Mental Health Scrutiny and Assurance Evidence Review

April 2024

Scottish Government
Riaghaltas na h-Alba

Forensic
Network

Contents

List of Abbreviations

AS Audit Scotland

ASD Autism spectrum disorder

AHP Allied health professional

CI Care Inspectorate

EiP Early intervention in psychosis

HB Health Board

HIS Healthcare Improvement Scotland

HIW Health Inspectorate Wales

SB Scrutiny Body

SPSO Scottish Public Services Ombudsman

ID Intellectual disability

IJB Integration Joint Board

JIAS Joint Inspections of Adult Services

MDMHT Multidisciplinary mental health team

NSACG Mental Health and Learning Disability National Scrutiny and Assurance Coordination Group

MWC Mental Welfare Commission for Scotland

NHS National Health Service (Scotland)

NES NHS Education for Scotland

SIHCG Sharing Intelligence for Health and Care Group

SMHLR Scottish Mental Health Law Review

SPSP Scottish Patient Safety Programme

TSH The State Hospital

VOX Voices of Experience

Executive summary

Scottish Mental Health services have a duty to the communities they serve to maintain the quality and safety of patient care. David Strang's (2020) Independent Review of Mental Health Services in Tayside noted that at a national level, there is currently limited scrutiny and oversight of mental health services in Scotland. He drew attention to organisations such as Healthcare Improvement Scotland (HIS) and Mental Welfare Commission (MWC), who currently have limited powers to monitor and enforce the recommendations they make. He recommended that the Scottish Government conduct a national review of the scrutiny and assurance of mental health services, including the powers of HIS and MWC. This review includes the Care Inspectorate (CI), due to their wider role in relation to mental health within care services and the relevance of their working relationships with HIS and MWC.

The aim of this review is significant and is to inform the Scottish Government's considerations around the scrutiny and assurance of mental health services – predominantly secondary services - mapping current arrangements and possible improvements to strengthen these. Ultimately, this work will contribute to the future of scrutiny and assurance of mental health services in Scotland, ensuring they are safe, timely, effective, person-centred and delivered for service users in equitable ways.

Methods

There were three distinct phases of the project: Phase 1 - a rapid review of literature to establish the existing evidence base; Phase 2 - a national survey to capture views from senior managers/clinicians, directors and chief executives; Phase 3 - a series of interviews, affording stakeholders opportunity to express their views on current practice, identify gaps and explore how best to strengthen scrutiny and assurance arrangements in the future. A written invitation to interview was extended to all potential participants. Appropriate representation was sought across 50% of the Scottish Health Boards ensuring contributions from North, South, East and West geographical areas, urban and rural locations, taking account of variation in size location and representative of Integration Joint Boards (IJB).

Existing evidence base

There is a growing body of evidence within the literature that outlines good practice at a local, national and international level. However, issues have been identified with current external scrutiny and local governance, namely: the inconsistent and varied use of measurement tools; lack of standardisation of measurement instruments used within mental healthcare systems; reporting and regulatory bodies' lack of communication and sharing of intelligence and data. This review identified international evidence and national examples of good practice to learn from and inform external scrutiny and local governance arrangements. There appears to be a consensus towards approaches and recommendations that may provide a solution to the issues highlighted.

Such as:

- The provision of leadership in establishing agreement on a common set of mental health quality measures and the development of an overarching framework necessary to obtain and manage this information.
- The collection of measurement data and reporting in a variety of ways understandable by different audiences such as patients, other quality oversight bodies, policy makers and healthcare providers.
- For professionals and services to routinely use validated assessment instruments to monitor and evaluate patient outcomes including standardised performance indicators to improve the quality of care.
- The increased service user and patient involvement in all aspects of scrutiny and assurance services.

Capturing the stakeholder perspective

There are a number of different stakeholders involved in governance and assurance processes including people with lived experience who are in receipt of mental health care and treatment; those who deliver and manage health and social care services, and those who oversee and are responsible for the scrutiny of services. Information was captured from organisations representing these perspectives through the use of a national survey using a questionnaire and discussion through one to one and

group interviews with stakeholder representatives. There were twenty-six responses to the survey and thirty participants were interviewed.

Findings from the questionnaire indicate that external scrutiny does capture key issues and involvement of people with lived experience improves the process. Collaboration and sharing intelligence between external scrutiny bodies is considered patchy and there is general agreement that there is scope for improvement. Follow up processes are a source of frustration, requiring further exploration of the powers associated with HIS and MWC, to ease implementation of recommendations.

Reflecting on discussions with stakeholders, there exists a question around whether scrutiny should be rights or process based, in order to establish the real value of mental health services and how well they function. Tensions exist between focussing on the individual or the organisation and its systems and processes. We suggest both can be of value, especially where there are different but complimentary approaches, allowing different perspectives to be explored. The importance of investigations taking account of the wider context cannot be underplayed, and reviewers must endeavour to keep abreast of current practice, in order to understand and account for the current context. People with lived experience understand both systems and processes, having had first-hand experience of the services, yet their representation at the highest level is not always evident. Finite resources must be used wisely and a more cohesive approach across all scrutiny bodies is necessary in order to be more productive.

A number of themes emerged through the stakeholder interviews, namely:

- the complex landscape of multiple scrutiny bodies and a need to improve the collective leadership and accountability;
- uncertainty as to whether the focus of scrutiny activity is on people or services and some examples of disconnect with what is happening ‘on the ground’;
- a need for improved joint working and communication between scrutiny bodies;
- the issues caused by a lack of power held by scrutiny bodies, as well as limited resources;

- a role for the meaningful involvement of people with lived experience and the prominence of their voice within reporting;
- the important role of internal governance in improving quality and safety, including creating opportunities for learning and follow-up on scrutiny recommendations;
- the improvements needed regarding measurement and data availability, access and sharing.

Conclusions

The wealth of data gathered from the rapid literature review, questionnaires and interviews has served to provide a real sense of strengths and areas for improvement that exist in current systems and processes. The literature highlighted areas of good practice that facilitated strong scrutiny and assurance, including: national standards of care; regular inspection of services; regular reporting of service performance to local and national government and publicly available performance indicators and benchmarking. The survey with stakeholders produced mixed results. A shared passion and desire for success was evident from all respondents, and an eagerness to achieve more and provide a better service for the people of Scotland was at the heart of each conversation. There were however clear differences of opinion in relation to how successful current practices are, and strong views on the need for change and improvement. In particular, there were calls for more external scrutiny of CAMHS, Intellectual Disability and Community mental health services.

A list of recommendations is enclosed with suggested solutions to issues raised with regard to current systems and processes.

Recommendations

1. Ensure a managed overarching framework that leads to a cohesive and coordinated approach to external scrutiny is implemented. This could be achieved through adjustment of the existing role of the Mental Health and Learning Disability National Scrutiny and Assurance Coordination Group

(NSACG) or creation of a new group. A clear remit for external scrutiny dedicated to mental health and learning disability requires to be adopted.

2. If the NSACG were to function in the capacity described above, rather than create a new group, it should review and strengthen the role and remit in order to optimise efficiency and minimise duplication of work. Consider and enhance collaboration between NSACG and SIHCG. Position MWC as permanent chair, replacing the existing rotating chair, due to their extensive focus on mental health and learning disability. This should be done recognising and respecting each organisations' independence and their own governance arrangements. The NSACG will require authority to support accountability of NHS Health Boards, which may require legislation.
3. Review and improve the way in which inspections/visits are scheduled collectively, to minimise duplication of work for both scrutiny bodies and Health Boards/IJBs. Co-ordinate joint and co-produced themed visits, with an agreed joint methodology to maximise resources.
4. Scrutiny bodies to support the full implementation of the new Mental Health Quality Standards and utilise the standards as a common framework to support the coordination of scrutiny activity.
5. Improve public awareness and increase visibility of all scrutiny bodies and their individual and collective roles, remits and responsibilities. Methods through which this could be achieved should feature on the workplan of the NSACG.
6. Review and strengthen the role and responsibilities of people with lived experience within scrutiny bodies, with a view to introducing roles at Board/senior level in order to ensure greater involvement and focus on people with lived experience. Influence at senior level is more likely to ensure the people with lived experience voice is respected and suggestions from people with lived experience in reports are safeguarded.
7. Ensure employees of scrutiny bodies have the opportunity and accept responsibility for keeping themselves abreast of changes in practice and appreciate current context to maintain credibility. Also, to give greater consideration to the wider context when undertaking inspections/reviews and reflect this more strongly in final reports, to give a greater focus on systemic issues.

8. Increase support from scrutiny bodies in the follow up of recommendations arising from reports, for example, through offering suggestions and sharing examples of good practice. Encourage the exploration of existing evidence captured in the literature; learning from tried and tested methods is both logical and pragmatic.
9. Review and improve existing data sharing mechanisms that exist at NES (Azure) with a view to implementation, as opposed to creating or purchasing new systems in order to expedite sharing of intelligence. Safety and security of data sharing is of critical importance.
10. Improve the equity of scrutiny across the lifespan, with a renewed focus on Community, Intellectual Disability (ID) and Child and Adolescent Mental Health Services (CAMHS).
11. Refocus on how and what is measured across the lifespan extending to use of softer outcomes, such as wellbeing and quality of care.
12. Explore any additional powers aligned to MWC in order to enable recommendations to be enacted in a timeous manner.
13. Provide awareness training for staff in Health Boards/IJBs in governance and assurance related issues.
14. Implement a two-strand approach to scrutiny, involving a regular cycle of reviews in addition to risk-based and intelligence led inspections. It is recognised that this recommendation may have resource implications for scrutiny bodies.
15. Continue good practice of engaging in rigorous review through thorough internal and external governance processes for mental health and Intellectual Disability services.

Introduction

Scottish Mental Health services use a governance framework through which organisations and their staff are accountable for continuously improving the quality of patient care. Staff are required to ensure that appropriate systems and processes are in place to monitor practice and protect high quality care. Scrutiny and governance frameworks provide mechanisms to do this by requiring Scottish Mental Health services to provide evidence that standards are upheld in the processes, systems and structures they use to deliver care. Importantly, governance is required to reassure the public that the care being received and delivered is of the highest standard. Scottish Mental Health services have a duty to the communities they serve to maintain the quality and safety of patient care.

Within Scotland most scrutiny and assurance activity takes place within the Boards, for example, each Board accept responsibility for measurement against key performance indicators, undertaking audits and internal investigations. There are also external scrutiny and clinical governance processes undertaken by organisations such as HIS, MWC, the Care Inspectorate (CI), and Scottish Public Services Ombudsman (SPSO). This mean reviews, visits and inspections of services are undertaken in order to assess and capture quality, safety and satisfaction with services and adherence to standards of care provision. In essence, these organisations seek to provide the quality assurance required to give people confidence in the services they use, and support improvement initiatives undertaken by services, whether they are NHS hospitals and services or independent healthcare services (HIS, 2022). In addition, these organisations carry out statutory duties by monitoring the law and its requirement for people providing care and treatment. David Strang's (2020) Independent Review of Mental Health Services in Tayside noted that at a national level, there is currently limited scrutiny and oversight of mental health services in Scotland. He drew attention to HIS and the MWC, who currently have limited powers to monitor and enforce the recommendations they make. He recommended that the Scottish Government conduct a national review of the scrutiny and assurance of mental health services, including the powers of HIS and MWC. The Scottish Government (2020) publicly committed to delivering this recommendation in the Mental Health Transition and Recovery Plan.

For the purposes of this review, we are focussing on mental health and learning disability services provided by Health Boards. The aim is to inform the Scottish Government's, scrutiny bodies and other relevant partners, considerations around the scrutiny and assurance of health-care provided mental health services, identifying current arrangements and possible improvements to strengthen these. In order to achieve this, current governance and scrutiny arrangements in Scotland were examined both at a local and national level. This included the statutory roles, functions and powers of HIS, the MWC, as well as the CI, although the role of CI is less relevant as they do not scrutinise services provided by Health Boards.

The review looked at international evidence and best practice, establishing what good scrutiny and assurance could and should look like for mental health services within Scotland. As part of this work, engagement was carried out with key stakeholders through a survey and a series of interviews, to gather the views on current practice, identify gaps and explore how best to strengthen scrutiny and assurance arrangements in the future. Ultimately, this programme of work is important and will contribute to the future of scrutiny and assurance of mental health services in Scotland, ensuring they are safe, timely, effective, person-centred and delivered for service users in equitable ways.

This review has been undertaken with similar timings to the Independent Review of Inspection, Scrutiny and Regulation (IRISR) by Dame Sue Bruce which was recently published in September 2023. The IRISR looked at how social care support and linked services are inspected, scrutinised and regulated across Scotland. The IRISR considered how to ensure a human rights-based and person-centred approach is central to the inspection, scrutiny and regulation of social care support and linked services, including how this can be applied to deliver improved outcomes for people. Both reviews were undertaken independently of each other. These reports both examine inspection, scrutiny and regulation, but focused on different sectors (mental health and social care support and linked services) and their recommendations are tailored to specific sectors of focus.

Methods

A mixed methods approach was adopted, with three stages: a rapid review of the literature, survey of representatives from organisations involved and interested in the scrutiny of metal health services, finally a series of semi-structured interviews with purposively selected respondents.

Literature review

A rapid literature review and narrative synthesis of evidence regarding the scrutiny and assurance of mental health services in Scotland was undertaken. This mapped current arrangements for external scrutiny and assurance, and local governance and assurance practices. The emerging findings from the review informed the qualitative study by shaping the topic guides for stakeholder interviews.

The search strategy incorporated literature from both published peer-reviewed academic research articles, and the grey literature, including formal reports published by public sector organisations and government. Further detail on method is outlined in Appendix 1.

Survey

A brief survey captured the national perspective of current scrutiny of mental health service provision within Scotland.

A structured pro forma (questionnaire) was developed and used to facilitate the collation of responses into a single, purpose-built electronic database prior to return to the contracting team for data analysis and synthesis. The questionnaire was brief to maximise completion rates, while soliciting the range of necessary information. It comprised of two parts, Part A and Part B.

Questions in Part A included the following subject areas:

- The accuracy of findings and information about current local governance and external scrutiny arrangements (as appropriate depending on the respondent)
- Views on the strengths of current local governance and external scrutiny arrangements (as appropriate depending on the respondent)

- Views on the weaknesses and gaps in current local governance and external scrutiny arrangements (as appropriate depending on the respondent)
- Views on how to strengthen current local governance and external scrutiny arrangements (as appropriate depending on the respondent).

Questions in Part B requested information on:

- The implementation process Health Boards/IJBs adopt following recommendations from scrutiny bodies.

Forms closed with an opportunity to share any other information or feedback about scrutiny of services, which may have been relevant for this exercise.

Participants

It was considered important to gather the perspective of scrutiny bodies, Health Boards/IJBs, but also wider views of organisations with an interest in the impact of mental health scrutiny, for example, NHS Education for Scotland (NES) and Voices of Experience (VOX). Participants were selected based on their knowledge and experience of the scrutiny processes and ability to respond to questions posed of senior level management; given their level of accountability and associated responsibilities.

A broad representation of views was gathered from twenty-six responses to the survey, see Table 1. Replies emerged from three special health boards (The State Hospital, NHS 24 and NHS Education for Scotland), nine Health Boards/IJBs (Ayrshire and Arran, Borders, Forth Valley, Greater Glasgow and Clyde, Highland, Lanarkshire, Lothian, Orkney and Shetland), VOX and three scrutiny bodies (MWC, CI and SPSO).

Part A (See Appendix 1) was completed by the Chief Executive/Lead for Health Boards/IJBs and representatives from MWC, SPSO, SIHCG, NES, CI and VOX. Part B (See Appendix 2) was completed by a Director of Nursing and/or Medical Director from Health Boards. Questions solicited a mix of numerical and free text responses.

Scrutiny bodies all commented that they found the survey questions quite restrictive and felt more able to provide information through interview. For this reason, only one completed the scale data; analysis is confined to narrative data for this small group. Members of the SIHCG respectfully declined to submit a response to the survey because many of the group members were invited to participate in interviews as part of the wider research process; their preference was to contribute via interview, in order to provide a more comprehensive response. HIS declined to respond to survey for the same reason, but a number of different members actively engaged in subsequent interviews.

Table 1: Survey and Interview Respondents

Table 1: Survey and Interview Organisation	Survey Part A - Number of respondents	Survey Part B - Number of respondents	Number of Participants interviewed
CI	1		3
HIS			4
MWC	1		3
NES	1	1	3
NHS 24	1	1	
NHS A&A	1	1	1
NHS Borders	1	1	2
NHS D&G			6
NHS FV		1	
NHS GG&C		1	
NHS Grampian		1	
NHS Highland	1	1	
NHS Lanarkshire	1	1	2
NHS Lothian	1	1	1
NHS Orkney	1	1	1
NHS Shetland	1		
SPSO	1		1
TSH	1	1	2
VoX	1		1
Total Number	**14**	**12**	**30**

Interviews

A topic guide was developed, it was separately informed by the literature review and early assessment of findings and informal discussion with a member of the represented groups. The contributing group member who assisted with the development of the interview guide was not subsequently invited to interview. Topic guides facilitated an interview of 45-60 minutes.

To address the representation of the views of a range of stakeholders and interested parties, 20 semi-structured qualitative interviews were conducted with a range of professional stakeholders, from a variety of Health Boards/IJBs, see Table 1. This was a purposive sample where participants were selected because of their knowledge on the subject area and ability to answer the questions. The interviews were designed to explore beyond areas of concern highlighted by previous reports

and to complement the quantitative elements. The sample size of thirty participants provided adequate information power (Malterud, Siersma and Guassora, 2016) accepted for the purpose of this research method.

A written invitation to interview was extended to all potential participants. Appropriate representation was sought across 50% of the Scottish Health Boards ensuring contributions from North, South, East and West geographical areas, urban and rural locations, taking account of variation in size location and representative of IJBs. A sample of 50% of the population eligible to participate is likely to result in an accurate representation of opinion. Interviews were undertaken via Microsoft Teams. With assent from interviewees, interviews were recorded then shared with the Researcher who facilitated interview transcription.

Ethical considerations

Consent from staff was implied if potential participants returned questionnaires issued to them or agreed to be interviewed. IRAS ethics committee was approached for ethical permission and advised ethical approval was not necessary since all communication was with members of staff and not patients. All data collected within the study was managed in accordance with Data Protection Act (UK Parliament, 1998) and Caldicott Principles (The Caldicott report, 1999).

Analytical Approach

Descriptive statistics were used to report findings from quantitative data, due to the sample size results did not reach statistical significance. Additional narrative/free text supported the scale data. Data is reported according to Health Board/IJBs, presented alongside salient characteristics of the respective organisations. The Strang report indicated that scrutiny was highly variable across individual Health Boards, so the standardised pro forma aimed to aid calculation of key variables, facilitate comparisons across Health Boards/IJBs, and identify good practice and gaps in current provision. Qualitative data was analysed by three members of the project team, coded in Nvivo using thematic analysis.

Literature Review

This section offers a review of the evidence base. It also describes the roles of each scrutiny body in relation to their mental health activity and identifies strengths and gaps in scrutiny activity.

Scrutiny Arrangements in Scotland

The Public Services Reform (Scotland) Act 2010 placed a duty on scrutiny bodies to cooperate and coordinate their activities with each other. A networked model was adopted in Scotland to improve the efficiency, effectiveness and economic performance of scrutiny bodies such as HIS, MWC and CI. Whilst the MWC's remit is concerned fully in regard to people with mental health issues and the services they use, HIS and CI acknowledge this aspect forms a smaller part of their remits. The volume of scrutiny inspections carried out by each of the organisation on specific areas of mental health is captured in Table 2.

HIS is a national improvement organisation and one of its key roles is independent assurance of quality of care. This sits alongside remits for improvement and redesign support for health and care services, independent assessment of evidence to underpin high quality care, and support to ensure citizens and communities are at the heart of change. Its evidence, improvement and community engagement functions all sit as equal partners alongside assurance under its overall quality management framework. Its priorities are driven by a range of stakeholder needs including system and policy priorities for evidence and improvement alongside key themes identified through assurance and scrutiny activities. HIS has the power to exercise the functions of Scottish Ministers to support, ensure, and monitor the quality of healthcare provided or secured by the health service and the discharge of the duty on NHS boards to encourage public involvement. HIS also evaluate and provide advice to the health service on the clinical and cost effectiveness of new and existing health technologies including drugs.

The MWC holds a duty to undertake enquiries and investigations under the Mental Health (Care and Treatment) (Scotland) Act 2003 (2003 Act). The MWC is narrowly defined within the legislation as their duty is specific to people detained under the Act, and the Adults with Incapacity Act. People receiving the support of mental

health services in hospital or using community settings are more likely not to be subject to the Act compared to the numbers of people who are. The MWC visits people to check that they are receiving appropriate care, where there are indications that appropriate care and treatment is not being received investigations are completed (MWC for Scotland, 2022a). The MWC aims to visit each hospital once a year and The State Hospital twice per year. The MWC undertake themed visits and produce closure reports to follow up on recommendations and to check progress, which are now published for transparency. Alongside the investigative duty, the MWC also has a number of other duties to discharge such as visiting individuals and services, providing information and advice, and influencing and challenging. The MWC is specific to mental health in their scope and remit, scrutinising services who deliver care to people with mental health conditions (Mental Welfare Commission, 2022b).

Table 2: An overview of inspections/visits conducted between 2018-2023

	HIS	MWC
Total	3 inspections	4809 visits
Community based	1 review and 1 meeting	1356 visits
Inpatient based	1 review and 1 meeting	3326 visits
CAMHS	0	14 (inpatient visits)
Psychological Therapies	1 review and 1 meeting	0
Liaison Psychology	0	0
Tertiary services e.g. forensic	0	113 (themed visits)

The CI do not have a locus to inspect the majority of the services detailed in the table. CI therefore have a limited role in inspecting secondary mental health services, which are the predominant focus of this review. The Public Services Reform (Scotland) Act 2010 gives the CI powers to inspect any social care support service or combination of social services, or the organisation or coordination of any social services, relating to the whole or any part of Scotland. As such, from the list of services in the table only those that are community based might be part of the Care Inspectorate's remit. This would only occur as part of a joint inspection with Healthcare Improvement Scotland, to reflect the integrated nature of such services. There have been no specific inspections of Community Mental Health Teams, so no

categories within Table 2 are relevant for the CI. However, from March 2022, the CI regulated 52 care homes for individuals experiencing mental ill health. A sizeable proportion of the 1,499 support services and the 1,054 housing support services will also provide care and support for this client group.

Jointly with HIS, the CI Adult Strategic Team conduct programmes of themed inspections, scrutinising how integration of community-based services positively support people and carers' experiences and outcomes. These themed inspections are not focused on the quality of specialist care for each care group but are a means of identifying groups of people with similar or shared experiences through which to understand how health and social care integration arrangements are resulting in good outcomes. Physical disability and complex needs were the themes of the first phase of these inspections from 2022 and from mid-2023 the CI will focus on mental health. The CI stratification of case records for adult service inspections includes mental health. As such, their inspections consider, and report on, the impact of mental health provision on service user groups.

Effective Communication and Information Sharing

Information sharing protocols and memorandum of understandings are in place between the MWC and the Health and Safety Executive (HSE), SPSO, CI, HIS and Scottish Government on areas of mutual interest to promote effective working relationships with other organisations (Mental Welfare Commission, 2022). In order to provide scrutiny, organisations such as HIS, MWC and CI require a platform to share, discuss and act upon emergent themes and any issues identified from their scrutiny activities. The Sharing Intelligence for Health and Care Group (SIHCG) provides this platform. SIHCG provides a mechanism that enables seven national organisations to share, consider, and respond to intelligence about health and social care systems across Scotland. These organisations consist of Audit Scotland, CI, HIS, MWC, NES, Public Health Scotland, and SPSO (Healthcare Improvement Scotland, 2022). The SIHCG aims to support improvement in the quality of care provided in Scotland by making good use of existing data and intelligence ensuring that if any agency on the group has a potentially serious concern, then this is shared and acted upon appropriately. The group aims to share concerns at the right time to ensure that emerging problems can be identified and addressed. The organisations

also inform each other about aspects of health and care systems that work well and sharing intelligence helps the different organisations within SIHCG carry out their work in an informed manner (Health Improvement Scotland, 2022). Their remit is generic, cuts across all health-related activity, meaning the scope for focus on mental health is limited, and as such, reduces its ability to contribute to mental health scrutiny. SIHCG is currently under review to move away from an NHS Board focus.

The Mental Health and Learning Disability National Scrutiny and Assurance Coordination Group (NSACG) was established in November 2022, with a rolling Chair. Unlike the SIHCG, the NSACG has a sole focus on mental health and learning disability, its aim is to provide opportunity for early, and where appropriate, coordinated intervention and support. It aims to clarify roles and support accountability among members in addressing issues for effective delivery of mental health and learning disability services, while recognising and respecting each organisations' independence current legislative arrangements. It also seeks to join up planned programmes of scrutiny, as appropriate, to ensure a cohesive approach across the organisations and reduce the burden on mental health and learning disability services. Currently it is an operational group, and still in its early stages, which means that its success is currently unclear.

National and International Good Practice

The rapid review aimed to source areas of good practice from other countries with a view to influencing change in Scotland. Information was synthesised from England, Australia, New Zealand, Ireland, Japan, Ireland, Germany, Wales, Italy and North America. Key issues such as challenges with measurement and approaches to scrutiny are presented, with examples of single regulatory bodies in England and New Zealand and framework models in Ireland and Australia.

Single body and framework

The English approach utilises a single body - the Care Quality Commission (CQC) - to regulate all health and adult social care services. Unlike the networked model used in Scotland, the CQC combines the work of HIS, MWC and CI. However, the Scottish and English models are two fundamentally different systems and not like for like. England has a single body for assurance and scrutiny but it also has a range of

different organisations which cover the work which HIS do in one body (CQC, NICE, various national quality improvement organisations, and no national equivalent to HIS Community Engagement Directorate). In addition, the CI has a much wider role than CQC covering, for example, some of what is overseen by Ofsted in England.

The CQC's role is to ensure that health and social care services provide people with safe, effective, compassionate, high-quality care. Health and adult social care providers in England are required to be registered with the CQC; facilitating improvement through monitoring and inspecting of services to see whether they are safe, effective, caring, responsive and well led. Similar to the CI, the CQC publish findings including quality ratings and have the legal powers to take action where poor care is identified. The CQC also communicates independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice (Care Quality Commission, 2021).

The approach to external scrutiny in New Zealand is similar to that in England, in that it has a single regulator, but the regulatory role is different. New Zealand's services are monitored by the Health and Disability Commissioner (HDC), which acts as an independent watchdog, providing people using health and disability services with a voice, supports the resolution of complaints, and holds providers to account to improve practices at an individual and system-wide level. The HDC is independent of consumers, of providers, and of government policy, facilitating them to be an effective watchdog for the promotion and protection of patient and consumers' rights. A single regulatory system has its benefits, such as reducing the potential confusion of not knowing what the multiple scrutiny bodies are responsible for, what each one of them does, and where to look for guidance on matters. This approach could be considered an option for Scotland, however, a well-functioning multi-body system would likely mitigate the major overhaul needed in creating a single body. The Independent Review of Inspection, Scrutiny and Regulation (IRISR) across social care support services (Scottish Government, 2022) has indicated that major structural reform, as part of the National Care Service is unlikely.

Ireland have adopted a framework approach and established a clinical governance framework for quality in healthcare in 2011, with an aim to clearly communicate the

fundamentals of clinical governance. The initiative took an approach that made clear within the clinical governance descriptor the actions staff would take in its implementation such as, specifying clinical standards and making measurements open to the public and transparent. This approach aimed to minimise some of the distrust between the patient and health professionals and create confidence that decisions were made on clinical quality statements (Flynn, Burgess and Crowley, 2015). The conclusion of the national initiative drew a variety of insights that could be applied to Scotland. The communication and sharing of information using an active listening approach with patients and staff was key. A trauma informed practice approach not only minimised distrust but also led to an increased understanding of what mattered to them, such as their experiences of care and what motivated staff.

Australia adopted a national strategic approach to mental health reform, through the creation of a mental health information strategy, due to a limited connection and exchange of data sets between their scrutiny bodies. Their National Mental Health Performance Framework was established in 2005 (updated in 2020). Their use of performance indicators and quality benchmarking across states and territories created a national approach to outcome measurement in mental health services and was considered a world leader in this regard at the time (Brown and Pirkis, 2009). It is important to note the difference between a performance framework and a scrutiny framework. However, there may be opportunities for Scotland depending on the metrics being developed from on-going standards work alongside existing measures from a variety of data sets to inform the development of a similar performance framework for mental health in Scotland.

Benchmarking and use of information

Herbstman and Pincus (2009) cite inadequate adoption of quality improvement practices and the complicating factors of having numerous quality/performance measurement initiatives and indicators across government bodies, health services, professional and non-governmental organisations as hampering the collection of good quality data. Whilst this raises an important point, underperformance is perhaps more complicated than suggested above. Herbstman and Pincus (2009) also argue that the failure to establish a single body to provide strategic leadership and oversight has led to a lack of coordination and the disjointed development of scrutiny services in some countries. Attempts have been made to address issues such as

these through identifying a number of differing approaches to improving practice. The ability to make comparison between services nationally and internationally through benchmarking is an extremely useful exercise. A number of countries have reported on their individual systems and processes.

The need for good quality data led the Republic of Ireland's healthcare system to use real time clinical measurement. This practice supported effective decision-making, thereby improving transparency and public/professional trust in the governance of quality and safety (Flynn, Burgess and Crowley, 2015). The importance of clinical and personal outcome measures alongside care experience data is clear to scrutiny bodies and access to this information to inform assurance activities would be of value. An example of data being used effectively in Scotland is the Scottish Patient Safety Programme Mental Health. This programme has been used to drive improvement to ensure that everyone in adult mental health inpatient wards experience high quality, safe and person centred care every time. Benchmarking and the sharing of information, therefore, are important factors to be considered within the Scottish context. Public Health Scotland produces benchmarking data across Scotland, including Mental Health Quality Indicators, which are published but not reported equally or fully across NHS Boards. Previous work led by Scottish Government in partnership with NHS Scotland Information Services Division (incorporated into Public Health Scotland) developed mental health benchmarking reports. There is utility in comparing services nationally and internationally with one another and for improving trust in scrutiny process and related activities.

England and Wales adopted a model using a single regulatory body, the Care Quality Commission (CQC), which provides regulation and scrutiny of services. The former Mental Health Act Commission and its functions were subsumed into this structure and many functions that are Rights Based continue within the CQC. However, this approach may pose a risk of systems based processes with associated metrics setting or appearing to set the scrutiny framework. The CQC continues to carry out visits similar to the way the MWC does as well as Inspections in the CQC model. The CQC monitors, inspects and regulates NHS trusts using CQC Insight. This system provides inspectors with data, a ratings overview, performance monitoring indicators, intelligence overview and featured data sources. CQC Insight analyses information from a range of sources and uses common

indicators to monitor performance across all types of NHS trusts. This is also tailored to each sector or type of service. CQC Insight for providers of specialist mental health services includes analysis of the findings from visits to people detained under the Mental Health Act 1983 and relevant notifications under the Act (Care Quality Commission, 2022). This appears to be a very thorough approach and it would be interesting to explore if the data have been used to influence changes in practice across health and social care settings. It would also be useful to know what systems are used to share this intelligence given the sensitivity of the content. The provision of a Scottish specific measurement and benchmarking system could see similar positive effects within Scotland.

The UK has an NHS benchmarking network that undertakes some mental health benchmarking but is not Scotland specific. Scotland has very limited routine information about the mental health system on workforce, finance and activity, and outcomes. This has made policy and planning for mental health improvement very difficult, as little quantitative evidence around the provision of mental health services exists across Scotland and the means of identifying variability in provision between areas. This led to a commitment by the Scottish Government to support Health Boards and HSCPs to improve the data available and the capacity to compare across areas. The UK NHS Benchmarking Network (NHSBN) is acknowledged as already having a substantial evidence base around Mental Health service provision, workforce, finance, quality standards, and ongoing improvement initiatives. It has made sense therefore, for the Scottish Government to facilitate Boards to participate in this existing network, which would bring benefit as well as reducing the data burden involved in any future data collections. The Scottish Government has now successfully negotiated a contract with the NHSBN that includes membership for all Health Boards that allows access to NHSBN data (including Scottish Boards' data) for the purpose of performance and improvement activities. Membership to the Network provides NHS Boards with a number of member benefits without having to dedicate additional resource. This includes submission of local data and participation in the three annual UK wide events in Mental Health (Adult and Older People's Mental Health; Learning Disabilities and Autism; and Children and Young People's Mental Health), as well as providing networking opportunities for lead clinicians and service managers across Scotland and beyond to share their experiences and good

practice. It is worth noting, however, that data gathered and analysed through the Network is not publicly available.

Lived experience

Lived experience in mental health refers to people with personal experience of mental illness and recovery. It can also refer to family members and/or carers who have experience in caring for people living with mental illness and recovery. people with lived experience are essentially 'experts by experience' due to their first-hand experiences of mental illness, their use of mental health services, and their recovery. Therefore, they can provide a unique and expert perspective when working alongside scrutiny bodies.

The IRISR strongly recommended that the scrutiny system should be inclusive of the voice of lived and living experience, while Strang (2020) highlighted the necessity for people with lived experience to be a part of all elements of scrutiny of a service: the design, clarity of governance and leadership, engaging with people and communication, including children and young people. Lundqvist, Lars-Olov, Schroder (2015) identified that people with lived experience and staff do not always have the same perspective of good quality care, thus the inclusion of all voices is necessary for providing information that will improve practice. An example of this is when adverse incident reviews cause dissatisfaction because the facts do not correlate with service users own understanding.

People with lived experience and their perspective should be involved in all aspects of quality assurance projects from initial vision to analysis and the presentation of results, thereby enhancing the evolution of quality assurance within organisations (Weinstein, 2006). Unfortunately, it appears that lived experience involvement has been seen as a token gesture at times (Moore, 2008; Ryan et al., 2019; Weinstein, 2006). It is more common for people with lived experience views to be sought during initial consultation, but rarely beyond this, with their perspectives lost to the planning and delivery stages of scrutiny. In North America for instance, people with lived experience involvement in planning and evaluation of quality assurance was viewed as problematic due to a lack of role clarity, discomfort from professionals and power dynamics (Weinstein, 2006). Contrastingly, in Japan, former people with lived experience publicly speak at conferences and government panels about the quality

of care in mental health services (Ito, 2009) leading to an increase in shared decision-making about services.

The Scottish approach has seen scrutiny bodies increasingly use people with lived experience in their preparation for inspections, as part of their inspections, and their involvement in the interpretation of findings and this is seen as good practice. The Crerar review in Scotland noted most scrutiny bodies now include the voice of lived experience in some capacity.

People with lived experience can and should be supported to be meaningfully involved in scrutiny and assurance practices. To facilitate and encourage this, having continuity in the care professionals working with individuals is necessary, to avoid a breakdown in trust and ensure people with lived experience feel listened to. Having this voice included, ensures organisations are able to learn from experience with a non-blame culture embedded, and gather a more meaningful response.

Summary

In Scotland, scrutiny bodies have their own particular remits, and as discussed, some more than others focus on mental health as part of their scrutiny portfolios. There are positives associated with this approach, for example, the MWC role is solely around the scrutiny of services delivering care to people with mental health conditions. HIS provides an evidence-base, delivers improvement and implementation support, and scrutiny practices. The CI regulates social care and social work services, undertakes strategic scrutiny, often in partnership with other scrutiny bodies, supports quality improvement, and has a duty to further improvement. However, there appears to be negatives associated with this approach too. The recently published Independent Review of Inspection, Scrutiny and Regulation (IRISR) by Dame Sue Bruce found that systems of inspection, scrutiny and regulation can be duplicative, which poses challenges for both service providers and those in receipt of social care support. The IRISR recommended that roles and responsibilities between organisations are clarified, and that inspection activity should be streamlined. Similarly, the current mental health scrutiny landscape and different remits of scrutiny bodies creates a potential dilution of awareness in health and social care services, third sector and the wider population over the purpose of

the individual scrutiny bodies. In addition, mental health inspection and regulation practices lack a coordinated approach to inspections across the bodies.

This rapid review has identified a number of key learning opportunities in the literature regarding good practice at local, national and international levels. Adopting a national approach and an overarching framework has been seen in Australia and Ireland to support the consistency of scrutiny practices. The standardisation of quality indicators and measures used to monitor and evaluate patient outcomes in order to improve the quality of care is considered necessary. A systematised and managed approach by government to the measurement of data, its collection, and reporting is important so ensure different audiences such as patients, scrutiny bodies, policy makers and healthcare providers have timely access to information in an understandable format. Finally, the increased recognition of the importance people with lived experience involvement can offer in all aspects of the scrutiny process and the assurance of mental health services.

Survey Results

There were three questions that overlapped on the two questionnaires (Part A and Part B) issued to senior personnel in Health Boards/IJBs/Special Health Boards. Findings from the 23 respondents are outlined, with quotes identified as either Health Board (HB) or Scrutiny body (SB) for ease of interpretation.

There was broad agreement from 17 (74%) respondents that pertinent issues were identified through local governance arrangements, 3 (13%) were neutral and 3 (13%) disagreed. The same proportion (17, 74%) believed that findings are presented accurately; 5 (22%) took a neutral stance on this issue and 1 (4%) disagreed.

Only 8 (35%) agreed that external scrutiny bodies worked well with service providers, following up and providing support to implement recommendations made; 10 (44%) took a neutral stance and 5 (21%) disagreed. There was a suggestion that:

> 'More work could be done once strategic scrutiny has been completed to support improvement and signpost good practice'. HB

Findings from the remaining questions from eleven respondents to Part A are outlined below.

Governance and scrutiny

When reflecting on the frequency of inspections only 4 (36%) agreed this was sufficient, 4 (36%) disagreed and remaining 3 (27%) were neutral. The Health Boards commented that scrutiny should be 'based on risk and intelligence' as well as being a cyclical approach.

Only 3 (27%) considered the co-ordination of external bodies to be adequate, 4 (36%) were neutral and 4 (36%) disagreed. It was thought the strategic scrutiny group did not always put in place effective co-ordination of scrutiny:

> 'Having come from a highly regulated environment (England) where everyone knows the standards expected of them, coming to Scotland was a shock. There are many many groups/people/advisors/regulators involved and it makes the landscape cluttered'. HB

There was however broad agreement (7, 64%) from Health Board respondents that the local governance arrangements raise standards of healthcare, 4 (36%) remained

neutral. In relation to external scrutiny arrangements 5 (45%) agreed they raised standards, 4 (36%) were neutral and 2 (18%) disagreed. This does perhaps indicate that the respondents have more faith in local governance than in external governance.

Gaps in scrutiny activity

There was a suggestion that there are gaps in external scrutiny activity, 5 (45%) agreed with this and 6 (54%) remained neutral.

Six (54%) respondents agreed that governance procedures were equitable across the lifespan of patient care, 2 (18%) were neutral, 2 (18%) disagreed and there was 1 (9%) non-response. Fewer agreed (4, 36%) external scrutiny was consistent across all Health Boards, 3 (27%) were neutral, 3 (27%) disagreed and 1 (9%) non-response:

> ‘It is a patchwork of regulators/standards and interested parties; I would say this increases the risk to patients’. HB

Leadership

A few issues emerged in relation to leadership, firstly the manner in which responses were reported. Only 3 (27%) respondents considered leadership of external scrutiny bodies adequate, 5 (45%) remained neutral and a further 3 (27%) disagreed. The free text comments associated with this section of the questionnaire implied a level of negativity towards existing leadership arrangements across scrutiny bodies collectively, rather than individual leadership, and a considerable proportion of neutral responses were recorded.

Involvement of People with Lived Experience

A leadership issue also emerged in relation to the presence/absence of people with lived experience at senior levels of the scrutiny workforce; the prominence of the people with lived experience voice and their ability to challenge management:

> ‘There needs to be greater leadership within external scrutiny bodies to ensure lived experience is not seen as a data gathering exercise, but is instead about lived experience leadership within scrutiny bodies (who are able to challenge management/clinicians)’. HB

The impression from Health Boards was that People with Lived Experience (people with lived experience) are engaged (7, 64%) and their voices are heard through local governance arrangements, 2 (18 %) were neutral and 2 (18%) disagreed. Six (54%) disagreed that people with lived experience involvement extended across all stages of the process, 2 (18%) were neutral and 3 (27%) agreed. A representative suggested that:

> ‘The problem lies in the idea that people are just involved, they should be leading and driving rather than being involved. There is a need to ensure scrutiny and assurance is not "done to" and instead "done with". This needs to be reflected in the workforce of scrutiny bodies to ensure openness and transparency’. HB

The overall impression was that more could and should be done to seek lived experience viewpoints. Respondents also reported that their Community Partnerships and NHS have worked hard to secure patient and family involvement throughout service provision, especially through the COVID pandemic. They acknowledged that the involvement of people with lived experience and their carers is important and can always be improved. Examples of local projects which were working well usually involved people with lived experience at the centre of the work and it was thought this might be due to local governance arrangements that facilitated involvement i.e. co-production with people with lived experience.

It was noticeable that there was an unusually high proportion of neutral responses in this section. One possible explanation for the reluctance to submit a negative response is because it is an assessment of colleagues and a neutral score is less contentious. The alternative explanation is that respondents do not have anything positive to say.

Part B: Twelve responses were received from Health Boards/IJBs. On more than one occasion, a collective view was gathered from a wider multi-professional group, and then submitted via either the Medical or Nursing Directors.

Response to inspections

Nine (75%) participants believed that scrutiny bodies were thorough in their approach and that findings were presented accurately, 3 (25%) disagreed. Nine

(75%) respondents also largely believed their own organisations were duty bound to act on the recommendations made, 3 (25%) remained neutral.

One of the more contentious issues outlined by the group - where there was greater variation - was the communication between organisations (HBs and SBs) on the implementation of recommendations; 5 (41%) believing it to be adequate, 4 (33%) remained neutral and 3 (25%) considered it inadequate. This perhaps indicates that some Health professionals were keen for more communication with scrutiny bodies following inspections and wanted visits to aid with implementing recommendations.

Eight (66%) agreed that follow up from scrutiny bodies is adequate, 2 (17%) were neutral and 2 (17%) disagreed. Nine (75%) agreed that reporting mechanisms for feedback on recommendations is clearly articulated by scrutiny bodies, 3 (25%) disagreed. This suggests that Health/Social Care professionals are broadly happy with feedback, yet there is always scope for improvement in this area.

Eight (66%) respondents also agreed that scrutiny bodies supported the inclusion and participation of people with lived experience more readily in the follow up process, 3 (25%) were neutral and 1 (8%) disagreed. Eight (66%) also believed there was a reasonable timeframe for recommended changes to be introduced, 2 (17%) were neutral and 2 (17%) disagreed with this statement.

Overall, a more positive response was received from respondents of Part B than Part A. One possible explanation for this is that the Chief Executives who responded to Part A had overall responsibility for their services and essentially need to be more critical/analytical in their approach.

Interview Results

Findings are presented from the twenty interviews conducted with professional stakeholders from Health Boards/IJBs, CI, HIS, MWC, NES, SPSO, The State Hospital (TSH), and VOX. Participants were willing to engage in discussion and shared both positive and negative experiences openly. With the exception of one Health Board, one council, and one member of a scrutiny body, all invitations to interview were accepted. It was heartening to see the commitment to progress the Scottish agenda in a positive manner, despite some differences in experience and opinion.

Five clear themes emerged from interviews: ‘Scrutiny Activity and Leadership’, ‘Assurance Approach’, ‘Lived Experience’, ‘Measuring and Reporting’ and ‘Learning and Development’, see summary in Table 2.

Table 2: Summary of themes and categories from Health Board/IJBs*, Scrutiny body representatives

Themes	Categories
Scrutiny Activity and Leadership	Cluttered and Changing Landscape Functions Resources versus Demand
Assurance Approach	Rights or Process Based Context Differences in Awareness and Focus Collegiate Approach Communication Power
Lived Experience	Inclusivity and Meaningful Involvement Revaluing Lived Experience and Prominence of Voice
Measuring and Reporting	Standards of measurement What to measure
Learning and Development	Learning opportunities Supporting change Knowledge Transfer Data sharing systems

*people with lived experience represented by an organisation (VOX) are captured in HB responses.

The first two themes ‘Scrutiny Activity and Leadership’ and ‘Assurance Approach’ highlight the tension in a number of key areas and consider the disconnect that is evident across Scottish scrutiny bodies; there is evidence of good working practice in individual organisations, but an overall lack of cohesion. The third theme ‘Lived experience’ relates to their meaningful involvement. The fourth theme ‘Measuring

and Recording' identifies areas for development and the final theme 'Learning and Development' outlines opportunities for improvement.

Each theme will be reviewed in turn. Quotes are again identified as either Health Board (HB) or Scrutiny body (SB) for ease of interpretation.

Scrutiny Activity and Leadership

Cluttered and Changing Landscape

Several respondents commented on the number of different organisations that contribute to the external scrutiny of services and the different focus of each. Their understanding was that most elements were covered technically (by scrutiny bodies), but:

> 'It is unclear who is doing what, and things might get missed amidst the plethora of information'. HB

Opinion was divided as to whether the differences were welcomed or a source of frustration, consequently creating confusion and lack of clarity. One respondent commented on the fact that Scotland does not have a single regulator and it is perhaps worth considering this and exploring how it performs by comparison to other national and international areas. Despite the absence of a single regulator, it was noted there are other ways in which scrutiny bodies, regulators and assurance mechanisms – like the Commission – come together. The example outlined was the Sharing Intelligence Health Care Group (SIHCG), which meets monthly, but has a wide remit that extends well beyond mental health and learning disability. Organisations also have a monthly huddle to discuss key quality improvement work priorities.

There was agreement from the majority of respondents that the creation of one large complex organisation was not necessarily seen to be the best or most effective solution, given the vast scale of health services that Boards provide. However, work is required to provide the necessary clarity about roles of the different organisations and how they fit together.

Functions

It became apparent that individually each scrutiny body felt able to identify issues through their different functions, whether it was through oversight, regulation or scrutiny. Yet there was:

> ‘No collective oversight’. HB

The Commission (MWC) described a variety of its functions, which allow it to have a good sense of what is happening in each area. Through various channels (described earlier), the Commission believes it is able to get a sense of what is happening both at an individual level and structurally.

HIS and CI acknowledged that the work they engage in with people who have mental illness or intellectual disability only contributes to a small proportion of their wider role. HIS contribute heavily to quality and improvement of services, rather than the focus on individuals. Respondents reported the substantial shift in the quality assurance system that has been created and the quality framework, highlighting this as an area of good practice. The Scottish Patient Safety Programme HIS lead on was viewed as a particularly sound initiative and a good example of improvement work.

The CI inspect standards of care across a wide range of organisations including, for example, child and adolescent, adult care services as well as care homes. Their body of work extends across the lifespan, but they do not scrutinise NHS delivered mental health services. There is an obvious crossover of activity that could be streamlined, whilst still maintaining unique purpose and function of each organisation. The existing scrutiny services complement one another and if they worked in tandem this would add rigour to the overall process.

Resources versus Demand

Some consider the output from each of the scrutiny bodies quite exceptional and several senior clinicians highly praised the organisations, sharing the view scrutiny bodies could do even better with more resources. Respondents from scrutiny bodies did acknowledge that:

> **‘**There’s a limited amount we can do with the resource we have’. SB

There was a concern that they could not cover everything they wanted with existing resources and feared this might lead to something being missed. One respondent noted that Scottish Government were good at:

> ‘Coming up with some wonderful policies and having fantastic intentions ….but they have no resources’. SB

There was a suggestion from HBs that if the SBs all worked smarter and in a more cohesive fashion there would be less pressure on Health Boards/IJBs. This could result in fewer visits/inspections and a better outcome, in that, a more comprehensive overview could be achieved with less duplication of effort; work smarter rather than harder. Despite these good intentions resourcing might still curtail activity.

Collegiate Approach

Taking a collaborative and partnership based approach was seen as an important step, to help move away silo-working both within (SBs) and between Health Boards/IJBs and SBs. The suggestion was that Health Boards/IJBs could:

> ‘Actually work together with the assurance bodies, to make it more of a process. We’re striving for improvement and quality and understand why this is important, but also think about it in that very collegiate, collaborative way.’ HB

This facilitative approach between Health Boards/IJBs and SBs could support staff to gain experience in working alongside one another in preparation for future scrutiny events:

> ‘One of the bodies (SB) did come to us to test a tool to see if it was fit for purpose and we were able to support them to see if it did what it aimed to do, which was good. As part of that process, our staff were getting a taste of what it was like to go through that process so I think it’s important to continue that partnership working.’ HB

An initiative by CI to employ ‘lay inspectors’ who have the opportunity to shadow and assist with inspections, in order to gain experience of the scrutiny process, is seen as an example of good practice.

Assurance Approach

Rights or Process Based

Differences in opinion emerged in relation to the focus of scrutiny activity, whether it ought to be rights based or process based. For example, should we scrutinise the way in which a person's human rights are satisfied through receipt of health care, or assess the merits of the organisational processes that are followed in order to improve an individual's mental health. A number of participants touched on this live issue, commenting on the tension between the two. The wider context is important because influences such as the Human Rights Bill (currently under review) may well influence and dictate that scrutiny will require being rights based. The impact on practice could be considerable. Whilst both were felt to be of importance, there seemed to be a conflict with it being one or the other approach or whether these could be complimentary to one another.

Context

A plea was made from a number of participants for those undertaking the scrutinising role to give greater consideration to the wider context within which any review/inspection is taking place and reflect this more strongly in reports. In situations where there has, for example, been a serious incident immediately before an inspection, then focus on the serious incident will take precedence and preparations for inspection will be hampered. The perceived inadequate consideration given to context was a major cause of angst for Health Boards, and high on the list for recommended changes:

> 'If one thing comes out of this research, please make it acknowledgement of the context'. HB

From the perspective of people with lived experience, the current method of scrutinising services was perceived as failing to capture the context and impact on the person and their family in its entirety, focussing simply on an assessment at a particular time point (i.e. during in-patient stay). Being part of the mental health system can have an enduring effect on people and their families, sometimes extending from months to years. Respondents felt passionately about the fact that only a small part of any service is scrutinised if you set standards and measure the

quality and value of in-patient service alone. The early intervention and follow up support form a hugely important part of the experience for people with lived experience of mental health or learning disability services. Service scrutiny should therefore be just as rigorous at primary care level and in the community. This is an identified gap in provision of scrutiny, albeit it is on the current and future agenda of the scrutiny bodies.

As services progress, staff - at all levels - need to understand why governance and assurance is such an important and integral part of their work. It is more than just inspection and ticking boxes. Services are constantly evolving and there is a desire to fill gaps that have become more obvious over the years. All services have to be considered. There has to be more focus on what scrutiny and assurance looks like and how that is delivered in a consistent and a proportionate way going forward. Examples of other services where gaps exist include people with a learning disability and children's services at the point of transition into adult services.

Differences in Awareness and Focus

There was a suggestion from some Health Board representatives that some people performing reviews and undertaking scrutiny of services are less aware of what is happening 'on the ground' in clinical practice, especially if they have been detached from services for a lengthy period. Questions arose about how those who are long out of service are able to assess what is relevant now. A respondent from one of the scrutiny bodies noted that:

> 'There's a real gap between what's happening in the thinking of organisations such as mine and what is happening on the ground'. SB

There was a perceived need for personnel working within scrutiny bodies to find the means to maintain close links with Health Boards/IJBs in order to maintain their knowledge and understanding of current clinical practice/social care related issues. Opportunity for engagement in relevant clinical professional development is another route through which this need could be met. An example of good practice was offered from respondents working in social care settings, whereby strategic inspectors meet monthly with the Social Care Clinical Advisors. It is unclear if this facility is available to all across Scotland.

Communication

To enable closer working ties and relationships, communication was considered key, and a mechanism for addressing disconnect between stakeholders. What is communicated, at all stages, needs to be in a language all can understand. Therefore, everyone involved, including people with lived experience and the public, understand the context, their role in events and the wider picture for moving forward:

> ‘If they (SBs) can provide user friendly communication then it doesn’t matter whether you’re a student, nursing assistant or director of nursing, but you’re fully cited on what’s happening. I think that will make the picture clearer for everybody and they can then understand the part they play in it’. HB

Issues relating to communication between professionals, people with lived experience and lay people emerge regularly in reviews and the importance of effective - user friendly - communication cannot be underplayed. Use of overly complex/technical language can cause division, so the necessity of communicating in a manner that everyone can understand is critical to successful communication.

Power

On occasion, it may feel like the scrutiny bodies are in a position of power, but the Commission, for example, has been described as a ‘critical friend’. The process of scrutiny is predominantly viewed as valuable and essential, leaders recognising a need to embrace the concept, but equally noting the responsibility on the scrutinisers to work well with the Health Boards/IJBs to make it the best experience for everybody involved.

One of the SBs felt they were currently able to exert influence largely through their ‘soft power’ and were concerned that if they gained the ‘harder’ power (through statutory legislation) there would be a risk of losing influence through the current approach. The challenge is getting the balance right.

> ‘When you make something regulatory as in a set of rules, it can have the unintended consequence of driving the behaviours and the processes to make sure you meet the rules which is not in the patient interest or their families’. SB

The issue around powers was raised in the Scottish Mental Health Law Review (SMHLR) and Scrutiny Body respondents commented they do want more, because in those exceptional circumstances where they feel they are being are ignored, they need to have the necessary capabilities to enforce their recommendations. The hope is that actually having the powers will be sufficient for them not to use them.

Improving public awareness and increasing visibility of the different organisations in order to dispel any myths in relation to existing statutory powers was also viewed as critical.

Collaboration

Scrutiny Body respondents accepted that they do not always have the capability to achieve what they aspire to within their own organisation, sometimes due to limited powers, and have to consider who is the best organisation to support them at different point points in time:

> 'I think that is where we lean on each other to good effect'. SB

There has been considerable effort to bring together groups in order to share intelligence and knowledge at a strategic level. One example of this is the Sharing Intelligence for Health and Care Group (SIHCG). Members of the SIHCG use it to share information and intelligence and while they reported that they find it useful; they accepted that the function and performance of the group requires further consideration and improvement. Data protection, for example, is perhaps used at times as a barrier to sharing information both within and between scrutiny bodies. Overall, the members of SIHCG appreciated attempts made by Government to take this in hand.

Respondents from Health Boards/IJBs were not always aware of the SIHCG in practice, nor did they fully understand the remit. There was a suggestion that a better facility to share information between regulators would probably pick up emerging issues and prevent hazardous situations occurring, and they could see a benefit if the focus was on mental health, rather on the much wider agenda assumed by SIHCG.

Partly as a response to the perceived gap in mental health, the Mental Health and Learning Disability National Scrutiny and Assurance Coordination Group (NSACG)

was recently formed. It is an operational group that aims to improve the sharing of mental health specific information and coordinate hospital based inspections between existing scrutiny bodies. If the role and remit of this group was strengthened it could serve a more crucial function in joining up the work of the scrutiny bodies.

Lived Experience

Inclusivity and Meaningful Involvement

Without exception, all participants were very positive towards the idea of inclusion and working with people with lived experience. Examples of good practice were highlighted, such as MWC and CI having people with lived experience on their Board and the wider role of these representatives. Other scrutiny bodies do have an element of people with lived experience involvement and employ people with lived experience to assist with reviews, but it appears to be on a smaller scale and less well established.

The possibility of a hypothetical new scrutiny body led by people with lived experience was explored; the suggestion was welcomed with open arms by some and met with a fair degree of hesitancy by others. The concerns about involvement at a senior level raised by some senior staff within Health Boards and in some scrutiny bodies included: this might lead to individuals presenting only one view; singular past experiences of people with lived experience may overly affect their judgement and influence their opinion; it may overly stress the individuals and be counterproductive for people with lived experience. A representative from HBs was quite clear that people with lived experience are ready to and genuinely want to be working at a higher level within these influential organisations, and that it was an interesting concept to have their own organisation. There was a suggested compromise, rather than another new scrutiny body, to work within and improve involvement of people with lived experience within existing systems. A ‘test of change’ and establishment of proper support systems was seen as a plausible option.

Revaluing Lived Experience/Prominence of the Lived Experience Voice

Interviews found that the voice of people with lived experience needs to feature more prominently. Part of this issue was the perceived need to retain the fidelity of

people's opinions from the initial interview through to final reporting. In addition, it was important to keep the people with lived experience voice pure and not lost or amalgamated with other viewpoints. There was legitimate concern that this granularity and purity of voice often became lost or rephrased in the process. The fear was that reports that were written did not reflect their feelings.

Another aspect of revaluing was the inclusivity of people with lived experience in the scrutiny process to help close gaps in understanding and make sense of how people find services:

> 'It's amazing how we don't have a snapshot sense of how people find services. It's all very very detailed and complicated and becomes almost meaningless'. HB

Including people with lived experience was helpful for remembering what was important in terms of value when deciding on the unit of measurement. The inspections are particularly important in relation to how they involve local communities and individuals but scrutiny bodies need to be mindful that people are individuals, they live with their families, have friendships networks and communities, they do not live within a service.

> 'We wouldn't have a fire extinguisher sitting in our bedroom in our own home. We wouldn't talk about who our carers are, we would talk about our friends and our family. We don't have a menu at home. We talk about scrutinising for outcomes yet we professionalise care services in a language, a narrative, a behaviour that's actually not the way we live our lives'. SB

There is a real opportunity for scrutiny to address this while still making an important contribution to improving the lives of people in Scotland.

Measuring and Reporting

Standards of measurement

There are many different ways in which the value, worth, effectiveness and efficiency of a service can be measured. The topic of what and how we measure is one that caused considerable debate. Respondents spoke of a focus on hard/tangible evidence such as waiting times and soft evidence such as people's experiences of

using the various services. The implication was that scrutiny bodies tend to measure what is easy to measure and not what is right to measure. Historically measurement was based on standards:

> ‘The workplace is clean, the workplace is safe, where we are now entering into are areas that are tougher, we’re talking about leadership, we’re talking about sustainability, effectiveness of care and these are perhaps more difficult judgements to make’. SB

Some agreed that information is captured well, but what emerges must be weighted differently, in order that is it presented in a more balanced manner, for example, to include a greater balance between professional and people with lived experience perspective. It was suggested that trust and empathy are not emphasised enough in reports; these are things that are not easy to change. The view that scrutiny bodies take is that trust comes from how they responsibly, fairly and transparently report what they find and do that in a way that is publicly available to service users. They want to be able to:

> ‘Report what they see without fear nor favour’. SB

However, it has all got be done in a responsible way that reflects the operating context of the service at that point in time.

What to measure

Respondents want clarity from Scottish Government on what to measure, what standards they expect and to see those standards being meaningful and not just about joined up care. There needs to be a shared framework that both service providers and SBs are working to, for example the new mental health standards that were published in September 2023.

> ‘We have a quality assurance system that informs all aspects of our work and again the key aim of that is to make sure while we’re carrying out a wide range of assurance activities, some of which are quite specialist and narrowly focused and others much broader, we’re doing so in as consistent way as possible’ SB

Respondents also want consistency of reporting where what was said during visits is reflected accurately in the reports, with no surprises.

Finally, respondents want to capture how people with lived experience feel about their care and treatment, so that it is focused on their outcomes and not just on the things that are easy for scrutiny bodies to measure. As it stands this has not been addressed and should be considered a gap.

> ‘What we don’t do is provide scrutiny framework that gives enough evidence around people’s happiness, wellbeing’ HB

This less tangible type of measurement could be built into a revised or refreshed set of standards that are truly focused on some of the softer elements that are very subjective to an individual, but it is actually, what makes us individuals. This is possibly a new direction for scrutiny and assurance that requires careful consideration.

Learning and Development

Learning opportunities

It became apparent through discussion that there are distinct gaps in knowledge at different levels. Within Health Boards/IJBs, there is an acceptance that staff require awareness training in governance and assurance related issues. They can take their guide from various sources, for example:

> ‘Carers Support and Support in Mind Scotland have got lots of experience and actually have been really, really valuable in making us think differently about how we engage and how we take things forward’. HB

The focus on education and training was also raised through conversation with HIS who wanted to focus peoples’ attention on learning from one another’s good practice with a focus on improvement. One Health Board had taken steps to set up a ‘mini review’ in preparation for an inspection, in order to aid understanding of the process, however this good practice did not appear to be widespread.

Supporting change

There is a suggestion that senior officials need to think about their reaction to scrutiny bodies picking up failings and shortcomings; the belief is that they need

support to deal with this. There is a sense of frustration from scrutiny bodies who make recommendations for change in their reports, but these have not been enacted during follow up visits. They would like assurance that the changes will be implemented but are often met with ‘we’ve got this in hand’. Services argue the timeframes, advice and follow up support are not always appropriate or realistic, so how can they successfully implement the desired change.

Knowledge Transfer

Sharing the findings of reviews between services, scrutiny bodies and government support the notion of collaboration to address concerns through targeted scrutiny:

> ‘I think key to it is how we continue to collaborate with partner organisations but also with service providers and with government around the findings from scrutiny and thinking about where serious concerns or emergent concerns are and how we continue to target scrutiny to best effect’. SB

Connecting similar issues, situations or events together and thematically reporting them across scrutiny bodies via sharing of intelligence was considered useful for identifying and sharing key issues. The notion was not necessarily to identify themes by service or local area, but to aggregate up and possibly generate themes around topics such as governance, resourcing, leadership, education or training.

Encouraging shared learning and the identification of risk avoidance in systems was an important aspect of proactive learning across the scrutiny bodies:

> ‘So things like submitting all adverse incident reviews into the monthly group helps identify and encourage shared learning and avoidance of risk in our systems’. SB

Reporting aspects of services that are not working to their full potential could be impactful in their sharing of information. The importance of highlighting where things are not working well was stressed by respondents and the need to report this.

Data sharing systems

Improving the means through which data is accessed and shared is invaluable, it can expedite processes and prevent duplication of work:

> ‘There is the ability for public organisations like NES to work with others on sharing data via cloud services such as azure and amazon web services. So there’s opportunity there for us to get much better at scrutiny information, reporting, intelligence, reporting for government, blending resources to outcomes, that it doesn’t need individual scrutiny bodies to invest heavily in these new systems’. HB

It is clear that work needs to be done to ensure data can be accessed and shared more readily, perhaps through existing or similar systems, as highlighted by NES. This could assist report writing following joint visits and thematic reviews. There is an ongoing commitment to digital transformation and proposed investment from Scottish Government which may serve to address this issue.

Discussion

A wealth of information was gathered through the process of reviewing Scottish mental health scrutiny and assurance services, much of which is supported by the existing evidence base.

Network Approach

A network approach to scrutiny and assurance was introduced to Scotland in 2010, involving HIS, MWC and CI. Since then, two groups have been created, the SIHCG in 2013 designed to share intelligence across scrutiny bodies in relation to health and social care, and the NSACG introduced in 2022 to coordinate activity on mental health and intellectual disability. Respondents in both survey and interviews described the current landscape as complex and cluttered, due to the existence of multiple bodies and groups. The sharing of information across bodies was viewed as problematic and roles were not always clearly defined. This is similar to the situation identified by the Crerar review (Scottish Government, 2007), which described scrutiny bodies as overly complex, costly and lacked clarity in their position.

Although scrutiny bodies were viewed as having many strengths, especially in the volume of their work and their ability to notice key issues, they felt restricted in part by limited resources and by the lack of regulatory power to enforce change when they felt it was required.

The combination of elements described above led to the consideration of adopting a modified approach, informed by available literature and views of respondents. A rapid review of the literature enabled comparisons of approach with other countries. Australia and Ireland favoured a framework model whereas England and New Zealand both had a single regulatory body; each approach with their own strengths. The overarching framework in Australia was designed because of limited connection and data exchange between their regulatory bodies, leading to the creation of a mental health information strategy which was described as a world leading approach some years ago (Brown and Pirkis, 2009) and anecdotal evidence suggests this continues to be the case. Similar issues of disconnect and challenges with data sharing were apparent in our Scottish system and the solution, which Australia have now tried and tested with success, is attractive. The Australian model is similar to what Scotland currently has in place but provides structure within a busy landscape, it is likely that it would be relatively straightforward to replicate. Respondents of both survey and interviews strongly advocated for an overarching framework or body to provide consistency. There seemed little appetite for a single regulatory system, which could provide an alternative solution. It was thought that the complexity of the task made it too onerous a challenge for a single body and multiple bodies with their unique remit - but shared focus on mental health – could be more effective.

Leadership and Oversight

It became apparent throughout the research process that overall leadership was an issue requiring attention. Issues such as this occasionally emerged discretely i.e., from what was not said - indicated by neutral responses in the survey - as well as opinion voiced through interview. Respondents seemed somewhat dissatisfied with the current situation but were hesitant to make suggestions for change. In keeping with the recommendations proposed by Strang (2020) that one service should be responsible for ensuring scrutiny activity accountability, a pragmatic solution is suggested. The recommendation is that MWC adopt the lead position for the recently created NSACG coordination group, to provide oversight and ensure accountability of scrutiny for mental health and learning disability, rather than maintain the current arrangement with a rotational lead. The rationale for this is the entire remit of the MWC is on mental health and learning disability, whereas HIS and CI have a limited proportion of their work plan assigned to focus on mental health. Links with the

existing SIHCG require to be considered as part of this process. It is hoped that the impact of new leadership will result in improved communication and coordination of effort across scrutiny bodies.

The assumption is that ultimate responsibility for mental health and learning disability scrutiny and assurance of NHS provided services will still rest with Scottish Government and the NSACG – or alternative group – will be accountable to Scottish Government. This is similar to the Care Quality Commission model in England (Care Quality Commission, 2021) in that it has oversight of scrutiny and assurance and is accountable to the government. The independence of any resultant activity of the NSACG - or alternative group with collective oversight - will need to be made clear, because each scrutiny body is independent from one another and each have their own different reporting/accountability structures. Any future model would need to recognise and respect each organisations' independence and their own governance arrangements.

Meaningful Involvement of People with Lived Experience

Findings from the recent Scottish Mental Health Law Review (2022) noted that external scrutiny bodies are essential for the improvement of mental health services. Their position allows them to influence cultural shift. One of the key findings from the survey and interviews was the desire for the voice of people with lived experience to be stronger, perhaps indicating a need for further cultural shift. A proportion of respondents noted people with lived experience were involved and included in all aspects of scrutiny, commonly in instances where they were paid employees. Others felt there was a distinct lack of people with lived experience involvement, and their contribution was restricted to certain stages of the process. Coia and Glassborow (2009) formerly commented on people with lived experience involvement in mental health scrutiny in Scotland as a 'tick box exercise', but there has been significant advancement in thinking since then especially within HIS, MWC and CI. Support for the inclusion of people with lived experience at Senior/Board levels in scrutiny organisations was welcomed and is recommended.

Shared Resources and Joint Working

There was general agreement that scrutiny should maintain two strands of work; regular cycles of routine reviews/inspections in addition to risk-based and

intelligence led visits. Respondents identified the breadth and depth of scrutiny activity these approaches created and subsequent benefit they provided. The main concern related to levels of activity with stretched resources and fears of errors or omissions. Having to prioritise areas of scrutiny based on resources rather than outcomes has been raised as a concern for a number of years (Flynn, Burgess and Crowley, 2015). Potential solutions to this resource problem were offered through discussion at interview. The suggestion was a more coordinated, collaborative approach with increased joint working and joint inspections between scrutiny bodies, resulting in less duplication of activity. This should free up some time to focus on follow up activity and increase the likelihood of recommendations being implemented. Comparable findings from the SMHLR review (SMHLR, 2022) suggested joint working is vital to address current gaps in service provision. Consideration should perhaps be given to how this might also apply to Community, CAMHS and Intellectual Disability services to enable greater equity of scrutiny across the lifespan.

Powers

The issue of follow up activity and the ability to implement recommended changes presented different challenges for Health Boards/IJBs and scrutiny bodies. The accuracy with which the reports reflected the situation and context, and the resultant recommendations and associated timeframes for change sometimes presented difficulties for Health Boards/IJBs, because they were neither in a position where they were able to make the changes, nor did they know how to go about it. The required change was sometimes delayed as a consequence. Scrutiny bodies on the other hand were keen to ensure recommendations were taken forward timeously and some had no statutory power to enforce change. Campbell (2017) noted persistent difficulties in modern day scrutiny frustrations in improving standards and enforcing legislation. Survey respondents note enforcement of regulation is both powerful and necessary to ensure the safety of individuals receiving care. They also note each scrutiny body requires using the powers they hold to enable change. Therefore, the powers aligned to scrutiny bodies should be reviewed – with a particular focus on MWC - to ensure they have the ability to enforce the implementation of their recommendations by service providers where circumstances require this.

Data Measurement and Sharing

Mental health and learning disability services have engaged in debate for decades in relation to what are the best and most accurate and appropriate outcome measurements for this type of service. Different standards have been developed, audited and measured by health and social care professionals over the years, some of which are tangible measures, often described as ‘hard data’, for example waiting times, assessments, treatments, delayed discharges and so on. Other measures focus on ‘soft data’ such as satisfaction of services. Respondents from the survey and interviews suggested this might be the right time to review what we measure and attempt to capture wider perspectives. Exploring patient perception and experiences of the care they receive is considered central to this process (Schroder, Agrim and Lundqvist, 2013).

The data gathered from inspections can often be sensitive and personal therefore use of appropriate mechanisms for sharing this information across differing scrutiny bodies (where necessary) is vital. The recent COVID pandemic has escalated the programme of online activity and necessitated the creation of secure systems where sensitive data can be shared. Given the network model scrutiny services currently work within, it is important to find a secure system that facilitates improved sharing of intelligence and expedites the process. Lora et al. (2017) have stressed the importance of using relevant data to inform quality. One of the special Health Boards has identified a system that will enable safe sharing of data; it is therefore part of the recommendations.

Learning and Development

A gap that emerged through the review relates to staff awareness of scrutiny and assurance processes. Scrutiny bodies and Health Board/IJB representatives must ensure they encompass the challenges of all stakeholders to understand the importance of steps taken to create the best possible service, are fully aware of scrutiny and assurance processes and can contribute to good practice. The SMHLR (2022) advocated external scrutiny bodies are essential for the improvement of mental health services, critically impacting a cultural shift in the awareness and increase of human rights of which these scrutiny bodies should be experts in. A collaborative approach to learning and development would have the greatest impact.

Report limitations

In addition to CI, further social work and social care colleagues were approached to take part but declined to respond. We do therefore acknowledge that accounts are provided from a predominance of health care-based informants, and this may have skewed the findings. Greater consideration of scrutiny activity in social work and social care would have been preferable in order to inform considerations in an integrated service.

The survey included three separate questionnaires focussed on specific groups with different questions. Due to a low response rate this stratification at the early stage meant there was little opportunity to analyse data with anything other than descriptive statistics, because the likelihood of a statistically significant result was minimal.

Conclusions

The wealth of data gathered from the rapid literature review, questionnaires and interviews has served to provide a real sense of strengths and gaps that exist in current systems and processes. The literature highlighted areas of good practice that facilitated strong scrutiny and assurance, including national standards of care, regular inspection of services, regular reporting of service performance to local and national government, publicly available performance indicators and benchmarking. The survey with stakeholders produced mixed results. It indicated that external scrutiny does capture key issues and involvement of people with lived experience improves the process. It also flagged areas of improvement in relation to communication and intelligence sharing between scrutiny bodies, follow-up and support to services following inspections and the frequency and equity of inspections across services and Boards. A shared passion and desire for success was evident from all respondents, and an eagerness to achieve more and provide a better service for the people of Scotland was at the heart of each conversation. There were however clear differences of opinion in relation to how successful current practices are, and strong views on the need for change and improvement.

A number of common issues emerged through the stakeholder interviews, namely:

- the complex landscape of multiple scrutiny bodies and a need to improve the collective leadership and accountability;
- uncertainty as to whether the focus of scrutiny activity is on people or services and some examples of disconnect with what is happening ‘on the ground’;
- a need for improved joint working and communication between scrutiny bodies;
- the issues caused by a lack of power held by scrutiny bodies, as well as limited resources;
- a role for the meaningful involvement of people with lived experience and the prominence of their voice within reporting;
- the important role of internal governance in improving quality and safety, including creating opportunities for learning and follow-up on scrutiny recommendations;
- the improvements needed regarding measurement and data availability, access and sharing.

Positive action is needed to address shortcomings in the current system. Recommendations are outlined overleaf.

Recommendations

1. Ensure a managed overarching framework that leads to a cohesive and coordinated approach to external scrutiny is implemented. This could be achieved through adjustment of the existing role of the Mental Health and Learning Disability National Scrutiny and Assurance Coordination Group (NSACG) or creation of a new group. A clear remit for external scrutiny dedicated to mental health and learning disability requires to be adopted.
2. If the NSACG were to function in the capacity described above, rather than create a new group, it should review and strengthen the role and remit in order to optimise efficiency and minimise duplication of work. Consider and enhance collaboration between NSACG and SIHCG. Position MWC as permanent chair, replacing the existing rotating chair, due to their extensive focus on mental health and learning disability. This should be done recognising and respecting each organisations’ independence and their own governance arrangements. The

NSACG will require authority to support accountability of NHS Health Boards, which may require legislation.

3. Review and improve the way in which inspections/visits are scheduled collectively, to minimise duplication of work for both scrutiny bodies and Health Boards/IJBs. Co-ordinate joint and co-produced themed visits, with an agreed joint methodology to maximise resources.
4. Scrutiny bodies to support the full implementation of the new Mental Health Quality Standards and utilise the standards as a common framework to support the coordination of scrutiny activity.
5. Improve public awareness and increase visibility of all scrutiny bodies and their individual and collective roles, remits and responsibilities. Methods through which this could be achieved should feature on the workplan of the NSACG.
6. Review and strengthen the role and responsibilities of people with lived experience within scrutiny bodies, with a view to introducing roles at Board/senior level in order to ensure greater involvement and focus on people with lived experience. Influence at senior level is more likely to ensure the people with lived experience voice is respected and suggestions from people with lived experience in reports are safeguarded.
7. Ensure employees of scrutiny bodies have the opportunity and accept responsibility for keeping themselves abreast of changes in practice and appreciate current context to maintain credibility. Also, to give greater consideration to the wider context when undertaking inspections/reviews and reflect this more strongly in final reports, to give a greater focus on systemic issues.
8. Increase support from scrutiny bodies in the follow up of recommendations arising from reports, for example, through offering suggestions and sharing examples of good practice. Encourage the exploration of existing evidence captured in the literature; learning from tried and tested methods is both logical and pragmatic.
9. Review and improve existing data sharing mechanisms that exist at NES (Azure) with a view to implementation, as opposed to creating or purchasing new systems in order to expedite sharing of intelligence. Safety and security of data sharing is of critical importance.

10. Improve the equity of scrutiny across the lifespan, with a renewed focus on Community, Intellectual Disability (ID) and Child and Adolescent Mental Health Services (CAMHS).
11. Refocus on how and what is measured across the lifespan extending to use of softer outcomes, such as wellbeing and quality of care.
12. Explore any additional powers aligned to MWC in order to enable recommendations to be enacted in a timeous manner.
13. Provide awareness training for staff in Health Boards/IJBs in governance and assurance related issues.
14. Implement a two-strand approach to scrutiny, involving a regular cycle of reviews in addition to risk-based and intelligence led inspections. It is recognised that this recommendation may have resource implications for scrutiny bodies.
15. Continue good practice of engaging in rigorous review through thorough internal and external governance processes for mental health and Intellectual Disability services.

Acknowledgments

The School of Forensic Mental Health research team would like to extend their sincere thanks to everyone who contributed to this study. The team is particularly grateful to the individuals who shared perspectives via the national survey, either their own or those of a colleague. The team would like to thank the multi-disciplinary group of professionals from a number of organisations for the time they offered in interviews, and the high level of engagement at a busy time with ongoing service challenges. Finally, the research team thanks members of the project's Research Advisory Group for their support, guidance and feedback.

References

Brown, P. and Pirkis, J. (2009) 'Mental health quality and outcome measurement and improvement in Australia', Current Opinion in Psychiatry, 22(6), pp. 610-618. doi: 10.1097/YCO.0b013e3283318eb8.

Campbell, M. (2017) The journey from first inspection to quality standards (1857-2016): are we there yet? The Journal of Adult Protection, 19(3), pp. 117-129. https://doi.org/10.1108/JAP-10-2016-0024

Care Inspectorate (2019) A quality framework for support services (not care at home). Communications. Available at: https://www.careinspectorate.com/images/A_quality_framework_for_support_services_not_care_at_home_September_2019.pdf (Accessed: 20/11/2022).

Care Inspectorate (2022a) Joint Inspection of Adult Services Integration and Outcomes Quality Indicator Framework. Available at: https://www.careinspectorate.com/index.php/knowledge-hub-wiki/9-professional/6642-joint-inspections-of-services-for-adults-ssaa (Accessed: 14/12/2022).

Care Inspectorate (2022b) Quality Improvement and Involvement Strategy 2022-2025. Available at: https://www.careinspectorate.com/index.php/publications-statistics (Accessed: 20/11/2022).

Care Quality Commission (2021) A new strategy for the changing world of health and social care - CQC's strategy from 2021. Available at: https://www.cqc.org.uk/about-us/our-strategy-plans/new-strategy-changing-world-health-social-care-cqcs-strategy-2021 (Accessed: 20/11/2022).

Care Quality Commission (2022) How CQC monitors, inspects and regulates NHS trusts. Available at: file:///U:/FN/Tenders/Scot%20Gov%20Scrutiny%20and%20Assurance/Lit%20review/Scrutiny%20grey%20lit/CQC-regulates-NHS-trusts-nov-2022.pdf (Accessed: 20/11/2022).

Coia, D. and Glassborow, R. (2009) 'Mental health quality and outcome measurement and improvement in Scotland', Current Opinion in Psychiatry, 22(6), pp. 643-647. doi: 10.1097/YCO.0b013e3283319ac2;.

Flynn, M.A., Burgess, T. and Crowley, P. (2015) 'Supporting and activating clinical governance development in Ireland: sharing our learning', Journal of Health Organization and Management, 29(4), pp. 455-481.

Health Improvement Scotland (2022) Mental Health Unit Inspection Methodology Infection Prevention and Control. Available at: https://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/mental_health_units.aspx (Accessed: 20/11/2022).

Healthcare Improvement Scotland (2022) Healthcare Improvement Scotland Scrutiny Plan 2022/23. Available at: https://www.healthcareimprovementscotland.org/scrutiny/scrutiny_activity_2021-22.aspx (Accessed: 20/11/2022).

Herbstman, B.J. and Pincus, H.A. (2009) 'Measuring mental healthcare quality in the United States: a review of initiatives', Current opinion in psychiatry, 22(6), pp. 623-30. doi: 10.1097/YCO.0b013e3283318ece.

Ito, H. (2009) 'Quality and performance improvement for mental healthcare in Japan', Current opinion in psychiatry, 22(6), pp. 619-22. doi: 10.1097/YCO.0b013e3283318ea5.

Lora, A., Lesage, A., Pathare, S. and Levav, I. (2017) 'Information for mental health systems: An instrument for policy-making and system service quality', Epidemiology and Psychiatric Sciences, 26(4), pp. 383-394. doi: 10.1017/S2045796016000743;.

Lundqvist, L. and Schroder, A. (2015) 'Patient and staff views of quality in forensic psychiatric inpatient care', Journal of forensic nursing, 11(1), pp. 51-8. doi: 10.1097/JFN.0000000000000060.

Malterud K, Siersma VD, Guassora AD. (2016) ‘Sample Size in Qualitative Interview Studies: Guided by Information Power’, Qual Health Res. Nov;26(13):1753-1760. doi: 10.1177/1049732315617444. Epub 2016 Jul 10. PMID: 26613970.

Mental Welfare Commission (2022a) Learning through review:
a summary of our investigative
role, and looking to the future. Available at:
https://www.mwcscot.org.uk/sites/default/files/2022-06/LearningThroughReview-SummaryOfOurInvestigativeRole_June2022.pdf (Accessed: 20/11/2022).

Mental Welfare Commission (2022b) Liaison Agreement between the
Mental Welfare Commission for
Scotland and the
Health and Safety Executive. Available at: https://www.mwcscot.org.uk/about-us/how-we-work-other-organisations#:~:text=The%20Health%20and%20Safety%20Executive%20Liaison%20agreement%20between,information.%20MOU%20with%20the%20Health%20and%20Safety%20Executive (Accessed: 20/11/2022).

Moore, J. (2008) 'Survey of service user involvement in clinical audit', Clinical Governance: An International Journal, 13(3), pp. 192-199. doi: 10.1108/14777270810892601.

Ryan, G.K., Semrau, M., Nkurunungi, E. and Mpango, R.S. (2019) 'Service user involvement in global mental health: what have we learned from recent research in low and middle-income countries?', Current opinion in psychiatry, 32(4), pp. 355-360. doi: 10.1097/YCO.0000000000000506.

Schroder, A., Agrim, J. and Lundqvist, L. (2013) 'The quality in psychiatric care-forensic in-patient instrument: psychometric properties and patient views of the quality of forensic psychiatric services in Sweden', Journal of forensic nursing, 9(4), pp. 225-34. doi: 10.1097/JFN.0b013e31827f5d2f.

Scottish Government (2007) The Crerar Review: the report of the independent review of regulation, audit, inspection and complaints handling of public services in

Scotland. Available at: https://www.gov.scot/publications/crerar-review-report-independent-review-regulation-audit-inspection-complaints-handling/ (Accessed: 20/11/2022).

Scottish Government (2017) Health and Social Care Standards: My support, my life. Available at: https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2017/06/health-social-care-standards-support-life/documents/health-social-care-standards-support-life/health-social-care-standards-support-life/govscot%3Adocument/health-social-care-standards-support-life.pdf (Accessed: 21/10/22).

Scottish Government (2020) Coronavirus (COVID-19): mental health - transition and recovery plan. Available at: https://www.gov.scot/publications/mental-health-scotlands-transition-recovery/pages/23/ (Accessed: 20/11/2022).

Scottish Government (2022) NHS Public Protection Accountability and Assurance Framework. Available at: https://www.gov.scot/publications/nhs-public-protection-accountability-assurance-framework/ (Accessed: 20/11/2022).

SMHLR (2022) Final Report. Available at: https://www.mentalhealthlawreview.scot/workstreams/smhlr-final-report-summaries-and-recommendations/ (Accessed: 20/11/2022).

Strang, C.D. (2020) Final Report of the Independent Inquiry into Mental Health Services in Tayside. London: British Medical Journal Publishing Group. Available at: http://dx.doi.org/10.1136/bmj.1.5533.175 (Accessed: 20/11/2022).

Caldicott, F. (1999) The Caldicott report. IHRIM, 40(2), pp.17-19.

Weinstein, J. (2006) 'Involving mental health service users in quality assurance', Health expectations: an international journal of public participation in health care and health policy, 9(2), pp. 98-109.

Appendix 1: Additional information relating to methods

The literature included UK and international evidence pertaining to governance, scrutiny and assurance methods including but not limited to; internal audit, data collection, early issue detection and escalation, patient feedback and wider use of lived experience data collection, accountability, co-ordination and intelligence sharing practices. Literature was limited to English language, full-text and articles published since 2002 to maximise relevancy to the Scottish context. Literature was identified through the systematic search of relevant databases indexed by a tailored string of search terms combining mesh headings, key words and exploding terms. The search strategy balanced specificity, to ensure the identified records were highly relevant to the review, and sensitivity, to limit the number of unrelated records identified in the search process.

A global assessment of study quality was undertaken. Strong studies included elements of transparency, reflexivity, clear descriptions of methodology, methods of data collection, analysis, and an overall fit with regards to the research questions and the design of the project.

Appendix 2: Survey Part A- Scrutiny and Assurance Questionnaire for Service Providers

Completion date:

Name:

Job title:

Organisation:

Region:

Instructions: Overleaf is a list of statements about scrutiny of mental health services in Scotland. The scrutiny bodies we refer to include: Care Inspectorate; Health Improvement Scotland; Mental Welfare Commission, Scottish Public Services Ombudsman and Sharing Intelligence for Health & Care Group. For each item please choose a box to indicate which answer applies best to you. Please answer all questions.

Information on current local governance and external scrutiny arrangements

		Strongly agree	Agree	Neutral	Disagree	Strongly disagree
1	Current local governance arrangements are able to identify the pertinent issues					
2	All aspects of care over the lifespan and speciality services are governed to the same extent e.g CAMHS, Adult, Older Adult, In patient, Community, Intellectual Disability					
3	Scrutiny bodies are supportive in their approach					
4	Findings on local governance arrangements are presented accurately					
5	Current external scrutiny activity is consistent across all Health Boards					

Comments on information and arrangements 1-5:

For each item please choose a box to indicate which answer applies best to you. Please answer all of the questions.

Views on the strengths of current local governance and external scrutiny arrangements

		Strongly agree	Agree	Neutral	Disagree	Strongly disagree
6	The frequency of current external scrutiny activity e.g. visits/inspections is sufficient					
7	Current local governance arrangements raise standards of health care					
8	Current external scrutiny arrangements raise standards of health care					
9	There is adequate leadership of external scrutiny bodies					
10	External scrutiny bodies work well with service providers, following up and providing support to implement recommendations made					

Comments on strengths (questions 6-10):

For each item please choose a box to indicate which answer applies best to you. Please answer all of the questions.

Views on potential areas of improvement in current local governance and external scrutiny arrangements

		Strongly agree	Agree	Neutral	Disagree	Strongly disagree
11	There is adequate co-ordination of external scrutiny bodies					
12	There are gaps in external scrutiny activity					
13	People with lived experience are engaged and through their voices are heard through local governance arrangements					
14	People with lived experience are involved at **all** stages in the scrutiny process (not simply consultation at the beginning)					

Comments on potential areas of improvement (questions 11-14):

How do you think we can strengthen current local governance and external scrutiny arrangements? Please continue comments overleaf .

Thank you for completing this questionnaire

Appendix 3: Survey Part B Follow up- Scrutiny and Assurance Questionnaire for External Scrutiny Bodies and Nursing/Medical Directors

Completion date:

Name:

Job title:

Organisation:

Region:

Instructions: Overleaf is a list of statements about scrutiny of mental health services in Scotland. The scrutiny bodies we refer to include: Care Inspectorate; Health Improvement Scotland; Mental Welfare Commission, Scottish Public Services Ombudsman, Sharing Intelligence for Health & Care Group. For each item please choose a box to indicate which answer applies best to you.

Part B: The accuracy of findings and follow up arrangements from work undertaken by scrutiny bodies

		Strongly agree	Agree	Neutral	Disagree	Strongly disagree
1	All scrutiny bodies are thorough in their approach					
2	Local governance and external scrutiny arrangements are currently able to identify the pertinent issues					
3	Findings on local governance arrangements are presented accurately					
4	The follow up from scrutiny bodies is adequate					
5	The reporting mechanisms for feedback on recommendations is clearly articulated by scrutiny bodies					
6	Scrutiny bodies support the inclusion and participation of people with lived experience in the follow up process					
7	Scrutiny bodies are supportive in their approach during the follow up process					
8	Scrutiny bodies allow a reasonable timeframe for recommended changes to be introduced					
9	Your organisation is duty bound to act on the recommendations made by scrutiny bodies					
10	There is adequate communication across scrutiny bodies on the implementation of recommendations					

Comments on follow up (questions 1-10) please continue overleaf:

Thank you for completing this questionnaire

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at

The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

ISBN: 978-1-80525-973-2 (web only)

Published by The Scottish Government, April 2024

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS1279242 (04/24)

w w w . g o v . s c o t