explore how we know systems are working. We spoke to people about issues related to informed decision making, digital technologies, data collection, and supporting good practice.

The people working within, and accessing, current systems of social care support, offered the Review many views, ideas, and insights into how these elements could be improved and strengthened. In general, people told the Review that they wanted to see high quality and accessible information, and the building of strong professional relationships.

The call for evidence asked a series of questions on what information people would find useful to assist in making informed decisions about social care support. Key questions asked at both the engagement events and through the call for evidence were:

- How can we ensure that people and their families who require care and support, have the information they need about how providers are performing to support their decisions about care and support?
- What information might that be?

The Review was also keen to explore:

- How can we make data collection and sharing better?
- How do we make sure inspection, scrutiny, and regulation supports good practice for people accessing care and support, people working in social care and providers delivering social care support?

Informed decision making

The Review received a clear message that people want a range of high quality and accessible information to be able to make informed decisions about their social care support. This included service provider improvement plans, feedback from people who use services, inspection reports and quality improvement frameworks. The Review heard that information about the role of the regulator and inspection outcomes was not always easily accessible. This suggests that, despite there being a duty for public organisations to provide information

online, in an accessible format, in line with [The Public Sector Bodies \(Websites and Mobile Applications\) Accessibility Regulations 2018](#), information might not be as clear or accessible to people as it should be and that the monitoring of information sharing should be better incorporated into scrutiny processes. The Review heard repeatedly that qualities such as, kindness and compassion, should be part of what is considered in inspection, scrutiny, and regulation processes. Evidence shared with the Review highlighted that there needs to be a re-evaluation of what qualitative data (people's experiences) is collected and used, and how.

The Review is aware that feedback mechanisms for continuous improvement will be co-designed and implemented across all NCS Services, including complaints and this should help contribute to the expanded collection of relevant data.

This Review goes wider than the NCS, and there is the potential for learning from the NCS work and that from linked services to be shared. An improved balance between the gathering and use of qualitative and quantitative data would help to ensure that people can be involved in identifying what they think is important to ask about in relation to services, and that people in receipt of social care support can express their own thoughts, and have their rights and feelings fully considered in the scrutiny process. Therefore, the Review recommends:

Recommendation 27 – It is recommended that qualitative measures should be co-designed by the regulatory agencies and people with lived and living experience to ensure that they include elements of services that are important to people.

It was also highlighted to the Review that information is available in a number of places, and it can be challenging for people to locate. On existing websites, content regarding inspection, scrutiny, and regulation should be clearly signposted and cross-referenced. There should be a single 'source of truth' available to people seeking information that is joined up to all other relevant sources to prevent conflicting information and to improve findability. Overall, it was felt that engaging with people receiving social care support and their families/unpaid carers about their information needs would help to ensure the right material is being provided in the best way.

The [Equality Act 2010](#) and [The Public Sector Bodies \(Websites and Mobile Applications\) Accessibility Regulations 2018](#) requires that all public services are as inclusive as can be reasonably expected, given the resources available to them, and to anticipate requirements of people with disabilities or impairments. This includes ensuring that information is accessible.

In Scotland, in addition, the [Digital Scotland Service Standard](#) (DSSS) is in place and is a set of 22 criteria that all digital services developed by Scottish Central Government sector organisations and Scottish Government corporate services must meet. This includes services for users or corporate services. The standard has 3 themes – user needs, technology, and business capability and capacity, and it aims to make sure that services in Scotland are continually improving and that users are always the focus. However, it is important to note that the DSSS standard and assurance process does not currently apply to Local Government or the NHS and Health Services.

The Review is aware that the CI takes account of the impact and quality of verbal and nonverbal communication between staff and care home residents as part of its inspections and makes recommendations for training and resources social care support staff can access to improve in this area.

Feedback received by the Review, however, suggested current systems are not always designed with the communication needs and preferences of people living with autism and dementia, sensory impairments, and other disabilities in mind. The communication needs of different people accessing social care support should be central to how a service is designed and delivered. In alignment with a person-centred and human rights-based ethos, all information should be jargon-free, cover all aspects of a service, and be available to suit a range of different formats.

The Review was also told that it is important to consider groups of people who may need additional or bespoke support to be able to choose their support options due to circumstances or capacity issues. People should also have easy access to information about independent advocacy and how to access this kind of support when needed. This supports findings under Theme 1 (page 25) about 'a person-centred approach' to social care support services.

The Review acknowledges some work is underway, for example, in relation to the NCS for all services to be multi-channel, in order to accommodate people's digital capacities, inclusion and needs. This includes online, face to face, telephony, physical formats to include translations, accessible formats and the use of assistive technologies.

On balancing the evidence heard, the Review recommends:

Recommendation 28 – It is recommended that the sharing of data is examined, with the people at the centre of the process having access to their own data in formats that facilitate their understanding of it in order to support decision making and their involvement in this. This data should also be utilised for service planning and improvement, both strategic and operational.


Data collection and sharing systems

The social care sector collects and generates large volumes of data in its day-to-day activities. However, the Review heard that we need to think more deeply about the purpose and value of social care support and the data we collect. There are well-recognised issues with the integration of data systems and it is challenging to share data seamlessly and safely across different platforms and between organisations.

Other issues include data standards, data sharing agreements and how people are using the systems in place. All of this can lead to valuable data remaining inaccessible for research, improvement and planning as well as duplication of data requests increasing the burden on providers. It can also make it challenging

for people to have prompt access to their own personal data and care records. One of the impacts can be people having to tell their story several times, which can be distressing and exhausting.

The Review heard that whilst it is essential to tackle current issues related to the integration of different systems, this requires significant investment. One representative body responding to the call for evidence summed up these challenges:

 **Data held about registered social care services by the service and workforce regulators is not currently linked. The regulatory bodies could significantly improve the social care data available by sharing what they already hold from inspection visits, annual returns, and registrations in an accessible and up to date format.**

People shared several suggestions with the Review regarding how data sharing and collecting could be improved including:

- Developing a single digital system or platform to help reduce duplication and administrative burdens.
- Improving the consistency of data collection by streamlining data collection and reporting requirements.
- Developing a national digital strategy that would allow for better collaboration, communication and data sharing and better performance management through good quality management information.
- Exploring lessons learned from the Covid-19 pandemic in relation to the rapid collection and sharing of data and the resources required to deliver this.

In relation to some of these suggestions, the Review is aware that work is already underway. For example, a National Digital Strategy with a new associated Digital Health and Social Care strategy has recently been developed. However, some people indicated that they were concerned about the cost and practicalities of developing a central platform and that the setting and implementation of technical and data standards may be a more cost-effective way of achieving improved outcomes. Therefore, the Review recommends:

Recommendation 29 – It is recommended that data is utilised for social care planning and individuals, and their advocates, have access to this to inform their choices.

Recommendation 30 – It is recommended that the type of data collected, and its purpose, is reviewed to ensure that the right data is collected for the right reasons, with a focus on data supporting performance management and service improvement.

Information management & governance

The Review is aware that the [Information Governance Review: Executive Summary: Review of the Information Governance Landscape Across Health and Social Care in Scotland](#) carried out in July 2021, found that the current Information Governance (IG) landscape in Scotland is fragmented and lacks the consistency to ensure efficient delivery of health and social care digital solutions, and effective access to data assets. These findings have been mirrored by feedback gathered by the Review.

Nonetheless, it has also been found that the COVID-19 pandemic accelerated digital transformation across health and social care and the development of more responsive, people-centred services, covering a spectrum of needs that are now being developed. The Review is also encouraged to see that a National IG Programme has been established to help address challenges related to data and digital across health and social care.

The Review heard that there is a lack of data skills and knowledge which has led to some people being unclear on the legislation and good practice governing the handling, use, and sharing of data. In particular, misunderstanding about what the [General Data Protection Regulations](#) (GDPR) entail and how they should be applied means that in some cases the sharing of data is unnecessarily restricted. This can create inefficiencies and delays in sharing intelligence and delivering support. It is important that people who are sharing their data, and those who are processing it, are clear about their rights and responsibilities so that everyone can get the maximum benefit from social care data.

A number of respondents felt that a duty to co-operate between service providers might help to improve the accessibility and sharing of data. However, whilst it was noted that this could be challenging if the culture of an organisation or other pressures make it difficult for people to co-operate without there being sufficient protections, investment, and capability in place, particularly across the voluntary and independent sectors. The focus should nevertheless be upon the people at the centre of the service – those who depend upon the social care support in question. The Review understands that a duty to co-operate is also a matter of consideration for the draft NCS Bill.

The Review found, that, in some instances, there are also misunderstandings about the legislation governing the collection, use, and security of personal data, potentially inhibiting legitimate data sharing. The way that GDPR is currently used in inspection, scrutiny, and regulation, can at times be a barrier to effective information sharing and this requires to be addressed; recognising this the Review recommends:

Recommendation 31 – It is recommended that a more tailored and contextualised approach is developed to how GDPR is used and interpreted within the regulatory landscape. It is also recommended that an Information Governance (IG) group is established to support the effective and proper use of information and engagement with IG experts.

The Review is mindful that there is a commitment within the draft National Care Service Bill to create a health and social care record (“the national care record”). This will seek to put the person receiving care and support at the centre, with the ability to access and personalise their record. If implemented, the national care record could potentially help to address some of the issues raised in relation to data sharing and access for the services it will include.

The draft Bill contains a provision (section 36) which gives Scottish Ministers the power by regulations to establish a scheme for sharing information so that services can be provided efficiently and effectively by, and on behalf of, NCS and NHS. While the Review welcomes the provisions within the draft Bill to strengthen the use and sharing of data, it is conscious that these provisions are still subject to Parliamentary approval.

The Review is also aware of the Care Home Data Review (CHDR) currently underway, which began in late 2022. A collaboration between Scottish Government, Public Health Scotland, and the Care Inspectorate working with stakeholders from across social care to review the current data being collected, how it is collected, its quality and what it is used for. This would seek to ensure a more strategic and co-ordinated approach to data gathering.

The Review is also aware of the SSSC’s Data and Intelligence Strategy for 2022-25 which sets out how the organisation will develop and use data and intelligence both internally and externally, to help improve ways of working.

The Review further acknowledges the work of Digital Healthcare Scotland and the Scottish Information Toolkit [Information Sharing Toolkit - Digital Healthcare Scotland](#). The Toolkit enables service-providing organisations directly concerned with the safeguarding, welfare, and protection, of the wider public to share personal information between them in a lawful and intelligent way.

This framework applies to all public sector organisations, voluntary sector organisations, and those private organisations contracted to deliver relevant services to the public sector and who provide services involving the health, education, safety, crime prevention, and social wellbeing of people in Scotland.

In particular, it concerns those organisations that hold health and care information about individuals and who may consider it appropriate or necessary to share that information with others.

Balancing the evidence shared, recognising work currently underway, the Review recommends:

Recommendation 32 – It is recommended that there is a ‘duty to co-operate’ placed upon service providers to share data appropriately and equally upon regulatory bodies to work together to avoid duplication in their requests for information.

Digital exclusion & technology

Although a significant proportion of the population have access to the internet and digital technologies, the Review was asked to be mindful of digital exclusion. Some people may lack confidence in using a computer and online services or they do not have access to the internet, or to a mobile device. If information is only accessible via a digital platform, this can leave people at a disadvantage when accessing services and information about their rights in relation to care and support.

In line with the human rights and person-centred basis of this Review, people should be afforded choice in how they access information about services. To ensure that information is available to all who require it, appropriate alternatives such as paper formats or telephone and in person contacts should be made available and the Review is aware that accessibility issues will be addressed via the NCS co-design process.

An example, is the [‘Near Me’](#) video consulting service, funded by the national [Technology Enabled Care](#) (TEC) programme, which enabled the choice of video appointments during the pandemic across health, social care, housing and the wider public and third sector. The roll out of ‘Near Me’ involved participation and collaboration with regulators, health and social care providers with 95% (a total of 1,100 services) of care homes and residential care providers for children and young people participating. By June 2020, 17,000 ‘Near Me’ consultations were taking place each week, and this high level of use has been maintained ever since. Hospital and community-care services account for 77% of ‘Near Me’ appointments, and general practitioner services for 23%.

Despite the benefits that technology can offer, the Review was told that it cannot replace people and relationships. Technologies are undoubtedly helpful tools, but they must be designed and used with people at the centre of all considerations.

Highlighting best practice and ensuring consistent standards

There are a variety of indicators and standards across health and social care, and this can be confusing. Key references for the social care sector are the [Health and Social Care Standards: My Support, My Life](#). The Health and Social Care Standards were driven by the Public Sector Reform Act (Scotland) 2010, developed in 2017 and launched in 2018. Two new standards were introduced in 2021 with an emphasis on helping family and friends remain connected with their loved ones in care homes and be involved in their care and support even in times of crisis.

The Standards are used by the Care Inspectorate, Healthcare Improvement Scotland and other scrutiny bodies, when conducting inspections of health and care services, as a minimum benchmark when carrying out their inspections and quality assurance functions, and when making decisions about care and health services which are, or are applying to be, registered.

A review of the Standards carried out by Scottish Government in 2019 suggested that their introduction was helping to influence improvement of the experience of people accessing social care support services. More recent feedback has also indicated support for the Standards; however, there have been some concerns raised about the consistency of implementation and with the use of the word 'minimum'.

This could suggest a low bar of quality and instead the emphasis should be placed on striving for the best in support provision. The Standards set out quite clearly what people should expect when accessing social care support services.

Most organisations who mentioned Health and Social Care Standards in their responses to the NCS consultation provided broadly supportive feedback in principle, but not necessarily about how they are delivered. There was support for a refresh of the current existing standards from a number of organisations, including National Education for Scotland:



NES considers that at the heart of any future model of regulation are refreshed integrated Health and Care Standards that build on human rights, outcomes focused seamless care, that is ethically commissioned, co-designed and delivered in the right place at the right time by a skilled, knowledgeable, and where appropriate qualified workforce. The refresh of the Health and Care Standards could potentially include a stronger focus on population health; ethical commissioning; and valuing the health and care workforce. These should form the basis on which outcomes-based scrutiny is focused.

Given proposals for a National Care Service, it is more vital than ever that standards are designed, implemented, and measured in a way that makes health, social care and social care support services better for everyone. They need to ensure every person is treated with respect and dignity and that the human rights we're all entitled to are upheld. Therefore, the Review recommends:

Recommendation 33 – It is recommended that a review of the Health and Social Care Standards takes place to ensure they are based on human rights, ethical commissioning and are outcomes focused. The Standards should be the basis on which social care support services are inspected, scrutinised and regulated.

9. Theme 5 - How will systems of inspection, scrutiny, and regulation support the workforce?



9. Theme 5 – How will systems of inspection, scrutiny, and regulation support the workforce?

One of the key aims of this Review is to identify and set out recommendations to help ensure inspection, scrutiny, and regulation works towards making the system better for everyone, including for those who work to deliver social care support. The Review was keen to understand views on how current support systems and arrangements for the workforce might be improved, built upon, and further strengthened, for the benefit of all.

To better understand the current landscape in relation to supporting and valuing the workforce whilst also seeking to ensure that the people who access social care support are safely cared for by appropriately qualified and trained staff, the Review considered two key questions under this theme:

- How do we ensure there is compliance and consistency with workforce registration requirements?
- How can we ensure that people who work in care and support services are able to contribute to inspection, scrutiny, and regulation processes?

Some elements of how compliance and consistency in the registration of the workforce should be achieved are addressed earlier in this report. In Theme 2, recommendations are made about ensuring there is a universal requirement to obtain registration with a regulatory body for all social care support staff, appropriate to their role and setting, and that a bespoke system of registration is developed for Personal Assistants. This theme considers in more depth different elements of registration and how people who work in the social care sector are able to contribute to, and are supported by, processes of inspection, scrutiny, and regulation.

The Review heard that some people would like the registration process for the social care sector to be as consistent, thorough and quick as possible. Those delivering social care support also indicated that they would like to see more flexibility and clarity in relation to training and professional development, alongside greater involvement in inspection processes and decisions affecting the workforce.

The Review also heard concerns about the cost of registration and about inconsistencies within the workforce registration system. For example, some social care staff are registered, and their costs are paid by their employer, some staff are not required to register, and others have to register and pay their own registration fees.

The Review heard that many of the workforce issues raised are currently being explored and addressed through different workstreams and initiatives. However, the challenges are in some instances complex, with no quick solutions.

Based on feedback gathered during the Review, it is apparent that improvement work is not necessarily being translated into noticeable change for everyone working in the social care sector. Therefore, the Review has set out recommendations to strengthen the support in place for those delivering social care support, whilst identifying where further exploration is required and acknowledging the various initiatives underway to improve processes and conditions.

Workforce registration

In addition to the findings and recommendation made in Theme 2, the Review consistently heard about the pressures across the social care support system in relation to staffing. Strong evidence was presented that workforce challenges underpin many of the issues faced in the social care sector. Whilst the Review was asked to focus on the regulatory and inspection framework, it is impossible to separate the relationship between workforce, the capacity to improve and the crucial role of regulation and inspection in the improvement agenda.

The analysis of the call for evidence detail and information from stakeholder engagement events found there was a view that:



... there is a need to ensure that it is easy to join the social care and support workforce, with a simple and transparent registration process and clear information on the requirements for any qualifications.

Once a person obtains employment in the social care sector, they must get their PVG scheme membership, start in their role and apply for registration with the SSSC as soon as reasonably practicable. For those that need to register, to maintain registration they must follow the SSSC Codes of Practice, maintain continuous professional development and for some roles, complete certain qualifications.

It was highlighted to the Review that it is crucial to have a registration process that is transparent, easy to initiate and maintain. It was felt that easier and clearer processes, with an increased emphasis on the benefits of registration would better support those working in the sector and potentially encourage those who might be interested in doing so.

There was a view that there should be immediate registration with SSSC for anyone joining the social care workforce. At present the full registration process can take up to three months and an employee must be registered within six months. An employer commits an offence if they employ someone after six months who is not registered without reasonable explanation and the CI can refer an employer who commits a breach to the Procurator Fiscal. However, an individual could potentially still move to another role shortly before the end of

the six month period when the period of registration starts again. This creates a risk of people slipping through the safety net of registration.

Some work in this area is currently underway by the [SSSC's Future Proofing Programme](#) which covers three interconnected pieces of work:

- the current SSSC Register;
- qualifications and skills; and
- the SSSC Codes of Practice.

The work of the [Future Proofing Programme](#) includes simplifying the process of registration, increasing the emphasis on the value of being registered, along with focusing on the standards, skills and qualifications needed to deliver high quality care. The Future Proofing Programme started in December 2021 and is expected to conclude in 2024.

Through the Future Proofing Programme, the SSSC are seeking to implement a three-month rule for registration to reduce the timescale from starting work to employment. To make registration immediate would require registration before starting employment which would mean that employers may be unable to fully assess fitness to practise over a probationary period. Shortening the time scales while ensuring that fitness to practise assessment remains robust, is an approach the Review welcomes.

It was also suggested by some that higher levels of support for the social care support workforce is required. Suggestion included supervision sessions to record and assess work completed or a framework for compliance so that there is clarity over what is required of staff to fulfil their role. Added to this was support for a single Code of Practice for staff so there are clear and consistent expectations for all.

The Review also heard evidence about the [Workforce Register](#) and the 23 different categories that are currently used to register people. There was a view that this demonstrated a rigidity which did not support flexible working across services and that those employed in areas that provided more than one type of support needed to register more than once. This is also supported by the findings of [The Review of Care Service Definitions: Challenges and Recommendations \(November 2021\)](#) as outlined in Theme 2.

It is the opinion of the Review that the Future Proofing Programme work underway by the SSSC has the potential to contribute to more effective registration practices that support the workforce and those using services. For example:

- a reduction from 23 categories of registration to 4, will support the streamlining and simplification of the registration process:

- a streamlined Code of Practice for members of the social care workforce should assist improved understanding; and
- a focus on the benefits of registration will potentially encourage uptake.

Powers of intervention and enforcement

Similar to other issues considered by the Review, some of the challenges relating to the registration of the social care support workforce are legislative. For example, the [Public Sector Reform \(Scotland\) Act 2010](#) requires the CI to take the relevant codes of practice into consideration when inspecting services, but the SSSC are unable to compel agencies to share information required to investigate complaints against staff or compel employers to follow their codes of practice. This leads to disparity as sometimes the reason staff do not meet the requirements of SSSC registration is due to employers not providing the training needed.

There is also some complexity and potential overlap around where responsibilities lie between the SSSC and other professional regulators. Currently, if a manager is registered with another professional regulator, the law specifically excludes them from registration with the SSSC, except for social workers who can be dual registered. This can lead to duplication or a lack of clarity around jurisdiction and intervention if issues arise with a provider around complying with the codes of practice.

A further exploration of how well current arrangements in relation to powers of intervention and enforcement are working would help to identify where changes or improvements might need to be made to ensure that providers are fully meeting requirements. Therefore the Review recommends:

Recommendation 34 – It is recommended that Scottish Ministers should review the powers of intervention and enforcement currently in place, where providers fail to meet workforce registration obligations or fail to follow the codes of conduct and consideration be given as to where powers of enforcement should lie.

Valuing and involving our social care support workforce

A key theme emerging from the Review's engagement events and call for evidence was the need to involve the social care support workforce more in decisions that affected them and to more fully value the critical role they play in improving outcomes for those using services. This included involving them in the inspection process and in the co-design of inspection, scrutiny, and regulation processes.

The Review heard that demonstrating positive experiences and outcomes were ways in which staff could be encouraged and motivated to become more involved and feel that their contributions are valued.

The Review heard that there should be a greater focus on collaboration, self-evaluation, outcomes, and sharing of good practice. The Review was also told there is a clear need for organisations and regulatory bodies to have systems in place that involve all those working within the social support care sector and linked services before, during, and after the inspection process.

Greater involvement of the workforce would help to reduce anxieties associated with the inspection process. Building professional, supportive and advisory relationships outwith inspections would also help to further develop confidence in regulators, the inspection process, and in their role in promoting improved outcomes. As noted by a representative body:

 **If the likely outcome of their engagement with regulators is perceived to be meaningful support and assistance, the incentive to contribute increases.**

To successfully promote a culture of collaborative endeavour and improvement the Review considers it essential that the workforce are supported in their roles. An example was shared from the [Regulator of Social Housing in England](#) where improvements led to a more collaborative approach and:

- a library of best practice;
- anonymised, recommended improvement;
- annual sector risk profile – looks at issues ongoing in the sector; and
- appropriate helpline for organisations – communication line to discuss issues and ask for support.

The Review is also aware that the SSSC develop and provide resources to support the workforce, including advice for employers in relation to responsibilities around fitness to practice and for employees requiring wellbeing support whilst being involved in the fitness to practise process.

During an inspection one element of a service that the CI will look at is quality of staffing, which includes their qualifications and training. At present no account is taken of other factors such as the quality of support provided to employees or fair work practices.

Through the work of the Fair Work in Social Care Implementation Group, a draft [Effective Voice Framework](#) (EV) has been developed for the Adult Social Care sector that recognises the important role that trade unions play in harnessing that voice to communicate with both employers and government. The framework sets out a number of basic standards by which both employees and employers can measure themselves.

Whilst union recognition and participation are not an absolute essential criterion in delivering an effective voice for workers, the framework highlights the benefits that this offers in that context. Work is currently underway on the phase 1 delivery ahead of a national roll out of the EV Framework.

There is the potential that the EV Framework, or something similar, could be used to assess the quality of support provided to employees, in the same way the CI assess the level of support provided to people who use social care support. Inspection for services could be extended to inspection of employment aligned to Fair Work practices, that enable employers to show they are Fair Work compliant. There would be a lot of legal complexities to address. However, the Review is supportive of a move toward employers and commissioners being aligned to a framework that enables them to demonstrate that they abide by Fair Work principles as better services can be directly related to better staff engagement and treatment.

Therefore, the Review recommends:

Recommendation 35 – It is recommended that regulators and providers examine ways in which the workforce can become more actively involved in the inspection process, on a basis of mutual trust and respect.

The Review is also aware of the [Skills Delivery Landscape Review Final Report - Fit for the Future: Developing a Post-School Learning System to Fuel the Economic Transformation](#) (SDLIR) (Scotland). SDLIR was initiated to ensure the public body landscape for skills remains fit to meet the challenges and opportunities of the future. It has set out fifteen recommendations that include:

- Improvements to national and regional skills planning and the establishment of associated employer network board.
- The creation of a single national funding body and a single qualifications body.
- Scoping and designing a digital training record.
- A comprehensive audit of post-school qualifications and pathways.

Whilst the SDLIR does not have direct input to systems of inspection, scrutiny, and regulation in relation to supporting the workforce, the recommendations it has made, should be combined with the Muir Review.

This Review notes the work of Fair Work in Social Care Implementation Group (co-led by the Scottish Government and CoSLA). The group has developed a set of proposed “Minimum Standard” terms and conditions for Adult Social Care Workers and these cover a range of issues from basic pay to maternity and paternity leave, sickness pay, pensions and development time.

The [Health and Care \(Staffing\) \(Scotland\) Act 2019](#) aims to enable high quality care and improved outcomes for people using services in both health and care, by helping to ensure appropriate staffing. The Act was passed by Parliament in

2019 but implementation was paused due to the pandemic. All the provisions within the Act will come into force in April 2024.

The Review has been encouraged to see collaborative working and a variety of timely and ambitious initiatives underway to help address workforce challenges such as staff attraction and retention, as well as workplace cultures. Nonetheless, based on some of the feedback shared by stakeholders, it is clear that there is work to be done to continue to progress and embed improvements. Many of these workstreams or initiatives are relatively recent and the benefits may take time to be fully realised. However, the Review would like to ensure that progress continues at pace, and that tangible and positive change is delivered across the workforce and therefore recommends:

Recommendation 36 – It is recommended that Scottish Ministers align the social care workforce in a coherent model, based on fair work, to support the sustainability of the workforce and to help drive continuous improvement.

Professional development and training

The Review is absolutely clear of the critical importance of a well-paid, well-respected and well-trained workforce with clear career development opportunities. This would support the culture change necessary to shift from a sector often seen to be on the brink of crisis and where the Review heard inspection, scrutiny, and regulation is often considered as punitive, to one that focuses on human rights and driving improvement.

Whilst the Review heard support for benchmarking standards across the sector, it was noted that there was a need for proportionality, depending on the work or role being undertaken. The Review also heard that if people are able to move on to better paid roles elsewhere that do not have training and qualification requirements, this can be a hindrance to retention in the social care workforce. The Review also heard that the skills necessary for the workforce should be part of the planning and design of social care support. In addition, there was a view that there was a need to take a collaborative approach in developing a high-level strategy for skills development.

Figures in the [Scottish Social Service Sector: Report on 2021 Workforce Data](#), tell us there are 200,000 individuals employed in the social service workforce in Scotland spanning the public, third and independent sectors and all areas of social care support. The Review heard that there is an inconsistent approach to training and development. In some sectors training is portable, whilst in others it is not. Additionally, whilst the onus is on the employer to provide in-service training and development, where required, it is challenging to enforce on a fair, effective, and equitable basis.

The Review heard there is a need for greater flexibility around qualifications and consistent compliance with standards. Added to this were suggestions for a minimum level of training to support individuals in acquiring the skills and qualifications for working in the social care sector. This would better equip the workforce to be able to access opportunities across different service types.

The Review was told of the importance of qualifications keeping pace with policy and practice. Consideration should be given to how staff can be supported in achieving mandatory qualifications including through improved support from social care providers with regard to training opportunities for staff. There was a focus on different models of training. For example, where people who use social care support services have a role in contributing to and informing training, and also where recognition or accreditation of prior learning and experience is made available and that this is encouraged.

The Review was made aware of the [Construction Industry Training Board \(CITB\)](#) for Scotland, England and Wales. The CITB's role has been to help the industry attract talent, and to support skills development. The CITB is a Non-departmental Public Body (NDPB) and is accountable to government ministers and ultimately to parliament.

This is a model the Review thinks has potential to be further explored by SSSC and the Scottish Government as an exemplar for the further development of social care support in Scotland and accountable to both the sector and to the Scottish Parliament. Equally there could be a collaborative model developed with other nations of the UK. Therefore, the Review makes the following recommendations:

Recommendation 37 – It is recommended that Scottish Ministers should review the sufficiency, quality and availability of resources for training, development and improvement.

Recommendation 38 – It is recommended that steps are taken to ensure that nationally recognised qualifications that reflect the skills required to work in the social care sector are developed and are portable across the social care sector.

10. Conclusion



In completing this Review and listening to a wide range of voices about the current systems of inspection, scrutiny, and regulation, it is clear that change is needed to meet the requirement of the current and future social care support landscape.

The Review recognises the intention of the inspection, scrutiny, and regulatory bodies to work in a way that is inclusive and human rights-based but the gap between this intention and the experience of people who use and work in social care support and linked services, was clear.

There therefore needs to be cultural and legislative changes to systems of inspection, scrutiny, and regulation to one that prioritises improvement, is comprehensive and is consistent in what it inspects, scrutinises and regulates. This ensures that high quality social care support is the responsibility of all relevant parties and that inspection, scrutiny, and regulatory bodies have the power to take decisive and effective action when required.

Some of the recommendations in this Review build on findings from earlier reviews, for example, those aimed at reducing duplication and increasing the involvement of people with lived and living experience. By doing so, the Review recognises the longstanding nature of some of these issues and takes the opportunity to consolidate and reinforce the importance of decisive action being taken to address them. Other recommendations are pertinent to new areas, for example, a bespoke system for the registration of Personal Assistants and extending inspection, scrutiny, and regulation to areas not part of the current system.

The Review has outlined why change is needed and sets out a comprehensive package of recommendations that, if implemented, will result in there being a human rights-based system of inspection, scrutiny, and regulation that is comprehensive, inclusive, joined up, proportionate and fair. The Review is under no illusion of the challenges in modernising and strengthening the inspection and regulatory system in Scotland but, with the plans for a National Care Service, now is the time to do just that.

11. Appendices



Chair - Dame Sue Bruce DBE

M.Phil. ;LLB; Dip; D.Univ Hon (University of Strathclyde); D.Univ, Hon (Heriot-Watt University)
FRSE; FRSA

Sue Bruce has 40 years of public sector experience, followed by a portfolio of non-executive director roles including SSE PLC; Convener of the Court of the University of Strathclyde; Chair of the Royal Scottish National Orchestra, Chair of the Prince's Foundation. She is the Electoral Commissioner for Scotland and a Deputy Lieutenant of the City of Edinburgh. In recent activity Sue has been the Independent Chair of the Expert Panel on Environmental Charging and other Measures and a member of the Advisory group on Economic Recovery, both commissioned by the Scottish Government.

Sue Bruce retired from a career in local government in 2015 in her 40th year of public service having started her career in community education specialising in social and economic regeneration and latterly served as Chief Executive of the City of Edinburgh Council having previously been Chief Executive at Aberdeen City Council and Chief Executive at East Dunbartonshire Council.

Vice Chair - Stuart Currie

Mr Stuart Currie has 15 years' experience of being a Local Councillor with East Lothian Council having served as the Depute Leader with responsibility for Housing. In May 2022, when he stepped down from Local Government, he had latterly served as the Spokesperson for Health and Social Care for The Convention of Scottish Local Authorities (COSLA) with responsibility for Integration, Public Health and Mental Health.

Stuart previously was a member of Independent Review of Adult Social Care and currently serves as a Non-Executive Director with the Scottish Ambulance Service and the State Hospital for Scotland.

Independent review panel members

Neelam Bakshi (FRSA) – Neelam has 30 years of public and third sector experience across health, local and Scottish Government, equality commissions and broadcasting. She currently holds a variety of posts including Lay Member and Depute Convenor (Staff) of University Court at the University of Strathclyde, Board Member of The Judicial Appointments Board Scotland and Public Appointments Adviser to The Commissioner for Ethical Standards in Public Life Scotland as well as serving as a lay member on judicial tribunals.

Gordon Black MB, ChB, FRCGP, DRCOG, DCH, MSc – Gordon was a panel member from September 2022 to April 2023, he then resigned from the IRP due to work priorities.

Lillian Cringles – Lillian was previously North Lanarkshire Council Manager of Justice and is now the Chief Social Worker at Dumfries and Galloway Council. Children, families, and criminal justice services fall within her purview which intersects with the alcohol, drug and mental health agenda. Lillian retired from her post as Chief Social Worker on 15th June 2023.

Lee Knifton – Lee is a Reader in Management Science at the University of Strathclyde.

Megan Moffat – Megan is the Policy and Public Affairs Officer at Who Cares? Scotland. Who Cares? Scotland advocates for a lifetime of equality, respect and love for all care experienced people. It provides individual relationship-based independent advocacy for care experienced people along with a range of connection and participation opportunities. Being care-experienced herself, Megan has a particular interest in The Promise.

Paul Redfern CMIIA, CIA, QIAL, MSc – Paul is an Audit Committee Adviser to The Electoral Commission and an Audit Committee Member of The Together Housing Group.

Professor Kate Sang – Kate is Professor of Gender and Employment Studies at Heriot-Watt University where she is also the Director for the Centre for Research on Employment, Work and the Professions.

Satjit Singh (FRSA) – Satjit has previously been appointed as CEO of two healthcare professionals' regulatory bodies. In addition, he was appointed Director at The Council for Healthcare Regulatory Excellence (now The Professional Standards Authority), an Arms-Length Body. Prior to this, he acted as Finance Director of various organisations within the NHS. During the Olympics, he was the Lead Commissioner for Health.

David Strang CBE, QPM – David served as HM Chief Inspector of Prisons for Scotland 2013-18. He was appointed Chair of the Scottish Government's Drug Deaths Taskforce in January 2022. He oversaw the publication of the Taskforce's Final Report, 'Changing Lives', which sets out an evidence-based strategy for tackling Scotland's drug deaths crisis.

Practitioner and stakeholder panel members

Adoption UK
British Association of Social Workers (BASW)
Care Home Relatives Group
Carer Centres Managers Network
Centre for Excellence for Children's Care and Protection (CELCIS)
Coalition of Carers in Scotland
Coalition of Care and Support Providers in Scotland (CCPS)
Community Justice Scotland
Convention of Scottish Local Authorities (CoSLA)
Early Years Scotland (EYS)
Inclusion Scotland
National Day Nurseries Association (NDNA) Scotland
People Led Policy Panel (PLPP)
Queen's Nursing Institute Scotland (QNIS)
SACRO
Scottish Adoption
Scottish Care
Scottish Childminding Association
Scottish Families Affected by Alcohol and Drugs
Scottish Kinship Care Alliance
Scottish Trade Union Congress (STUC)
Self-Directed Support Scotland (SDSS)
Shelter Scotland
SIAA
Social Work Scotland
The Health and Social Care Alliance (The Alliance)
The Promise Scotland
The Royal College of Nursing Scotland (RCN)
The Scottish Young Carers Services Alliance Network

Subject matter expert meetings

Age Scotland Orkney
Audit Scotland
Care Inspectorate (CI)
Centre for Excellence for Children's Care and Protection (CELCIS)
Chief Inspector of Prisons
Coalition of Care and Support Providers in Scotland (CCPS)
Common Weal Care Reform Group
Department of Health – Northern Ireland
Enable Scotland
Equality and Human Rights Commission (EHRC)
General Medical Council Scotland (GMC)
Harry Cayton – Professional Standards and Governance
Healthcare Improvement Scotland (HIS)
Homes for Scotland
Inclusion Scotland
Mental Welfare Commission (MWC)
NHS Education for Scotland (NES)
Office of the Scottish Charity Regulator (OSCR)
Police Scotland
Scottish Care
Scottish Federation of Housing Associations
Scottish Government – Chair of Scottish Executive Nurse Directors
Scottish Government – Chief Nursing Officer
Scottish Government – Digital & Data Division, Social Care and NCS Development
Scottish Government – Early Learning and Childcare
Scottish Government – Office of Chief Social Work Adviser
Scottish Government – Response to the Scottish Child Abuse Inquiry
Scottish Government – Workforce, Fair Work and Standards & Quality, Social Care and NCS Development
Scottish Human Rights Commission (SHRC)
Scottish Independent Living Coalition
Scottish Public Services Ombudsman (SPSO)
Scottish Social Services Council (SSSC)
Self-Directed Support Scotland (SDSS)
Social Care Wales
Society of Local Authority Chief Executives – Scotland (SOLACE)
The Promise Scotland
Who Cares? Scotland

12. Definition of key words and phrases



12. Definition of key words and phrases

Accessibility	The practice of making information, activities, opportunities, services and environments as fairly, equally, meaningfully and usable for as many people as possible regardless of their circumstances.
Adults with Incapacity (Scotland) Act 2000	The purpose of the Act is to provide for decisions to be made on behalf of adults who lack legal capacity to do so themselves because of mental disorder or inability to communicate. The decisions concerned may be about the adult's property or financial affairs or about their personal welfare, including medical treatment.
Call for Evidence	A call for evidence is an information-gathering exercise that seeks expertise from people (members of the public and professionals), organisations and individuals with knowledge of a particular issue.
Care Act 2014	This Act contains provisions which reform the law relating to care and support for adults and carers. It also makes provision about safeguarding adults from abuse or neglect, about care standards, about integrating care and support with health services and it establishes, and makes provision about, the Health Research Authority.
Care Home Data Review (CHDR)	The CHDR is a collaboration between Scottish Government, Public Health Scotland and Care Inspectorate which commenced in late 2022. The review is considering improvements around the content, quality and frequency of current data collections, and alternative methods of data collection and aims to ensure a coherent suite of data collections, reduce the burden on data providers and meet the existing and emerging needs of data users.
Care Home Review	A rapid review established to identify the characteristics and risk factors of outbreaks in, and the transmission of, Covid-19 in care homes in Scotland. The review identified contributory factors and root causes and produced high-level recommendations to support quality improvement in the safe management of care for residents within care homes across Scotland.

Care Inspectorate (CI)	The Care Inspectorate is the regulatory body for care services in Scotland. It regulates a range of care and support services including child minding, child day care, adult day care, care homes, care at home and housing support services. The CI also carries out regular comprehensive inspections of all care providers in Scotland. In addition, the CI is a scrutiny body which supports improvement. This means that it looks at the quality of care in Scotland to ensure that it meets high standards. Where it finds that improvement is needed, the CI supports services to make positive changes. By law, all care providers in Scotland must be registered with the CI.
Care Pathways	A care pathway is a plan for patient care that manages patient care from the beginning to the end of treatment in a focused, comprehensive and integrated way. It is a way of setting out a process of best practice to be followed in the treatment of an individual with a particular condition or with particular needs. It will map out the care journey an individual can expect, should be multi-professional, crossing organisational boundaries and can act as a prompt for care. It can also create a consistent standard of documentation which will provide the basis for ongoing audit.
Care Quality Commission (CQC)	The CQC is the independent regulator of health and adult social care in England. It monitors, inspects and regulates services and publishes its findings. In doing so, it ensures that health and social care services provide people with safe, effective, compassionate, high-quality care while encouraging care services to improve.
Carer	A carer is anyone who looks after a family member, or a friend, who requires their help and support. This could be caring for a child, parent, sibling, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems. The care they provide is unpaid.
Charter of Rights and Responsibilities	This will set out people's rights and responsibilities when accessing NCS support and provide a clear pathway to make a complaint if their rights are not met or respected.

Children (Care and Justice) (Scotland) Bill	This Bill intends to change the law by improving the court process in contact and residence cases. Contact and residence cases decide the living and visiting arrangements for children. It also covers contact and residence cases of children when parents are no longer together. It also covers changes to aspects of the Children's Hearings system.
Code of Practice for Social Workers and Employers	This sets out the responsibilities of employers in the regulation of social care work at a national level. The Code sets out a list of statements outlining the standards of professional conduct and practice which are expected of social care workers.
Co-design	Co-design is a collaborative process with individuals specifically within the design development process to ensure the results meet their needs and are usable.
Construction Industry Training Board (CITB) for Scotland, England and Wales	The CITB is the industry training board for the construction sector in England, Scotland and Wales. It is an executive non-departmental public body, sponsored by the Department for Education, which is accountable to government ministers and, ultimately, to Parliament.
Digital exclusion	Digital exclusion is experienced by those who do not have access to an appropriate digital device, an affordable or reliable internet connection or the right skills to be able to use digital tools.
Digital Scotland Service Standard (formerly Digital First)	The Digital Scotland Service Standard is a set of 14 criteria that all organisations delivering public services should work towards. The standards are based around three themes: meeting users' needs, providing a service and using the right technology.
Digital strategy	The Digital Strategy is a cross-government strategy which sets out a coherent articulation of the government's ambitious agenda for digital policy.
Disclosure Scotland	Checks and shares information about people's criminal records. In doing so, it helps employers make safer decisions when recruiting people. It also makes sure that unsuitable people do not work with vulnerable groups, including children and protected adults.

Disclosure (Scotland) Act 2020	This Act sets out the legislative framework to modernise and improve the proportionality of the disclosure system in Scotland. It focuses on safeguarding children and vulnerable adults, while balancing the need for people with convictions to move on from past convictions and contribute to society.
Drug and Alcohol Information System (DAISy)	DAISy is a national database developed to collect drug and alcohol referral, waiting times and outcome information from staff delivering specialist drug and alcohol interventions. This data provides a better understanding of the impact of drug/alcohol treatment services at both a local and national level and consequently facilitates improvements in service planning and delivery.
Duty of Candour	The Organisational Duty of Candour is a statutory (legal) duty placed upon Scottish organisations providing health and social care. They have a duty to be open and honest when something goes wrong that is not related to the course of the condition for which the person is receiving care. This means that when unintended or unexpected events happen that result in death or harm, the people affected should understand what has happened and receive an apology. The intention of this duty is to improve professional practice, patient and user service and public confidence.
Duty of Candour Procedure (Scotland) Regulations 2018	These Regulations set out the procedure to be followed by organisations providing health, care and social work services when there has been an unintended or unexpected incident that results in death, harm or additional treatment.
Early Learning and Childcare (ELC)	This term describes the full range of early childhood education for children under school age in Scotland.
Equality Act 2010	This Act has two main purposes: to harmonise discrimination law and to strengthen the law to support progress on equality.
Equality and Human Rights Commission Scotland (EHRC Scotland)	The EHRC is an independent statutory body responsible for encouraging equality and diversity, eliminating unlawful discrimination and protecting and promoting the human rights of everyone in Britain.

Ethical commissioning	In relation to the procurement process within social care services, ethical commissioning operates a person-centred care first/human rights approach which ensures that strategies focus on high quality care. This includes fair work practices which encourage the development of a quality, sustainable and appropriately valued work force; climate and circular economy considerations in Scottish Government's service footprint to support a just transition to net zero; financial transparency and commercial viability of any outsourced services; full involvement of people with lived and living experiences throughout; putting the person at the centre of making the choice and a shared accountability between all partners and individuals involved in delivery.
Ethos	A set of beliefs or ideas about the social behaviour and relationships of a person or group.
Fair Work in Social Care Implementation Group (FWSCIG)	Formerly known as the Social Care Living Wage Implementation Group, the FWSCIG aims to improve the working experience of those in the adult social care workforce. The group's membership comprises representatives from Scottish Government, COSLA, Integration Authorities, third and independent sector providers and the Scottish Trade Union Congress. The group focuses on the implementing the recommendations outlined in the Fair Work Convention Report.
Fair Work Principles	The concept of Fair Work balances the rights and responsibilities of both employers and employees. It aims to offer everyone an effective voice, opportunity, security, fulfilment and respect.
Future Proofing Programme (FPP)	<p>This programme brings together the SSSC's work on modernising their Register, qualifications and skills and the SSSC Codes of Practice for Social Service Workers and Employers (the Codes). The FPP aims to make registration with the SSSC simple, easy to understand and inform people about the benefits and value of being registered as well as the skills, standards and qualifications needed to deliver high quality care.</p> <p>The FPP is expected to conclude in 2024.</p>

General Data Protection Regulations (GDPR)	The GDPR is a regulation in EU law which controls how personal information is collected and processed by organisations, businesses or the government. The UK Government implemented the GDPR in The Data Protection Act 2018.
General Medical Council (GMC)	The GMC maintains the official register of medical practitioners within the UK. It is a public body whose aim is to “protect, promote and maintain the health and safety of the public” by controlling entry to the register and suspending or removing members as appropriate.
General Teaching Council for Scotland (GTCS)	The GTCS is the teaching profession’s independent registration and regulation body. It is a legal requirement for all those employed as teachers in Scottish schools, along with college lecturers, to be registered with the GTCS.
GIRFEC (Getting It Right for Every Child)	GIRFEC is the Scottish Government’s commitment to provide all children, young people and their families with the right support at the right time in order that every child and young person in Scotland can reach their full potential. GIRFEC provides Scotland with a consistent framework and shared language for promoting, supporting, and safeguarding the wellbeing of children and young people. It is the national approach in Scotland to improving outcomes and supporting the wellbeing of our children and young people by offering the right help at the right time from the right people. It supports them and their parent(s) to work in partnership with the services that can help them.
Health and Social Care Partnerships	Health and Social Care Partnerships, (HSCPs) are organisations which integrate services provided by Health Boards and Councils in Scotland. They are statutory bodies and each of the 31 HSCPs is jointly run by the NHS and respective local authority. All are responsible for adult social care, adult primary care and unscheduled adult hospital care - some also take responsibility for children’s services, homelessness and criminal justice social work.
Health and Social Care Standards: My support, My life	The standards set out what people should expect when using health, social care or social work services in Scotland and aim to provide better outcomes while ensuring that human rights are observed and everyone is treated with respect and dignity.

Healthcare Improvement Scotland (HIS)	HIS' focus is to reduce healthcare associated infection risk to hospital patients, to improve the care of elderly patients and to regulate independent healthcare services through an inspection framework.
Healthcare Support Workers (HCSWs)	This term describes the wide range of staff whose work supports the delivery of care and services across health and social care organisations, e.g. healthcare assistants, nursing assistants, theatre support workers and maternity support workers amongst many others.
Human Rights Bill	The Bill will give domestic effect to a wide range of internationally recognised human rights within the limits of devolved competence. Incorporating international human rights standards and obligations into the domestic legal framework is expected to further the protection of economic, social, cultural and environmental rights for the people of Scotland.
Hybrid approach	The combination of two or more methods or techniques that provide more advantages than each by itself.
Independent Living Fund Scotland (ILF Scotland)	The ILF Scotland is a Non-Departmental Public Body which provides funding and support to help disabled people in Scotland live independently.
Independent review	An independent review is commissioned by a government to carry out a formal yet impartial examination of a particular matter in order to establish whether or not it can be improved.
Inspection	The checking or evaluation of an organisation against established standards. In respect of social care, inspections are carried out for the purpose of determining if a body is complying with the regulations which govern it.
Institute for Research and Innovation in Social Services (IRISS)	IRISS is a charity that supports people, workers and organisations in social work and social care to help them use knowledge and innovation to make positive change happen.
Intersectional barriers	This describes the ways in which systems of inequality based on gender, race, ethnicity, sexual orientation, gender identity, disability, class and other forms of discrimination meet to expose an individual to overlapping forms of discrimination and marginalisation.

Linked services	Linked services in respect of social care refer to the co-ordination and collaboration between different organisations and agencies involved in providing social care support to individuals and communities with an aim to improving the overall quality of care, promoting wellbeing and ensuring the efficient use of resources.
Lived experience	This is a term which describes a particular experience that a person has lived through.
Living experience	This term describes someone's experience and perspective gained from the circumstances in which they are currently living their life.
Memorandum of Understanding (MoU)	An MoU is an agreement, between two or more parties, which is outlined in a formal document. It is not a legally binding document, instead, it sets out the scope, purpose, intentions and expectations of the parties with regard to their working relationship. It is the written version of a 'gentlemen's agreement'.
Mental Health (Care and Treatment) (Scotland) Act 2003	This Act replaces the 1984 Act and restates and amends the law relating to people living with a mental health issue. It establishes new arrangements for the detention, care and treatment of such people. It also refines the role and functions of the Commission and establishes the Tribunal as the principal forum for approving and reviewing compulsory measures for the detention, care and treatment of people living with a mental health issue.
Mental Welfare Commission	The Mental Welfare Commission is a non-departmental public body which is responsible for safeguarding the rights and welfare of people in Scotland who have a learning disability or a mental health issue.
National Care Service (NCS)	The IRASC recommended the establishment of a National Care Service, with Scottish Ministers being accountable for the delivery of consistent and high standards in health and social care services. The Scottish Government is committed to delivering a National Care Service by the end of this parliamentary term that will ensure the quality, fairness and consistency of provision of social care services meets individuals' needs, regardless of where they live in Scotland.

National Care Service (Scotland) Bill	The Bill aims to create a National Care Service and improve the quality of social work and social care services in Scotland by ensuring that these services are offered in the same way and to the same standard throughout Scotland.
National Performance Framework (NPF)	The NPF is Scotland's wellbeing framework. It sets out five strategic objectives and 11 national outcomes. Scottish Government uses the framework to set priorities, plan, allocate funds and monitor progress and performance.
'Near Me'	'Near Me' is a video consulting service that enables people to attend appointments from home or wherever is convenient. The service is widely used across NHS Scotland for health and care appointments.
NHS Education for Scotland (NES)	NES is an education and training body and a national health board within NHS Scotland. It is responsible for developing and delivering healthcare education and training for the NHS, health and social care sector and other public bodies. It participates in undergraduate, postgraduate and continuing professional development.
Nursing and Midwifery Council (NMC)	The NMC is the independent regulator for nurses and midwives in the UK (and for nursing associates in England).
Office of the Scottish Charity Regulator (OSCR)	OSCR is the independent Regulator and registrar for Scotland's charities, including community groups, religious charities, schools, universities, grant-giving charities and major care providers. There are currently 25,324 charities registered with OSCR.
PANEL Principles	Adopting a human rights-based approach is about making sure that people's rights are placed at the very centre of policies and practices. The PANEL principles are one way of breaking down what this means in practice. The principles are Participation, Accountability, Non-Discrimination, Empowerment and Legality.
Personal Assistant (PA)	A Personal Assistant is someone who is employed directly by an individual to support them to live independently by means of SDS.

Power of attorney	A power of attorney is a document which gives someone else the permission and authority to make decisions about your money and property as well as your health and personal welfare. It provides an individual with the opportunity to set out they want to happen in the future, or immediately, should they no longer be able to look after their own affairs. As a power of attorney gives legal authority for someone else to act on your behalf, it is important to take advice from a solicitor when completing one.
Professional Standards Authority for Health and Social Care, England	An independent organisation, accountable to the UK Parliament which helps to protect the public through its work with organisations that register and regulate people working in health and social care. Its reports help Parliament monitor and improve the protection of the public. The Health and Social Care Committee uses the Authority's performance reviews to question the regulators about their work.
Protecting Vulnerable Groups Scheme (PVG)	This scheme is managed by Disclosure Scotland and aims to protect children and protected adults by preventing unsuitable people from working in regulated areas of work.
Public Bodies (Joint Working) Scotland Act 2014	This Act provides the framework which supports the improvement of the quality and consistency of health and social care services in Scotland. The framework requires the integration of certain local authority services with health services. The Act also provides for NHS Scotland to provide goods and services to public bodies, including local authorities. It also allows the Scottish Ministers to form a wider range of joint venture structures, and to form joint ventures for a wider range of purposes, in order to make the most effective use of resources.
Public Sector Bodies (Websites and Mobile Applications) Accessibility Regulations 2018	The Regulations aim to ensure public sector websites and mobile apps are accessible to all users, especially those with disabilities. All new public sector websites must meet accessibility standards and publish an accessibility statement which must make clear the level of accessibility across the site or app. Where there are barriers, the statement must provide alternative routes of access and enable users to contact the website owner if they identify any issues.

Public Sector Reform (Scotland) Act 2010	The purpose of this Act is to simplify and streamline the public bodies landscape in Scotland to deliver improved public services and better outcomes for the people of Scotland. Amongst other things, it created Social Care and Social Work Improvement Scotland which now operates under the name of the Care Inspectorate. It also established Healthcare Improvement Scotland.
Putting Learners at the Centre: Towards and Future Visions for Scottish Education (The Muir Review)	This Report focuses on the replacement of the Scottish Qualifications Authority, reform of Education Scotland and removal of its inspection function. Its recommendations place children, young people and those teachers and practitioners who support their learning more firmly at the heart of the education system and aim to establish a revised infrastructure that begins to simplify the landscape and ensures all teachers and practitioners have greater clarity as to the roles and functions of key national bodies.
Qualitative	Qualitative data is descriptive and relates to events which can be observed but not measured (such as language, images and sounds). The focus is on exploring subjective experiences, opinions and attitudes through observation and interviews. The aim of qualitative research is to uncover new insights and meaning.
Quantitative	Quantitative data is information about quantities, and therefore numbers which is analysed using statistical methods. The aim is to produce objective, empirical data that can be measured and expressed in numerical terms. Quantitative research is often used to test hypotheses, identify patterns and make predictions.
Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017	These Regulations set out the requirements for service providers, in Wales, in relation to the standards of care to be provided in to care homes, secure accommodation, residential family centre and domiciliary support services. The aim is to ensure high standards of care for all service users.
Regulation	The control of an activity or process, usually by means of rules. In respect of social care, the purpose of regulation is to protect the public from the risk of harm which may result from the provision of social care support services.

Regulation of Care (Scotland) Act 2001	The main aim of the Act is to improve standards of social care services. The Act meant that far more care services and staff came under scrutiny and had to conform to established standards. Failure of a care service or an individual to comply with the act and associated regulations means they can be de-registered and no longer able to provide services.
Regulator	A regulator is a person or body with functions under legislation relating to the regulation of a regulated profession. Regulators carry out a range of functions in relation to the professions they regulate, including making sure individuals have the necessary qualifications and/or experience to practise the profession and taking any necessary enforcement action. In some cases, these functions are carried out by a single regulator for an individual profession and in other cases the functions are distributed across several regulators. Regulators include bodies to which regulatory functions have been delegated, where the delegation is authorised by legislation and irrespective of whether the regulator is specified in the legislation.
School Age Childcare (SAC)	This comprises a range of organised age-appropriate structured programmes, clubs and activities for school-aged children and young people (between the ages of 4 and 18 years) which takes place within supervised environments outside of school hours.
Scotland Act	This Act provides for the establishment of a Scottish Parliament and Administration. It sets out changes in the constitution and functions of certain public authorities along with other connected purposes such as legislative competence, tax raising powers and other devolution issues.
Scottish Drug Deaths Taskforce	The Taskforce was established to provide independent expert advice and guidance on how to tackle the challenge of deaths attributed to drugs.
Scottish Housing Regulator (SHR)	The SHR is a non-ministerial department responsible for regulating social housing in Scotland. It has a statutory objective to safeguard and promote the interests of tenants living in homes provided by social landlords, homeowners who receive services from social landlords and local authorities and Gypsy/ Traveller families who use official sites provided by social landlords. In addition, the SHR holds a Register of all social landlords in Scotland.

Scottish Housing Regulator’s (SHR) Tenant Advisor Panel	The SHR regulates social housing in Scotland to protect the interests of people who receive the services of social landlords. Tenant Advisors are tenants of either Registered Social Landlords or Local Authorities, who volunteer to participate in the regulation work of the SHR.
Scottish Mental Health Law Review Final Report	The main aim of the review was to improve the rights and protections of people subject to mental health, incapacity or adult support and protection legislation, in line with developments in international human rights standards.
Scottish Social Services Council (SSSC)	The SSSC is responsible for registering people who work in the social services and regulating their education and training.
Scottish Social Services Council Codes of Practice	The Codes set out the national standards of conduct and practice that apply to everyone who works in social services in Scotland. They also outline the standards expected of employers of social service workers in Scotland.
Scrutiny	The process of careful and detailed observation or examination of something.
Self-Directed Support (SDS)	<p>Anyone who is eligible for social care support is entitled to exert choice and control over how they receive services. Accordingly, care services can be adjusted to fit their needs and wants. There are four options to choose from:</p> <ul style="list-style-type: none"> • option 1 – a direct payment, which is a payment to a person or third party to purchase their own support; • option 2 – the person directs the available support; • option 3 – the local council arranges the support; and • option 4 – a mix of the above. <p>A budget will be provided and the individual may use it to fund their care as they choose.</p>
Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011	These Regulations set out requirements which must be complied with by providers of care services. The aim is to ensure that care services provide good quality care and support in a way which promotes quality and safety

Social Care (Self-Directed Support) (Scotland) Act 2013	This Act makes legislative provisions relating to the arranging of care and support (“community care services” and “children’s services”) in order to provide a range of choices to individuals as to how they are to be provided with their support.
Social Care Support	Social care support is about supporting people to live independently; to be active citizens; to participate and contribute to our society and to maintain their dignity and human rights.
Social Care Support Services	Services include all forms of personal and practical support for children, young people and adults who need extra support, for example, the provision of care at home, placement in residential or care homes and supporting unpaid carers to help them continue in their caring role.
Stakeholder	Stakeholder refers to individuals, groups or organisations who have an interest in the policy or action being proposed or are impacted by it.
Stakeholder engagement	This is a process that organisations follow in order to listen to, collaborate with, or inform (or a combination of all three) their existing stakeholders when developing new policies.
Technology Enable Care (TEC) Programme	The TEC Programme is part of the Scottish Government’s Digital Health and Care Directorate and is guided by the overarching Digital Health and Care Strategy. The programme focuses on citizen-facing digital solutions where outcomes for individuals in home or community settings are improved through the application of technology as an integral part of quality, cost effective care and support to look after more people at home.
The Crerar Review	This review considered how Scotland’s systems of regulation, audit, inspection and complaints handling for public services could be improved. It made proposals for improvements to the complaints handling system to give the public better access to redress and scrutiny and recommended a system of complaints handling for all public services with the SPSO taking responsibility for its implementation and oversight.
The Independent Review of Adult Social Care in Scotland (IRASC)	The principal aim of the IRASC was to recommend improvements to adult social care in Scotland. The review recommended the creation of the National Care Service, amongst other things.

The Promise	The Promise is that Scotland’s care experienced children and young people will grow up loved, safe and respected and is built upon five foundations: family, voice, care, people and scaffolding. The Promise Scotland is an organisation that exists to support Scotland in keeping its promise to care experienced people.
The Scottish Drugs Deaths Taskforce Final Report: Changing Lives	The Taskforce was established to provide independent expert advice and guidance on how to tackle the challenge of deaths attributed to drugs. This Report outlines a suite of evidence-based recommendations and actions to reduce drug-related deaths and harms and improve and save the lives of people who use drugs were made.
Third Sector	This term describes organisations that are non-governmental and not-for-profit. They are socially focussed and operate within the voluntary, community and charitable fields.
UK GDPR	The UK General Data Protection Regulation refers to the legislation that governs the protection of personal data in the United Kingdom. It is a set of rules and guidelines designed to ensure the privacy and security of individuals’ data.

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14. Recommendations



1. It is recommended that inspection, scrutiny, and regulatory bodies consistently apply a human rights-based approach that places people at the centre of the process.
2. It is recommended that matters of trust, respect, relationships, ethos and culture be placed at the heart of inspection, scrutiny, and regulation and should be reflected in reports.
3. It is recommended that inspection, scrutiny, and regulatory bodies must set out clearly in their annual report how they have led and cultivated a culture of openness and trust.
4. It is recommended that inspection, scrutiny, and regulatory bodies make appropriate arrangements to engage people with lived and living experience in co-designing engagement tools and developing the inspection and regulatory frameworks.
5. It is recommended that a system be put in place for people to have a **formal** role as lay inspectors in the process of inspection, scrutiny, and regulation, including young people with care experience. An appropriate level of remuneration should be made available.
6. It is recommended that inspection bodies' approach to engagement must be flexible, inclusive and appropriate. This includes allowing sufficient time for responses to be made and making suitable arrangements for conversations to take place with individuals, family members and staff, ensuring consistency and accessible information is available.
7. It is recommended that independent advocacy is available for people to help them to exercise their rights, and when necessary, to provide support to navigate complaints and any escalation processes.
8. It is recommended that a co-produced and bespoke scheme of registration for Personal Assistants (PAs) which recognises their skills and role, and opens up access to training and development, should be developed. Such a scheme would **expressly** seek not to create barriers, and through co-production, would create positive opportunities for both the Personal Assistant and their employer.
9. It is recommended that there should be a universal requirement to obtain registration with a regulatory body for all social care support staff appropriate to their role and setting, and that this should be a condition upon joining the social care workforce.
10. It is recommended that inspection, scrutiny, and regulation should be extended to areas not part of the current system, including agencies who provide social care staff, to help drive continuous improvement and deliver better outcomes.
11. It is recommended that further development of stronger links between regulatory bodies across all areas within and out with the borders of Scotland should be established to ensure better regulation, transparency and accountability of providers of social care support services.

12. It is recommended that the best practice from other nations' regulatory landscape is explored and considered with a view to enhancing transparency and accountability, particularly in relation to there being a named, accountable link to registration, inspection and local employees.
13. It is recommended that The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 be reviewed to ensure consistent, effective and comprehensive applicability of the fit and proper person provisions across social care support services in Scotland.
14. It is recommended that Scottish Ministers make appropriate arrangements for market oversight and sustainability in the social care sector.
15. It is recommended that the list of care service types and set of corresponding definitions as set out in Schedule 12 of the Public Services Reform (Scotland) Act 2010, are assessed for fitness for purpose.
16. It is recommended that inspection, scrutiny, and regulation processes more fully take account of an individual's experience of service delivery and their overall care journey to understand, follow and evaluate the person's social care support experience over time and their impacts.
17. It is recommended that clear and accessible information about the agencies and their roles, responsibilities and accountabilities is provided for all those who require social care support services.
18. It is recommended that Scottish Government work with the regulators to clarify roles and responsibilities between organisations to streamline inspection activity, remove repeat inspections by different agencies and to reduce duplication and omission. This should include reviewing how joint inspections are currently carried out, encouraging more partnership working and joint inspections, and greater involvement of people in receipt of social care support in inspection, scrutiny, and regulation.
19. It is recommended that inspectors and regulators, whilst fulfilling their statutory duty to identify shortcomings in improvement, should also place equal weight on identifying good practice, innovation and improvement across the sector.
20. It is recommended that an emphasis on outcomes and continuous improvement becomes a central focus of inspection, scrutiny, and regulation.
21. It is recommended that there should be a duty on the regulator/inspector to work more closely with the provider on agreeing action plans and timescales for continuous improvement recommendations that are additional to regulatory requirements and improvement notices.
22. It is recommended that the Scottish Government updates and clarifies its expectations regarding the National Performance Framework (NPF) in relation to publicly funded delivery bodies, particularly with respect to outcomes for social care support services.

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23. It is recommended that Scottish Ministers should review legislation to ensure that regulatory bodies have adequate enforcement powers.
 24. It is recommended that a duty to self-report should be reviewed to ensure that self-reporting is inherently linked to continuous improvement, whilst also ensuring the regulatory bodies have appropriate powers to act when issues are identified.
 25. It is recommended that there is clear and accessible public information about how to raise a concern and systems of complaints. Those systems of complaints should be easy to use, have accessible detail about routes of escalation with clearly defined outcomes that can include redress for people.
 26. It is recommended that the Scottish Government should make arrangements to ensure appropriate oversight of regulatory provision of social care support and consider whether there should be separate arrangements put in place for Scotland, in this respect.
 27. It is recommended that qualitative measures should be co-designed by the regulatory agencies and people with lived and living experience to ensure that they include elements of services that are important to people.
 28. It is recommended that the sharing of data is examined, with the people at the centre of the process having access to their own data in formats that facilitate their understanding of it in order to support decision making and their involvement in this. This data should also be utilised for service planning and improvement, both strategic and operational.
 29. It is recommended that data is utilised for social care planning and individuals, and their advocates have access to this to inform their choices.
 30. It is recommended that there is a 'duty to co-operate' placed upon service providers to share data appropriately and equally upon regulatory bodies to work together to avoid duplication in their requests for information.
 31. It is recommended that the type of data collected, and its purpose, is reviewed to ensure that the right data is collected for the right reasons, with a focus on data supporting performance management and service improvement.
 32. It is recommended that a more tailored and contextualised approach is developed to how GDPR is used and interpreted within the regulatory landscape. It is also recommended that an Information Governance (IG) group is established to support the effective and proper use of information and engagement with IG experts.
 33. It is recommended that a review of the Health and Social Care Standards takes place to ensure they are based on human rights, ethical commissioning and are outcomes focused. The Standards should be the basis on which social care support services are inspected, scrutinised and regulated.
 34. It is recommended that Scottish Ministers should review the powers of intervention and enforcement currently in place, where providers fail to

meet workforce registration obligations or fail to follow the codes of conduct and consideration be given as to where powers of enforcement should lie.

35. It is recommended that regulators and providers examine ways in which the workforce can become more actively involved in the inspection process, on a basis of mutual trust and respect.
36. It is recommended that Scottish Ministers align the social care workforce in a coherent model, based on fair work, to support the sustainability of the workforce and to help drive continuous improvement.
37. It is recommended that Scottish Ministers should review the sufficiency, quality and availability of resources for training, development and improvement.
38. It is recommended that steps are taken to ensure that nationally recognised qualifications that reflect the skills required to work in the social care sector are developed and are portable across the social care sector.



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