An exploratory study of the views of stakeholders about the role of regulation in social care service provision in Scotland.

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Abstract

Performance management of social work and social care services, complemented by effective regulation, is viewed as key to improving delivery and providing public assurance about care quality, and the value of listening to stakeholders as contributors to the knowledge base has long been recognised. The evidence base as it relates to stakeholders' experiences of regulation, however, has not been comprehensively explored. Many studies seek the views of stakeholders in the development of individual services, yet fewer studies seek their views in shaping regulatory methodology. The rationale for this research was to contribute to a knowledge base from evidence using an empirical approach and to contribute to better understanding of regulation from the perspectives of stakeholders.

The research was undertaken using an explanatory sequential mixed methods design. For the quantitative phase, a descriptive analysis of data held by the regulator in relation to the evaluations of care services, improvement in evaluations over a specified period of time and the impact of complaints, requirements or enforcements on this performance was undertaken. Data in relation to inspection satisfaction questionnaires was also descriptively analysed. Findings from the quantitative phase informed the qualitative phase.

The qualitative phase began with a co-productive approach involving ten individuals: both regulatory staff and inspection volunteers. Themes arising from their responses, complemented by the findings from previous research phases, then informed the design of individual interviews with six service providers. A thematic analysis was undertaken for both parts of the qualitative phase.

The research demonstrated some contradictory views between regulators and those being regulated. Regulators described building positive relationships with services within a model of responsive regulation. Service providers experienced a bureaucratic process with a compliance focus and relationships in which the power imbalance and a lack of knowledge often led to feelings of anxiety and fear.

In the current environment in which high quality care is expected by both public and government alike, despite the impact of austerity measures, this research recommends that further dialogue needs to take place to ensure the impact and outcomes from regulation are better understood and explicitly articulated.

Identifying key words for indexing and information retrieval:

- Regulation
- Social care
- Social work
- Inspection
- Stakeholder / stakeholder views
- Mixed methods research
- Co-production

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I have always had the support of my parents in everything I do and this Doctorate is no exception, so my enduring thanks go to them both for their constant encouragement.

This thesis is dedicated to the memory of my dad who is always with me.

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Glossary

Community Planning Partnership

The multi-agency arrangement in which public agencies work in partnership locally with communities, the private and third sectors to plan and deliver services.

Co-production

An asset-based approach to delivering public services in which citizens are involved in the creation and planning of policies and services.

Delphi study

A structured communication method which relies on a panel of experts to offer comment on a particular topic of interest or concern through a series of 'rounds' in which a statement is discussed, comments gained, and a consensus reached.

Health and Social Care Partnership

A partnership formed as part of the integration of health and social care services as legislated in the Public Bodies (Joint Working) (Scotland) Act 2014. The Act required health boards and local authorities to integrate the governance, planning and resourcing of adult social care, adult primary care and community health services, including some hospital services.

Inspection

A time limited approach to gathering and evaluating information about a service or sector.

Inspection Satisfaction Questionnaire

A questionnaire issued to services following a process of proportionate sampling. These are a voluntary means of providing feedback on the conduct of the inspector, how he/she undertook the inspection, the process followed and whether the individual completing the questionnaire believes that improvements will be made – or that already high standards will be maintained – as a result of the inspection.

Inspection Volunteer

An individual adult or young person with direct experience of social care services who undergoes training to be able to support regulated care service or strategic inspections.

Integration Joint Board (IJB)

An arrangement established by the Public Bodies (Joint Working) (Scotland) Act 2014 whereby delegated health and social care functions are planned, resourced and managed jointly. Each IJB has strategic oversight of all adult health and social care services and can make the decision about which, if any, children's services fall within its scheme of delegation.

Involvement Co-ordinator

A member of Care Inspectorate staff with responsibility for the co-ordination of recruitment, training and support of inspection volunteers.

Local Area Network (LAN)

A network of professionals involved in scrutiny activity for each of Scotland's local authority areas. The purpose of the LAN is to share intelligence and agree scrutiny risks for each council.

Non departmental public body (NDPB)

A body which has a role in the process of national government but is not a government department or part of one, and which accordingly operates to a greater or lesser extent at arm's length from Ministers.

Regulation (of social care)

A process by which social care services, community planning partnerships or health and social care partnerships are evaluated to ensure adherence to specific standards of practice and positive outcomes for those using care services.

Chapter 1: Introduction

This chapter introduces the research topic and the background, including the provision of social care in Scotland and regulation of care services; regulation by the Care Inspectorate; reasons for undertaking the study, its rationale and significance; the research question, aims and objectives; an overview of the research methodology; ethical considerations; limitations of the study and an introduction to the researcher.

1.1 The provision of social care services in Scotland

The promotion of social welfare in Scotland, through the provision of social care and social work services, is enshrined in the Social Work (Scotland) Act 1968, hereafter referred to as the 1968 Act. This Act brought together comprehensive service provision, addressing issues which affected individuals, families and communities: it legislated for the care and protection of children, including compulsory measures of care and the processes of the Children's Hearing System (which began in 1971), community care (adult social services) and criminal justice services, which before this, had been segregated.

The duty to implement the provisions within the 1968 Act lies with local authorities, however, they can commission services from other organisations such as voluntary organisations or private providers, to deliver provisions under the 1968 Act. Social work moved from "a generalized activity, undertaken by private individuals and charitable organizations, to its position as both a new profession and an established state function" (Brodie, Nottingham and Plunkett 2008 p. 698). The 1968 Act was the driver for inter-agency working, the promotion of social welfare and community empowerment, now enshrined in community planning legislation.

The participation and involvement of those using services and engaging them in designing and planning services is now accepted as best practice across the public sector (Andrioff, Waddock and Rahman 2002; Kay et al. 2008; Brodie, Nottingham and Plunkett 2008).

Since the 1968 Act, many other pieces of legislation have been developed to enhance specific aspects of that Act, or to accommodate related legislation, however, the provisions made within it remain core to the delivery of social work and social care service provision in Scotland.

1.2 The regulation of social care in Scotland

Prior to 2001, local authorities and NHS boards were responsible for the regulation of care services in their area. Different service types were subject to different requirements:

1.2.1 Early years inspections

The Scottish Executive funded universal provision of free pre-school education for every child by 1998-1999 and for all eligible 3-year olds by 2002 (Her Majesty's Inspectorate of Education 1999). The Standards in Scotland's Schools (Scotland) Act 2000 placed a statutory duty on local authorities to secure places for eligible children from April 2002. Childcare provision expanded, with new services required to register with Her Majesty's Inspectorate of Education (HMIE). HMIE was responsible for registering and inspecting services funded to provide pre-school education until 1st April 2002. From then, HMIE worked in partnership with the (then) Care Commission to undertake inspections (HMIE 2002).

1.2.2 Residential care

The registration and inspection of residential care in Scotland was governed by the Social Work (Scotland) Act 1968 and the National Health Service and Community Care Act 1990, the latter requiring local authorities to establish 'arm's length' inspection units. The Social Work (Scotland) Act 1968 (part 4) delegated specific tasks to key individuals. Care providers were compelled to allow local authorities to enter care homes to ensure residents' wellbeing and compliance with regulations. The resulting inspection report was then published (Pearson and Riddell 2003).

1.2.3 Nursing homes

Registration and inspection of nursing homes was governed by the Nursing Homes Registration (Scotland) Act 1938 which gave responsibility for inspection to local health boards. Each health board was required to inspect all local nursing homes at least bi-annually, however, the resulting inspection reports were not required to be published. If both nursing and residential care were provided, nursing care was inspected by the health board and residential care was inspected by the local authority, with each producing their own agency's inspection report.

1.2.4 Care at home services

Before 2002, care at home services were not statutorily required to be inspected, however, Audit Scotland, in its 2001 report 'Homing in on Care' recognised the driver

placed on local authorities to continuously improve the quality of services it provided and purchased through the Best Value programme, a programme which focused on the governance and management of resources with an emphasis on improvement. This led to an increase in benchmarking, creating a level of quality assurance in the sector (Audit Scotland 2001 and 2009).

1.3 Variation in the regulation of care services

There was inconsistency in the above approaches to regulation and locally, different agencies could apply different standards when inspecting the same service. Although agencies such as HMIE were using associate assessors and lay members, this was not an approach used across all agencies. The views of those using services were secondary to that of the service provider, if recorded at all. Inspection reports were unclear in their intended output or audience and inspectors focussed on procedures more than care quality (Pearson and Riddell 2003).

In 1999, the Scottish Office proposed regulatory reform to strengthen performance and ensure better safeguards for vulnerable adults and children. The proposals outlined the principles of good regulation set out by the Better Regulation Taskforce as transparency, accountability, targeting, consistency and proportionality (Scottish Office 1999).

1.4 Regulation of Care (Scotland) Act 2001

The Regulation of Care (Scotland) Act 2001 placed a duty on a new body, the Scottish Commission for the Regulation of Care ('the Care Commission'), to register and inspect social care services, with a duty to further improvement in the quality of care services. The Care Commission came into effect on 1st April 2002 as the independent regulator in Scotland.

The Social Work Inspection Agency (SWIA) had the remit to inspect all social work services in Scotland, reporting publicly and to parliament on the quality of these services, locally and nationally. HMIE had the remit of scrutinising education services and had a specific role to inspect and report on child protection services in Scotland.

The 2001 Act also established the Scottish Social Services Council as the responsible body for the regulation and training of social care service workers. The 2001 Act further established the definitions of care services which required to be registered with the Care Commission and empowered Scottish Ministers to establish National Care Standards – a

set of standards setting out what those using care services should expect from services and, against which, the Care Commission would undertake its regulatory duties.

1.5 Public Services Reform (Scotland) Act 2010

The Public Services Reform (Scotland) Act 2010 again changed the landscape of regulation, aiming to simplify the myriad of regulatory organisations across Scotland. This Act placed the duty of regulating and scrutinising social work and social care services in Scotland solely onto another new body created under that Act: Social Care and Social Work Improvement Scotland (SCSWIS). SCSWIS merged the Care Commission, the Social Work Inspection Agency and the child protection functions of HMIE. This new body operates as the Care Inspectorate and came into being on 1st April 2011. Its role will be explored in Chapter 2.

1.6 Problem statement and rationale

This research was an exploratory study of how stakeholders, including those delivering services and those receiving services, experienced regulation as delivered by the Care Inspectorate in Scotland. This section explores research in the social work field, and how those using services are involved in research in general and research about regulation.

1.6.1 Research in the field of social work

There is a growing demand for "evidence in many areas of social life" (Rapport 2004 p. xviii) and, indeed, evidence-based practice is gaining momentum in an environment in which resources have tightened, finances are restricted and staff are urged to deliver more with the same, or less resource (Patterson Silver Wolf et al. 2014; Social Work Services Strategic Forum 2015; Audit Scotland 2016). The importance of social work research is widely acknowledged as a driver for its professionalisation, for supporting a core profession founded on, and committed to, praxis (Morago 2010; Beddow 2011), for developing discipline-specific knowledge (McLaughlin 2012; Maynard, Vaughn and Sarteschi 2014) and for understanding the significance of learning in informing practice (Boswell and Cannon 2014; Pease and Fook 2016).

Evidence-based practice is also critiqued in literature: it is challenged for undermining professional social work practice through its scientific and ideological bases, engendering a greater emphasis on a performance culture (Webb 2001), for its social construction of problems which can lend themselves to greater political control (Harrison and Sanders 2014), and for the complexity in measuring outcomes to indicate success or

failure of interventions arising from evidence (Bick and Graham 2013). Despite these challenges, research is a core function of health and social care with the purpose of improving the evidence base, reducing uncertainties and leading to improvements in future care (Engel and Schutt 2013; Health Research Authority 2015).

The evidence base as it relates to regulation has not been comprehensively explored. This study used an empirical approach to contribute to better understanding of regulation by building on an ever-growing body of knowledge (Engel and Schutt 2013; Faulkner and Faulkner 2014; Walliman 2016).

1.6.2 The importance of an evidence base

In Scotland, the approach to public policy is set out by the National Performance Framework to ensure that the interests of individuals and communities remain integral to public policy (Scottish Government 2016d and 2019). The Carnegie UK Trust promotes the use of an evidence-based approach to supporting policymaking by investing in research and supporting the National Performance Framework by, among other things, investing in, and helping decision-makers to effectively use, high quality research (Coutts and Brotchie 2017).

Performance management of social work services, complemented by effective regulation, are believed to be key to improving delivery and providing assurance (Social Work Services Strategic Forum 2015). Performance management and regulation cannot be effective without involving those using services who should be listened to throughout every aspect of the system as a measurement of effectiveness and a means of shaping better services (Ackoff 2010; Engel and Schutt 2013; Berwick 2015; Coutts and Brotchie 2017; Campbell, Taylor and McGlade 2017). It was, therefore, integral to this research to listen to, and understand, the perceptions of those using services, and other stakeholders, in order to contribute to the knowledge base.

1.6.3 The evidence for involving those using services in research

Seeking the views of those using services to support mutual learning is good practice within social work research, without seeking or perpetuating a consumerist approach to involvement (Warren 2007; Barber et al. 2011; Beresford and Carr 2012; Cossar and Neil 2015). There are acknowledged challenges in this, including clearly defining the levels and expectations of involvement with those using services, a dissonance in understanding between researchers and those using services as to the purposes, aims,

methods and roles in research and, at times, the researcher's anxiety in experiencing a loss of control over the research (Sweeney et al. 2009; Wallcraft and Schrank 2009; Bowling 2014).

The involvement of those using services is, in the views of this researcher, predominantly beneficial. As well as being good practice, research is based on individuals' experience and informs professional responses to service user needs (Howe 1987; Murphy, Estien and Clare 1996). Research can also be more accessible, in terms of language (Sequeira and Halstead 2002; Ross et al. 2005; Lowes and Hulatt 2005), and focussed on what is important to research participants about the topic under research (Doel and Shardlow 2005; Coffey 2006; McCrystal and Wilson 2009; Buckley, Carr and Whelan 2010).

1.6.4 Research about regulation with those using services

The researcher's interest was in ascertaining the views of those using services and other stakeholders within the field of regulation. The role of regulation should be "centred on the views and experiences of the people using the service being inspected, reflecting their quality of life" (Faulkner 2012 p. 4). Without understanding the perspectives of those receiving services, the value of regulation itself cannot be known (Leistikow 2018).

This research explored the ways in which those using services were already involved in the regulation of services and, through a review of literature, the ways in which they were involved in informing the methodology of regulation itself. The dominant paradigm from those using services about their experiences of inspection in their care service is broadly a positive one (Adams, Dominelli and Payne 2009). Research can support professionals in moving away from the dominant paradigm, thereby viewing things differently and ultimately benefitting those who use services, carers, the sector, and colleagues.

This research has an important contribution to make to the field of regulation because it delivers knowledge based on research evidence from listening to, and understanding, the perspectives of stakeholders, whose interests remain integral to public policy. That provision of evidence supports policy-makers and regulatory bodies to evaluate regulation, its impact on further improving future care, its ability to manage the performance of care services, and define the effective use of regulation, to provide assurance and deliver improved interventions which, ultimately, will support best outcomes for people using care services.

1.6.5 The significance of this study

In summary, there is little written about the views and perceptions of those using services and other stakeholders about the regulation of social care services, yet the importance of doing so is widely acknowledged and this was worthy of further investigation. There is increasing emphasis on listening to the voices of individuals using services and other stakeholders to help shape their design, planning and delivery. This study placed the voices of stakeholders in regulation at its heart, bringing unique and original knowledge to the field, knowledge which is also transferable to other contexts. The field of regulation is changing and, therefore, it is important that the views of stakeholders help shape this change.

1.7. Research question, aims and objectives

The research question, its aim and objectives all seek to address the above.

1.7.1 Research question

This research was an exploratory study to answer the question 'how do stakeholders involved in social care service provision experience regulation as delivered by the regulator in Scotland?'

1.7.2 Research aim

The aim of the research was to explore the views and perceptions of a range of stakeholders involved in care service regulation in Scotland.

1.7.3 Research objectives

The study addressed the following three objectives:

1. To describe the performance of all care service types regulated in Scotland over an identified time period (1st April 2013 – 31st March 2017).
2. To identify knowledge, understanding and perceptions of regulation among those receiving care services, among those providing care services, and other stakeholders.
3. To identify stakeholders' perceptions about the process, delivery and framework of care service regulation in Scotland.

1.8 Overview of the research

1.8.1 Research approach

The researcher undertook an explanatory sequential mixed methods research design in three phases (Faulkner and Faulkner 2014; Creswell 2013 and 2015). Phase one was quantitative, phase two was qualitative and involved a co-productive approach and phase three was qualitative and involved individual interviews. The researcher's epistemological approach to the quantitative phase was positivist and her epistemological approach to the qualitative phase was interpretivist, because it was necessary to use a pragmatist lens to support mixed methods research. The researcher's ontological approach to the quantitative phase was objectivist and her ontological approach to the qualitative phase was constructivist, because it was necessary to use a pragmatist lens to support mixed methods research.

1.8.2 Mixed Methods

The explanatory sequential mixed methods design supported the iterative nature of learning (Faulkner and Faulkner 2014). This meant that evidence was gained through the application of different methods and the collection of data was informed by themes from earlier stages of research. Using mixed methods enabled the researcher to integrate both quantitative and qualitative approaches to enhance the strengths inherent in each (Creswell 1998; Maxwell 2005; Burke-Johnson, Onwuegbuzie and Turner 2007).

1.8.3 Quantitative phase

The overarching research question is 'how do stakeholders involved in social care service provision experience regulation as delivered by the regulator in Scotland?'. In order to answer this question, the researcher developed sub questions to ask of the quantitative data. The researcher considered the data routinely collected by the regulator and identified the most relevant aspects which would support the answers to these sub questions.

The regulator, at the time of the research, used a six-point scale against which care services were evaluated across three or four quality themes (see Chapter two for a full explanation). This scale was: Excellent (6), Very good (5), Good (4), Adequate (3), Weak (2) or Unsatisfactory (1) (Care Inspectorate 2017c). A definition of the evaluations can be found at Appendix 1.

The research compared two evaluations to descriptively analyse change in performance over time (see Chapter 2): services which had received at least one evaluation of 'Adequate' at 1st April 2013 and, of those, services which had achieved at least one evaluation of 'Good' at 31st March 2017.

The 'Adequate' evaluation, at the time of this study, was defined as follows:

"An adequate evaluation means that most aspects of the quality theme/quality statements are met. Aspects which are not met may be subject to recommendations but don't cause concern. The 'adequate' grade applies to performance at a basic but adequate level. This grade represents a standard where the strengths have a positive impact on the experiences of those using services. While weaknesses will not be important enough to have a substantially adverse impact, they are constraining performance. This grade implies the service should address areas of weakness while building on strengths. This is likely to be reflected in recommendations for improvement in respect of relevant National Care Standards". (Care Inspectorate 2017c) For a full definition of all evaluations, see Appendix 1).

These services had been evaluated with at least one grade of 'Adequate'. This meant that, of the three or four quality themes evaluated, at least one was 'Adequate'. The other two or three themes were evaluated as either 'Adequate' or at any of the other grades: 'Unsatisfactory', 'Weak', 'Good', 'Very good' or 'Excellent'. For these services, where the other quality themes were evaluated poorer than 'Adequate', inspectors had judged there was a need to improve and the capacity to do so; where the other themes were evaluated better than 'Adequate', inspectors had judged there remained room for improvement. None of these 1835 care services had received only grades of 'Weak' or 'Unsatisfactory'.

These services were chosen because the evaluation of 'Adequate' meant that the service had capacity to improve and the ability to deliver the improvements required and expected. These services are, therefore, referred to in this study as 'services with the capacity to improve at 2013'.

The second group of care services included were selected by investigating those from the group of services which had the capacity to improve and which had actually improved to receive one or more 'Good' at 31st March 2017.

Choosing these criteria meant that, over the course of regulatory intervention, there had been some improvement in these services. The complaints, requirements and enforcements carried out by the regulator in these care services were also reviewed and a descriptive analysis undertaken of themes arising in relation to care services' evaluations over the four-year period. Next the responses to inspection satisfaction questionnaires were descriptively analysed to investigate the views of stakeholders about their experience of being regulated. Finally, the researcher investigated the improvement work undertaken by the regulator.

A descriptive analysis of themes arising from the quantitative data was undertaken and these themes informed the next stage of the research.

1.8.4 Qualitative phase: co-productive approach

Using the key themes which arose from the quantitative data analysis, coupled with findings from the literature review, the researcher employed a co-productive approach to begin the qualitative phase and engaged virtually with a group of individuals to seek their expert views. This supported the triangulation of evidence and the design of interview schedules for the next stage of the qualitative phase. To facilitate this approach, the researcher's original intention was to undertake a traditional Delphi study (Okoli and Pawlowski 2004; Iqbal and Pipon-Young 2009; Wilkes 2015), however, this approach was modified through the process of iterative learning (Keeney 2011).

1.8.5 Qualitative phase: interviews

Individual interviews elicited further rich text data. The researcher contacted services within the criteria described in the quantitative phase to offer individuals the opportunity to be part of the research. Following a process of sampling, seven individuals expressed an interest with six individual interviews undertaken. Participants were given the opportunity to take part in either face-to-face or telephone interviews. Three face-to-face interviews and three telephone interviews took place. A thematic analysis of this was undertaken of both stages of the qualitative phase using the 'phases of thematic analysis' model developed by Braun and Clarke (2006).

1.9 Ethical and other considerations

The researcher sought ethical approval through the Robert Gordon University review process and explored several ethical elements in this research, including:

1.9.1 Value relevant research

This refers to the relationship between the researcher, topic and any assumptions made. In this research, the social relevance was in exploring the perspectives of stakeholders involved in care service regulation (Hammersley 2017).

1.9.2 Anonymity, confidentiality, and consent

It was acknowledged that a guarantee of anonymity could not be given as it may have been possible to identify services and perhaps, by extension, individuals, particularly those referred to in specialised roles. Confidentiality was maintained, however, and the informed consent of all participants was sought and recorded at every stage.

1.9.3 The role of the 'self' as researcher and employee

This research was undertaken as independently as possible, notwithstanding the role of the researcher as both researcher and as an employee of the regulator. The researcher acknowledged that her own background also shaped her interpretation of findings, highlighting an appreciation of the researcher as an instrument of data collection (Creswell 1998).

1.9.4 The balance of power

Given the researcher's employment role, it was acknowledged that participants could have perceived an imbalance of power. This research took an ethical approach based on transparency, honesty, and informed consent.

1.9.5 Trustworthiness

Trustworthiness was achieved by ensuring the research was credible, transferable, confirmable, and dependable (Lincoln and Guba 1985).

1.10 Limitations of the study

There were several limitations throughout this study. These are explored in Chapter 9.

1.11 The researcher

The researcher is a qualified and experienced social worker and manager, having worked across children's and adults' services, in statutory and voluntary organisations and in operational, management and strategic roles across social services in Scotland. Her current role is as a strategic inspector with the regulator. Since joining the organisation in 2013, she has worked across several functional areas, including scrutiny

and assurance for regulated care services for adults, strategic development, and joint strategic inspection of services for children and young people. She has also undertaken a secondment to Social Work Scotland, the professional leadership body for social work and social care in Scotland.

As a strategic inspector, she leads and participates in joint strategic inspections of services for children and young people as delivered by community planning partnerships, undertakes quality assurance, national policy work and internal and external development initiatives. She also acts as a link inspector to designated local authority areas, supporting partners in the continuous improvement of social care and social work services.

The researcher chose to undertake the Doctorate of Professional Practice to ensure that the research would be relevant to her area of work and to the regulator and that it would provide unique knowledge of the practice area. Studying while working within the field of regulation enabled the researcher to continually be reflexive in her thinking and, importantly, to apply learning to the developing knowledge gained through the research.

1.12 Chapter summary

This chapter has given a brief history of the delivery and regulation of social care in Scotland, highlighting key legislative drivers which changed the course of regulation of these services. The chapter also outlined the problem statement, rationale and the approach taken by the researcher in addressing the research question, aim and objectives. Consideration was given to ethics, limitations and other factors impacting on the study and the researcher outlined her current role and career to ensure transparency from the beginning.

1.13 Thesis structure

Chapter one provided a brief historical overview of the provision and regulation of social care and social work in Scotland. It outlined the problem statement, research question, aim and objectives and gave a short overview of the research. Chapter two will outline the focus and methodology of the scrutiny work undertaken by the social work and social care regulator in Scotland, the Care Inspectorate. Chapter three will explore a review of the literature. Regulation's key principles, purposes, models and critiques will be highlighted. Chapter four will outline the research methodology and describe the mixed methods approach across the quantitative and qualitative phases, including the co-

productive approach. Chapter five will highlight the findings from phase one: the quantitative data analysis. Chapter six will outline the findings from phase two: qualitative phase - the co-productive approach. Chapter seven will explore the findings from phase three: qualitative phase - interviews. Chapter eight will provide an analysis of the overall research findings. Chapter nine will conclude the thesis and will propose recommendations arising from the research.

Chapter 2: Social care regulation in Scotland

Introduction

This chapter will outline the role and function of the Care Inspectorate, the social work and social care regulator in Scotland.

2.1 The Care Inspectorate

The Care Inspectorate is the independent regulator for social care and social work in Scotland, formed via the Public Services Reform (Scotland) Act 2010. The methodology used by the Care Inspectorate to undertake its scrutiny and assurance work at the time of the research has since developed, both for regulated care services and for joint strategic inspections. Changes were made incrementally in order to place an emphasis on outcomes for people, take more proportionate approaches to services which perform well and to focus on supporting improvement in the quality of care (Care Inspectorate 2017a). This study is based on the framework in place at the time this study began in 2015. Despite changes, both the original and the reviewed frameworks measured the quality of care for those using care services in order to give public assurance.

2.2 Registration of care services

Under section 47 of the Public Services Reform (Scotland) Act 2010, all eligible care services must register with the regulator to operate. Services are defined in the following categories:

(a) support service
(b) care home service
(c) school care accommodation service
(d) nurse agency
(e) childcare agency
(f) secure accommodation service
(g) offender accommodation service
(h) adoption service
(i) fostering service
(j) adult placement service
(k) child minding
(l) day care of children
(m) housing support service

The service must continuously meet the requirements of:

- The Public Services Reform (Scotland) Act 2010
- The Social Care and Social Work Improvement Scotland (Registration) Regulations 2011 (SSI 2011/28)
- The Social Care and Social Work Improvement Scotland (Applications) Order 2011 (SSI 2011/29)
- The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210)
- The National Care Standards (now reviewed, see section 2.4)
- Any other legislation which is service-specific

2.3 The regulator's duties

Under the 2010 Act, the regulator must apply specific principles in delivering regulation:

I. "The safety and wellbeing of all persons who use, or are eligible to use, any social service are to be protected and enhanced.
II. The independence of those persons is to be promoted.
III. Diversity in the provision of social services is to be promoted with a view to those persons being afforded choice.
IV. Good practice in the provision of social services is to be identified, promulgated and promoted".

(Public Services Reform (Scotland) Act 2010, part 5, section 45)

Additionally, Section 44 (b) of the above Act specifies that the regulator has a legislative duty to support improvement in care services. As a non-departmental public body, the regulator is accountable to both the public and Scottish Government. Accountability extends to giving assurance that public monies are being spent effectively and efficiently.

2.4 National Care Standards

The National Care Standards exist to specify the standards of care which people should, and have a right to, expect from care services (Scottish Executive 2002). The Standards, tailored for different service types, were developed by Scottish Ministers to ensure individuals receive the same high quality of care provision, no matter where they live. The regulator ensures care is delivered in accordance with the National Care Standards. Following a review and consultation of the National Care Standards, new National Health and Social Care Standards 2017 were implemented on 1st April 2018 (Scottish

Government 2017b). The quantitative data analysed for this study relates to data gathered between 1st April 2013 and 31st March 2017, therefore, evaluations given by the regulator were cognisant of the original National Care Standards which, although more process-focussed, still provided a clear framework for evaluating the standards of care which those using services had a right to expect.

2.5 The Care Inspectorate approach to the regulation of care services

The regulatory framework took account of the Report of the Independent Review of Regulation, Audit, Inspection and Complaints Handling of Public Services in Scotland (Crerar 2007). This review highlighted the five guiding principles for external scrutiny as proportionality, independence, accountability, transparency, and public focus.

During the period of research, the regulator began a change programme of reviewing, testing, and evaluating its methodology for scrutiny and improvement, implemented in April 2017. The quantitative data analysed for this research and the framework for scrutiny described throughout the study relate to the original scrutiny framework.

2.6 Evaluation of registered care services

For registered care services, the regulator assesses services by (largely) unannounced inspections (Care Inspectorate 2017c). It also takes account of information and intelligence received on the performance of care services: from people who use them, complaints investigated and from notifications received from services about significant events or any major change that affects the service delivered.

The regulator evaluates services using a six-point scale which was also numerically based on the original framework, as follows: Excellent (6), Very good (5), Good (4), Adequate (3), Weak (2), or Unsatisfactory (1) (Care Inspectorate 2017c). A definition of the evaluations can be found at Appendix 1.

In the year 2015-2016, there were 13,929 care services registered with the regulator. Of these, 92% of services were evaluated as ‘Good’ or better. Of those high performing services, 96% maintained or improved their grades (Care Inspectorate 2016a and b).

2.7 Using the evaluations

These evaluations relate to four themes illustrating the quality of:

- Care and support
- The environment
- Staffing
- Management and leadership

Each quality theme has several quality statements, from which an inspector has discretion to choose those appropriate for each inspection, using a minimum of two quality statements per theme.

2.8 Joint strategic inspections

Joint strategic inspections use a published quality indicator framework to evaluate performance across community planning partnerships (for services for children and young people) and health and social care partnerships (for services for adults) (Care Inspectorate 2014). This same framework is designed to be used by partnerships for self-evaluation as part of their ongoing continuous improvement cycle. At the time of the study, this original framework applied, however, has also since been reviewed. For the purpose of this study, data and research were confined to the regulation of registered care services.

2.9 Supporting improvement

The regulator employs several methods to support improvement and better outcomes for people, as follows:

2.9.1 Signposting

Signposting supports a care service to understand how other similar service types deliver their service differently, resulting in better outcomes for people and promoting learning across the sector (Rosenbach and Hughes 2010).

2.9.2 Recommendations

Making recommendations, based on good practice principles, allows the service provider to understand areas of their service which require development, but which do not, at that point, necessitate further action (Care Inspectorate 2015a).

2.9.3 Requirements

The regulator can make a requirement to support improvements (Care Inspectorate 2015a). Legislation does not define a requirement but does identify regulations which service providers must meet. These are set out in:

- The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011
- The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Amendment Regulations 2013
- Regulation 19 to 24 of the Regulation of Care (Requirements as to Care Services) (Scotland) Regulations 2002

A requirement must be linked to a breach in the Act, its regulations, orders made under the Act, or a condition of registration. Requirements are legally enforceable.

2.9.4 Enforcements

Finally, and particularly where a service has failed to apply good practice principles, has failed to 'learn' from other options, continually fails to deliver the quality and standards of service expected and, ultimately, is placing – or continuing to place – those using its service at risk of harm, the regulator can take enforcement action. Enforcement actions can result in the regulator petitioning the court for necessary action: the service can be legally compelled to undertake a specific action outlined by the regulator. Where all other measures have failed and serious concerns remain for the safety or wellbeing of those using the service, the regulator can petition the court for closure of a service.

2.10 The involvement of stakeholders in inspection

The Care Inspectorate has a legislative duty to, and views as good practice, listening to the views of those using services and other stakeholders in carrying out its regulatory functions (Care Inspectorate 2012 and 2016c). Section 112 of the Public Services Reform (Scotland) Act 2010 established the duty of user focus for all scrutiny bodies, placing a statutory duty on these bodies to make arrangements which:

a) secure continuous improvement in user focus in the exercise of their scrutiny functions
b) demonstrate that improvement

2.10.1 The regulator's approach to involvement

The regulator's intention in meeting the duty of user focus is to be an organisation that:

- "Thinks creatively about involving people who use scrutinised services in order that they can express their views about the services they receive and want
- Is not only influenced in its day to day activities by the feedback of people who uses care services and carers but works alongside them in different ways to produce the best results" (Care Inspectorate 2012)

2.10.2 How the regulator involves people

Often, the people and communities which interventions are intended to affect, are those furthest away from involvement in policy making and often their voices are those least heard (Audit Scotland 2014). To ensure people who use services, and their carers, are involved in its scrutiny work, the regulator has a range of opportunities to involve people, including:

Care Inspectorate board

At least two board members are required to be people who use services or carers, bringing different perspectives to the board. All appointed individuals are full and equal members.

Inspection volunteers

The regulator has an inspection volunteer programme which is open to both adults and young people. Inspection volunteers are adults who use care services and informal carers, such as family members; or young inspection volunteers, aged 18-26 years with experience of using care services. Their personal experience, along with the ability to engage and empathise with people using services who have the same shared experiences supports the regulator in its scrutiny activity. The feedback they receive, along with their own views, informs inspection reports.

Involving People group

The Involving People group is a national group where people who use care services and carers come together quarterly to consult and engage on the work of the regulator.

Project work and one-off events

The regulator organises a variety of different project groups, events and conferences in which involved people can participate. These have included improvement projects, representing the regulator at external conferences and participating in staff recruitment.

2.11 How the regulator seeks the views of those using services

The regulator's commitment to involving people, and its duty of user focus, extends to seeking the views of those using services, their families, and carers as part of inspection activity.

2.11.1 Care Standards Questionnaires (CSQs)

CSQs are issued in advance of an inspection to the service staff and manager for distribution to those using services, to seek their views about the service. These views support the inspector's preparation for inspection and, together with other information gathered, enable the inspector to define focus areas for each inspection.

2.11.2 Inspection Satisfaction Questionnaires (ISQs)

ISQs are issued to services following a process of proportionate sampling once inspection planning is completed for the year. They are also distributed by the inspector to those he/she speaks with during an inspection, including those using services, relatives or visitors to the service that day. These are not mandatory, however, are used to give feedback to both the inspector and the regulator on the conduct of the inspector, how he/she undertook the inspection, the process followed and whether the individual completing the questionnaire believes that improvements will be made – or that already high standards will be maintained – as a result of the inspection. There are two types of ISQs: questionnaires for those using services, relatives, or visitors; and questionnaires for staff and managers. Both types of questionnaires are suitable for all care service types.

2.11.3 The voices of those using services during inspection

As well as questionnaires, inspectors speak to those who use the service, their relatives, and visitors, as well as staff and the manager to gather as many views as possible to inform their inspection. All views are recorded and inform the published inspection report.

2.12 Following inspection

Following an inspection, initial verbal feedback is given to the manager of the service. The inspector compiles a written report outlining the process and findings and this report is published on the regulator's website.

2.13 Chapter summary

This chapter has outlined the duties and methodology of the regulator for registered care services in Scotland and has demonstrated the ways in which the regulator seeks the views of those using services to support inspections, consultations, and wider work.

Chapter 3: Literature Review

Introduction

The purpose of this literature review is to support ongoing dialogue, explore current understanding of regulation in social care and to provide a framework for establishing the significance of this research (Creswell 2002; Thody 2006; Thomas 2016; Onwuegbuzie and Frels 2016).

This literature review was a traditional narrative review, approached systematically and in an organised manner (Hewitt-Taylor 2017; Efron and David 2018). Sources were critically selected for inclusion and other sources were excluded. The literature review search terms cascaded from the general to the specific to determine the research scope.

An initial search term of “regulation” of the Robert Gordon University library search facility elicited over 7 million results. To refine this further, the researcher applied Boolean operators and limited results by use of filters such as publication types, dates and language. For example, searching “regulation + social + care” reduced the results to just over 634 000; the addition of “+ social + work” further reduced this to just over 500 000. Applying a filter to reduce the time frame to reflect the establishment of the (then) Care Commission (2001) until the date of beginning the literature review (2016) reduced this number further to 330 000. The addition of “+ inspection” reduced this figure to 25 000 results. To refine this to a more manageable starting point, the results were filtered by “social work” only and this led to just over 400 results. The researcher began her reading as a preliminary starting point by identifying articles from well-respected academic social work journals. To give one example, the researcher identified which of those 400 articles were published in the British Journal of Social Work and this accounted for 27 articles. This journal was chosen as a starting point because it is a leading academic social work journal in the UK, so the researcher was aware articles would have been peer reviewed in a well-respected journal. Winchester and Salji (2016) note that it is “essential to read published peer-reviewed original research articles to formulate your literature review” (Winchester and Salji 2016 p. 309). This enabled the researcher to begin to identify themes within regulation in this area. This also allowed the researcher to learn the names of writers writing in the field of regulation and, of course, reference lists in these articles provided another avenue for further suggested reading. Later, historical texts were included to provide context. Equally, the researcher excluded some sources, for instance, once regulation in sectors other than caring sectors had

been investigated (i.e. financial regulation, regulation in industries) this enabled the researcher to focus on the caring sectors.

It was essential to read published peer-reviewed original research articles which included both primary and secondary research studies to formulate the literature review (Fallon 2016; Winchester and Salji 2016). There were several other journals which enabled the researcher to source important articles. These included the Journal of Social Work Research, The Journal of Mixed Methods Research and Research on Social Work Practice, among many others. The researcher also utilised several databases which were helpful in sourcing relevant literature. These included SocINDEX, Social Care Online and SAGE Discipline Hub (Social Work and Social Policy). Using EbscoHost, other databases searched included eBook collection, MEDLINE and CINAHL. As well as articles arising from these searches, the researcher also read books and reports. Through exploring the content of this literature, the researcher became familiar with authors and theorists writing in specific fields of interest which related to her research. For example, the work of John Creswell supported the researcher's understanding of research design and methodology, the work of Anthony Onwuegbuzie supported the researcher's understanding of mixed methods research, the work of Michel Foucault supported the researcher's understanding of the relationship between regulation and society, the work of John Braithwaite supported the researcher's understanding of different regulation types and their evolution and the work of Kieran Walshe offered the researcher opportunities to consider critiques of regulation, among many others. The researcher only referred to grey literature (Adams et al. 2016) on a few occasions to exemplify a point.

Once the scope of the literature review was determined, and reading undertaken, the researcher undertook a thematic analysis of the literature (Fetters, Curry and Creswell 2013; Braun and Clarke 2017). The researcher critically summarised theories and examined studies and synthesized these into an interpretation of the main trends, issues and complexities (Jesson, Matheson and Lacey 2011).

This chapter reviews relevant UK and international literature about regulation, its purpose, the context of the regulation of social care and social work, models of regulation, the involvement of stakeholders in regulation and learning from regulation. Finally, the chapter will review key themes arising from the literature review and highlight areas for further exploration in this research.

3.1 Regulation in history

Forms of state governance, such as census taking, can be dated from Roman times. The censor was both an individual who made a count of adult males and their property "to determine political status and military obligations" and an individual charged with controlling acceptable behaviour (Rose 1991 p. 674). Rose (1991) discusses the "numericization" (Rose 1991 p. 674) of society across the ages as a means of quantitatively evaluating that society, for instance, counting numbers of certain groups of people as a correlation against an actual or perceived societal issue.

Rose argues that "the exercise of politics depends upon numbers" (1991 p. 673). This is often reflected in government rhetoric: citing the rates of divorces or percentages of lone parents as a means of focussing a debate on the erosion of 'traditional' family life, or publicising statistics regarding the numbers of individuals receiving housing and other benefits as a means of debating poverty (Easton 2007; Department for Work and Pensions 2015). Foucault (2014) describes this form of controlling and exercising judgement on behaviour as a form of 'normalisation', a means of social control, the idea that social processes could and should introduce and encourage conformity to specific systems or ways of acting and behaving in society. Foucault describes regulation as a disciplinary force which imposes compliance through a hierarchical structure, thereby, making desired behaviours normal. This 'governmentality' presumes to evaluate conduct and behaviours against an accepted set of norms and standards (Dean 1999). The idea that behaviour can and should be controlled, presumes it is possible to do so and "that there are agents whose responsibility it is to ensure that regulation occurs" (Dean 1999 p. 10).

Similarly, the role of a regulator is viewed as one which is "to minimise harm and to seek to do so by changing individual or organisational behaviour" (Professional Standards Authority 2015a p. 4).

Some writers focus the debate about social control specifically in the sphere of deviancy, seeing social control as an "organized response to deviant acts" (Innes 2003 p. 15; Goode and Ben-Yehuda 2009). Cohen's writing on penal systems describes the "great incarcerations of the 19th century as: thieves into prisons, lunatics into asylums, conscripts into barracks, workers into factories and children into schools" (Cohen 1985 p. 17). These institutions were a response to a perceived erosion in the abilities of the family, the community and religion to continue to ascribe that social control.

Many deem regulation to evidence the control by the state over public service provision – a government-created mechanism by which influence can be directed and oversight of behaviours attained (Selznick 1985; Baldwin, Cave and Lodge 1999 and 2010; Hood et al. 1999; Dixon 2005; Lewis, Alvarez-Rosete and Mays 2006; Better Regulation Task Force 2016). Selznick, for instance, defines regulation as the "sustained and focussed control exercised by a public agency over activities which are valued by a community" and this view of regulatory policy as a means of social control is reflected by others (Selznick 1985 p. 363; Foucault 2014; Harrison and Sanders 2014). Regulation can be viewed as extending a degree of governmental leverage over organisations not directly under government control, thereby facilitating a simplistic governmental response to a complex issue (Walshe and Boyd 2007). Regulation is also viewed as a specific set of commands or instruments used directly or indirectly to exert state influence over organisations providing public services and, ultimately, give state approval (Baldwin, Cave and Lodge 1999; Lewis, Alvarez-Rosete and Mays 2006; Wiles 2011). The control by the state – directly or indirectly – over service provision, is a core aspect of all these definitions.

There have been accusations of inspectorial overload and some writers reflect the direct link between regulation and state control and a perceived increase in regulation (Moreno 2014). The "overall growth of the regulation of Britain's public services has, in fact, little to do with improving the service for its consumers. Rather it has to do with central desires to increase control over costs and the policy agenda…" (Gummerson 2004 p. 3).

The regulator is subject to policymakers and lawmakers who, in turn, are subject to political and governmental pressures. Regulators, therefore, are both challengers of these pressures as well as being leaders, upholders of the law and improvers (Braithwaite and Drahos 2000).

In the UK in the 1990s, the movement towards greater privatisation and decentralisation saw the development of a new role for Government as a regulatory welfare state (Scott 2017; Benish, Halevey and Spiro 2018). Figure 1 outlines the changing culture in the UK from a welfare state to a regulatory state:

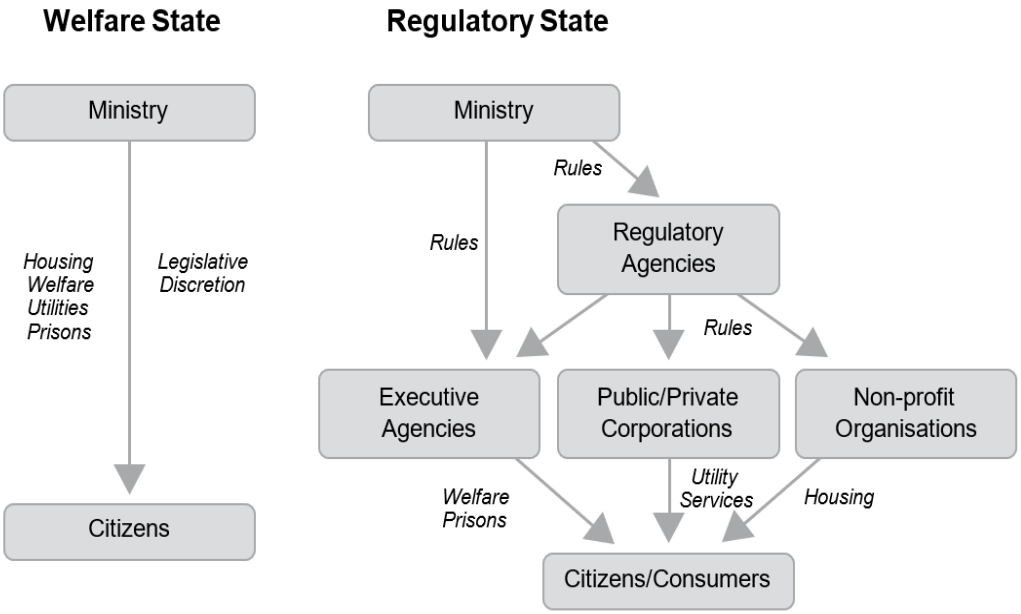

Figure 1: Simplified model of the United Kingdom's shift from welfare state to regulatory state (Scott 2017)

In Figure 1, Scott exemplifies differences between the welfare state and the regulatory state: The welfare state was originally established to enable the state to direct some degree of welfare responsibility both locally and nationally and create an environment in which workers could improve their own welfare (Morel, Palier and Palme 2012; Behling 2018). This welfare state maintained direct control and protection over its citizens, as exemplified above. In this model, the welfare state both legislated and regulated operations.

In Scott's model, the regulatory state delegated direct control and protection of its citizens via executive agencies, the regulation of which was implemented by independent regulatory agencies. The key factor in this was a separation between policy making and operations. The regulatory state describes a systematic oversight of compliance with state rules which could be undertaken by these independent regulatory agencies (Majone 1994; Leisering 2012; Levi-Faur 2014; Haber 2017). This model demonstrates an increased reliance on private sector organisations and a market-type arrangement in which governments are increasingly challenged by maintaining regulatory control while promoting innovation and professional discretion (Kroger 2011). Regulatory approaches have developed and so, too, has the approach to regulation taken by successive UK governments. The UK Coalition Government approach, for instance, was to encourage government departments to seek alternatives to regulation and, if regulation was necessary, then de-regulation in other spheres had to be found to

support the costs of new regulation (Lord Wallace 2015). This was known as the ‘one in, one out’ rule (Department for Business Innovation and Skills 2014).

The UK government’s Better Regulation Framework sets out the means by which government departments measure the impact of, and adopt, a more proportionate and efficient regulation system (Better Regulation Taskforce 2016). The UK Government’s annual report (2019) states that “as we leave the EU, it is the government’s aspiration to oversee a regulatory system which is increasingly proportionate, optimised for UK conditions, innovation friendly and easier for businesses to deal with” (2019 p. 4). The Scottish Government states it follows the principles of Better Regulation, which are being proportionate, consistent, accountable, transparent and targeted only where needed (Scottish Government 2018). As the regulatory framework has developed and adapted, many writers have sought to further define its purpose and principles.

3.2 Defining regulation

There has been a change in the vocabulary around regulation: from the command and control perspective of the 1960s and deterrence-based regulation to responsive regulation then the movement towards self-regulation, meta regulation and more hybrid models (Ayres and Braithwaite 1992; Braithwaite 2008; Drahos 2017). The models themselves are explored later in this chapter.

Within the literature defining the regulation of social work and social care, there is no one agreed definition, rather there are core themes which serve to define the main elements and purposes of the function of regulation.

3.3 The language of regulation

Regulation is a contested domain (Walshe 2003; Lewis, Alvarez-Rosete and Mays 2006; Baldwin, Cave and Lodge 2010). In economics, regulation is viewed as an instrument to address identified problems such as failures in market competition. In legal terms, regulation is about compliance to a prescribed law or agreed standard. In sport, regulation is about upholding the central tenets of “no cheating, no fixing, no doping and no discrimination” (Long 2013 p. 46). In social care and social work, regulation is interested in assurance and the impact of services on wider stakeholders. The context of regulation is varied as are the words used to describe the function of regulation, for instance, ‘social care audit’ (Healthcare Quality Improvement Partnership 2017); ‘supervision’ (Tuijn 2011); ‘quality reviews’ (Ehren 2016); ‘scrutiny and assurance’ (Care

Inspectorate 2018a); and ‘audit’ (Audit Scotland 2018). A simple online word search elicits even more synonyms, for instance ‘governance’, ‘supervision’, ‘direction’, ‘administration’, ‘adjustment’, ‘rule’, or ‘control’ (Collins Dictionary 2018). The language of regulation, therefore, is contextual and fluid.

3.4 Findings from the literature review

The literature cites several core purposes of regulation.

3.4.1 Assurance and accountability

A primary purpose of regulation is viewed as the provision of assurance and the formalising of accountability. This entails the implementation of effective governance which includes robust quality assurance frameworks, processes, and procedures with a view to driving improvement in quality and standards. In this way, regulation is a tool for providing assurance to the regulator, the public, the service being regulated and to the government (Boyne, Day and Walker 2002; Tuijn 2011; Ehren 2016). The unique role of external scrutiny in providing independent assurance that services are well-managed, safe and fit for purpose and that public money is being used properly are also a core part of the provision of assurance and accountability (Scottish Government 2011). Systems and processes must also assess, monitor, and mitigate any risks. The UK Government states that “the job of regulators… is mainly to provide information and advice to ensure that organisations assure themselves effectively and reliably and intervene when they do not” (UK Government 2017 p. 5). This description of regulation is reflected in models of regulation with moves across a spectrum from compliance to self-regulation.

The Care Inspectorate aims to “give public assurance and build confidence that social care and social work in Scotland is rights based and world class, through robust and independent scrutiny and improvement processes” and further defines quality assurance as “all activity that contributes to improvement and assures the organisation that agreed standards are being met and quality outcomes achieved” (Care Inspectorate 2017a). Assurance and accountability, therefore, are core aspects of regulation as delivered in the social care sector in Scotland.

3.4.2 Public safety and protection

The safety and protection of the public is another key purpose of regulation (Alsop 2013). The Scottish Housing Regulator, for instance, defines its core objective as “to safeguard and promote the interests of tenants, people who may be homeless and those who use

housing services provided by social landlords" (Scottish Housing Regulator 2015). In relation to the regulation of the workforce, public protection is viewed as an integral component of regulation. The purpose of regulation of the social care and social work workforce in Scotland is to assure individuals that social services are provided by "a trusted, skilled and competent workforce" (Scottish Social Services Council 2020).

Regulation as a means of public protection is often cited following highly publicised 'failings' in care. For instance, in the review report of the Mid Staffordshire NHS Foundation Trust, an investigation into the high patient mortality rate attributed this solely to poor care and, in the resulting report, the primary purpose of regulation was described as public safety (Mid Staffordshire NHS Foundation Trust Public Inquiry 2013; Spencer-Lane 2014). Similarly, an inquiry was undertaken into the regulation of care for older people following concerns about care quality after the deaths of two residents at the Elsie Inglis Nursing Home in Edinburgh in 2011 and the announcement later that year that Southern Cross Healthcare Group would cease to operate as a care home operator, affecting more than 90 care homes in Scotland (BBC news 2011). Regulation is, therefore, viewed as contributing to a system of care which is safe and of good quality (Palsson 2018).

3.4.3 Value

Another purpose of regulation is seen as giving assurance about services being value for money and creating added value (South West Joint Improvement Partnership 2010; Leistikow 2018). Value for money is about the cost effectiveness of services, but it is also about ensuring good governance, effective management of resources, and a focus on improvement to deliver the best possible outcomes for the public (Audit Scotland 2018b).

3.4.4 Compliance

Compliance to legislation, prescribed standards or requirements is another identified component of regulation (Makkai and Braithwaite 1994; Ehren 2016; Black 2017; McKinney and Paulus 2017; Bourne 2018). Indeed, the Regulation of Care (Scotland) Act 2001 established the functions of the Scottish Commission for the Regulation of Care (the predecessor body of the Care Inspectorate) and the Scottish Social Services Council in relation to the regulatory compliance of social care services and the social care workforce in Scotland respectively. The Care Inspectorate includes 'quality control' as part of its quality assurance processes, ensuring deliverables conform to requirements (Care Inspectorate 2017b). It has, however, also developed its approach

from one of compliance to an overall approach that supports services to improve (Care Inspectorate 2017a). Models of regulation explored later in this chapter emphasise a move towards other regulatory approaches and away from a purely compliance-based approach.

3.4.5 Identifying, addressing and learning from failures

Many writers cite a core purpose of regulation as the identification of, and protection from, poor practice or market failures (Viscusi 1996; Feintuck 2004; Lewis, Alvarez-Rosete and Mays 2006; Tuijn 2011). They acknowledge that market failure presents a potential role for government action, but this action must be "well-conceived" (Viscusi 1996 p. 1424). There are also considered to be benefits in regulation which identifies unmet need and unacceptable variations in care through these failures (the Healthcare Quality Improvement Partnership (2017).

3.4.6 Regulating risk

The regulation of risk is also viewed as an important function of regulation. Tuijn (2011) notes the trend of the Dutch Healthcare Inspectorate towards the greater use of government regulation in healthcare, noting however, that scientific research on the effects of regulation is relatively young and focusses, in the main, on risk regulation regimes, the consequences of enforcement and "surveyor styles" (Tuijn 2011 p. 1).

In Scotland, there is a national approach to the analysis of risk in social care on a local authority basis. A local area network (LAN) consisting of representatives from all the main scrutiny bodies for local government represents each of Scotland's 32 local authorities (Strategic Scrutiny Group 2018). The purpose of the LAN is to share scrutiny intelligence and, from an analysis of this, agree the scrutiny risks for each council, agree scrutiny activity to investigate these risks and publish a national scrutiny plan annually. The regulation of risk is integral to this process and remains a core element in the regulation of social care to support its improvement (Manthorpe 2007; Brown 2010).

3.4.7 Supporting change or improvement

Regulatory bodies themselves often describe a key purpose of regulation as supporting services to change and improve. In the UK, the care regulators all express this slightly differently. The Care and Social Services Inspectorate Wales (CSSIW) sees their purpose as to "register, inspect and take action to improve the quality and safety of services for the well-being of the people of Wales" (CSSIW 2016 and 2018); the Care

Inspectorate in Scotland defines itself as a scrutiny body which supports improvement (Care Inspectorate, 2018a); the Care Quality Commission in England (CQC) states it will monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety (Care Quality Commission 2016a and 2018); and the Regulation and Quality Improvement Authority (RQIA) in Northern Ireland defines itself as monitoring and inspecting the availability and quality of health and social care services and encouraging improvements in the quality of those services (Regulation and Quality Improvement Authority 2018). In a regulatory environment in which regulators are changing their emphasis from inspection to improvement, some commentators view this as a move "from guard dogs to guide dogs" (Davis, Downe and Martin 2004 p. 44).

Regulation is viewed as a catalyst for change and improvement with the ability to influence events, actions, and processes (Crerar 2007; Parker 2013; Ouston, Earley and Fidler 2018; Furnival, Boaden and Walshe 2018).

The Scottish Government, in its report into the child protection improvement programme cites that "inspections play an essential role in helping to drive improvements in outcomes for Scotland's children and young people" and recognises the fundamental rationale (of scrutiny) as providing assurance regarding the effectiveness of services and to support continuous improvement in services (Scottish Government 2017a p. 44).

However, regulation as a conduit for improvement is also questioned: in a study of hospital inspections in Wales, the author found that positive inspection results demonstrated no evidence of improvement (Hanser 2018). Similarly, Boyd et al. (2017) questioned the reliability of assessments by inspectors, while Martin et al. (2010) questioned the validity of measures and the sustainability of the approach in supporting improvement.

The relationship, then, between regulation and improvement remains complex. McKenzie states that "innovation takes many forms, and 'incremental innovation' (improvement to many) is often happening on a daily basis" (McKenzie 2015). Measuring this improvement, however, proves more difficult. Ellis and Whittington state that quality improvement is "everyone's willingness to change what they do for the sake of the improvement" (Ellis and Whittington 1998 p. 72). Although this was written prior to much of the recent legislation and changes in regulation, the statement places much emphasis on the voluntary nature of change and places the focus on improvement, not the

experience of people who use services (McDermott, Kitchener and Exworthy 2017). Again, a point made by other writers above, and one which would be central to the intent in regulatory frameworks – the impact of regulation and improvement on the individual receiving services.

“Quality assurance is about getting it right first time, but this is an aim that will forever remain on the horizon; the important thing is that the journey is in the right direction” (Hughes and Williams 1991 p. 167).

3.5 Complexities of regulation in the care sector

3.5.1 Regulation of the workforce

There have been changes to the way in which the social work profession is regulated in England. The Children and Social Work Act 2017 created a new organisation, Social Work England, to take over from the Health and Care Professions Council as the profession’s regulator. The Act also established a requirement for the new regulator to obtain the education secretary’s approval for professional standards; established new powers for the education secretary to set improvement standards for social workers and introduced assessments for practitioners. This means that social workers in England are the only health and care professionals directly regulated by government. Those within the social work profession opposed the proposal and saw it as a threat to the independence of a profession which should be led by practice and research rather than government policy and ideology (British Association of Social Work 2018). In Scotland, the social services workforce of approximately 203 000 people is regulated by the Scottish Social Services Council (SSSC 2020). In Wales, this role is undertaken by the Care Council for Wales. In Northern Ireland, it is undertaken by the Northern Ireland Social Care Council.

3.5.2 Complexities of the care sector

As noted elsewhere, regulatory systems are complex. So, too, are the sectors to which they are applied. The social care sector has a myriad of players involved: national and local government, service providers and care staff (local authority, private, third and not-for-profit sectors), professionals and professional registration bodies, service users, service user advocacy groups, family members and carers.

Added to that is the changing political and social climate; the current financial environment of austerity; the expectations that services must be delivered in different ways; approaches to commissioning and procurement practices; changes to the UK welfare system; advances in medical treatments and an ageing population predicted to live longer. Finally, increased duties imposed on public bodies via legislation such as the Social Care (Self-Directed Support) (Scotland) Act 2013, Children and Young People (Scotland) Act 2014, Public Bodies (Joint Working) (Scotland) Act 2014 and the Carers (Scotland) Act 2016, as only a few examples, all place challenges on the social care system, its delivery methods and its staff (Osborne et al. 2012; Trowler 2014; Jones 2015).

3.5.3 The complex role of the regulator

It is amongst this complex field that regulators navigate their myriad roles: as agents of social control; as a mechanism of addressing government and market failures; as challengers of policy and as improvers of practice – all within the disparate regulatory environments. Regulators must also take cognisance of their own corporate social responsibility and respond to changing dynamics, working in partnership with those they regulate and other stakeholders in a form of tripartism, as a means of counteracting the risk posed when partnerships established through responsive regulation dilute the independent role of the regulator (Ayres and Braithwaite 1992; Vidal and Torres 2005; Drahos 2017).

3.5.4 Regulation and performance management

Performance management in social services supported by regulation is seen as key to improving outcomes for people who use services because it can facilitate the understanding of staff, decision-makers and the public about the performance of social services and the ways in which they can improve (Social Work Services Strategic Forum 2016). The forum believes it is “not about developing a standard or centralised approach to performance management, rather it is about how to interpret performance at local level to improve delivery and ensure better outcomes for service users” (Social Work Services Strategic Forum 2016 p. 20), echoing the principles of the report into the future delivery of public services (Christie 2011).

The Professional Standards Authority, conversely, claims that “regulation is asked to do too much, to do things it should not do, things it cannot do and things that don’t need doing” (Professional Standards Authority 2015b p. 3). This report goes on to say that the

very fact that regulatory bodies exist merely serves to impede change and improvement in the sector and makes a plea for these bodies to redefine what they are seeking to achieve based on a ‘what works’ agenda.

3.5.5 The evidence base of care regulation

The journey to the effective regulation and evaluation of quality in social care fundamentally requires a consensus as to the definition of what constitutes quality in care, a definition which, several writers agree, is difficult to pin down (Harvey and Newton 2004; Dadd 2013; McKitterick 2015). In fact, a direct causal link between a programme of work and its outcome cannot be demonstrated, resulting in the systematic gathering of process data as a means of producing evidence of a “chain of impact” (Dadd 2013 p. 6).

It is this evidence which is the most challenging aspect in regulating the impact of social care. Webb and others strongly critique the scientific and ideological bases of evidence-based practice, arguing that a focus on this “undermines professional practice and perpetuates a performance culture” (Webb 2001 p. 58; Maynard 2007). The practice of social work involves a robust application of theory, of values, of social justice, of deliberation in heuristic decision-making and an analysis of the professional’s understanding of the circumstances of those using services and the myriad of impact factors present at the time of engagement which ensures that “a prudent professional does not move directly from evidence to action” (Webb 2001 p. 68).

This makes the business of social work more nuanced than other professions which may rely more heavily on evidence from practice, for example evidence-based healthcare, where the explicit impact of specific interventions results in a direct predictive intervention under similar circumstances in future (Florida State University 2015).

3.6 Models of regulation

Models of regulation have developed alongside theories. These range from the deterrent to accommodative styles of enforcement applied as approaches to the purposes of regulation (Reed and Stanley 1999; Walshe 2002 and 2003; Schweppenstedde et al. 2017; O’Dwyer 2015; Ajay and Gregg 2018). These models include those of compliance, responsive models, smart regulation, self-regulation, voluntarism, right touch regulation and anticipatory regulation.

3.6.1 Compliance

Models focussing on compliance have, broadly speaking, a legislative or standards-based framework to which organisations must adhere and use regulation as a means of preventing the escalation of risk. For example, in the nuclear industry, where safety is paramount, the Office for Nuclear Regulation is the body responsible for nuclear safety and security across the UK and takes a compliance-based approach to ensure relevant safety and licensing standards are achieved (Office for Nuclear Regulation 2019). The Health and Safety Executive, similarly, uses regulation as a means of enforcing the Health and Safety etc. Act 1974 to prevent workplace death, injury or ill health (Health and Safety Executive 2019). While many regulatory bodies take a compliance-based approach to regulation, all regulatory bodies must adhere to the regulators code, part one of which states that “regulators should carry out their activities in a way that supports those they regulate to comply and grow” (UK Government 2015). Compliance, therefore, remains one element of regulation, complemented by different regulatory approaches.

3.6.2 Responsive regulation

Healy and Braithwaite (2006) argue that regulation should be responsive to the context, culture and conduct of services and propose a model in which there is an increasing need for external regulation only where internal regulatory models are insufficient:

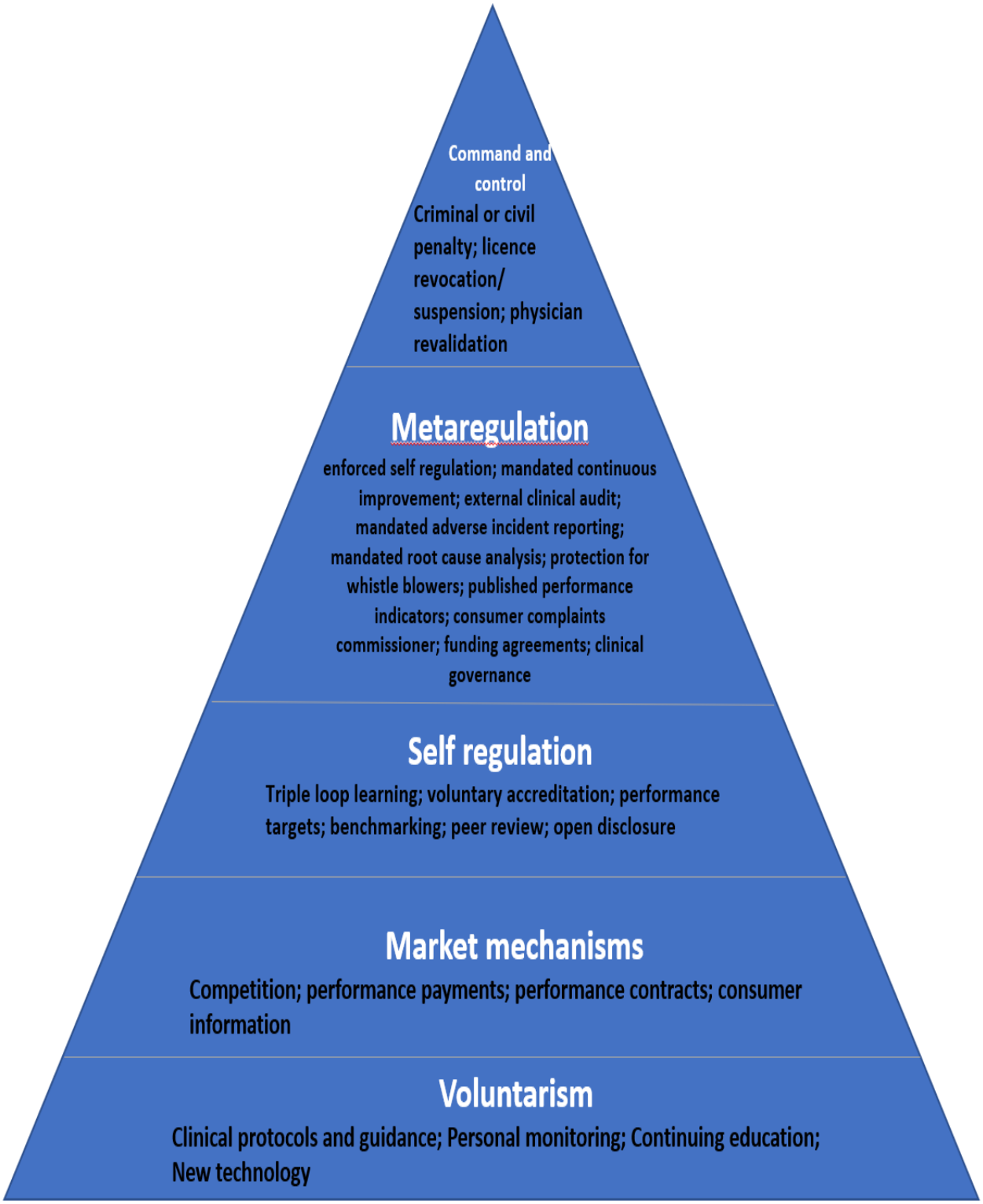

Figure 2: Regulatory pyramid and examples of safety and quality mechanisms (adapted from Healy and Braithwaite 2006)

In Figure 2, at the base of the pyramid is the least interventionist approach – that of voluntarism, in which (in this example) health care professionals follow agreed protocols, participate in their own learning, use technology, and monitor themselves. Travelling upwards in the pyramid demonstrates regulatory options which become increasingly interventionist. Healy and Braithwaite describe meta regulation as “publicly regulated self-regulation” (2006 p.57), a model in which an external regulator scrutinises the organisation which is self-regulating to ensure that external accepted standards are being applied.

Governance, through meta regulation, is applied through a network. In Healy and Braithwaite’s example, learning from one setting is monitored by those in similar settings and applied in order to support continuous improvement, for instance, learning from one hospital is analysed and applied in a different hospital. At the top of the pyramid, the ‘command and control’ approach is the one with the highest degree of intervention from an external regulator.

“The challenge for safety and quality is to design safer systems and inculcate a culture of safety, while the challenge for governance is to ensure that these systems and practices are actually applied” (Healy and Braithwaite 2006 p. 58).

Regulation which is responsive to context is a means of combining state-endorsed regulatory functions with proportionate approaches. For instance, Connolly (2017) promotes ‘restorative regulation’ as a combination of state regulation and restorative justice approaches, allowing regulators to gauge levels of risk and respond in a flexible and proportionate manner.

Writing about financial regulation, Singh and Singh (2018) apply responsive regulation to small scale regulatory areas. They define reactive regulation when regulatory compliance is automatic and not intuitive. In this model, they argue that positive reinforcement through support and recognition of achievements can be effectively combined with recognition of efforts in implementing practices. Braithwaite (2011) argues that responsive regulation highlights a paradox, whereby, having the capacity to escalate regulatory intervention often results in increasing collaborative capacity building.

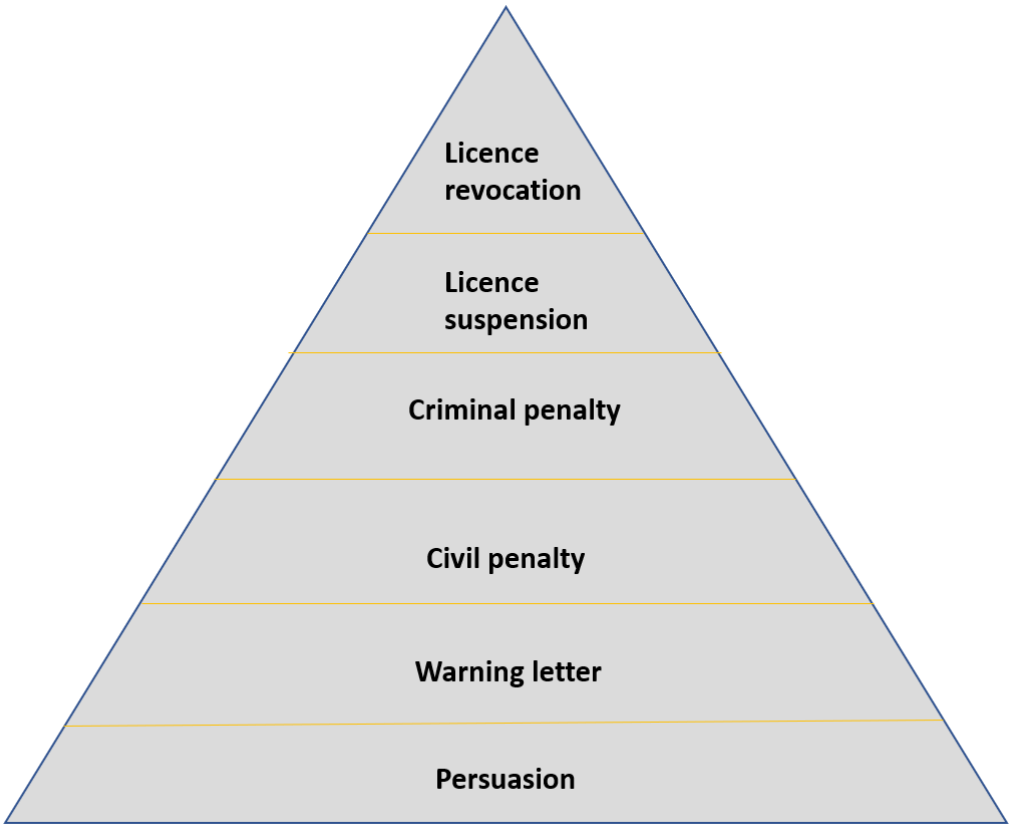

Figure 3: A regulatory pyramid of sanctions (adapted from Ayres and Braithwaite 1992 p.35)

The pyramidal responsiveness with sanctions in Figure 3 demonstrates the approach of engaging in meaningful dialogue first (Persuasion) before escalating regulatory responses and engaging in a more controlling manner as evidenced upwards through the pyramid. Using this approach, some writers argue that coercive control is more likely to be viewed as fair and compliance with the law, for example, is more likely when regulation is seen as procedurally fair with incremental steps having been taken (Johnson, Lanaj and Barnes 2014; Drahos 2017).

Really responsive regulation seeks to add to the development of responsive regulation: this calls for regulators to be responsive to the "attitude of the regulated company, its operating and cognitive framework, its institutional environment, performance of the regulatory regime, the different logics of regulatory tools and strategies and to changes in each of these elements" (Baldwin and Black 2008 p. 61).

3.6.3 Smart regulation

Smart regulation – the process by which the use of multiple policy instruments, as opposed to one single policy instrument, coupled with a broader range of regulatory 'actors', produces better regulation (Gunningham and Sinclair in Drahos 2017). This process is underpinned by regulatory design principles which include third parties as surrogate regulators. They describe the example of the Forest Stewardship Council (FSC), a global environmental standards-setting system for forestry products. The FSC sets standards which certify forestry products as being sustainably managed, thereby its "enforcement 'clout'" is based on the idea that consumers of forestry products demand FSC-certified products and the setting of environmental standards by this third party complements government regulation (Gunningham and Sinclair in Drahos 2017 p. 140). In the UK, the Red Tractor scheme, governed by the Assured Food Standards Board, works on similar principles: Red Tractor is the largest food safety scheme in the UK covering all aspects of food safety including animal welfare, food safety, traceability and environmental protection. All the major UK supermarkets use the Red Tractor standards as their basis for UK-sourced food (Red Tractor Assurance 2020). Like consumers of the FSC scheme, UK food buyers trust that all Red Tractor labelled products meet recognised standards of safety and sustainability.

3.6.4 Self-regulation

Self-regulation has three distinct functions: monitoring one's own behaviour, judging one's behaviour against personal standards and reacting to this (Bandura 1991). Self-regulation is the process by which an organised industry-level group regulates the behaviour of its members and is an approach which can be linked to best outcomes (O'Dwyer 2015). In Healthcare regulation, historically, a model of self-evaluation and self-regulation was applied. "This was based on the assumption that medical expertise was beyond the ability of unqualified people to understand or evaluate" (Law Commission 2012 p. 3). Professional workforce regulatory bodies such as the Scottish Social Services Council or the General Medical Council take a primarily self-regulatory approach: they register professionals, set standards for practice, conduct, training and education to which members must adhere, investigating and taking action where individuals fail to meet these standards (Scottish Social Services Council 2020).

The UK Government believes the future of regulation is about regulated self-assurance and earned recognition, different to self-regulation in that it encourages

companies to make use of their internal quality assurance frameworks and their own internal regulatory processes to promote better outcomes (UK Government 2017).

3.6.5 Voluntarism

Voluntarism in regulation is an approach taken by organisations to self-regulate without any basis in coercion. This can be initiated by governments but based on a voluntary agreement between government and the organisation. Many writers agree that voluntarism works best as part of a complementary regulatory approach and not a stand-alone regulatory approach (International Council for Human Rights Policy 2002; Milligan and Conradson 2006; Gunningham and Sinclair in Drahos 2017).

3.6.6 Right touch regulation

'Right touch' regulation is regulation which is proportionate to that which is being regulated; being clear about which risks are being addressed; finding responsive ways to promote good practice and support improvement (Cayton and Webb 2014). The key principles of right touch regulation are proportionality, being targeted in approach, being accountable, being transparent, remaining consistent and being agile (Professional Standards Authority 2015a). Taking this approach, "it is the skill and competence of regulated professionals that delivers high quality care…and not the regulators" (Cayton and Webb 2014 p. 199). The regulatory process, delivered using a right touch approach builds on an effective assessment of the sector and the risks within it then applying the 'right' amount of regulation, using the appropriate method, to gain the desired results (Professional Standards Authority 2015a). The Professional Standards Authority uses the analogy of getting the balance correct on a set of scales:

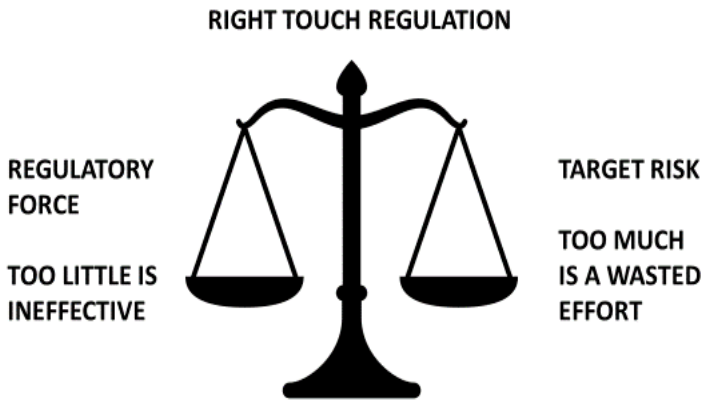

Figure 4: Regulatory Force (adapted from Professional Standards Authority 2015a p. 5)

In Figure 4, the balance is achieved when the regulatory force applied is just the correct amount to address the risks identified. Any more regulatory force applied would be a 'wasted effort', any less would be 'ineffective'. Using the principles outlined above, right touch regulation can be further exemplified as:

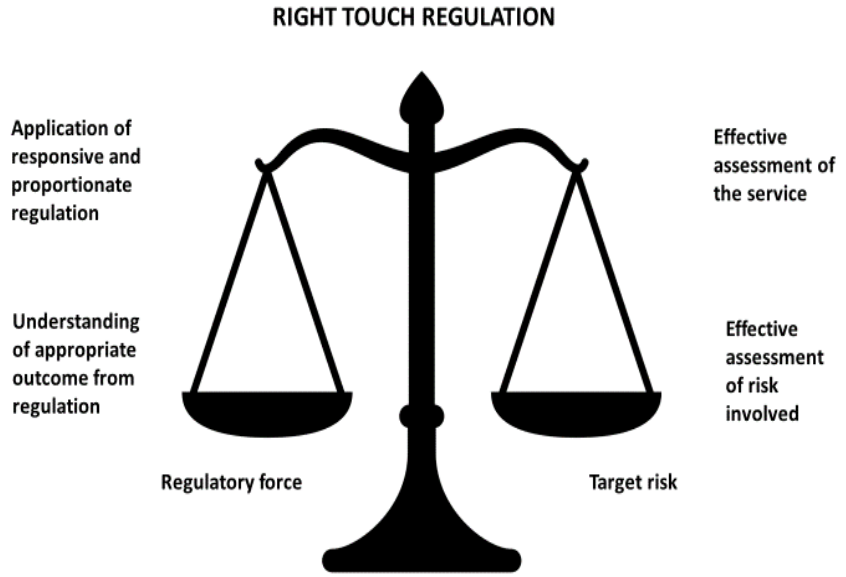

Figure 5: Achieving right touch regulation (adapted from Professional Standards Authority 2015a p.5)

In Figure 5, right touch regulation means the equilibrium is achieved between regulatory force and target risk. The amount of regulatory force is calculated by understanding what is to be achieved by regulation and using methods which are responsive and proportionate. Targeting the risk means effectively assessing the service and understanding what the inherent risks to the service and its users are.

3.6.7 Anticipatory regulation

Armstrong and Rae (2017) define three different models of regulation: advisory, adaptive and anticipatory.

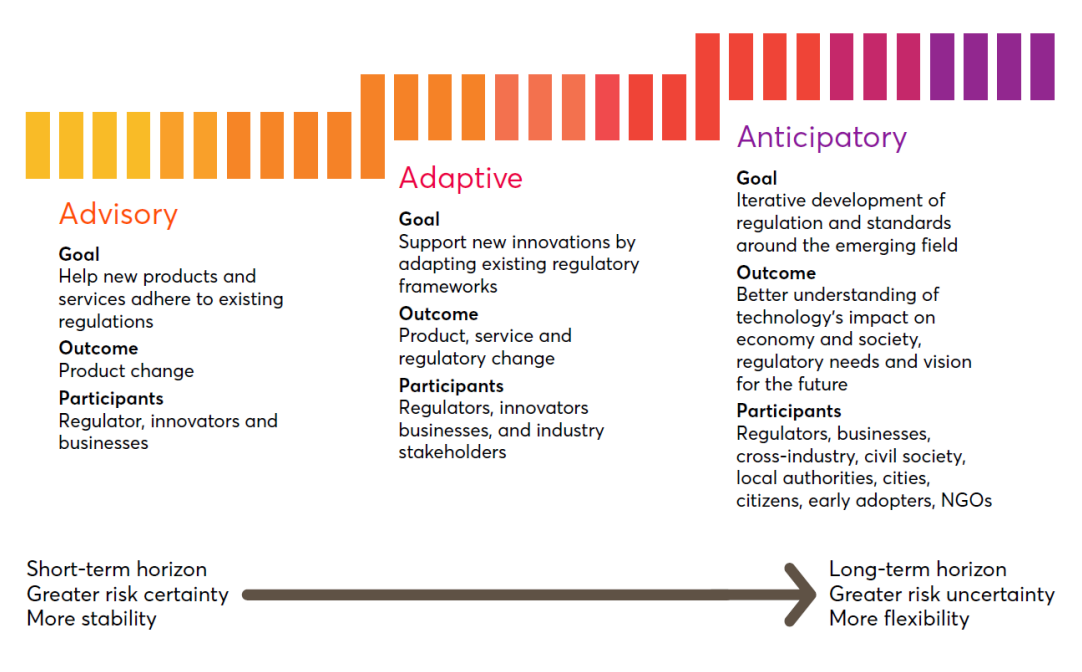

Figure 6: The AAA model of anticipatory regulation (Armstrong and Rae 2017)

In their models, advisory regulation makes it easier for businesses to approach the regulator to test new models or products in the context of existing regulation. Adaptive regulation views the regulator as facilitating the development of new products but recognising that existing regulatory frameworks must be adapted to do so. Anticipatory regulation, which they argue is the most future-focussed, sees the regulator keen to understand the impact any new product might have and, consequently, what future regulatory needs may be.

3.6.8 Regulatory sandboxes

A model developed by the Financial Conduct Authority (FCA), the regulatory sandbox is described as having the potential to deliver more effective competition in the interests of

the consumer by reducing the time and cost of getting innovative ideas to a market, facilitating greater access to finance for innovators and enabling more products to be tested, all by removing unnecessary barriers to innovation (Financial Conduct Authority 2015). The model waives normal regulatory requirements to support innovation. The Financial Conduct Authority has reviewed its regulatory sandbox approach and has concluded that it has been successful at meeting its objective of reducing the time and cost of getting innovative ideas to market, although recognises that it is too soon to make conclusions about its impact on the market (Financial Conduct Authority 2017).

The social care regulator in Scotland states it is moving from a compliance-based to collaborative approaches in regulation:

Compliance		**Collaboration**
Regulation is independent and external to the delivery system	→	Regulation remains independent but sees itself as part of the system
Regulation is focussed on whether minimum standards are met	→	Regulation is focussed on continually improving experiences for people
Power is vested in a regulator which exercises power-based relationships	→	Power is shared with regulatees and their workforces, engaging in collaborative relationships
Models of delivery are pre-defined	→	New models of delivery are tested and evolve
Regulatory approaches are inflexible	→	Regulators are willing to work together to solve problems and improve care
Changes are made because the regulator requires them	→	Ownership for improvement is vested in the regulatee and workforce

Figure 7: A model for supporting a new approach (adapted from Care Inspectorate 2018c)

Building on responsive regulatory models and the regulatory sandbox approach, the Care Inspectorate believes this adapting practice from compliance-based approaches to more collaborative approaches, and regulatory sandboxes can “design and lever innovation without the prescription of legislation” (Care Inspectorate 2018c).

Collaborative approaches, from a base of self-evaluation, can, the Care Inspectorate believes, support care providers to deliver innovative care practices which are focussed on outcomes, something many care providers have long requested (Community Care Providers Scotland 2010).

The key purposes identified in the literature and outlined above can, when considering a move from a compliance-based approach to an approach more oriented towards supporting improvement, be viewed as a spectrum:

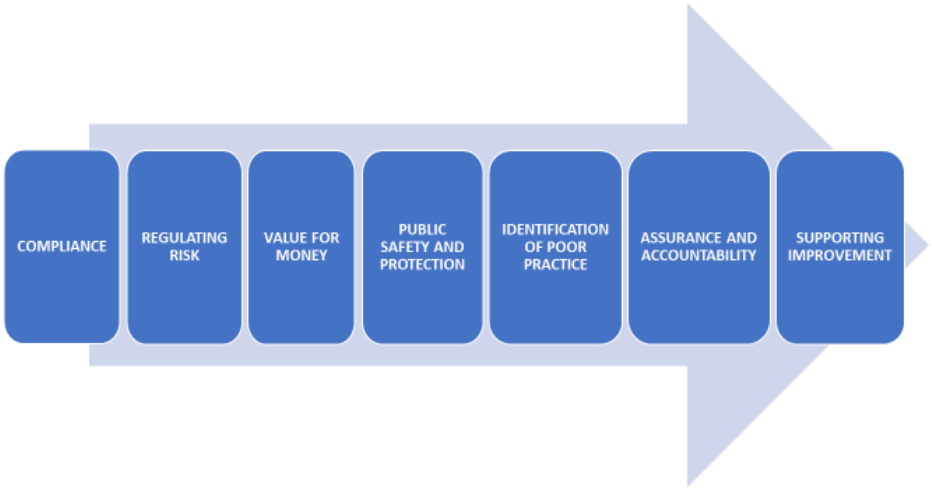

Figure 8: The spectrum of regulatory purposes

In Figure 8, each identified purpose of regulation is placed on a continuum and can be viewed as a reflection of the move from a compliance-based approach to one which more readily supports change or improvement.

3.6.9 The integrated model of regulation

In summary, the literature notes different internal and external regulatory models from the 'command and control' approach, which focusses on compliance, to responsive regulation. As responsive regulation has developed, so too have different models of responsive regulation. These include smart, 'right touch', advisory, adaptive and anticipatory regulation, including a regulatory sandbox approach. Self-regulation and voluntarism have also developed. Most writers agree that the complementary use of different approaches works best, although the use of hybrid models is complex (Braithwaite 2011; Cayton and Webb 2014: Drahos 2017; Furnival, Boaden and Walshe 2017 and 2018).

Each of the models described above determines an approach to the different outcomes from regulation. For instance, models focussing on compliance with legislation may take a 'command and control' approach, while models focussing on improvement may take a more responsive approach, although these are not fixed. If the core purposes of

regulation encompass all the elements outlined above, however, the researcher suggests a more integrated approach and a new model of regulation:

Figure 9: An integrated model of regulation

In Figure 9, the researcher demonstrates the integrated nature of models of regulation built around the aim of effecting better outcomes for people, captured within the core purposes of regulation as defined in the literature. To address all eight aspects which form the core purposes of regulation as identified in a review of the literature, no one model will suffice. Rather, approaches to regulation must adapt to address the eight identified purposes of regulation. In the above integrated model, approaches must remain fluid and adaptable. The optimum approach is one which encompasses internal, external, and collaborative approaches to regulation in a proportionate, responsive way.

3.7 Critiques of regulation

Regulation is a “problem-based activity” (Black 2014 p. 9). An apparently simple definition of the role of regulation being to “pick important problems and fix them” helps to exemplify the complex nature of regulation: that simple definition requires the regulator and those being regulated to agree precisely what the problem is, or to agree which problem to focus on and agree how, exactly, it can be fixed (Sparrow 2000 p. 314). Critiques of regulation cite several issues which remain problematic and these tend to

relate to the process of regulation, regulatory practice or the impact and outcomes from regulation.

3.7.1 The process of regulation

Regulation is often critiqued as being process-focussed. Despite the assertions of the UK regulatory bodies of health and social care that the purpose of regulation is to provide assurance and to improve care services (Care and Social Services Inspectorate Wales 2016; Care Quality Commission 2016a, b and c; Regulation and Quality Improvement Authority 2018 and 2020; Care Inspectorate 2018b), some studies found that regulation serves to increase risk management or concentrates on the process elements of care and service outputs rather than outcomes for those using services (Clarke and Newman 1997; Ashworth, Boyne and Walker 2002; Fenech and Sumsion 2007; Palsson 2018; Hood 2019). There is a tension in regulation between evaluating the experience of the person at the heart of the service and the delivery of that service itself. While intending to quality assure an individual's experience, regulators often actually only evaluate the processes of delivery (Harvey and Newton 2004).

The process of regulation, from the point of view of those receiving it, is also challenged in relation to querying the motivation behind compliance, or a lack of compliance, with regulation (Braithwaite and Drahos 2000; Tankebe 2009; Drahos 2017). Ehren describes the impact of "voice, choice and exit" (Ehren 2016 p. 130): the pressure exerted by stakeholders to conform to inspection standards. He argues that the school inspection regime, for instance, largely focusses on a single school, using a pass/fail judgement system of indicators, which does not support learning across the wider education system. In fact, the Office for Standards in Education, Children's Services and Skills (OFSTED) has been criticised for judging schools on the academic ability of students rather than the quality of education (Times Higher Education 2016).

Some writers believe that the motivation to comply with regulatory processes is borne out of shame (Braithwaite 1989; Makkai and Braithwaite 1994; Harris and Wood 2008). Regulatory interventions are thought to be either implicitly or explicitly expressing disapproval, thereby, combining the concept of shame with compliance to the system. "Reintegrative shaming increases compliance, while stigmatic shaming increases offending" (Drahos 2017 p. 72). In other words, in regulation, acknowledging a failure leads to complying with regulation, failing to acknowledge the error can lead to defiance and recidivism. Some writers have noted, however, that the process of regulation can

cause anxiety in those being regulated (Earley 1998; Francis 2013; Oates 2015; Dunlop and Radaelli 2016; Furnival, Boaden and Walshe 2017). In one example of school inspection, the teachers described feeling threatened by the presence of OFSTED, to the extent that the language of their own reporting began to mirror that of OFSTED, behaving in such a way as to "escape the regime" (Perryman 2006 p. 156). The idea of regulation being viewed as a threat is reflected in the literature: regulation is viewed as a "focus of anxiety, fear and negative publicity" (Hopkins 2000 p. 67), "a potential threat to freedom and wellbeing" (Drahos 2017 p. 37), creating a "culture of fear" (National Advisory Group on the Safety of Patients in England 2013) where "regulatory compliance may be linked to fear" (Moloney 2016 p. 94) and "regulation stifles the soul" (Lloyd 2006 p. 32). Lipsky (2010) defines inspectors as frontline bureaucrats in this process.

Viscusi, in reviewing agencies in the USA responsible for product and occupational safety, found that "the value placed on fatalities in agencies' regulatory analyses can be a factor of 1,000 times greater than the magnitude of the corresponding sanctions that the agency levies for regulatory violations that led to the fatalities" (Viscusi 2018). His research demonstrated that there was no correlation between the regulatory failure and the sanction imposed.

Tighter regulation is often a government reaction to high profile instances of failure, with regulatory bodies responding to criticisms by strengthening their approaches and processes (Bailey and Kavanagh 2014; Lord Wallace 2015; Furnival, Boaden and Walshe 2018). Documented failures in care have also driven discussion and dialogue about regulation, however "regulation may not be the best answer to a quality issue" (Cayton and Webb 2014 p. 198). Walshe also critiques the limited effectiveness of regulation in identifying wider contextual issues, stating: "even if several agencies had serious concerns about the performance of a particular organisation, it is unlikely that any one of them would be able to see the bigger picture of organisational failure" (Walshe 2002 p. 968).

Regulatory agencies have also been questioned for over-zealousness and misuse of regulatory powers. As regulatory inspections can be time intensive and expensive, some writers query whether companies choose to settle quickly rather than face protracted investigations and call for greater accountability for regulators (Bird 2011; Hodge 2013). Lord Wallace (2015) stated that "well-crafted regulation encourages and stimulates open,

competitive markets. Bad regulation chokes innovation and stifles economic growth" (2015 p. 3).

The process of regulation in social care is critiqued for its potential to undermine engagement with, and empowerment of, stakeholders involved. For instance, in the field of child protection, investigations often begin when failings have been identified by professionals who then want to impose a solution to protect a child. Solutions are often imposed through institutional structures which can use coercive powers if there is a (perceived) lack of co-operation from those involved. Investigations depend on an assessment process which, in turn, depends on compliance from families and individuals (Melton 2005; Harris and Wood 2008; Harris 2011). It can be argued that responsive regulation offers an alternative approach, however, this is challenged by institutional factors which determine how child protection processes should be undertaken (Harris 2011). In studies pertaining to the regulation of individual social workers, regulatory processes face challenges that procedures which seek to address the practice of individual social workers miss opportunities to acknowledge the structures and context in which social workers and other professionals operate, thereby failing to identify wider organisational or systematic failings, such as high caseloads, inadequate resources and poor staff supervision (Worsley, McLaughlin and Leigh 2016; Kettle and Jackson 2017).

The process of regulation itself can, therefore, be open to challenge.

3.7.2 Regulatory practice

Regulation is accused of promoting the mimicking of practice (Ehren 2016). Ehren argues that school regulation legitimises practice in schools deemed to be better performing which, in turn, encourages other schools to mimic this practice: for example, through the publication of performance league tables, benchmarking or publicising good practice, schools simply mimic other schools, replicating elements of what works elsewhere without analysing the impact on their school. In Germany, the Inspectorate of Education does not publish its inspection reports. Instead, the head teacher decides how it is disseminated and to whom, which parts of a report should be published and under what conditions, thereby, selecting inspection findings in accordance with his/her own priorities (Ehren 2016).

The practice of report writing following a regulatory intervention, as well as the regulator him/herself, is thought to be subjective. A report from Scottish Care (2015), an umbrella

body of care service providers in Scotland, highlighted inconsistency and subjectivity in the application of regulation, as they experienced it, from the regulator. Their assertion then, echoes points made by participants from Perryman's study, that the unpredictability of the outcomes of regulation makes it almost impossible to develop and improve in a way which aligns those services with the regulator's priorities.

The views expressed in individual inspection reports are often also accused of being subjective and inconsistent. In a 2017 report, OFSTED reviewed its short inspection approaches and found that, in 22 out of 24 occasions, "inter-observer agreement between the lead inspector and the methodology inspector was strong" (Care Inspectorate 2017d; OFSTED 2017a and b). On the remaining two occasions, the disagreement between inspectors was attributed to subjectivity in interpreting the same evidence. OFSTED concluded that its protocols helped reduce subjectivity overall. Others, however, question the role of subjectivity in inspection reports (Choi, Nelson and Almanaz 2011; Scazzero and Longenecker 2011; Hussain 2012; Pope 2018; Palsson 2018). Tuijn (2011) reviews the instruments of healthcare regulation as applied in the Netherlands and note two instruments – one highly structured and one lightly structured in which the criteria, interventions and measures used differ in response to risks. Tuijn notes that there are variations in the meanings of judgements made by inspectors which exacerbate problems of validity, for instance, the lightly structured instruments lacked explicit standards against which inspectors measured progress, which meant that judgements were determined individually by inspectors. Tuijn argues that "verifiable confidence is an important element of the regulation process" (Tuijn 2011 p. 65). In the above findings, there is limited accountability of the regulator. It is clear a balance must be struck between enabling inspectors' discretion in regulation without inspections becoming a one-dimensional tick box activity.

Regulatory capture is the term used to describe a situation when the organisation regulated is in a position to dominate the regulator (Boyne, Day and Walker 2002; Abbott, Levi-Faur and Snidal 2017; Tai 2017; Manish 2018; Slayton and Clark-Ginsberg 2018). The regulator, therefore, loses its independence. For instance, regulation of complex industries such as civil aviation or the nuclear industry, requires expert knowledge, much of which may come from within the industry itself. Regulatory capture, in this example, would mean the regulator may be dependent on that internal industry knowledge, could lose its independence and act for the benefit of the industry, and not in the public interest.

3.7.3 The impact and outcomes from regulation

Regulation has been accused of not promoting an agenda of personalisation in care: Bowman (2010) argues that focussing on measurable aspects of compliance through regulation is detrimental to the agenda of personalisation, instead suggesting that regulation should be about licensing organisations to work to a care code. The focus should then be about risk and safety, thereby, tightening the role of commissioners and enabling care providers to move away from simply meeting standards to developing personalisation in services (Bowman 2010). As budgets are cut for regulators alongside the continuing push for more risk-based, proportionate regulation, regulators must continue to provide protection and assurance for people who use care services, and other key stakeholders (Wiseman 2011).

The effectiveness of regulation in improving outcomes for people is challenged. For example, Drakeford (2006) comments on its limitations in supporting the interests of older people in care and the Department for Business Innovation and Skills (UK Government) notes that "some regulations are ineffective and unnecessary" (UK Government 2015 p. 6). Norton (2009) also argues that inspection uses a rhetoric of service user expertise, but it is "hamstrung by a particular form of management values and practice" and is increasingly focussed on audit (Norton 2009 p. 1), a point echoed by Hasler (2003). In Burton's review of the Care Quality Commission (Burton 2017), he is highly critical of the CQC: he states it rarely uncovers abuse or neglect, it responds too slowly when issues are raised; it delivers flawed judgements; its ratings are inaccurate and unhelpful; its inspection reports are poorly written and constructed; the organisation costs a lot and imposes unnecessarily high costs on providers and it distorts the care sector. He argues that, as social care is a local service, regulation should be a local response and accountable to local communities.

Cayton and Webb (2014) reflect this view of local regulation and, in fact, state that regulatory action is distant and removed from the point of care, where issues are better addressed closer to the point of care. Spencer-Lane (2014) comments on the complex landscape of regulation in saying "the future direction of regulation may not lie so much in more regulation but rather in ensuring that existing regulatory systems speak to each other and the various regulators work more closely together" (Spencer-Lane 2014 p. 58).

In their studies of improvement in higher education, Harvey and Newton (2004) find little changes in the student's experience through the intervention of regulation, a point

echoed by Perryman (2006) in her case study of one failing school subjected to special measures by OFSTED over a 4-year period. Her case study approach identified a disempowering process of struggle, acceptance and normalisation which, she purports, led only to short term outcomes, stifled innovation and creativity and the ultimate outcome of which was – for both the regulator and the school – reduced inspection frequency, but not necessarily improvement. A problem was identified (the school was not achieving targets); a regulatory regime was applied ('special measures', i.e. increased frequency and more in-depth inspections); continual observation by OFSTED led to accepted practices (or normalisation), with the school's language mirroring that of OFSTED; the school's practice was then measured as 'acceptable' enough to remove the special measures.

Regulation is also felt to have unintended consequences: Bravo et al. (2014) carried out a study of the impact of regulation on private long-term care facilities in Canada and found several unintended consequences of regulation, following a review of quality assessments before and after regulation: the quality of care assessments increased following regulation, however, on further examination, following regulation, many private care home providers in the study had closed their smaller homes and initiated a change in the resident demographic which saw residents with less complex needs being admitted to their homes. Their study was unable to determine a direct link between regulation and improvement in care quality.

Similarly, Leistikow (2018), describes the unintended consequences of one intervention by the Dutch Healthcare Inspectorate: the number of instances a specific medical procedure was carried out in hospitals was subject to review by the Inspectorate. This procedure, although often resulting in better outcomes for patients, was measured and reported on by the Inspectorate. To avoid this reporting, some hospitals eschewed this procedure in favour of another procedure, which, although medically effective, was not always in the best interests of the patient.

In summary, regulation has been, and continues to be, critiqued based on regulatory processes, regulatory practice and the impact and outcomes of regulation. Regulatory processes are felt to be process-driven and to promote a mimicking of practice which results in organisations reflecting the language and standards of the regulator or risk being viewed as defiant and recidivist. Regulation can also be experienced as threatening or anxiety-provoking, distant from the point of care and not

supportive of personalisation in care or outcomes for people. Regulatory practice can be viewed as subjective and can result in unintended consequences. There also remain noted differences in how researchers view the impact of regulation, with both positive and negative views expressed.

3.8 Involving stakeholders in regulation

There is an “enthusiasm for userism” (Buckley, Carr and Whelan 2010 p. 210): an abundance of examples of seeking the views of those using services (Ross et al. 2005; Warren et al. 2005; Coffey 2006; Mor, Miller and Clark 2008; McCrystal and Wilson 2009; Buckley, Carr and Whelan 2010; Barber et al. 2011; Cossar and Neil 2015; Palumbo 2017). Conversely, many of the high profile ‘failures’ in care comment on the ways in which those using the service were – or were not – involved in the design, development or evaluation of that service or whether, and how, their views were sought (Walshe 2002; Cayton and Webb 2014; Spencer-Lane 2014). Involving stakeholders in regulation first requires an understanding of who stakeholders are.

3.8.1 The stakeholders of regulation

The stakeholders of regulation are many and varied. Fryzel (2015) argues that organisations have a responsibility to take account of their organisation’s ontology, i.e. its stakeholder composition. Organisations are adaptive social systems, responding to influences in their environments, whether they be political, social, cultural, financial etc. Each of these can put pressure on the organisation to adapt. In the case of care regulation, these pressures can include political drivers, significant case reviews which focus practice on one area or a shortage of resources. It is the system’s responsibility to take on the demands of its environment, strengthen its ability to meet that demand and weaken any barriers to successfully doing so (Fryzel 2015).

The stakeholders of care regulation range from those who receive services, to government ministers who propose policy drivers which impact on regulation, with a variety of ‘actors’ in between. In the case of healthcare, Healy (2016) describes patients as regulatory actors in their own health care. Pragmatically, most people will receive some type of health care at some point during their lives, therefore, patients are most likely to suffer from the consequences of poor healthcare. This analogy is reflective of wider care services as well. The impact of poor care has become more prominent in recent years, for example, the reports into care at Winterbourne View Hospital and the

Mid Staffordshire Hospital Trust, as described elsewhere in this study. The role of the person receiving services as a stakeholder in regulation is, therefore, an important one.

3.8.2 Engagement with stakeholders

The Francis Report (2013) focusses on professional regulation as provided by the Nursing and Midwifery Council (NMC) and the General Medical Council (GMC) and criticises the two different regulatory systems which, it states, create inconsistency, as well as the regulatory approach of the Care Quality Commission (CQC). One clear recommendation was about the ways in which patients could be better involved. Leape et al. (2009) developed five key concepts to transforming healthcare, equally transferable and applicable to other types of regulation: transparency; an integrated care platform; consumer engagement; joy and meaning in work; medical education reform. Consumer engagement, as they describe it, is a key concept.

From the inception of corporate social responsibility in the 1960s, the performance of organisations has been under increasing scrutiny, as those using services, and consumers, are demanding that organisations are more transparent in their actions. Stakeholder theory is strong and reflected across sectors (Campbell 2007; Benn and Bolton 2010; Crane and Ruebottom 2011; Bilney and Pillay 2015; Bonnafous-Boucher and Rendtorff 2016). “Since companies are taking advantage of, and relying on, social and environmental resources, stakeholders have the right to be informed about their actions” (Rahim and Idowu 2015 p. 3). Leistikow echoes this point that “a good reputation enables the Inspectorate to table matters with authority and to influence the social and political debate” (Leistikow 2018 p. 9). Regulation, in fact, is believed to work well when it is influenced by input from its stakeholders and is “in touch with, and up to date with, experiences and real-world practice” (Cayton and Webb 2014 p. 199).

There are acknowledged barriers to effective stakeholder involvement in regulation. For example, patients’ involvement in regulating healthcare is described as meeting: “a class barrier of fewer resources, both educational and financial, a cultural barrier of different expectations and language, a knowledge barrier given the esoteric nature of medical expertise and a power barrier given the unequal relationship between doctors and patients” (Drahos 2017 p. 615). Healy and Braithwaite (2006) view patients in relation to the regulatory pyramid and outline their six roles as informed patients, selective consumers, vocal complainants, entitled citizens, active partners and aggrieved litigants (Healy and Braithwaite 2006; Drahos 2017 p. 616).

All four UK social care regulators state they work in partnership with people who use services in broadly similar ways. The CQC employs 'experts by experience' who support inspections by speaking to people using services and their family or organisations that support them (CQC 2016b and c). They can also observe how the service is delivered and speak to staff. Their findings are then used to support the inspectors' judgements on services and can be included in inspection reports. The CQC also involves experts by experience in activities including training inspectors and taking part in working groups (CQC 2017). Similarly, the Care Inspectorate involves people experiencing care, their families and local communities in a similar way, recognising that they may wish to become involved by simply giving their views on care services or on a particular issue. Alternatively, they may wish to become more involved in project group work and policy development, for example by taking part in staff interviews, strategy groups and inspections, as well as in contributing to discussions about design and delivery of inspections, for instance, young inspection volunteers (Care Inspectorate 2015b). The Care and Social Services Inspectorate Wales states that participation means, "giving people the opportunity to have a say, for example, about what we inspect and how we inspect. It also includes being involved in inspections and sharing ideas and experiences; it will affect what we do and how we do it so that services improve and meet your needs" (CSSIW 2012). The Regulation and Improvement Authority in Northern Ireland involves various groups and individuals in a range of aspects of its work, including as peer reviewers, lay assessors or consultation respondents (RQIA 2018).

Stakeholders are involved in regulation to different degrees, as identified above. Their views are sought about services and service development, in the main, and less so on the methodology of regulation itself.

3.9 Learning from regulation

There have been many high-profile incidents of failure in care settings which have resulted in, not only greater political interest in regulation, but also greater learning for regulators of health and social care. Over recent years, reviews of care have impacted on regulation and regulatory approaches, usually prescribing tougher action by regulators and the work of the regulator being "scrutinised under a social microscope" (Leistikow 2018 p. 7).

In Scotland, in 2011, police began an investigation into residents' deaths at the Elsie Inglis Nursing Home in Edinburgh. The situation was a contributory factor in the decision

to review the regulation of care for older people and increase unannounced inspections by the regulator to one each year (instead of one every two years). In that same year, one of the UK's largest care home operators, Southern Cross, ended its operations, raising questions about the funding of care across the UK. The company had successfully expanded and continued to buy properties to develop its care home business when, following the financial crisis of 2008, it found itself in debt and unable to sell these properties and, consequently, unable to pay its loans. Following a period in which the company renegotiated its finances and sold off its properties at a loss, it continued to operate, however, posted a profits warning in 2010, eventually becoming insolvent in 2011 (Weardon 2011).

In the wake of the Elsie Inglis nursing home enquiry and the collapse of the Southern Cross group, a Scottish Parliament enquiry noted that "the current regulatory system is sufficiently rigorous to identify care services for older people which are failing to deliver high quality care", although acknowledged that some weaknesses existed (Scottish Government 2011).

In the same year, a review was conducted into abuse highlighted at Winterbourne View, a hospital in South Gloucestershire, England, for individuals with learning disabilities or autism, following a BBC Panorama programme shown in May 2011. The review report was highly critical of the Care Quality Commission (CQC) at the time for failing to act on reports of abuse from a whistle-blower, failing to hold the provider to conditions of registration and failing to follow up with enforcement action. The review report resulted in the regulator strengthening its approaches to inspection and regulation, including unannounced inspections, although it noted that there was nothing found in the pattern of notifiable incidents which would have led the organisation to make different regulatory judgements (Care Quality Commission 2011).

Regulators are deeply involved in reviewing significant care failings, for instance the Care Quality Commission's review of the involvement and action taken by health bodies in the case of 'Baby P', an 18 month old baby who died at the hands of his mother and two of her acquaintances (CQC 2009). In 2013, a report was published into the failures in healthcare at the Mid Staffordshire NHS Foundation Trust (referred to as the Francis report). Concerns were raised about the poor quality of care and high mortality rates within the Trust between 2005–2009, leading to a public enquiry and a published report in 2013. The review found a professionally endorsed and evidence-based means of

compliance with standards and argued that the focus of the regulator was on arduously pursuing compliance to these standards to the detriment of all other aspects of care or context (Francis 2013).

The review was critical of the Care Quality Commission at the time, describing it as an organisation which was not mature. A national advisory group on the safety of patients in England was commissioned, leading to the publication of 'A promise to learn – a commitment to act' (National Advisory Group on the Safety of Patients in England 2013) which highlighted three key points for learning: poor priorities, lack of accountability and ignoring warning signs. The Francis report highlighted that the Trust did not sufficiently listen to patients or staff and that there were a "number of weaknesses in the concept of scrutiny" (Francis 2013 p. 44). The review continued by stating that "a healthcare regulator needs to be a model of openness and, therefore, welcome constructive criticism" (Francis 2013 p. 47).

As a consequence of the review report, the Care Quality Commission refreshed its approach by undertaking a process of data gathering and analysis, undertaking a rapid response review involving a team of inspectors, clinical experts and patient representatives and submitting an agreed action plan. The National Audit Office (2017a) noted, however, that despite making some improvements, the regulator required to address the timeliness of its regulation activities, the effectiveness of its information systems, the consistency of its judgements and ratings and its actions following safeguarding alerts.

Although the latter two reviews referred to incidents in England, the reports clearly had far-reaching consequences across all care sectors and across all parts of the UK and more widely.

The role of the regulator is always analysed following high-profile events such as failings in care and regulators often appear to respond by changing their approaches to, or the methodology of, regulation. Often, these changes involve a degree of consultation with stakeholders regarding new processes. For instance, the Care Quality Commission's changes in methodology above, prompted by criticisms following failings in care.

3.10 Themes arising from the literature

The literature review highlights that there is variation in the terms used to define regulation and in the defined purposes of regulation. There are shared ideas about the core purposes of regulation and shared ideas about the critiques of regulation. Writers agree that regulation, no matter which model used, has aspects of assurance and accountability, has an eye to public safety and protection, comments on value for money, assures compliance to prescribed standards, has a focus on improvement and supports the sharing of learning or good practice.

Conversely, regulation is also critiqued for promoting the 'mimicking' of practice without analysis to context, focussing on processes and service outputs more than outcomes for people, failing to see the wider context of the system, not supporting personalisation, being of limited effectiveness, being far removed from the point of care, being inconsistent and subjective, engendering unintended consequences or provoking anxiety or fear. Regulators must themselves be more accountable in the use of their powers, to avoid regulatory capture (Day and Klein 1990). Tighter regulation is also noted often as a governmental response to high profile failings in care.

The qualitative phase of this study explored further the various purposes defined in the literature ascertaining to what degree stakeholders involved in the process of regulation recognise and agree with these purposes.

The regulation of social care and social work is less well covered in the literature than the regulation of other sectors. While there have been some very comprehensive studies about the impact of regulation, these have tended to be about the impact of regulation on the users of specific services, service types or settings, rather than on the wider context of regulation itself. This study will add unique knowledge to the existing body of research.

Regulation, across sectors, has a rich and diverse history and there has been significant development in approaches and models. The literature notes different internal and external regulatory models from the 'command and control' approach which focusses on compliance to responsive regulation. As responsive regulation has developed, so too have different models of responsive regulation. These include smart, 'right touch', advisory, adaptive and anticipatory regulation, including regulatory sandbox approaches. Self-regulation and voluntarism have also developed. Writers agree that there is no 'one size fits all' approach and that the complementary use of different approaches works

best (Furnival, Boaden and Walshe 2017). The researcher has proposed an additional model for consideration, which shows an integrated approach to regulation, placing the individual receiving care services at the heart of the process.

The qualitative phase of this study reflected on the empirical knowledge and perceptions of stakeholders about regulation, the perceived effectiveness of the process in addressing the agreed purposes, the extent to which stakeholders felt they were, or should have been, involved in regulation and the impact stakeholders perceived as a direct, or indirect result of regulation.

The significance of this research is that stakeholder views were sought about regulation itself: their knowledge, understanding and perceptions of regulation as delivered by the Care Inspectorate and their perceptions about the process, delivery and framework of care service regulation as delivered in Scotland. These views were thematically analysed through the co-productive approach via the modified Delphi Study and individual interviews to address the above points.

To assist in the above analyses, the themes arising from this literature review supported both the quantitative and qualitative phases of research.

3.11 Chapter summary

This chapter has reviewed the literature about regulation and outlined the key purposes of regulation, offering critiques of regulation within a context of the complexity of regulation of the care sector. The chapter also reviewed specific models of regulation and offered the researcher's own model of integrated regulation, building on existing models. Finally, the chapter included a discussion of the involvement of regulatory stakeholders, then discussed the key findings which informed the qualitative phase.

Chapter 4: Methodology

Introduction

This chapter outlines the methodology used to undertake the research.

4.1 Methodology overview

To propose a research methodology, it is important to consider the research philosophy, approach and design. The approach taken to the research determines the methods of research and provides information about its quality (Jonker and Pennink 2010).

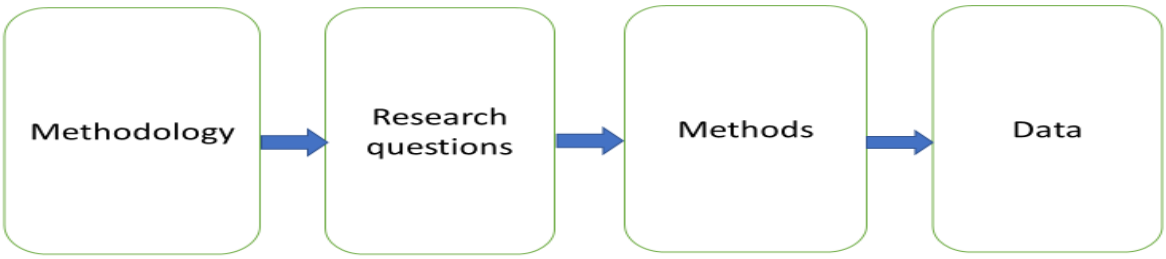

Figure 10: The ordering of methodology, research questions, methods and data in the research process (Watkins and Gioia 2015 p.4)

The above figure demonstrates the linear research process: the methodology determines the research questions which, in turn, determine the methods to be used, determining the data to be collected.

4.2 Research approach

“Paradigmatic influences can determine the selection of evaluation questions and the selection of research methods to deal with those questions” (Kazi 2003 p. 4).

Phase one of the mixed methods research design was quantitative, phase two was qualitative and involved a co-productive approach and phase three was qualitative and involved individual interviews. Ghiara (2020) describes the “ontological and epistemological pluralism” of mixed methods research (Ghiara 2020 p. 19). The researcher’s epistemological and ontological positions varied in the quantitative and qualitative phases. “Ontology and epistemology provide insight into what the researcher believes to be the nature of truth, the nature of the world, and ways of being in that

world; together they describe the world view of the researcher" (Berryman 2019 p. 272).

4.2.1 The researcher's world view

It is important to describe the researcher's world view to explain the choices made as to the methodology and approaches taken to research:

"Ultimately, it is the researcher who makes the choices and decides what methodology is appropriate, and those choices are certainly influenced by the aspects of socio-political location of the researcher, his/her personal history and his/her belief system" (Morgan 2007 p. 56).

In order for the study to achieve its aims, the researcher reflected on her dual positivist and interpretivist philosophical positions in relation to the various aspects of the investigation. This meant that she was using a pragmatist philosophical approach. Kaushik and Walsh (2019), in writing about social work research, state that pragmatism embraces the plurality of methods and "is based on the proposition that researchers should use the philosophical and/or methodological approach that works best for the particular research problem that is being investigated" (Kaushik and Walsh 2019 p. 2).

A pragmatist philosophy allows the researcher flexibility to carry out his/her enquiry from a variety of perspectives (Johnson and Onwuegbuzie 2004). It was necessary to adopt two seemingly opposing standpoints in her approach to the research design and methodology as this was the approach which worked best for this particular research problem and produced the desired consequences of the inquiry (Tashakkori and Teddlie 2008). Epistemologically, these seemingly opposing standpoints were a positivist approach to the quantitative phase and an interpretivist approach to the qualitative phase and, ontologically, an objectivist approach to the quantitative phase and a constructivist approach to the qualitative phase. The mixed methods approach reflected these seemingly opposing standpoints.

Epistemological assumptions about the nature of knowledge are linked to, and direct, the theoretical framework within the research, the research questions, the methods employed and the research praxis (Hartman 1990; Moser 2002; Tashakkori and Teddlie 2010; Marsh 2012; Grinnell and Unrau 2011; Carey 2013; Pritchard 2016; Zagzebski 2017). The researcher considered what those involved in regulation believe their 'knowledge' about regulation to be, what the provenance of this knowledge is and the

ways in which they made sense of this knowledge (Creswell 2009).

While the evidence base for inspection as a conduit for regulation has not been conclusively studied, regulatory bodies continue to apply their regulatory duties through the application of inspection as a core method. The source of this knowledge about the relationship between inspection and regulation could be described as knowledge through 'tradition', i.e. accepting things that 'everyone knows'; knowledge through authority, i.e. those in a position of authority or with expertise determine something to be the case; knowledge through 'common sense', i.e. knowledge through seemingly logical reasoning, i.e. it appears logical that a process of inspection would enable regulatory duties to be achieved; and knowledge through popular media, all within a 'hierarchy' in which knowledge generated by empirical methodologies is placed at the top and knowledge developed from personal experience is placed at the bottom (Campbell 2006; Faulkner and Faulkner 2014; Ruben and Babbie 2017).

The researcher, through the qualitative research phase, explored sources, perceptions and understanding of individuals' a priori knowledge (knowledge which is independent of experience) and a posteriori knowledge (knowledge through experience) (Moser 2002; Pritchard 2016).

Epistemologically, and informed by her pragmatist worldview, the researcher took a positivist approach to the quantitative phase and an interpretivist approach to the qualitative phase (Burke-Johnson, Onwuegbuzie and Turner 2007). Positivists believe that different researchers addressing the same problem will generate a similar result and that there are social facts with an objective reality separate to the beliefs of the individual (Creswell 2009; Bahari 2010). Interpretivists believe that "reality is constructed by social actors and people's perceptions of it. They recognise that individuals with their own varied backgrounds, assumptions and experiences contribute to the on-going construction of reality existing in their broader social context through social interaction" (Wahyuni 2012 p. 71). In an interpretivist position, the emphasis is on "the understanding of the social world through an examination of the interpretation of that world by its participants" (Bryman 2016 p. 375).

Ontological approaches are concerned with defining the nature of reality (Creswell 2009; Tashakkori and Teddlie 2010). Objectivism is the belief that social phenomena and their meanings are not dependent on social actors, i.e. "facts that have an independent

existence" (Walliman 2006 p. 17). Constructivism is based on a belief that humans construct their own social interpretations, gaining knowledge and meaning from their experiences (Wisker 2008; Jonker and Pennink 2010; Creswell 2014).

The researcher's beliefs reflected constructivism which supports social work theories of systems, a belief in understanding an issue from the point of view of the individual concerned and his/her particular context and support systems, and their resulting interdependencies, as well as concepts such as client self-determination and empowerment (Berger and Luckmann 1967; Fisher 1991; Rodwell 1998; Von Glasersfeld 2005; Teater 2010; Sturmberg 2013). Constructivism also supports social work research in "the creation of meaningful knowledge to guide useful practice" (Rodwell 1998 p. 3) and aligns very clearly to social work theories which acknowledge the service user as the vehicle for change (Banks 2001; Healy 2014; Payne 2014).

Although some writers comment on the limitations of constructivism because it is an approach that focusses on the needs and perceptions of stakeholders (Creswell 1998, 2009 and 2014; Flick 2006; Wisker 2008; Howes and O'Shea 2014), the researcher believes that constructivism reflected her social work values of recognising the importance of the views of those receiving services to further develop services (Banks 2001; Healy 2014; Payne 2014; Walliman 2016). In constructivist studies, it is this view that is used as the basis for analysis and the researcher felt that the views of participants were integral to this study (Creswell 2009). Participants' opinions were vital in shaping ideas and learning (Von Glasersfeld 2000; Kazi 2003; Howes and O'Shea 2014). The researcher acknowledges this involved subjectivity, however, believes that social work research is not simply about extracting information from those using services, but also about engaging with people in order to make a difference (Hardwick and Worsley 2011). The pragmatic lens, therefore, enabled the researcher to adopt both the objectivist and the constructivist approaches.

4.3 Research design: mixed methods research

Mixed methods research involves creating a coherent research design by integrating both quantitative and qualitative approaches to enhance the strengths inherent in each (Creswell 1998; Maxwell 2005; Burke-Johnson, Onwuegbuzie and Turner 2007; Bickman and Rog 2009; Hesse-Biber and Leavy 2010) and support the triangulation of learning

and evidence (Tashakkori and Teddlie 2010; Creswell and Plano Clark 2011; Faulkner and Faulkner 2014; Watkins and Gioia 2015; Schoonenboom 2018).

There is recognition that real world complex issues which require resolution need an approach which is flexible and gives the optimum chance for the researcher to explore the topic in depth (Checkland and Poulter 2006; Corbin and Strauss 2008; Richards and Hallberg 2015). Mixed methods research supports this and is useful when “you have a need to both explore and explain” (Bronstein and Kovacs 2013).

The researcher used a mixed methods approach to facilitate the generation of themes and the forming of theories as well as in the implementation of the research. In a mixed methods approach “quantitative results present the measure of prevalence which is then illustrated with qualitative findings” (Campbell, Taylor and McGlade 2017 p. 52). It also allowed the researcher to identify emerging insights (Torrance 2012). The use of mixed methods ensured that findings could be triangulated, giving a greater understanding of the research problem under discussion and a more robust analysis than either qualitative methods or quantitative methods on their own would give. Gaps in findings from one method were compensated, to some extent, by use of the other. Munafo and Smith (2018) argue that triangulation of data is important because “consistent findings could take on the status of confirmed truths” (2018 p. 399).

Mixed methods research does, however, have its challenges. Both quantitative and qualitative research studies have their individual challenges of representation: quantitative research often uses sample sizes which are too small to ensure statistically valid representation and in qualitative research, similarly, researchers focus on the lived experience of a small group of individuals. Mixing these methods, therefore, still results in challenges regarding wider representation (Denzin and Lincoln 2005; Collins, Onwuegbuzie and Jiao 2007; Teddlie and Tashakkori 2012).

Mixed methods research presents challenges of validity or legitimation, i.e. the ability to ensure that findings are credible, trustworthy, dependable, transferable and confirmable (Morse et al. 2002; Onwuegbuzie and Johnson 2006; Onwuegbuzie and Collins 2007). There is also a challenge in persuading the audience of the mixed methods research, including stakeholders and policy makers, to value the findings which arise from both the quantitative and qualitative phases of a study, (Collins, Onwuegbuzie and Jiao 2007). Using numbers in a research methodology which promotes subjectivity could be viewed

as a mismatch and "the vivid narrative description and depth that is indicative of qualitative reports needs to flow and be well integrated with the numbers and tables that typically tell the story in quantitative reports" (Bronstein and Kovacs 2013 p. 354; Roulston and Shelton 2015). There will also be variability in the skills of the researcher in integrating quantitative and qualitative approaches (Creswell 2009).

Additionally, some writers have questioned how mixed methods are assessed, the lack of a clear research design, questions of validity if quantitative and qualitative variables are unclear, the trustworthiness of qualitative data and even the lack of a clear definition of mixed methods research itself (Guba 1981; Tashakkori and Teddlie 2010; Denzin and Lincoln 2013; Mertens and Hesse-Biber 2013; Ritchie et al. 2014; Hegde 2015; Creswell 2015; Lincoln and Guba 2016). Others cite the cautiousness of researchers who, if they do not trust their own findings, engender that same caution in their recommendations (Olson, Young and Schultz 2016).

There are strengths in mixed methods approaches, as it is important to understand human interactions in evaluating services and there are benefits to be gained from using the strengths of both quantitative and qualitative approaches. It is a powerful tool for investigating processes which are complex (Waldrop 2007; May 2011; Fetters, Curry and Creswell 2013). While these benefits are acknowledged, if a criticism of "methodological eclecticism is to be avoided, the design quality and interpretive rigour of the research must be pivotal" (Tashakkori and Teddlie 2010 p. 8).

Social work increasingly operates in multi-disciplinary partnerships and social work research benefits from mixed methods approaches which engender increased validity through triangulating data, utilising the strengths of both quantitative and qualitative approaches and allowing congruence with the social work principle of studying the topic holistically (Menon and Cowger 2010; Holland et al. 2011; Wisdom et al. 2012; Cunningham, Weathington and Pittenger 2013). Encapsulating this, Watkins and Gioia (2015) proposed their own definition of mixed methods research in social work: "the rigorous and epistemological application and integration of qualitative and quantitative research approaches to draw interpretations based on the combined strengths of both approaches for the purpose of influencing social work research, practice, and policy" (Watkins and Gioia 2015 p. 12).

Mixed methods research provides a depth of understanding of the topic from stakeholders' perspectives and creates a unique contribution to the knowledge base in this research.

In addressing the challenges raised above, the researcher used a combination of approaches. Issues of wider representation, validity and trustworthiness are discussed later in this chapter. To ensure that the reading audience values the findings from both the quantitative and qualitative phases, the researcher employed a clear research design and methodology, acknowledged her research paradigm and approach and was transparent about processes used, also acknowledging the limitations of the research. The researcher acted as a reflexive practitioner, used supervision effectively and learned iteratively throughout the research (Scottish Association of Social Work 2016). This allowed her to develop or enhance the practical, academic and logistical skills required.

Importantly, researcher bias was reduced through the co-productive approach. Participants in the co-productive phase were not only asked for their views on points arising from a review of the literature but were also asked to give suggestions for interview questions for the next phase. Their suggestions, as well as their own views, supported the design of the individual interview phase. The co-productive phase is further discussed later in this chapter.

Consequently, it was felt that mixed methods research would provide the most effective means of answering all three research aims within this study.

4.3.1 Explanatory sequential mixed methods

Using an explanatory sequential mixed methods approach (Creswell 2013 and 2015) provided the researcher with the iterative learning required in linking the quantitative and qualitative phases and supported the collection of data based on earlier stages of research. In explanatory sequential mixed methods research, the researcher collects and analyses the quantitative data first. These results then shape the qualitative phase, including its design, sampling and data collection. The qualitative data then further elucidates the quantitative findings.

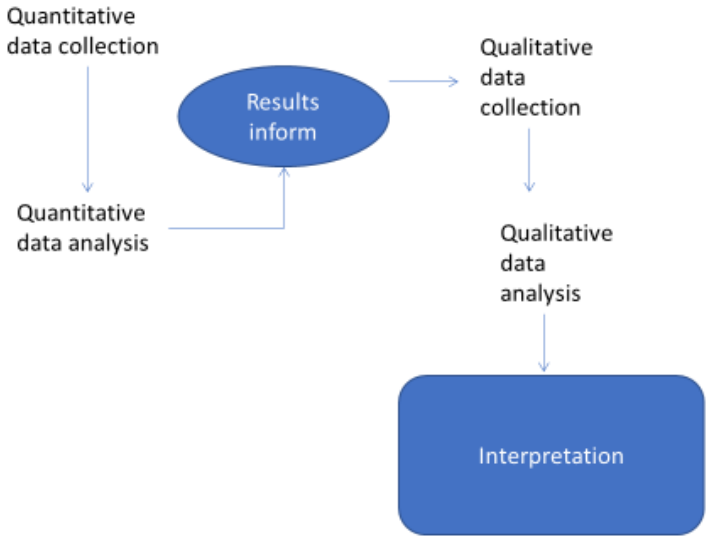

Figure 11: Explanatory sequential design (adapted from Watkins and Gioia 2015 p. 18)

Figure 11 demonstrates the explanatory sequential relationship between different phases of data collection and analysis. First, the quantitative data is collected, then analysed, then these results inform the qualitative data collection. Next the qualitative data is analysed, and the findings are then interpreted together. In this research, however, the researcher also chose to undertake a linking phase – that of a co-productive approach. This process is shown in Figure 12:

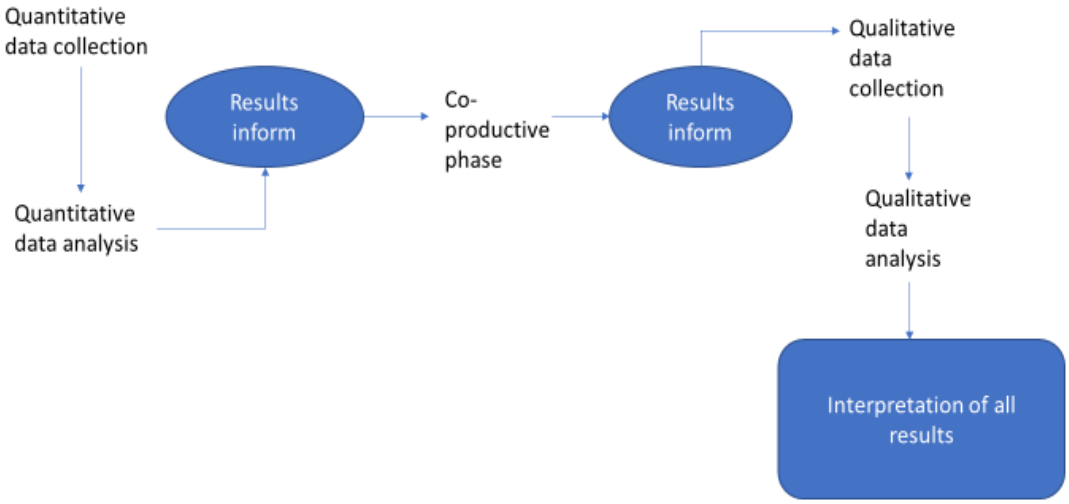

Figure 12: Explanatory sequential design incorporating a co-productive phase (adapted from Watkins and Gioia 2015 p.18)

In Figure 12, the researcher collected then analysed quantitative data, using these results to inform questions for the co-productive phase. Results from this then supported the development of questions for the qualitative phase. Findings from the quantitative, co-productive and qualitative phases were analysed together.

Research implemented using an explanatory sequential design benefits from being relatively linear, straightforward and gives clear opportunities for the researcher to explore the findings from the quantitative data through the qualitative phase (Tashakkori and Teddlie 2010; Creswell and Plano Clark 2011).

The explanatory sequential design is not without its challenges: the researcher must decide what 'weight' is given to each phase of the research, the sequence and timing of when each occurs, when the phases are connected and how and when the findings are integrated. There are also challenges in the length of time such a study can take (Ivankova, Creswell and Stick 2006). In this research, equal weight was given to both the quantitative and qualitative data, with each phase addressing specific research objectives, informing subsequent sections and, together, providing an answer to the research question.

4.3.2 'Within subject' design

Quantitatively, the research outlined a 'within subject' design (Creswell 2014). Grades and intelligence derived from a statistical analysis of information were analysed, from the same services and longitudinally across a given time period (Flick 2014; Corbin and Strauss 2015). This compiled secondary data – data which was already published and in the public domain. The researcher used this published data to make an analysis relevant to this specific research.

4.3.3 'Between subject' Design

Qualitatively, the research examined a 'between subject' design (Creswell 2014). The views and perceptions of a variety of stakeholders were gained to analyse different interpretations of regulation and the different experiences of those involved (Thyer 2002; Creswell and Plano Clark 2011).

4.3.4 Mixed methods research using a co-productive approach

Chapter 5 outlines the detailed approach to co-production taken in this research and Figure 13 below demonstrates the researcher's original model for the research design:

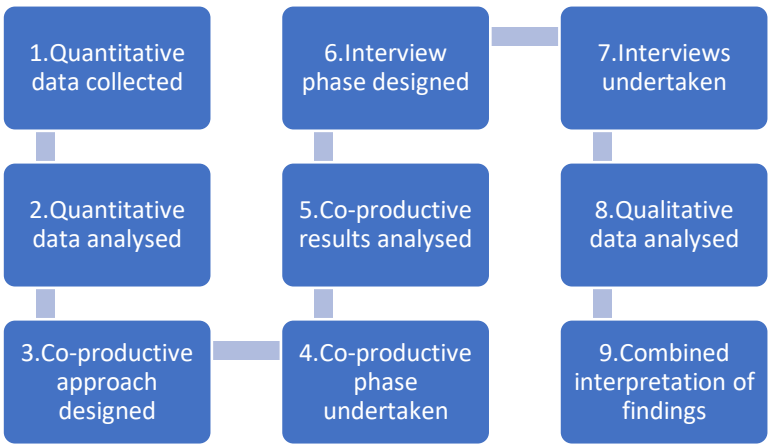

Figure 13: Mixed methods research using a co-productive approach

In Figure 13, the researcher demonstrates the process taken to this research study starting from the top left corner, moving vertically downwards and across, following the process. First, quantitative data was collected then analysed. The findings from this phase informed the design of the co-productive approach. These findings, together with the quantitative data and literature review findings, were used to develop the interview schedules. Once qualitative data was collected and analysed, findings from all phases

were interpreted together to address the research aim and objectives.

4.4 Phase 1: approaches to the quantitative phase

The methodology provides the theoretical approach to be taken in collecting the data. The research methods are the tools used to collect the data required to answer the research questions, i.e. a technique for the sampling, data collection or data analysis, through which methodologies are implemented (Sandelowski 2003; Schoonenboom 2018). Data collection must result in findings which address the question being asked.

The overarching research question was ‘how do stakeholders involved in social care service provision experience regulation as delivered by the regulator in Scotland?’. To answer this question, it was important to “tackle big questions by answering several smaller ones (smaller in scope, not in importance)” (Fallon 2016, p. 59). For the quantitative phase, research questions were identified to answer this larger overarching question, linked to the aims of the research (Chapter 1, section 1.7).

The researcher’s first task was to identify which data would address the research question. In discussion with an intelligence analyst from the regulator, the researcher familiarised herself with what data was held by the regulator and, therefore, what data would best support the research. Through discussion with the intelligence analyst, the researcher decided that an analysis of care services over a given time period would be an effective way of reviewing the performance of care services and allow the researcher – in the qualitative phase - to further explore how stakeholders experienced regulation informed by themes arising from an analysis of quantitative data and the literature review. The researcher began her fieldwork for this research in 2017, therefore, at that time, the regulator held up-to-date data till 31st March 2017. The intelligence analyst advised that a four-year period was sufficient to identify any themes arising from data and, therefore, the period 2013-2017 was identified by the researcher for the quantitative data analysis phase. This allowed the researcher to undertake linear steps to the quantitative data analysis (Mertler 2007).

Research aim one was: to investigate the performance of all care service types regulated in Scotland over an identified time period. In order to address this, the researcher developed three questions:

The first question was**: 'How can care services which received at least one 'Adequate' in 2013 be described in relation to geographic location, service type or provider type?'**. This enabled the researcher to understand the landscape and performance of care services registered and regulated in Scotland at that time.

To address question one, the researcher investigated data held by the regulator in relation to care services registered at 1st April 2013. She investigated:

- The numbers of care services which received at least one evaluation of 'Adequate (and, therefore, had capacity to improve)
- The types of services with this evaluation
- The numbers of these care services viewed as a percentage of all services of this type registered
- The geographical location of these services
- The service provider type for these services
- The quality themes against which this evaluation had been given
- An identification of which service type accounted for the largest of these services by volume (care homes and, within this, care homes for older people)
- The number of care homes with this evaluation per local authority area as a percentage of all registered care homes in that area

The second question was: **'How can care services which received one 'Good' or better in 2017 be described in relation to service type or provider type?'**. This enabled the researcher to understand how care services had changed and improved four years later.

To address question two, the researcher investigated data held by the regulator in relation to care services registered at 31st March 2017. From those which had been evaluated as having the capacity to improve (at least one evaluation of 'Adequate' at 1st April 2013), she investigated:

- The numbers of care services which had improved and were evaluated with one 'Good' or better at 31st March 2017
- These improved services by care service type
- An identification of the four largest care service types showing improvement by volume of services
- The numbers of each of these four care service types which had improved

- The percentage of improvement across these four care service types

The third question was: **'How was performance affected over the four years between 2013-2017 by complaints, requirements and non-technical enforcements?'** This enabled the researcher to examine the impact of interventions by the regulator on these improved services.

To address question three, the researcher investigated:

- Data in relation to complaints received for the improved care services 2013-2017
- Data in relation to requirements made during inspections in these improved care services 2013-2017
- Data in relation to non-technical enforcements made in these improved care services 2013-2017

Research aims two and three were: to identify knowledge, understanding and perceptions of regulation among those receiving care services, among those providing care services, and other stakeholders; and to identify stakeholders' perceptions about the process, delivery and framework of care service regulation in Scotland. It was recognised that an analysis of quantitative data would not address these in full, however, would go some way to supporting this and complementing qualitative data.

Accordingly, a further two questions were developed:

The fourth question was: **'How have stakeholders experienced regulation in care services over these 4 years?'** This enabled the researcher to investigate how stakeholders from care services experienced regulation in services which had been inspected over the four years through feedback gathered.

To address question four, the researcher investigated data related to the two types of inspection satisfaction questionnaires (ISQ) used by the regulator (those for staff and managers; and those for people using care services, their family members and visitors to the service). This data included:

- The numbers of each ISQ type returned in each of the four years 2013-2017
- The percentage of positive responses made per statement within each ISQ type over each of the four years 2013-2017

- The average percentage of positive responses made to each ISQ type over the four years 2013-2017

The fifth question was: **'How has the regulator supported improvement in care services over these 4 years?'** This enabled the researcher to understand what work the regulator had undertaken to support improvement in care services.

To address question five, the researcher investigated improvement work undertaken as reported by the regulator over the four years 2013-2017. This included:

- A definition, by the regulator, of improvement activities taking place 2013-2017
- Improvements made by the regulator to inspection methodology 2013-2017
- A discussion about the regulator's improvement strategy and improvement team

In summary, the five questions for the quantitative phase were:

1. How can care services which received at least one 'Adequate' in 2013 be described in relation to geographic location, service type or provider type?
2. How can care services which received one 'Good' or better in 2017 be described in relation to service type or provider type?
3. How was performance affected over the four years between 2013-2017 by complaints, requirements and non-technical enforcements?
4. How have stakeholders experienced regulation in care services over these 4 years?
5. How has the regulator supported improvement in care services over these 4 years?

A descriptive analysis of quantitative data held by the regulator about relevant aspects of service provision and data from supporting processes was undertaken, as outlined above. This allowed the researcher to focus on the data which was "most important to telling the story" (Loeb et al. 2017 p. 17).

4.4.1 Quantitative data

Quantitative data is that which is represented through numbers and analysed using statistics (Mackenzie and Knipe 2006). In this study, the researcher analysed secondary data held by the regulator and already in the public domain. Secondary data is that which is not collected by the researcher but to which he or she has access and is using for the purpose of research (Vartanian 2011; Watkins and Gioia 2015; Fallon 2016).

In this case, the secondary data was performance information already published by the regulator about regulated care services in Scotland. The regulator collects data via its regulatory processes: registration of services, receiving service variations, preparing and undertaking inspections, investigating complaints and carrying out enforcement activities. It also collects data via annual returns, questionnaires, notifications and through file reading processes. The data includes registration conditions (i.e. service type, numbers of individuals to which a service can be provided and any other relevant terms), inspection gradings (and all four quality theme grades), service provider types (local authority, voluntary or not-for-profit, or private sector), health board and geographical areas in which services are provided, as well as information on staffing, management, numbers of individuals receiving the service, complaints made and any other relevant information. The overview and analysis of data is the responsibility of the regulator's Intelligence Team.

Huston and Naylor (1996) outline questions for researchers when considering the use of secondary data:

"Was consent to use the secondary data obtained (if appropriate) and confidentiality maintained throughout the study?
Was the information drawn from the data source specified fully?
Was the accuracy and completeness of the data source assessed, particularly for the specific information being sought?
Do the data provide appropriate information or measures to answer the research question?" (Huston and Naylor 1996 p. 1700)

The answer to all the above questions was "yes", therefore, it was appropriate to use the secondary data to support an answer to the research question.

4.4.2 How the regulator uses data

The regulator collects and stores data in its datastore (Care Inspectorate 2019b). Data is analysed and used for the following purposes:

- To effectively regulate care services by keeping accurate records, identifying and targeting services/themes which may require more scrutiny (i.e. maintaining a risk-focussed approach) and inspection planning
- To scrutinise the delivery of joint adults', children's and criminal justice services

- To contribute to national scrutiny programmes (e.g. Local Area Network processes)
- To measure and monitor the regulator's performance
- To provide information about the quality and availability of care services via registers of care services and via regular reports (i.e. published reports on the Care Inspectorate website)
- To fulfil statutory duties (i.e. requests under Freedom of Information Act 2000 or the Data Protection Act 1998 or 2018)
- To reduce duplication of information requests by public bodies through sharing information, including Scottish Social Services Council (SSSC) workforce information; Information Services Division (ISD)/Scottish Government Care Home Census

4.4.3 External statistics to which the regulator contributes

To support the collection and analysis of data of other bodies, the regulator administrates, and contributes to, other processes, including:

- The Scottish Government/Information Services Division care home census of long-stay residents in care homes. The regulator administrates and maintains this on behalf of Scottish Government
- National postcode file which provides links for each service, via the postcode, to local authority area, NHS board, small area geographies and associated information, such as the Scottish Index of Multiple Deprivation (SIMD) categories
- Use of national statistics publications, neighbourhood statistics products, census products

4.4.4 How the regulator's data can be accessed

The data held can be accessed via:

- The regulator's website (e.g. for service grades, published inspection reports)
- The regulator's publications (e.g. Childcare Statistics, annual report)
- Submitting an information request
- Receipt of information requests from Scottish Government or as background for ministerial briefings etc. (via an agreed protocol)
- The regulator's data store – an online statistics tool for professionals

4.5 Sampling

Within the framework of data routinely collected by the regulator and held by the Intelligence Team, the researcher defined the boundaries of the quantitative data required in order to address the first research aim: To describe the performance of all care service types regulated by the Care Inspectorate in Scotland over an identified time period (1st April 2013–31st March 2017) and to specifically answer the five sub questions.

The researcher considered data routinely collected by the regulator, as described above, and identified the most relevant aspects for further investigation, as follows:

- The total number of care services registered at 1st April 2013 and 31st March 2017 to describe the volume and spread of these
- Data regarding services evaluated with at least one evaluation of 'Adequate' at 1st April 2013 (services with capacity to improve)
- Of the care services with capacity to improve, a breakdown of services by provider type and local authority breakdown
- A review of the quality themes against which these evaluations had been made
- The difference in the volume of services registered between 2013 and 2017
- Data regarding the services which had improved between the two dates
- A review of interventions undertaken by the regulator in these improved services: complaints upheld, requirements made, and enforcements undertaken
- Data regarding Inspection Satisfaction Questionnaires to evaluate the views of those who have experienced an inspection in their care service

4.6 Methods

A designated Intelligence Team staff member was allocated to assist and liaise with the researcher to ensure clarity about the request, then extract the requested data from the intelligence database, providing information to the researcher via Excel spreadsheets. In describing the performance of care services between the dates outlined above, the researcher considered that it was important to evaluate whether change in performance had occurred across the care service landscape in that period. One of the core roles of the regulator is to support improvement in care services, therefore, any description of the performance of care services required to account for change in performance and any improvement.

The researcher made a comparison between two evaluations to analyse change in

performance over time. This was achieved by looking in more detail at services which had been evaluated with at least one evaluation of 'Adequate' at 1st April 2013 (services with capacity to improve) and, from those, the services which had improved to be evaluated with one or more 'Good' at 31st March 2017. The movement between 'Adequate' and 'Good' would demonstrate services in which originally *most* aspects of the quality themes and statements had been met but subsequently, *all* aspects of these had been met, thereby reflecting services which had had the capacity to improve and which had delivered the improvements required and expected (see the definitions of 'Adequate' and 'Good' in Appendix 1).

Firstly, quantitative data from services which had the capacity to improve at 1st April 2013 was analysed, then quantitative data from services which had at least one evaluation of 'Good' at 31st March 2017 was analysed, then the key points from both sets of data were analysed together.

4.7 Analysis of the quantitative data

Analysis of the quantitative data was undertaken using descriptive statistics, i.e. the data collected involved no inference and the data was simply described in the analysis (Woodrow 2014; Hanna 2016). Winkler states: "Description, after all, is the reason why statistical efforts are undertaken in the first place" (Winkler 2009 p. 232). The analysis of the quantitative data in Chapter 5 is presented to illustrate the properties of the samples of care services reviewed.

4.8 Limitations

While there was a significant volume of quantitative data gathered by the regulator, the researcher acknowledges she only sampled a small part of this data and used it for the specific purpose of comparison between a specified date range and between certain service types. Any alternative sampling method could, therefore, result in different findings.

4.9 Linking the quantitative phase to the qualitative phase – the co-productive approach

The findings from the quantitative data analysis gave a picture of the care services which had improved over a particular four year period, measured by a change from services

which had the capacity to improve in 2013 and, of those, the services which had improved to have one 'Good' or better in 2017. This picture included an analysis of geographical location, service type and provider type for care services. An analysis of data held in relation to complaints, requirements and non-technical enforcements was also undertaken. Analysis of inspection satisfaction questionnaires demonstrated a high number of respondents were satisfied with the conduct of the inspection and inspector within their service. Finally, an analysis of the improvement work undertaken by the regulator was also undertaken.

Integrating these findings with the themes arising from the literature review enabled the researcher to develop questions and statements to pose to participants in the co-productive phase. For example, on week 4 of the co-productive approach, the researcher posed a question about the high degree of satisfactory responses given to inspection satisfaction questionnaires and asked for participants' views on this.

4.10 Phase 2: approaches to the qualitative phase - the co productive approach

The approach to the gathering of data, both quantitative and qualitative, reflected the values of the research study – that of a co-productive approach. This approach was demonstrated by the application of a 'connecting framework' between the quantitative and qualitative phases (Fetters, Curry and Creswell 2013).

4.10.1 Defining co-production

From its conception in the 1970s by economist Elinor Ostrom (Filipe, Renedo et al. 2017), co-production has developed from a process involving users and providers of public services in the assessment, management and delivery of those services (Cahn 2004; Alford 2009; Boyle and Harris 2009), to encapsulate principles of social justice and social capital (Kickbush and Gleicher 2012; Pestoff, Brandsen and Verschuere 2012) and has become recognised as a means of working together to create and improve user-led, people centred services (Ryan 2012; Brandsen and Honingh 2015; Pestoff 2019). There are a variety of ways in which co-production is defined, indeed it can be a "slippery concept" (Social Care Institute for Excellence 2017a). There is no one agreed definition which translates across all fields and disciplines and those involved in the approach agree it is still developing and changing, particularly in understanding how it can transform public services (Boyle and Harris 2009; Scottish Care Institute for Excellence 2017a; Think Local Act Personal Partnership 2018).

Many writers cite its contributary elements or principles, as opposed to a specific definition. These principles include recognising individuals as experts and assets in their own communities with skills which can contribute towards sustainable solutions; providing opportunities for personal growth; empowering individuals and devolving roles and responsibilities (particularly around leadership); placing an emphasis on relationships; involving a degree of reciprocity and supporting resilience. Rather than defining co-production, these elements present a picture of what successful deployment of co-production might look like (Boyle, Clark and Burns 2006; New Economics Foundation 2008; Boyle and Harris 2009; Street Ambassadors 2013; Filipe, Renedo and Marston 2017). Activities which involve co-production can be varied and, although valuable in their own right, can also lead to more social cohesion and a changed relationship between public service institutions and the communities they serve, better connecting organisations with their stakeholders (Boyle, Clark and Burns 2006; Akhilesh 2017).

In the field of social care, co-production is the process by which organisations involve those using services as partners in the delivery of services, “with the intention of improving their lives and lengthening and strengthening basic services, so they can reach out to the community in a broader way” (Boyle, Clark and Burns 2006 p. viii). It is increasingly being recognised as an approach which delivers long term positive outcomes for individuals and communities, through applying the principles of corporate social responsibility (Dunston et al. 2009; Rahim and Idowu 2015; Fugini, Bracci and Sicilia 2016; Akhilesh 2017; Scottish Community Development Centre 2018). The Scottish Coproduction Network describes a relationship between the service provider and the service user which draws on the knowledge, ability and resources of each to develop solutions to issues which, it claims, are successful, sustainable and cost effective, thereby changing the balance of power from the professional towards those using services (Scottish Co-production Network 2017).

The lack of agreed definition is one of the key challenges with co-production. Providing strong principles of inclusion, shifting the balance of power and creating greater demands for transparency, co-production has much to offer, yet requires a stronger agreed understanding and evidence base if it is to make a real impact in policy and in mainstream public services (Boyle and Harris 2009). There is a significant cultural shift required for professionals to stop being fixers and start being catalysts focusing on individuals’ and communities’ strengths-based abilities (Boyle, Clark and Burns 2006); for

those in local government to be truly open to suggestions from communities and those using services, recognising the accompanying relinquishing of power that this entails (Loeffler et al. 2012 and 2013); and for everyone involved in co-production to accept the need to “disagree well and constructively” (McGrath 2016).

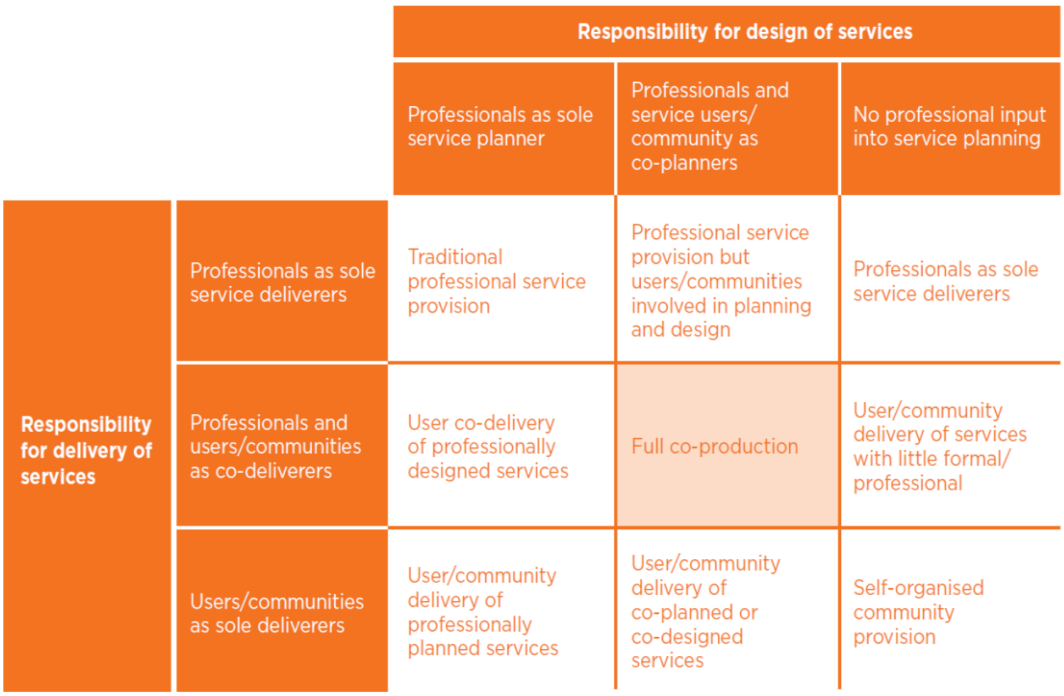

Figure 14: Beyond engagement and participation, user and community co-production of services (Boyle and Harris 2009 p.16)

Figure 14 represents two aspects of services (in solid orange): responsibility for their design and responsibility for their delivery. The grid places full co-production firmly in the centre of the grid, aligned vertically to professionals, those using services and the community as planners and, aligned horizontally, as co-deliverers. In other words, when professionals, those using services and communities plan, design and deliver services together, full co-production is achieved. The rest of the grid can be viewed across and down the matrix grid, each describing different levels of involvement and participation, dependent on role.

This research took the principles inherent in a co-productive approach, combined with ensuring the values of stakeholder involvement were considered through the research planning, design and delivery to implement the co-productive phase.

4.10.2 A co-productive approach in this research

Co-production can also be described as an “exploratory space and a generative process that leads to different, and sometimes unexpected, forms of knowledge, values and social relations” (Filipe, Renedo and Marston 2017 p. 1). Developing the first part of the qualitative phase of this research took the form of a co-productive *approach*, rather than attempting to reflect all the principles outlined above which might be thought of as a more traditional method of co-production. It was important to the researcher to reflect the values of the research throughout, including through the methodology design.

Consideration of a co-productive approach involved reflecting on wider aspects of how individuals with expertise in care regulation could be involved in developing relevant aspects of the research strategy (Payne 1997 and 2006; Warren 2007; Bellinger and Elliott 2011), while also maintaining consideration of social work approaches to the research, in particular approaches which focus on a value base of empowerment, participation and a strengths-based approach (Cooperrider et al. 2008; Cooperrider and Whitney 2011; Hammond 2013; Kessler 2013; Gomez, Bracho and Hernandez 2014; Stone and Harbin 2016).

There were several reasons for undertaking a co-productive approach in this research. Firstly, it was important to seek the views of a range of ‘experts by experience’ who offered a unique perspective (Skilton 2011; Graham et al. 2017). In the case of this research, experts by experience were those involved in the regulation of care services in Scotland. Secondly, involving experts from the earliest point possible maintained greater integrity and objectivity in the research design phase. Thirdly, involving experts in supporting the design of the qualitative phase reduced researcher bias in the research design (Chenail 2009). Fourthly, working together with experts supported the researcher to be a reflexive researcher, i.e. a researcher who considers the impact he/she has on the research, and the impact the research has on him/her, using learning to inform development (Berger 2015; Attia and Edge 2017).

Using the values expressed in the research and the values and principles of social work, the researcher chose to employ an approach which would reflect these and designed a co-productive approach to link the quantitative and qualitative phases of research. A Delphi Study was initially considered for the co-productive phase.

4.10.3 Consideration of a Delphi study

A Delphi study is an iterative process of structured communication among a group of selected experts based on the idea that it is possible to reach a consensus of opinion on a complex problem (Okoli and Pawlowski 2004; Iqbal and Pipon-Young 2009; Keeney 2011; Wilkes 2015). Although there is no 'one size fits all' model of Delphi, there are characteristics which can be found across different studies: iteration in the process; anonymity of subjects; confidentiality of views and a process which is controlled and timebound (Hsu and Sandford 2007).

Pfleger et al. (2008) used a staged Delphi technique to determine pharmaceutical health competencies for Scottish community pharmacists. The authors claimed that conclusions gained from this technique were more valid than those from less formal processes of decision-making. Martin and Manley (2018), in a Delphi study to propose standards for interprofessional teams working in integrated health and social care, used a three-stage Delphi study to attain consensus, following modifications to validate its content.

The challenge in involving experts in a Delphi study is in their identification – it is subjective, at the behest of the researcher, therefore, it could be open to criticism (Keeney, McKenna and Hasson 2011). This research acknowledges the purposive sampling involved in identifying individuals, however, specific individuals were targeted precisely for their knowledge of different aspects of the process of regulation - both as regulators and as users of services.

A traditional Delphi study would entail the researcher opening up one weekly discussion thread, inviting responses, refining the thread based on responses received, then re-issuing the refined thread until a consensus of opinion was reached, or an agreed period of time had ended, whichever occurred first. In this study, the researcher felt there was such a breadth of themes arising from both the literature and the quantitative data, that she decided to make the best use of the experts' knowledge by exploring all the key themes which had arisen rather than seek consensus on one topic.

Taking principles commonly found in a Delphi study as outlined above, the researcher designed the approach. This was an electronic survey issued weekly. Specific themes were then aligned to each week of the survey so that, rather than coming to a consensus as would occur in a traditional Delphi study, participants were asked for their views about

different themes each week then offered the opportunity to comment on all responses at the end of the four week period. This will be explored further in Chapter 6.

4.11 Sampling

Social work researchers often perceive challenges with the sampling of research subjects. These challenges can include having access to limited resources, small numbers of individuals or sensitivity to the phenomenon under study or challenges in gaining access to individuals willing and able to participate in research. Therefore, purposive sampling may be key to addressing these (Guo and Hussey 2004; Suen, Huang and Lee 2014; Shuai and Macduff 2016; Gerrish and Lathlean 2015; Stennett, De Souza and Norris 2019). Purposive sampling lends itself well to qualitative research and involves the researcher targeting specific individuals or groups for the research topic under study, with the expectation that those individuals have a specific knowledge of the topic and can, therefore, make a unique and rich contribution to the research (Cunningham, Weathington and Pittenger 2013).

To make best use of the co-productive phase in this study, the researcher identified individuals from the regulator. Individuals were purposively sampled from two distinct groups: inspection staff and inspection volunteers (see Chapter 2).

4.11.1 Numbers of individuals

From traditional Delphi studies' literature, there is no prescribed optimum number or quorum of experts by experience. Studies have, in fact, shown that numbers ranged from four to 3000, making a decision about numbers involved a pragmatic one (Thangaratinum and Redman 2005). Twelve individuals in total were identified for this part of the research (six members of staff and six inspection volunteers). The researcher felt that this number would allow for some individuals withdrawing before, during or after the co-productive phase, recognising participants' rights to do so (Stark 1998).

4.11.2 Regulatory staff

The researcher identified six members of staff whose job roles covered different aspects of regulation. These included one senior inspector (children's services); one team manager (early years); one inspector (children's services); one strategic inspector (adults' services); one improvement advisor; one team manager (adults' services). These individuals were purposively sampled to gain the views of a diverse but experienced group of individual experts.

An email was issued directly by the researcher to each individual employee identified. There were two main reasons for the researcher contacting colleagues directly:

- Time: as described later, the co-productive phase was time bound and, as such, necessitated contact with participants within a quick timeframe
- Knowledge of participants: to seek views on all themes, the researcher required a breadth of knowledge across different aspects of regulated care. Therefore, targeting specific individuals enabled the researcher to ensure this breadth of knowledge across service types was achieved

Of the six contacted, five individuals agreed to participate in the co-productive phase.

4.11.3 Inspection volunteers

Inspection volunteers are both young people and adults who have care experience and who wish to be involved, on a voluntary basis, in supporting the work of the regulator. They undertake specific training to support inspectors during both regulated care service inspections and joint strategic inspections. Inspection volunteers carry out a variety of tasks during inspections, including meeting with those using care services and discussing their experiences. This information supports the inspector and inspection team.

The researcher contacted the Involvement Co-ordinators from the Care Inspectorate's Involving People team, informed them about the purpose of the wider research and the co-productive phase and asked them to identify six inspection volunteers (ideally, three adults and three young people) who they would approach to invite to participate. The researcher outlined specific criteria to the Involvement Co-ordinators regarding potential participants, including confidentiality, their availability during set timescales, access to a computer throughout and willingness to participate across the duration of the study.
Five inspection volunteers expressed an interest to the Involvement Co-ordinators (three adults and two young people). The researcher asked the Involvement Co-ordinators to pass on the participant information leaflet and further details to these five volunteers. With their agreement, the Involvement Co-ordinators passed on email contact details to the researcher to contact them directly.

This enabled the co-productive phase to be undertaken with ten participants. These two groups resulted in a manageable number of participants. There is no one agreed

optimum number of participants in any such study and, in fact, many researchers believe that representation and expertise are viewed as more valuable than group size (Wheeldon 2010; Torrance 2012; Pinto, Wall and Spector 2013).

Emails to both staff and inspection volunteers included a participant information leaflet which outlined the broad research; the explanation of, and the purpose of, the co-productive phase; the terms and criteria for involvement and contact details for further information and for expressions of interest (Appendix 2).

4.11.4 Identification of co-productive participants

To ensure participants were not identifiable and to maintain confidentiality, participants in the co-productive phase were identified as CP1-CP10 (Co-productive participant 1 – co-productive participant 10). Codes were not allocated to individual roles because of the small number of individuals in any one given role which would mean that individuals may have been identifiable in this research study.

CP 1 - 10	Senior inspector (children and young people's services)
	Team manager (early years services)
	Inspector (children and young people's services
	Improvement advisor
	Team manager (adults' services)
	Three adult inspection volunteers
	Two young inspection volunteers

4.12 Co-productive phase design

To inform the co-productive phase, the researcher reviewed the findings from both the quantitative data analysis and the literature review and aligned these to the two research aims in relation to the qualitative phase.

From the analysis of quantitative data, there were ten points raised which the researcher intended to explore further and learn iteratively from through the qualitative phase. These

can be found in detail in Chapter 5. From the review of literature to date, key themes were also emerging. These can be viewed in detail in Chapter 3.

The purpose of the qualitative phase was to answer research aims two and three:

2. To identify knowledge, understanding and perceptions of regulation among those receiving care services; and among those providing care services, and other stakeholders.
3. To identify stakeholders' perceptions about the process, delivery and framework of care service regulation in Scotland.

Accordingly, the questions arising from the quantitative data analysis and the themes arising from the literature were analysed further with a view to creating several statements or questions with which to undertake the co-productive phase.

4.12.1 Method

The researcher identified four key areas on which she wished to seek the views of the co-productive phase participants. Each key area was the focus for one week of the phase.

On week one, the theme was the identified purposes of regulation and consideration of barriers to their achievement. On week two, the theme was critiques and perceptions of regulatory processes. On week three, the theme was the benefits and disadvantages of different models of regulation. On week four, the theme was the views of regulation by stakeholders. The researcher also asked the participants to comment on their experience of participating in the co-productive phase in this week's questions.

To allow participants an opportunity to use feedback from others to reflect on and, potentially, revise their responses, the researcher issued a summary of all anonymised responses to participants the week following the closure of the survey. One month later, the researcher issued a final brief survey asking participants for their reflections, once they had had an opportunity to review and consider others' contributions.

The findings from the four weeks of the co-productive phase and from the one-month follow-up survey are discussed in detail in Chapter 6. The phase ran from 21 January to 15 February 2019. The follow up survey ran from 18 to 22 March 2019.

4.12.2 Data collection methods

To comply with Robert Gordon University's guidance regarding General Data Protection Regulation (GDPR), the researcher employed the Bristol Online Survey as a method for the collection of data from the co-productive phase (Shenmeng, Brown and Hemminger 2018; Bristol Online Surveys 2020). This is an online survey tool recognised by Robert Gordon University and specifically designed for academic research, education and public sector organisations. The Bristol Online Survey enables the researcher to design the survey questions, set a specified timescale for opening and closing the survey, distribute the survey via a hyperlink, then analyse the responses following the closure date. The researcher registered with the survey's administrator then undertook online training to be conversant with the survey tool.

To test the technical process of the co-productive phase via the online survey, the researcher contacted one of her supervisory team who agreed to test the link and a pilot question. The researcher designed one question, issued the hyperlink to the supervisor who completed the test survey and confirmed that the process was easy to use and there were no technical issues. This enabled the researcher to design further surveys with confidence.

Each week, the researcher used a theme arising from a review of the literature and an analysis of the quantitative data. From the theme, the researcher designed three to four key questions on the topic, seeking views from the participants' experiences. The co-productive phase programme can be found in Appendix 3. The dates for the week's survey were then established: the survey was opened on the Monday morning at 0800 hours and the closure date and time was set for the Thursday of the same week at 1700 hours. This gave the participants four days to complete the survey for that week. The researcher emailed each participant individually from her university email account and enclosed a hyperlink to that week's survey questions. Following the survey's closure, the researcher analysed the responses to that theme. The researcher then established the questions for the following week of the study using the next theme from an analysis of the quantitative data and the literature review.

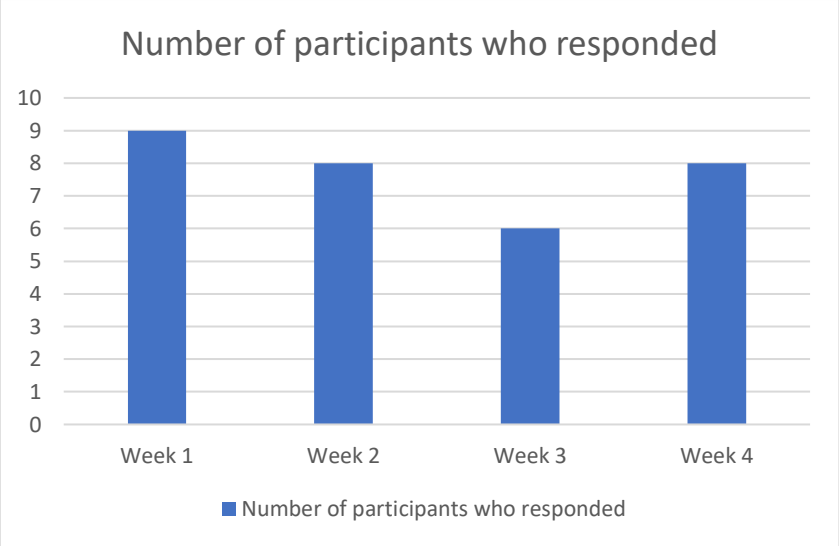

Table 1: Number of participants responding each week

Table 1 demonstrates participation over the course of the four-week study. To ensure equity of the process, the researcher strictly maintained the boundaries set around the process. This included adherence to timescales. On two occasions, two different respondents contacted the researcher after the survey had closed one week to ask if the timescale could be extended as they had been unable to complete it in time. The researcher acknowledged their frustration, however, made it clear that all respondents had been given clear guidelines prior to consenting to participate.

Unfortunately, therefore, there was no further opportunity to complete that week's questions, however, they would receive the following week's questions as usual. It is acknowledged that this may have impacted on the survey and this will be discussed further in the following section.

4.13 Limitations of the co-productive phase

There were several limitations in this phase.

4.13.1 Participants

As anticipated, the number of participants who agreed to take part in the co-productive phase changed over the period of the study. This could have limited the effectiveness of the study, however, the sampling process had accounted for this: seeking 12 individuals from the beginning of the process meant that, should participants decrease over the course of the study, there would still be a large enough group to ensure legitimacy of responses. Even in week three in which two participants contacted the researcher to

request more time for completion, there remained six participants who completed the survey.

From seeking 12 participants at the outset, ten agreed to participate. Of these ten participants, nine responded on week one, followed by eight in week two, six in week three and eight in week four. Six participants responded in the final follow up survey. This demonstrates a mean of 7.4/10 responses each week.

4.13.2 Process

The process of using the Bristol Online Survey could have limited the effectiveness of responses, given the time commitment and regularity of input required from participants. From feedback from the eight participants in week four, however, the process was felt to be a positive one. The process of issuing three to four questions each week by hyperlink was described by participants as user friendly and manageable in time and commitment. One participant from week four felt that a discussion board may have enhanced conversation, however, all participants felt that the study had enabled them to reflect on their own views of regulation both in a wider sense and as delivered by their organisation. As a researcher, the use of a tool such as the Bristol Online Survey was invaluable in supporting the design and distribution of the survey and the evaluation of the responses. The process, once learned, was easy to use, accessible and subject to clear timescales.

4.13.3 Questions

The questions in the co-productive phase were led by the findings from the quantitative data analysis and from themes emerging from the literature review. Some participants in week one demonstrated, however, that the language used in the questions was not accessible to them and, therefore, they felt they did not contribute to the degree they wanted, with some not responding in future weeks at all. In the designing of questions, the researcher had reflected the language from the findings, believing that, as these reflected current terminology in the field of regulation, words and phrases would be understood by all participants. Unfortunately, this proved to not be the case.

Given the tight timeframe, the logistics of organisation and the short time for preparation involved in designing, analysing and issuing the survey for the following week, the researcher was unable to re-issue the questions using different language on this occasion, although the learning from this was significant. The researcher’s intention was

not to deliberately exclude any participants, however, it is acknowledged that this may have contributed to a few participants choosing not to respond in future weeks. This has been an indication to the researcher that, in any future similar study, she will need to consider the audience for the study and will need to better consider issues of accessibility and language. Given the researcher's role and professional background, consideration of accessibility issues should have been more of a focus in designing the co-productive phase. This learning was considered in the design of interview schedules for the next part of the qualitative phase.

Otherwise, the feedback from participants who did take part was that the questions enabled them to reflect on their role and regulation and, although some may have felt they did not contribute as they would have liked, the depth and richness of data collected by the researcher was very detailed.

4.13.4 Small scale study

With a mean of 7.4 respondents, the co-productive phase was a small-scale study, however, its intention was always as a connecting framework between the quantitative and qualitative phases of interviews. There was a wealth of data gathered and it had a richness and depth to it which further added to data previously gathered. Together with consideration of participants' own suggestions for questions, the researcher used findings from the co-productive phase to support the design of interview schedules for the next part of the qualitative phase.

4.13.5 Time

As highlighted earlier, to ensure equity of the process for all participants, the researcher strictly maintained the boundaries set around the process, including adhering to timescales. Two participants contacted the researcher after one week's survey had closed to ask if the timescale could be extended as they had not been able to complete it in time. The researcher made the decision not to extend the timescale and acknowledges that, in adhering to this, this may not only have contributed to a loss of data on that occasion but could also have impacted on participants' responses in future weeks. Although the participant information leaflet disseminated in advance of the phase was very clear about the commitment required, it is a point of learning for future research that consideration should be given to circumstances such as these which may arise.

4.13.6 The impact of the researcher

The researcher acknowledges that, although ethical practice was followed in the design of the co-productive phase and the researcher minimised any impact which her role as employee of the regulator could have had at this point, once initial communication had been made directly with participants, they would have recognised her as a colleague.

This could potentially have led to the Hawthorne Effect in which research participants can act and report situations differently because they are part of a study (Rees 2016). It is, therefore, acknowledged that, despite attempts to reduce the impact of the researcher on this element of the research process, knowledge of the researcher may have had an impact on participants' responses and potentially compromised validity of the results from this phase. From the responses given, however, the researcher believes this was minimal, as comments showed clear reflection and consideration from participants.

4.14 Linking the co-productive phase to the interviews phase

Learning iteratively, the researcher integrated findings from the literature review, the quantitative phase and the co-productive phase into the interviews phase. For example, there were several core purposes of regulation identified in the literature review. These were explored with participants in the co-productive phase and their responses (including additional suggestions) were posited in questions to interview participants. Similarly, in the quantitative data analysis, there was a high degree of satisfaction noted by those responding to inspection satisfaction questionnaires and analysis of these responses informed questions about interview participants' experiences of regulation.

4.15 Phase 3: approaches to the qualitative phase - interviews

4.15.1 Sampling

In Chapter 5, the researcher explored quantitative data regarding the performance of care services registered with the regulator between 2013 and 2017. To evaluate the performance of services and identify those in which improvement had been attained, the researcher reviewed services which had been evaluated with at least one 'Adequate' at 1st April 2013 (services with capacity to improve) and which had improved to have at least one evaluation of 'Good' at 31st March 2017. At 1st April 2013, 1,835 care services had capacity to improve. At 31st March 2017, 844 of these care services had shown improvement and had been evaluated with at least one 'Good'.

The researcher was interested to explore the experiences and perspectives of stakeholders within some of these 844 care services where change and improvement had occurred and use their perspectives to discuss the findings to date from the literature review, quantitative data analysis and the co-productive phase.

Accordingly, a sample of these 844 care services was further explored in the qualitative phase.

In the quantitative data analysis, care services with capacity to improve in 2013 and those with one 'Good' or better in 2017 encompassed all service types, all provider types and were located across Scotland. In the co-productive phase, stakeholders had experienced various care service types when involved in regulation and had undertaken inspections across Scotland. The researcher reviewed her original plan which was to undertake focus groups and individual interviews across a variety of service types and geographical locations. It was important to recognise the already significant amount of data gathered from the literature review, the quantitative phase and the co-productive approach and to use themes raised to inform a smaller, more targeted, approach to the remaining part of the qualitative phase. The researcher, therefore, decided to undertake a smaller number of interviews than originally conceived.

The qualitative phase required "the kind of humility that acknowledges that the researcher always has a particular standpoint, and the kind of openness that is prepared to risk having that standpoint changed" (Attia and Edge 2017 p. 34). Qualitative research has its challenges. Asking open questions means "working with uncertainty" (Jonker and Pennink 2010 p. 88). The researcher decided to employ criterion sampling to identify participants (Sandelowski 2000; Robinson 2014; Krysik 2018). In the case of this research, the criteria chosen were individuals from whom the researcher had not yet heard in the research to date: care service providers. Careful thought was given to the inclusion criteria for the sample from which qualitative data would be sought (Offredy and Vickers 2010). The researcher chose the following inclusion criteria:

- Care services had to be currently 'active', i.e., continuing to operate and registered with the regulator
- Care services had to represent a mix of different care service types
- Care services had to be geographically accessible to the researcher

The researcher first ascertained which of the 844 care services remained in operation and had continued to be registered with the regulator. Linking with the Intelligence Team, the researcher requested further work be completed to identify the active status of the 844 care services. An Intelligence Team member prepared an Excel spreadsheet for the researcher containing the names, care service types, reference numbers, geographical locations and contact details for all the 844 care services.

Using a filter function, the researcher identified the care services from the total of 844 which continued to operate and remained registered with the regulator at 31st May 2019. This reduced the 844 care services to 715 which remained in operation.

This number was then subject to a further filter based on the criteria of convenience and accessibility for the researcher (Dornyei 2010). Of the 715 care services which remained active, the researcher determined that they constituted a mix of care service types then filtered those which were located within the three local authority areas geographically closest to her location. This would allow her reasonable travelling distance, time and cost in undertaking interviews. Once these criteria were filtered, this reduced the sample to 82 care services.

Using further purposive random sampling, the researcher selected the first of each ten care services from the list of 82 (Lune and Berg 2017; Krysik 2018). This further reduced the list to eight care services. These included two care homes for children and young people; one care home for adults with learning disabilities; two childminders; two care homes for older people and one centre for the day care of children. Although not representing all care service types, these gave a broad representation of care services registered with the regulator.

To mitigate potential feelings of coercion to participate and avoid undue influence (Appelbaum 2007; Davies and Peters 2014; Collings, Grace and Llewellyn 2016), the researcher requested that a business support assistant working with the Care Inspectorate make direct contact with the manager of each of the eight identified care services. This assistant sent an email drafted by the researcher to the service manager. This email outlined the ways in which that service had been identified, the purpose of the research and enclosed a participant information leaflet (Appendix 2). The email also included contact details of the researcher, should the manager wish to discuss any aspects of the research further. Finally, the email requested those interested to contact

the business support assistant by a particular date and agree that their contact details could be passed to the researcher. A copy of the email can be found in Appendix 4. Unfortunately, none of the eight services had responded to the business support assistant by the deadline date. Given the potential impact of the holiday period, the researcher asked the business support assistant to again email all eight care services, extending the response deadline.

None of the care services had replied by the end of the second deadline. Following discussion with her supervisory team, the researcher selected the next ten care services in the larger sample, re-issued the information materials via the business support assistant and gave another deadline for responses. On this occasion, one manager responded to say she was not interested in participating in the research, however, no-one else responded.

Following further discussion with her supervisory team, the researcher identified the next ten care services from the larger sample and contacted these services in person by telephone, before issuing information materials to those who were interested.

This method elicited seven responses, all of whom indicated they were happy to be approached for interview. The researcher offered these individuals the choice of being part of a small group or conducting a face-to-face or telephone interview. Four participants chose to be interviewed individually by telephone and three participants chose to be interviewed individually in person. Of the seven planned interviews, six were undertaken as one individual was unavailable on the agreed day.

4.15.2 Methods

It was important to consider a range of interview methods, however, all six participants chose to be individually interviewed.

4.15.2.1 Interviews:

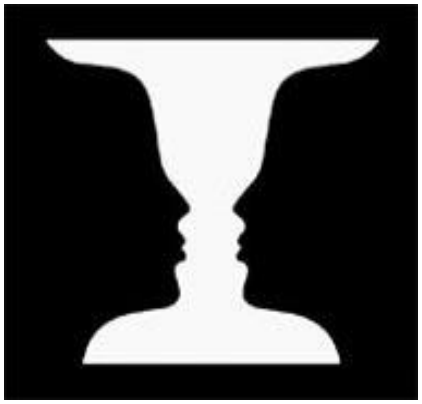

Figure 15: The Research Interview seen as Inter Views (Kvale and Brinkmann 2009 p.3)

In Figure 15, the picture can be viewed as either two faces or as a vase, but not as both at the same time. Kvale and Brinkmann argue that the two faces can be viewed as the interviewer and interviewee, with the interview being interaction between the two; and that the vase can be seen as containing the knowledge constructed between ('inter') the two (their 'views'). This illustrates the two aspects of any interview: the relationship between the interviewer and the interviewee; and the knowledge which comes from their dialogue.

Interviews are the "planned interactive process between a researcher and a respondent for the purpose of gathering data about perceptions, meanings and understandings of the respondent's experience" (Campbell, Taylor and McGlade 2017 p. 50). They are commonly used to collect in-depth information based on the participant's beliefs and experiences and conversation is one of the most frequent methods by which to generate data (Jonker and Pennink 2010; Creswell 2013; Turner 2014; Mitchell 2015; Mann 2016). There are three main types of interviews: structured, semi structured and unstructured (Wilson 2016).

Structured interviews involve a researcher asking a participant closed questions which allow responses from several participants to be compared, for instance, asking a question to which the answer can only be either 'yes' or 'no'. Semi-structured interviews are fluid in nature and involve the researcher asking open questions and being guided by the answers given by the participant, enabling the researcher to ask follow-on questions. Some writers assert that interview questions should be open and begin with the word 'how?' and follow a semi-structured format to elicit the most open responses (Tong,

Sainsbury and Craig 2007; Brinkmann 2014). Unstructured interviews are guided, in the main, by the participant and can be used if the researcher has little or no knowledge of the topic or if in-depth personal experience is required (Adams et al. 2007; Green and Thorogood 2013).

In this research, the researcher employed semi-structured interviews, developing core open questions, thereby maintaining the flexibility to respond to participants' answers and explore these further, within the topic (Creswell 1998; Hardwick and Worsley 2011; Berg and Lune 2012; Zeynep 2017).

As Hardwick and Worsley (2011) note: "There is no task more fundamental to social work than asking questions, no more universal process for social workers than interviewing" (Hardwick and Worsley 2011, p.68). As a qualified and experienced social worker, the researcher was confident in the process of interview using structured, semi-structured and unstructured formats, however, the facilitation of interviews for research required specific preparation and planning particular to the research aim and objectives.

Interviews also have their own challenges. For example, from an epistemological perspective, it was important to consider whether data gathered from interviews was truly representative of the beliefs and views of those interviewed or whether it was it a construct of what the individual believed the researcher wanted to hear (Speer 2002; De Fina and Perrino 2011). Interviews are also 'co-constructs' between the interviewer and interviewee (Mann 2016). Interviews can result in a significant amount of data which the researcher must try to make sense of during analysis (Wahyuni 2012; Brinkmann 2013). To support this, the researcher chose to record her interviews in writing and analyse her record of the interviews using NVivo 11, a qualitative data analysis computer software package hosted by Robert Gordon University. The researcher was already familiar with this tool, having used it previously in a work context.

Literature suggests 10–12 interviews as an optimum number for a research study or until the point of data saturation, at which point no new insights or observations are revealed (Guest, Bunce and Johnson 2006; Onwuegbuzie and Collins 2007; Krysik and Finn 2013).

The researcher conducted six individual interviews: three by telephone and three face-to-face in a venue chosen by the participant. Participants were from local authority,

voluntary and private sector services and from a range of service types: two childminders, one manager of a day care of children service, one housing support service manager and two managers of care homes (one for children and young people and one for older people). Interviews were conducted in August and September 2019.

Participants in the interview phase were identified as IP1-IP6 (Interview participant 1 – interview participant 6). These codes were applied as follows:

IP1	Childminder A
IP2	Childminder B
IP3	Day care service manager
IP4	Housing support service manager
IP5	Manager – care home for older people
IP6	Manager – care home for children and young people

4.15.2.2 Telephone and face-to-face interviewing

In this research, interviews were conducted both face-to-face and by telephone. Telephone interviewing can have both advantages and disadvantages: it is an inexpensive data collection method, negating the need for travel and lessening time on the parts of both the interviewer and interviewee; respondents may be less biased by a telephone interviewer and it can limit emotional distress, especially when sensitive topics are discussed (Pieper 2011). Face-to-face interviewing can, however, support the researcher to additionally pick up on visual cues or make observations about behaviour, if that is relevant to the research (Marcus and Crane 1986; Ritchie and Lewis 2003; Reddy et al. 2006; Mealer and Jones 2014). In this research, three participants selected to undertake a telephone interview and three chose to meet the researcher face-to-face. All participants chose a day and time which suited them. The researcher sought informed consent verbally both in advance of the interview and on the day and offered participants the opportunity to ask any questions before the interview began.

The researcher decided to make handwritten notes during interviews rather than audio record interviews. As a regular part of her job, the researcher conducts face-to-face and

telephone interviews, as well as facilitates focus groups for which she also makes handwritten notes. She was, therefore, very confident in her ability to record all relevant data through this method of recording without audio recording interviews. Some writers also agree in the validity of written field notes (Tessier 2012) or state that those being interviewed are also more likely to relax when an audio recording device is not present (Sturges and Hanrahan 2004).

Following completion of all interviews, the researcher sent a copy of the notes she made to each participant to give them the opportunity to make any amendments, clarify points made or comment further on the issues raised. Of the participants, three responded. Two indicated they had no amendments to the researcher's notes; one participant requested a change in emphasis in one statement. This was incorporated into the final findings.

The researcher also sent anonymised copies of the notes of each interview to her supervisory team as an additional means of ensuring rigour by seeking their views on her interpretation of themes. The purpose of these actions was to enhance the trustworthiness of the data (credibility, transferability, dependability and confirmability). The supervisory team confirmed congruence between interview notes and the researcher's interpretations of themes arising.

4.15.2.3 Coding interviews

The researcher analysed the interviews using Nvivo 11, a research tool to support qualitative and mixed methods data analysis (Bazeley and Richards 2000). Within NVivo 11, the interviews were recorded and then coded against themes which arose. The researcher compiled some codes prior to fieldwork informed by her background study (Walliman 2016). These codes were refined during data collection.

4.16 Analysis of the co-productive phase and the individual interviews

The researcher employed thematic analysis (Braun and Clarke 2017) as a means of analysing the rich data gained from both the co-productive phase and the individual interviews with service providers as this can be widely used across a "range of epistemologies and research questions" (Nowell et al. 2017 p. 2). Thematic analysis provided a systematic procedure for generating themes from the qualitative data. Figure 16 describes the different phases within thematic analysis:

Thematic analysis: analysis phases and their descriptions	
Familiarising with data	Transcribing data, reading and rereading the data, noting down initial ideas.
Generating initial codes	Coding interesting features of the data systematically across the entire data set, collating data relevant to each code.
Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
Reviewing themes	Checking if the themes work in relation to the coded extracts and the entire data set, generating a thematic map.
Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis

Figure 16: Phases of thematic analysis (Braun and Clarke 2006 p. 87)

Chapters 6 and 7 provide an analysis of the qualitative data gained from the co-productive phase and the interviews phase.

In accordance with Braun and Clarke's phases of thematic analysis (2006), the researcher took the following steps:

Step one: familiarisation with the data

For both the co-productive phase and the interview phase, this involved transcribing her notes into Nvivo 11, a qualitative data analysis package (Bazeley and Richards 2000). As highlighted in section 4.15.2.2, for the notes arising from individual interviews, the researcher sent these to each participant and requested they check these for accuracy, clarify points made or comment further on the issues raised. Of the six participants, three responded. Two indicated they had no amendments to the researcher's notes; one participant requested a change in emphasis in one statement. This was incorporated into the final findings. Each participant was allocated an individual identifier: CP represented a co-productive participant and IP represented an interview participant. Each group was

numbered: CP1 – CP10 for co-productive participants and IP1-6 for interview participants.

Step two: generating initial codes

Next, the researcher generated codes within Nvivo 11. For example, participants in both the co-productive phase and the interview phase spoke about their views of the purposes of regulation. The purpose of regulation, therefore, was identified as one code. Nvivo 11 enables the researcher to identify codes and record each as a 'node' (Bazeley and Richards 2000). The researcher identified, for example, the purposes of regulation as one node. Each occurrence of the purposes of regulation was recorded under this node (known as the 'parent node'). Within each node, it is possible to construct a hierarchy. For instance, under the node for purposes of regulation, these were further organised into separate sub-nodes (known as 'child nodes'). For 'regulation' as a node, the child nodes were 'educative/developmental', 'protection', 'assurance', 'accountability' and 'value for money'.

Step three: searching for themes

These parent nodes became themes and the child nodes became sub-themes. Through coding, themes arising from the co-productive or interview notes in relation to the purposes of regulation were, therefore, easy to search for from the nodes identified. All data relevant to each theme was gathered. Other codes were similarly structured as nodes, as described above.

Step four: reviewing themes

The researcher then began the process of checking and reviewing the themes across the data set and compiled a map of themes.

Step five: defining and naming themes

The researcher then further refined the themes in order to understand what the data was saying. This allowed the themes to be clearly defined and named.

Step six: producing the report

The researcher undertook a final analysis, aligning this to the research question and was able to report on the themes arising from interviews.

4.17 Issues for consideration

Rigour in research is closely scrutinised and researchers are supported by assessment frameworks, for example, those of the Economic and Social Research Council, the Research Evaluation Framework or the Equator network for healthcare research (Altman et al. 2008). Jonker and Pennink (2010) describe two sets of criteria for judging the quality of research: the scientific criteria and the practical criteria. Scientific criteria include truth, testability, controllability, objectivity, precision, consistency, reliability, validity and repeatability (2010 p. 98). Practical criteria include relevancy, grounded in practice, comprehensiveness, timeous, affordable, considering sensitivities and interests, usability and completeness (2010 p. 98). In considering her methodology and research methods, the researcher acknowledged these and other issues for consideration.

4.17.1 Value relevant research:

It was important to explore the relationship between the researcher, topic and any assumptions made. The researcher has already acknowledged how her values, beliefs and position in the organisation may have impacted on the research. It is probably impossible to undertake value-free research, however, it is possible to undertake value-relevant research to describe the social relevance of research (Everitt et al. 1992; Gomm 2004; Cardiff University 2014). In this case, the social relevance was in gaining evidence of stakeholders' perceptions of the regulation of social care in Scotland within a defined context.

4.17.2 Sampling

Purposefully sampling participants represents a key decision point in a qualitative study (Creswell 1998; Chevalier and Buckles 2008). Purposeful sampling enabled the researcher to "choose strategically elite cases or key informants based on perception that they will yield a depth of information or a unique perspective" (Tashakkori and Teddlie 2010 p. 357). This would, in turn, support a systematic approach to research design (Campbell, Taylor and McGlade 2017). Depth, rather than breadth, of knowledge was the driver for this research. Specifically, the research incorporated a random purposeful framework for sampling, identifying a sampling frame from which individual participants were selected for both the focus group and interviews (Onwuegbuzie and Collins 2007).

4.17.3 Validity

Research validity is the degree to which a study accurately reflects the specific aims or

objectives originally set out and the quality of inferences made (Jonker and Pennink 2010; Zumbo and Chen 2014). In constructivist approaches, validity is recognised as trustworthiness and authenticity, with both internal and external validity viewed as important. Denzin and Lincoln (2011) describe external validity as “the degree to which findings can be generalised to other settings similar to the one in which the study occurred” and internal validity as “the degree to which findings correctly map the phenomenon in question” (2011 p.100).

4.17.3.1 External validity

The generalisability of the findings from this research to other similar settings is difficult to achieve. Qualitative researchers are more concerned with gaining an in-depth understanding of a topic, rather than gaining a breadth of perspective (Tashakkori and Teddlie 2010; Creswell 2014). The findings of this research, therefore, are not transferable across wider populations or settings in the way a larger scale quantitative study might be, however, this study gives enough detail, without allowing for the identification of participants, to enable readers to extract meaning and interpretation applicable to their own setting.

4.17.3.2 Internal validity

In quantitative research, study design can often be repeated to confirm the results, however, in qualitative research, this is less likely, given the nature of the approach (Chivanga 2016; Campbell, Taylor and McGlade 2017). To achieve internal validity in this study, however, the process the researcher followed is made clear, so that another researcher could replicate this work.

4.17.3.3 Trustworthiness

Trustworthiness in qualitative research is confidence in the accuracy of research findings and of the researcher’s interpretation of data (Rees 2016; Yorke and Vidovich 2016). Criticism often relates to research credibility, transferability, dependability and confirmability (Shenton 2004; Tappen 2011). In this research, these were addressed as follows:

Research participants were selected using a random purposeful framework for sampling. This reduced researcher bias, supported the integration of analyses from findings and iterative questioning. Regular debriefing and scrutiny from supervision supported the researcher’s learning and research development. The researcher is also a respected

professional in the social work and regulatory field, thereby supporting credibility in the research.

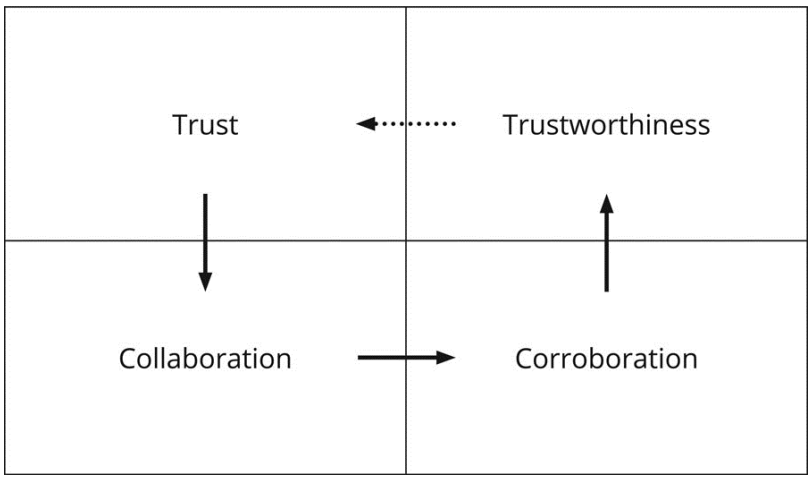

Figure 17: From trust to trustworthiness (Attia and Edge 2017 p. 41)

In Figure 17, Attia and Edge demonstrate the interconnectedness between trustworthiness and trust for a reflexive researcher. Establishing trust is an important part of the researcher's role and, in turn, it supports research validity (Mercer 2007). Collaborating effectively with others is an important part of establishing trust. In this research, the co-productive approach was one way in which collaboration began. Collaborating well and effectively leads to the generation of data which is credible and valuable (Creswell and Miller 2000). Attia and Edge (2017) argue that close communication between the researcher and the participants during research can motivate participants to offer alternative sources of data, which are likely to corroborate findings and contribute to the development of trustworthiness.

In this research, trustworthiness was established throughout the process. This included developing participant information materials to fully explain the study, developing a co-productive approach, involving a variety of stakeholders, introducing and re-visiting the importance of explicit consent – and the right to withdraw that consent at any stage – and offering participants the opportunity to comment on co-productive findings and consider reviewing their responses.

Confirmability is the qualitative equivalent of maintaining objectivity during quantitative research (Tappen 2011; Mills and Birks 2014). To ensure objectivity during the study, researcher bias was reduced as described above to ensure the results of the study stemmed from the views of the participants, rather than the researcher.

4.18 Impact of self

As an employee of the regulator, the researcher acknowledged her values, beliefs and position in the organisation may have impacted on the research, or on how participants perceived her role as both employee and independent researcher. It was important to acknowledge this from the outset and try to alleviate any imbalance of power. Using "relational ethics" (Danchev and Ross 2014 p.68) the researcher required to maintain a sense of realness between her and participants while remaining alert to potential power dynamics. To do this, the researcher acted as a reflexive practitioner: reflecting continually on the research and locating herself within the research process (Hardwick and Worsley 2011; Attia and Edge 2017). This extended to reviewing the original proposal with the breadth and depth of information gained via the quantitative and co-productive phases then amending the original approach which was to hold both focus groups and interviews.

Regular academic supervision also supported this process. The involvement of stakeholders through the co-productive phase was vital in informing the research design through the qualitative phase and helping to reduce researcher bias. In other words, the involvement of stakeholders ensured the researcher did not design the qualitative phase of the research through a predetermined pathway with questions already prearranged.

4.19 Ethics

Research ethics, or research integrity, is important in upholding high standards in research (Stark 1998; Mauthner et al. 2002; Nichols-Casebolt 2012; Suckow and Yates 2015). Firstly, it was important to consider whether the problem was of such importance that the researcher was justified in exposing individual participants to research which may have been burdensome or carried some risk (Knotterus and Tugwell 2018). Careful consideration was given to the recruitment of those using services as research participants, both to support ethical considerations and to support a reliable and valid study (Emanuel et al. 2008; Iphofen 2011). Access to those using services was carefully planned and considered.

Epistemological arguments can be made for involving those using services in research. It is important for the researcher to understand what difference their involvement makes, if any, to research design and findings. It has been argued that those using services can help to ensure the relevance of research questions for others, and this will support services to develop and offer greater validity to research by improving research design

(Staley and Minogue 2006; Wallcraft and Nettle 2009; Morrow et al. 2010; Cossar and Neil 2015).

Involving those using services in research also has some challenges. Firstly, there may be a power imbalance inherent in the researcher-service user dynamic (Telford and Faulkner 2004). Some researchers may see the involvement of those using services as a loss of control over the research. In this research, it was, therefore, vital that the researcher undertook clear negotiation and agreement about roles and the content of the research from the outset (Faulkner 2009). Even where roles are clear, tensions may emerge as the research progresses. Those using services may also be keen to be involved in a study which could, ultimately, lead to service improvement, so may find research timescales or the outcome of findings frustrating (Ross et al. 2005).

As outlined in the literature review, there is a paucity of literature on stakeholders' perceptions of regulation and, given that the core elements of regulation reportedly include the assurance of safety and high quality, the researcher felt it sufficiently important to expose individuals to the research to gain their valuable insight into the process and practice.

Addressing ethics in this research, therefore, included consideration of areas such as informed consent, anonymity and confidentiality, the principles of beneficence and non-maleficence, the voluntary nature of participation, as well as practical issues such as secure storage of information and consideration of dissemination (Butler 2002; Gregory 2003; Loue and Pike 2007; Miller, Birch and Mauthner 2012; Gillan and Pickerill 2015; Sweifach, Linzer and LaPorte 2015). For example, participant information leaflets offered participants written information at the co-productive and qualitative stages and inclusion of the researcher's contact details on these offered the opportunity for potential participants to ask questions to gain more knowledge of the research or their potential involvement. Seeking informed consent, confirming that participation was voluntary and re-visiting this in the qualitative approaches, supported this approach and demonstrated respect for persons (Suckow and Yates 2015). The researcher followed the principles of beneficence and non-maleficence, ensuring that any potential risks in the research were considered and that participants' involvement was beneficial, both to them and to the research or, at the very least, not harmful.

During the co-productive phase, the first page of the survey for week one included a statement highlighting the contents of the participant information leaflet, to remind participants that their participation was voluntary, that they would not be identifiable through their responses and that responses would only be shared between the researcher and her supervisory team. The statement ended with a clear reminder of Robert Gordon University's data collection and storage procedures, to which data collected would be aligned. Finally, the statement concluded by acknowledging that, by completing the survey, participants were confirming their consent and by thanking them for their participation.

Research ethics provides us with "the norms of conduct that define what is acceptable and unacceptable in how we go about research" (Hardwick and Worsley 2011 p. 29) and Wiles urges "ethical literacy" for all researchers – the ability to be aware of, account for and address ethical dilemmas throughout the research process (Wiles 2013 p.2). Participants could have been subject to response bias and said what they believed the researcher wanted to hear (Ary, Jacobs and Razavieh 2009). The qualitative element of the research was based on participants' subjective views, however, this was also what gave the research its depth of meaning. The research was complemented by clear written and verbal communications to outline its purpose, intent and remit; and informed consent forms which recognised the participants' rights of withdrawal and confidentiality (Appendix 5).

The researcher developed good reflective processes, using supervision effectively and regularly and building in a process of reflexivity (Martyn and Atkinson 2000; Ritchie and Lewis 2003; Silverman 2006; Bulman and Schultz 2013; Knott and Scragg 2013). The social work profession emphasises the importance of reflexivity as an integral part of applying theory to practice because social workers work in an applied profession and reinforces the importance of research to support the principles of beneficence and non-maleficence (Barsky 2010; Engel and Schutt 2013; Resnik 2018).

A research ethics proposal was submitted to the Robert Gordon University's School of Applied Social Sciences Ethics Panel, accompanied by proposed supporting materials including consent forms and information leaflets. Ethics approval was duly received. When the research format changed, this was discussed initially with her tutors and also during the annual appraisal interview with the head of school at Robert Gordon University and approval agreed during this process.

4.20 Chapter summary

This chapter outlined the approach taken to this research study. The researcher designed a mixed methods research study to explore the views of stakeholders about the role of regulation in social care service provision in Scotland.

The explanatory sequential mixed method design was initiated by the analysis of quantitative data. This was secondary data held by the regulator for care services and already in the public domain. Findings arising from the quantitative data informed the development of the co-productive approach. The researcher then integrated the findings from the co-productive approach with those from the quantitative data analysis and the literature review to develop the semi-structured interview schedule. The ethics of the research were considered at every stage and the chapter outlined the clear methods by which research integrity was maintained.

Chapter 5: Quantitative data findings

Introduction

The research questions for the quantitative phase were:

1. How can care services which received at least one ‘Adequate’ in 2013 be described in relation to geographic location, service type or provider type?
2. How can care services which received one ‘Good’ or better in 2017 be described in relation to service type or provider type?
3. How was performance affected over the four years between 2013-2017 by complaints, requirements and non-technical enforcements?
4. How have stakeholders experienced regulation in care services over these 4 years?
5. How has the regulator supported improvement in care services over these 4 years?

The data in this chapter is presented in accordance with the above research questions.

To answer question 1 of the quantitative phase, ‘How can care services which received at least one ‘Adequate’ in 2013 be described in relation to geographic location, service type or provider type?’, the researcher investigated data relating to care services registered with the regulator at 1st April 2013.

5.1 Services with capacity to improve at 1st April 2013

From the total 14,236 registered care services, 1,835 (12.8%) had been evaluated with at least one evaluation of 'Adequate'. The ‘Adequate’ evaluation, at the time of this study, was defined as follows:

“An adequate evaluation means that most aspects of the quality theme/quality statements are met. Aspects which are not met may be subject to recommendations but don’t cause concern. The ‘adequate’ grade applies to performance at a basic but adequate level. This grade represents a standard where the strengths have a positive impact on the experiences of those using services. While weaknesses will not be important enough to have a substantially adverse impact, they are constraining performance. This grade implies the service should address areas of weakness while building on strengths. This is likely to be reflected in recommendations for improvement in respect of relevant National Care Standards”. (Care Inspectorate 2017c) For a full

definition of all evaluations, see Appendix 1). These services had been evaluated with at least one grade of ‘Adequate’. This meant that, of the three or four quality themes evaluated, at least one was ‘Adequate’. The other two or three themes were evaluated either also as ‘Adequate’ or at any of the other grades: ‘Unsatisfactory’, ‘Weak’, ‘Good’, ‘Very good’ or ‘Excellent’. For these services, where the other quality themes were evaluated poorer than ‘Adequate’, inspectors had judged there was a need to improve and the capacity to do so; where the other themes were evaluated better than ‘Adequate’, inspectors had judged there remained room for improvement. None of these 1835 care services had received only grades of ‘Weak’ or ‘Unsatisfactory’. Therefore, for the research, services with at least one evaluation of ‘Adequate’ are referred to as ‘services with the capacity to improve’.

Table 2 represents a list of services by:

- their care service type
- the number of these services with at least one evaluation of ‘Adequate’ at 1st April 2013
- the total numbers of these types of services registered at that time
- the proportion of services evaluated this way as a percentage of that total

Table 2: Services with capacity to improve at 1st April 2013

Care service type	Number of services with at least one 'Adequate' evaluation at 1st April 2013	Total number of service type registered at 1st April 2013	No. of services with 'Adequate' as a % of the total no. of services
Adoption service	4	39	10.3%
Adult placement	4	37	10.8%
Care home	451	1527	29.5%
Alcohol and substance misuse	3	21	14.3%
Children and young people	40	245	16.3%
Learning disabilities	54	226	23.9%
Mental health	14	71	19.7%
Older people	331	906	36.5%
Physical and sensory impairment	6	41	14.6%
Respite care and short breaks	3	16	18.8%
Childcare agency	6	34	17.6%
Child minding	591	6192	9.5%
Day care of children	469	3817	12.3%
Fostering service	6	63	9.5%
Housing support	117	1047	11.2%
Nurse agency	5	42	11.9%
School care accommodation	8	67	11.9%
Secure accommodation	2	5	40%
Support service	172	1352	12.7%
Care at home	122	814	15%
Other than care at home	50	538	9.3%
Total	**1835**	**14236**	**12.8%**

5.1.1 Analysis of care services with capacity to improve

Table 2 demonstrates that, overall, almost 13% of care services registered at that time were evaluated with at least one 'Adequate' evaluation (1,835 of all 14,236 care services registered) and, therefore, had capacity to improve. This meant that most aspects of the quality theme or quality statements had been met. Aspects which had not been met may have been subject to recommendations but were not sufficient to cause concern about

the quality of care provided (for the full definition, see Appendix 1).

Although the table presents 40% of secure accommodation services with at least one 'Adequate', these services are low in number. Care homes – and within this, care homes for older people (n+331) was the largest group overall and received the next highest percentage of evaluations with at least one 'Adequate' evaluation 451/1,527 in total) with 29.5%). Support services (other than care at home) received the lowest percentage of these 'Adequate' evaluations (50 services out of 538 services registered, 9.3%.

In Table 2, by subtracting 1,835 (the services with at least one 'Adequate' evaluation and capacity to improve) from 14,236 (the total number of registered services at the time), there were 12,401 services remaining. These services, therefore, constituted the majority of care services registered at that time (almost 87%) and were evaluated as 'Good' or better across all four quality themes (Figure 18, below).

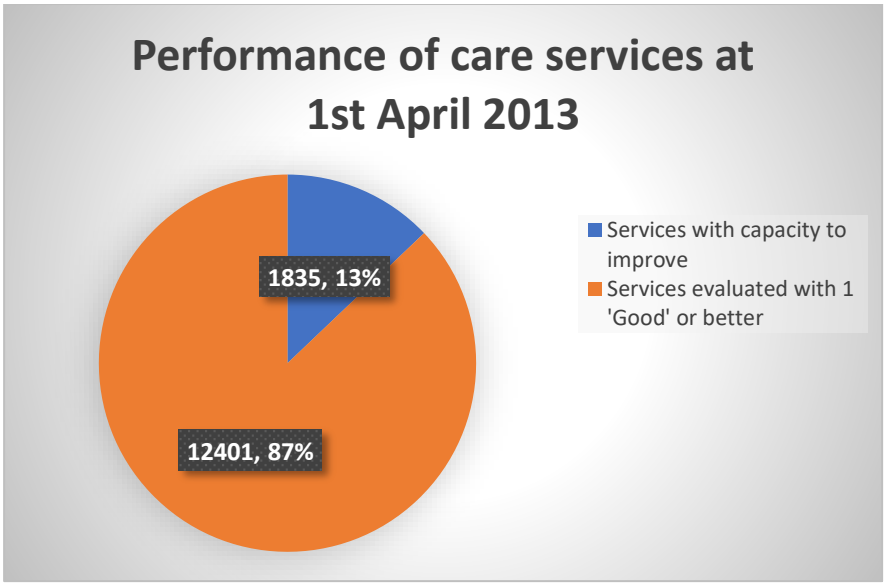

Figure 18: Performance of care services at 1st April 2013 (data from Care Inspectorate)

5.1.2 Care services with capacity to improve – local authority breakdown

Analysing the spread across Scotland of these 1,835 care services shows a variation between local authorities. To explore the geographical spread in more detail, the research focussed on one specific service type - care homes for older people – as this was one of the largest registered care service types by volume.

Figure 19 outlines the data for the 331 care homes for older people evaluated with at

least one ‘Adequate’, per local authority area:

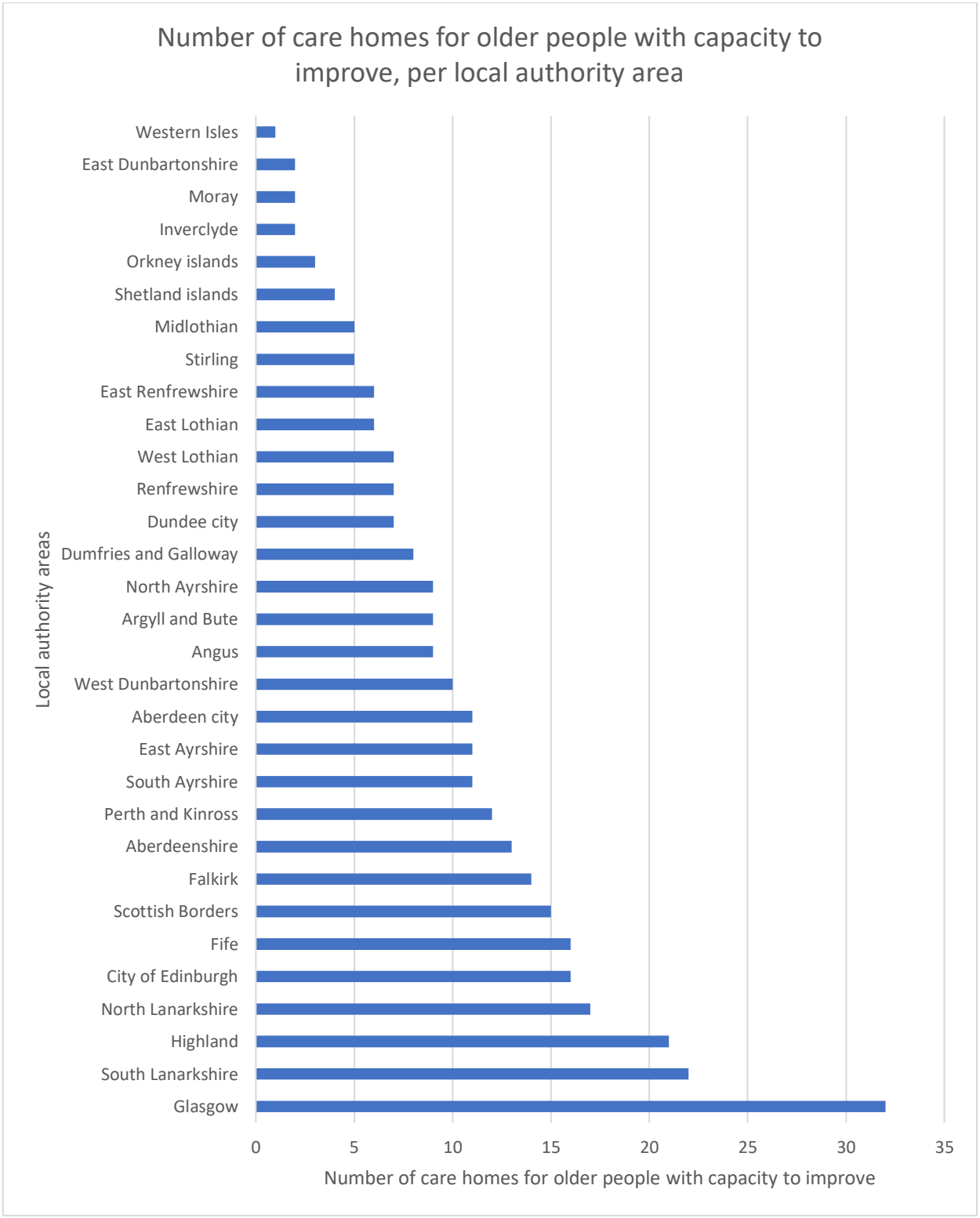

Figure 19: Care homes for older people with capacity to improve at 1st April 2013

Figure 19 demonstrates the number of care homes for older people with capacity to improve in each local authority area, with Glasgow having most of these services and the Western Isles the least. By reviewing these numbers as a percentage of the total number of care homes in each local authority area, Table 3 shows the following:

Table 3: Breakdown by local authority area: the % of services with capacity to improve out of the total number of services registered

Local Authority	Number of services with a grade of at least one Adequate	Total number of services	%
Care Home Service – older people	**315**	**905**	**34.8%**
West Dunbartonshire	10	12	83.3%
Scottish Borders	15	22	68.2%
Clackmannanshire	4	6	66.7%
Falkirk	14	22	63.6%
Orkney	3	5	60.0%
North Lanarkshire	17	34	50.0%
East Ayrshire	11	22	50.0%
East Renfrewshire	6	13	46.2%
South Ayrshire	11	24	45.8%
South Lanarkshire	22	51	43.1%
Midlothian	5	12	41.7%
Argyll & Bute	9	22	40.9%
Shetland Isles	4	10	40.0%
Glasgow City	32	80	40.0%
West Lothian	7	18	38.9%
North Ayrshire	9	25	36.0%
Highland	21	62	33.9%
East Lothian	6	18	33.3%
Aberdeen City	11	33	33.3%
Angus	9	30	30.0%
Renfrewshire	7	24	29.2%
Perth & Kinross	12	44	27.3%
Aberdeenshire	13	50	26.0%
Stirling	5	17	29.4%
Dundee City	7	27	25.9%
Dumfries & Galloway	8	32	25.0%
Fife	16	75	21.3%
City of Edinburgh	14	66	21.2%
East Dunbartonshire	2	10	20.0%
Moray	2	14	14.3%
Inverclyde	2	16	12.5%
Western Isles	1	9	11.1%

In Figure 19, Glasgow had the highest number of care homes for older people with capacity to improve. In Table 3, however, Glasgow did not have the highest percentage

when viewed as a ratio of the care homes in that area. West Dunbartonshire was the local authority area with the highest percentage of care homes for older people with capacity to improve, when viewed as a percentage of care homes in that area. For several of the areas which demonstrated higher percentages, the number of services was relatively small.

5.1.3 Care services with capacity to improve - service provider type

These 1,835 care services which had capacity to improve reflect provision by all service provider types registered with the regulator. Care services can be provided by the local authority, health boards, private sector organisations or voluntary/not-for-profit sector agencies.

Figure 20 shows the spread of service provider types of the 1835 care services with capacity to improve.

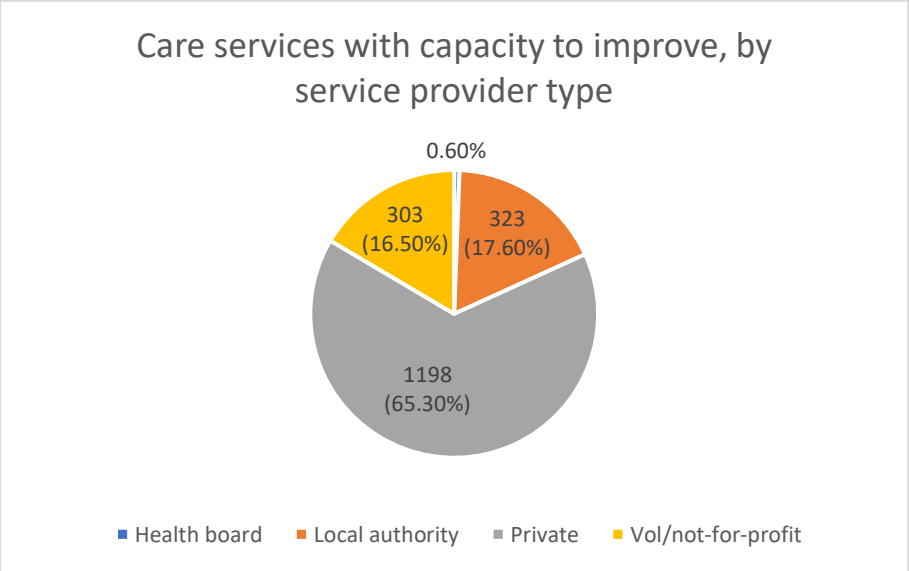

Figure 20: care services with capacity to improve, by service provider type

Figure 20 demonstrates that private sector services were the largest provider type for these 1,835 care services, followed by local authority services, then voluntary or not-for-profit sectors. Services provided by the health board accounted for the lowest number of these services, by service provider type.

5.1.4 Quality themes evaluated for care services with capacity to improve

Quality themes are the aspects of care service performance evaluated during inspection (Chapter 2, section 2.7). Table 4 below demonstrates the quality themes against which

the 1,835 services received the ‘Adequate’ grade:

Table 4: The 1,835 services by quality theme

Quality theme	Number of services	Number of services cited as a % of the total 1835
Quality of staffing	1216	66.3%
Quality of management and leadership	1027	55.9%
Quality of care and support	985	53.7%
Quality of environment	818	44.6%
Total	**1835**	**100%**

Figure 21 demonstrates the percentage of services against these quality themes:

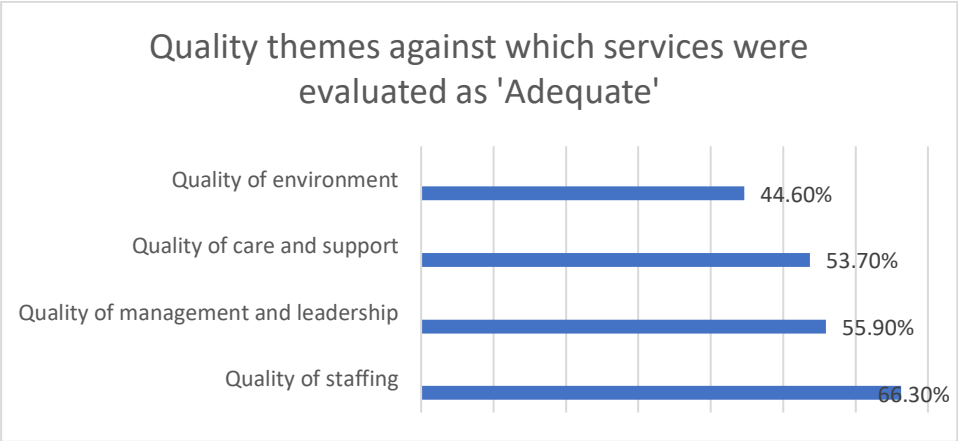

Figure 21: Quality themes against which services were evaluated as ‘Adequate’

This meant that, of the 1,835 services with capacity to improve at 1st April 2013, the area most commonly reported as an area of concern was service staffing (66.3%) and with environment the lowest area of concern at 44.6%. It is important to note that, for services delivered within an individual’s own home, such as certain support services, the quality of the environment is not evaluated. (NB In the above figure, evaluations of ‘Adequate’ will have been awarded to some services across more than one quality theme).

5.1.5 Addressing question 1 of the quantitative phase: ‘How can care services which received at least one ‘Adequate’ in 2013 be described in relation to geographic location, service type or provider type?’

A descriptive analysis of the above data demonstrated that:

- of the care services registered with the regulator at 1st April 2013, the four largest by volume were childminding, day care of children, care homes (specifically care homes for older people) and support services
- almost 13% of care services registered at 1st April 2013 were evaluated with at least one 'Adequate' (services with capacity to improve)
- from this, the highest percentage of care service types which had capacity to improve were care homes and, specifically, care homes for older people
- larger local authorities did not necessarily have the highest percentage of care homes for older people with capacity to improve when viewed as a percentage of those care home types in the area, however, there was variation in the number of care homes in different local authorities
- the private sector constituted the largest provider type for registered services, and this was found in the high number of childminding services, most of whom were private individuals

To answer question 2 of the quantitative phase 'How can care services which received one 'Good' or better in 2017 be described in relation to service type or provider type?', the researcher investigated data relating to care services registered with the regulator at 31st March 2017.

5.2 Care services with one 'Good' or better at 31st March 2017

5.2.1 Services showing improvement

Of the1,835 services with capacity to improve in 2013, 844 (46%) had shown improvement and had at least one grade of 'Good' or better at 31st March 2017 (Table 5).

Table 5: Services with one evaluation of 'Good' or better at 31st March 2017

Care service type	Number of services	% of the 844 improved services
Adoption service	4	0.5%
Adult placement service	4	0.5%
Care homes	205	24.3%
Children and young people	31	3.7%
Learning disabilities	17	2%
Mental health	8	0.9%
Older people	143	16.9%
Physical / sensory impairment	3	0.4%
Respite care and short breaks	3	0.4%
Childcare agency	1	0.1%
Childminding	212	25.1%
Day care of children	252	29.9%
Fostering services	5	0.6%
Housing support	64	7.6%
Nurse agency	1	0.1%
School care accommodation	5	0.6%
Secure accommodation	1	0.1%
Support service	90	10.7%
Care at home	61	7.2%
Other than care at home	29	3.4%
Total	**844**	**100%**

The largest number of individual service types showing improvement were day care of children services, childminding, care homes (specifically, care homes for older people) and support services. These four care service types also represented the largest volume of registered services.

Subtracting 844 from the 1,835 care services, left 991 services. An analysis of data in relation to these 991 services showed that 658 of these (66%) had ceased trading and cancelled their registration between 2013 and 2017. This left 333 of the original 1,835 care services which were still registered but which had not shown improvement between these dates (18%).

This section focusses on the 844 care services which showed improvement.

5.2.2 Registered care services at 31st March 2017

By this date, the total number of registered care services had reduced by 716, from 14,236 to 13,520. The four largest care service types registered, by volume, remained childminding, day care of children, support services and care homes. With reference to data at 1st April 2013 (Table 2), these four largest registered care service types by volume had changed substantially (Table 6):

Table 6: Changes in the four largest care service types by volume

Care service type	Number of services registered at 31st March 2013	Number of services registered at 31st March 2017	Difference in number of services	Difference as a %
Care homes	1527	1428	Decrease of 99	- 6.5%
Childminding	6192	5556	Decrease of 636	-10.3%
Day care of children	3817	3726	Decrease of 91	-2.4%
Support services	1352	1457	Increase of 105	+7.8%

Table 6 shows that the greatest change was a 10.3% decrease in the number of registered childminders at 31st March 2017.

5.2.3 Improved services by provider type

The 844 services which had demonstrated improvement were analysed by service provider type (Figure 22):

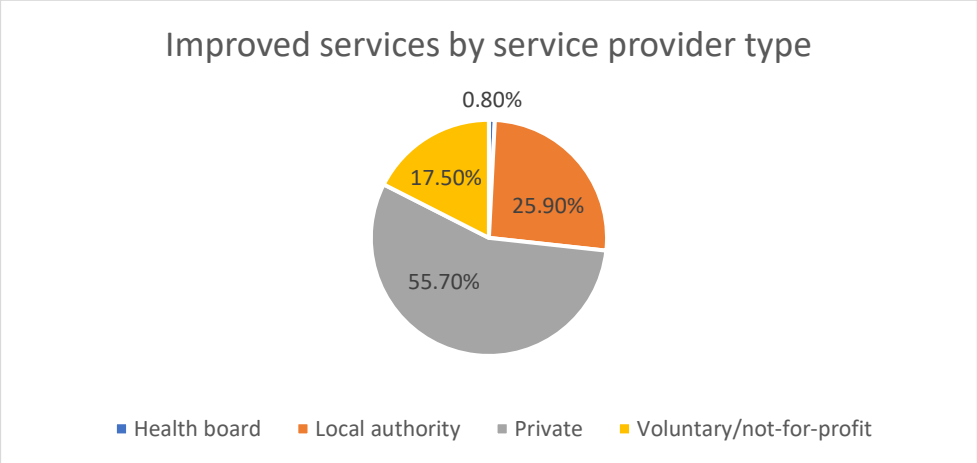

Figure 22: Improved services by service provider type

Of those services which had shown improvement in the intervening period, the largest sector which showed improvement was that of private sector services, with the smallest sector being services provided by health boards.

5.2.4 Addressing question 2 of the quantitative phase: 'How can care services which received one 'Good' or better in 2017 be described in relation to service type or provider type?'.

A descriptive analysis of the data demonstrated that:

- 46% of care services which had capacity to improve in 2013, had improved to receive one 'Good' or better in 2017
- The largest percentage of care services demonstrating this improvement were day care of children services, childminding, care homes (specifically, care homes for older people) and support services
- There had also been a change in the volume of these four care service types registered with the regulator. The largest change by volume had been a 10.3% reduction in the number of childminders registered in 2017 and an increase of 7.8% in the number of support services registered in 2017
- The private sector remained the provider type with the largest number of registered services

5.3 Changes in performance 2013-2017

To answer question 3 of the quantitative phase 'How was performance affected over the four years between 2013-2017 by complaints, requirements and non-technical enforcements?', the researcher investigated data relating to complaints received, requirements made during inspections and non-technical enforcement action taken over the four year period 2013-2017.

5.3.1 Complaints data

Table 7 shows the numbers of complaints upheld, or partially upheld, for the 844 care services which showed improvement, 2013-2017:

Table 7: Complaints data for the 844 improved services

Care service type	Complaints 2013-2014	Complaints 2014-2015	Complaints 2015-2016	Complaints 2016-2017
Adoption service	0	0	0	0
Adult placement	0	0	0	0
Care homes	58	63	56	40
Children and young people	1	1	0	0
Learning disabilities	1	3	2	0
Mental health	1	1	0	0
Older people	52	58	54	39
Physical / sensory impairment	2	0	0	1
Respite care/ short breaks	1	0	0	0
Childcare agency	0	0	0	0
Childminding	4	2	2	0
Day care of children	18	18	9	18
Fostering	0	1	1	0
Housing support	5	5	2	6
Nurse agency	0	0	0	0
School care accommodation	2	1	2	0
Secure accommodation	0	1	0	0
Support services	12	16	8	7
Care at home	10	15	8	0
Other than care at home	2	1	0	0
Total	**99**	**107**	**80**	**71**

Of the 844 care services which showed improvement from 2013-2017, the aggregated number of complaints upheld, or partially upheld, increased between 2013-2014 and 2014-2015 then decreased subsequently. For some services, the number of complaints increased, most notably day care of children – which saw a 50% decrease followed by a 50% increase and an increase for complaints in housing support services, which had tripled between 2015-2016 to 2016-2017, albeit a low number. In care homes for older people, where data showed one of the highest proportions of services with capacity to improve, complaints had been falling steadily from 2014-2015 (58) to 2016-2017 (39). All care homes also saw a decrease in the volume of complaints over that period.

5.3.2 Requirements data

Some care services are subject to requirements following inspection (see section 2.9.3).

Table 8: Requirements for the 844 improved services

Care service type	Requirements 2013-14	Requirements 2014-15	Requirements 2015-16	Requirements 2016-17
Adoption	1	1	0	0
Adult placement	1	2	0	0
Care homes	149	118	70	28
Children young people	12	10	5	0
Learning disabilities	12	9	3	1
Mental health	6	1	2	0
Older people	115	95	59	26
Physical / sensory impairment	1	0	0	0
Respite care/ short breaks	3	3	1	1
Childcare agency	0	0	0	0
Childminding	46	21	7	1
Day care of children	99	58	27	3
Fostering	3	0	0	2
Housing support	32	25	17	7
Nurse agency	0	0	0	0
School care accommodation	4	2	1	0
Secure accommodation	1	1	0	0
Support service	19	10	6	2
Care at home	8	4	4	2
Other than care/ home	11	6	2	0
Total	**355**	**238**	**128**	**43**

From Table 8, aggregated data shows a sharp reduction in the overall number of requirements against the 844 care services between 1st April 2013 and 31st March 2017, from 355 to 43. The exception over that period was fostering services, which, although overall had decreased from 3 to 2, had received no requirements in the intervening 2 years. All care homes showed a decrease in requirements over that period, similarly childminding, day care of children and support services (the largest care service types by volume).

5.3.3 Non-technical enforcement (NTE) data

The regulator has the authority to implement both ‘technical’ and ‘non-technical’ enforcements in care services. ‘Technical’ enforcements relate to procedural matters, for example, if services have been inactive over a long period of time or have not been available or contactable for inspection. ‘Non-technical’ enforcements relate to concerns about the quality of care provision. As this research relates to the experiences of those using services and other stakeholders, the focus of the analysis was on non-technical enforcements applied when there were concerns about care quality (Table 9).

Table 9: Non-technical enforcements in the 844 improved services

Care service type	NTEs 2013-14	NTEs 2014-15	NTEs 2015-16	NTEs 2016-17
Adoption service	0	0	0	0
Adult placement service	0	0	0	0
Care homes	0	5	1	0
Children and young people	0	0	0	0
Learning disabilities	0	0	0	0
Mental health	0	0	0	0
Older people	0	5	1	0
Physical and sensory impairment	0	0	0	0
Respite care and short breaks	0	0	0	0
Childcare agency	0	0	0	0
Childminding	1	9	12	2
Day care of children	3	0	1	0
Fostering service	0	0	0	0
Housing support service	0	0	0	0
Nurse agency	0	0	0	0
School care accommodation	0	0	0	0
Secure accommodation	0	0	0	0
Support service	0	0	0	0
Care at home	0	0	0	0
Other than care at home	0	0	0	0
Total	**4**	**14**	**14**	**2**

Table 9 demonstrates the low number of non-technical enforcements undertaken by the regulator. There was an increase in the total number of NTEs undertaken in the 844 improved services between 2013-15 then a large decrease in these since 2015 (14 to 2).

5.3.4 Additional factors

It was important to recognise that the above data were those recorded by the regulator and those which related directly to an intervention on its behalf. There were, however, additional factors which may have occurred in both the improved and non-improved services, which could, themselves, have had an impact on the quality of service provision and, potentially, have contributed to improvement or lack of improvement in evaluations. These could have included changes in:

- Management or staffing of the service
- Resources or funding
- The service's organisational approaches
- Training input
- Organisational / service policies or practice
- The numbers of those using the service
- The complexity of the needs of those using the service
- External factors impacting on the service

Each of the above would have had some degree of impact on a service, however, the degree to which each led to improvement, no change or a decrease in the quality of service provision was not evaluated directly by the regulator. These factors, therefore, were not investigated in this research study.

5.3.5 Addressing question 3 of the quantitative phase: 'How was performance affected over the four years between 2013-2017 by complaints, requirements and non-technical enforcements?'

A descriptive analysis of the data demonstrated:

- Despite an initial increase, the numbers of complaints upheld against the 844 improved services had steadily reduced between 2013-2017
- There had been a sharp reduction in the overall number of requirements made in the 844 improved care services 2013-2017
- There had been a large reduction in non-technical enforcements in these care services between 2013-2017

5.4 Inspection satisfaction questionnaires (ISQs)

To answer question 4 of the quantitative phase, 'How have stakeholders experienced regulation in care services over these 4 years?', the researcher investigated the data relating to inspection satisfaction questionnaires 2013-2017.

Inspection satisfaction questionnaires (ISQs) are issued by the regulator following a process of proportionate sampling. These are not mandatory, however, are used to give feedback to both the inspector and the regulator on the conduct of the inspector, the process followed and whether the individual completing the questionnaire believes that improvements will be made – or that the already high standards will be maintained – as a result of the inspection.

Many inspectors invite inspection volunteers to be part of an inspection (see Chapter 2). If an inspection volunteer was involved in the inspection, there are also opportunities in the ISQs for the individual responding to comment on their involvement. There are two types of ISQs: questionnaires for those using services, relatives or visitors and questionnaires for staff and managers. Both are suitable for all care service types.

5.4.1 Sampling

Inspection Satisfaction Questionnaires (ISQs) are not completed for all care services. Only certain inspections are included in the sample for ISQs. The regulator's Intelligence Team creates a sample based on services for which an inspection is planned during that inspection year. In order that a proportionate spread of services is included, the sample is proportionate to service types, whereby some smaller service types (for example adoption services, nurse agencies, school accommodation services) have a proportionately larger sample and the sample for services larger in volume (for example, childminders) is slightly reduced. Additionally, the sample is also broadly representative across inspection teams. Should a service be cancelled during the year, an alternative selection is made at random.

5.4.2 Process

Questionnaires to staff and managers

Following completion of an inspection and the issue of a draft inspection report, the regulator's business support staff send a proportionate number of ISQs to the service for the attention of staff and managers, requesting that those who were involved in the inspection complete these. On average, six ISQs, with stamped addressed return

envelopes, are sent to each service. In the case of childminders, who, in the main, are self-employed individuals, only one is issued, unless the childminder employs staff.

Questionnaires to those using services, family members or visitors

On the day of inspection, the inspector takes ISQs, with stamped addressed return envelopes, to distribute to individuals with whom he/she speaks during the inspection. These include individuals using the service, relatives or visitors to the service that day.

5.4.3 Support to complete ISQs

Alternative formats for completion are available as required, for example, Braille, large print or languages other than English. Inspectors use their professional judgement when considering issuing a questionnaire to a child or vulnerable adult. If anyone needs assistance in completing the questionnaire, they may request help from staff within the service or relatives/carers etc.

5.4.4 Data from ISQs

ISQs are issued on a random and proportionate basis, therefore, the services targeted annually may be different. Accordingly, because of the magnitude and manual nature of the task, analysing returned ISQs against the 844 improved care services, or against the 333 care services which did not improve, was not possible. However, an analysis was undertaken on data over the four-year period of this research, but on aggregated information from annual returned ISQs.

5.4.5 Number of returned ISQs 2013-2017

The following table outlines the numbers of both types of ISQs returned over the period 2013-2017:

Table 10: Numbers of ISQs returned 2013-2017

	2013-14	2014-15	2015-16	2016-17	Total: 2013-17
ISQs for those using the service, relatives and visitors	488	452	489	533	1962
ISQs for staff and managers	934	1278	1359	1232	4803

Total: 6765

Over this time period, 1,962 ISQs were returned by those using services, relatives or visitors (just under one third) and 4,803 ISQs were returned by staff or managers in services (almost two thirds). In total, 6,765 individuals commented on their experiences of care service inspections.

In the ISQs, there is a brief selection of statements against which individuals are asked to 'agree', 'strongly agree', 'disagree', 'strongly disagree' or say if they 'don't know'. There is also a section for narrative comments. The statements are the same for both types of ISQs, with three additional statements for staff or managers. To review any changes in responses over time, the researcher undertook a descriptive analysis of responses to statements only. Given the volume and the free nature of the narrative comments, these were not analysed.

The tables outlining responses to ISQs can be found in Appendix 6.

Analysis of the percentages (Hanna 2016) for positive responses (agree/strongly agree) to the ISQ statements demonstrated the following:

Table 11: Percentages of positive responses per statement (ISQs for those using services) 2013-2017

Statement	% of positive responses to 1962 ISQs 2013-2017
1 Inspector suitably involved me in the inspection	1913 (97.5%)
2 Inspector appeared to be well prepared	1939 (98.8%)
3 Inspector tried not to disrupt the normal running of the service	1913 (97.5%)
4 Inspector was polite and treated me with respect	1948 (99.3%)
5 Inspector had the right level of contact with people using the service	1448 (73.8%)
6 I am satisfied with how the inspection was carried out	1939 (98.8%)
7 I believe service quality will improve as a result of the inspection	1795 (91.5%)
Average % of positive responses to ISQs across all statements	**1842 (93.9%)**

In the main, positive responses were consistently high. There were two statements which demonstrated more variation in positive responses than the others. These were:

statement 5 ‘the inspector had the right level of contact with people using the service’, and statement 7 ‘I believe service quality will improve as a result of the inspection’.
In descriptively analysing responses to these two statements further, most of the responses to statement 5 in every year was ‘don’t know’: for instance, in 2013-2014, of the 33% who disagreed, or disagreed strongly with the statement, the majority (28%) said they did not know if the inspector had the right level of contact or not. Similarly, for statement 7, those respondents who disagreed, or strongly disagreed with the statement, felt that the quality of the service was already so high that it could not improve further.
Overall, those using services, relatives or visitors gave very positive responses to the ISQ statements, with the average % for all positive statements at 93.9%.

Responses from staff and managers were also very positive. Only one statement showed variation for staff and managers: statement 6: the amount of contact which the inspector had with people who use services during inspection.

Table 12 demonstrates the average percentage of statements calculated over the four-year period:

Table 12: Average % for each statement (ISQs for staff and managers) 2013-2017

Statement	% of positive responses to 4803 ISQs 2013-2017
1 Inspector suitably involved me in the inspection	4649 (96.8%)
2 Inspector gave clear feedback on inspection findings	4601 (95.8%)
3 Inspector appeared to be well prepared	4707 (98%)
4 Inspector tried not to disrupt the normal running of the service	4707 (98%)
5 Inspector was polite and treated me with respect	4731 (98.5%)
6 Inspector had the right level of contact with people using the service	4299 (89.5%)
7 The draft report was clearly written	4745 (98.8%)
8 The reasons for recommendations and requirements are clear	4659 (97%)
9 I am satisfied with how the inspection was carried out	4649 (96.8%)
10 I believe service quality will improve as a result of inspection	4587 (95.5%)
Average % of all statements	**4635 (96.5%)**

Overall, staff and managers gave very positive responses to the statements in the ISQs over the course of the four-year period, with the average percentage for all positive statements at 96.5%.

In summary, most ISQ respondents were very positive about their experience of an inspection in their care service.

5.4.6 Addressing question 4 of the quantitative phase: 'How have stakeholders experienced regulation in care services over these 4 years?'

A descriptive analysis of the data demonstrated:

- Of the 6765 ISQs returned 2013-2017, just under one third were completed by those using services, relatives and visitors to the service; and just over two thirds were completed by staff and managers
- Over the four year period, the mean percentage of positive responses from those using services, relatives and visitors was 93.9%
- Over the four year period, the mean percentage of positive responses from staff and managers was 96.5%

5.5 The regulator's improvement work

To answer question 5 of the quantitative phase, 'How has the regulator supported improvement in care services over these 4 years?', the researcher investigated data in relation to improvement work undertaken by the regulator over the period 2013-2017.

5.5.1 Improvement work

Section 44 (1) b of the Public Services Reform (Scotland) Act 2010 places a duty on the regulator to further "improvement in the quality of social services" (Public Services Reform (Scotland) Act 2010). In the 2015-2016 inspection year, the regulator started to specifically record its improvement work and define exactly what this consisted of. Inspectors were asked to undertake a diary exercise for a specified period. The report 'Monitoring our performance 2016-17: Quarter 1 report' (Care Inspectorate 2017b) noted the following:

"In 923 inspections carried out during quarter 1, inspectors recorded time spent on improvement work: A total of 1,304 hours was spent on improvement work during these

923 inspections (for an average of 1.4 hours per inspection activity). This was in addition to the average time spent of 27.4 hours per inspection in 2016/17. In that year, 28% of inspections where improvement work was carried out were in childminding services, 31% were inspections in day care of children's services, 21% were in care homes and 17% were in care at home and housing support services" (Care Inspectorate 2017b).

Recorded 'improvement activities' included:

- improving care plans so that meaningful activity was recorded
- developing improvement action plans in the service
- advising on infection prevention
- advice on revalidation for nurses working in the service
- guidance around notifications and legislative requirements
- signposting to best practice

(Care Inspectorate 2017b p. 2)

5.5.2 Changes in inspection methodology

From April 2016, the regulator introduced a new inspection methodology which was intended to be proportionate, targeted and outcome based. New public-facing outcome-focussed reports were developed with the intent of better informing the public about services and these focussed on the difference the service made to those using the service.

A new complaints format was also developed, with one report informing both the individual making the complaint and the service against which the complaint was levelled, clearer information on the outcome of the complaint: why it was, or was not, upheld, in whole or in part. This system reportedly enabled evidence of decision-making to be more transparent (Care Inspectorate 2017b).

5.5.3 Improvement strategy and team

In 2017, the regulator published an improvement strategy, further defining the direction and focus of its approach to supporting improvement in care (Care Inspectorate 2017a). This was supported by an improvement support team comprising individuals with subject matter expertise in a wide range of health and wellbeing areas.

5.5.4 Addressing question 5 of the quantitative phase: 'How has the regulator supported improvement in care services over these 4 years?'

A descriptive analysis of the data demonstrated:

- the recording of improvement work by the regulator began in the 2015-16 year
- inspectors spent an average of 1.4 hours per inspection specifically on improvement activity in addition to the average of 27.4 hours per inspection
- the four services in which the largest percentage of improvement work was undertaken were childminding, day care of children services, care homes and care at home/housing support services
- from 2015, the regulator developed new inspection methodology, new public facing inspection reports, a new complaints format and a new improvement strategy and team

5.6 Summary of key findings from the quantitative data

A descriptive analysis of the quantitative data relating to the five research questions for this phase was undertaken and the following themes resulted:

Theme	**For further exploration**
Performance of care services	The majority of care services registered with the regulator in Scotland perform well. Explore the views of stakeholders in several local authority areas and across different care service types.
Care service types with most improvement	Improvement was demonstrated both in evaluations and in reductions of complaints, requirements and enforcements in services. Explore the views of stakeholders within care homes, childminding, day care of children services and support services and across different provider types.
Stakeholder experiences	Stakeholders consistently reported positive experiences via inspection satisfaction questionnaires. Explore the views of other stakeholders.
The regulator's improvement activity	The regulator reports a high degree of improvement activity in addition to inspection activity, as well as the development of new procedures and processes to support improvement. Explore stakeholder views of improvement and inspection.

The above themes were integrated into the themes arising from the literature review and developed into questions and statements for the co-productive phase (see Appendix 3).

5.7 Chapter summary

This chapter has provided a descriptive analysis of the quantitative data and has addressed the five research questions as outlined at the beginning of the chapter and relevant to the quantitative phase. In addressing these questions, research objective one was fully achieved. Some data was descriptively analysed which supported further exploration in the qualitative phases.

Chapter 6: Co-productive phase findings

Introduction

This chapter outlines the findings from the co-productive phase.

Participants in the co-productive phase included:

CP 1 - 10	Senior inspector (children and young people's services)
	Team manager (early years services)
	Inspector (children and young people's services
	Improvement advisor
	Team manager (adults' services)
	Three adult inspection volunteers
	Two young inspection volunteers

Quotes have been included in the participants' own words as per their written submissions during the co-productive phase. The researcher has not changed any spelling or points of grammar.

6.1 Process

Using the findings from a review of the literature and the themes arising from a descriptive analysis of the quantitative data, the researcher identified four key areas on which she sought the views of participants in the co-productive phase. Using principles from a traditional Delphi study, the researcher pursued one theme on each of the four weeks of the co-productive phase because there was such a breadth of themes arising from both the literature and the quantitative data on which she wanted to seek the views of the experts (Okoli and Pawlowski 2004; Iqbal and Pipon-Young 2009; Keeney 2011).

Themes were explored as follows:

- Week one: the identified purposes of regulation and consideration of issues which may act as a barrier to those purposes being achieved
- Week two: critiques of processes and perceptions of regulation
- Week three: the benefits and disadvantages of the identified models of regulation
- Week four: the views of regulation by stakeholders

To allow participants an opportunity to use feedback from others to reflect on and, potentially, revise their responses, the researcher issued a summary of all responses to participants the week following the closure of the survey. After a further month, the researcher contacted participants with a view to ascertaining whether this period of consideration had allowed them to reflect on others' responses and, perhaps, review their own contributions. This was achieved by issuing a brief final survey to ascertain what views, if any, had changed. This controlled feedback supported the iterative learning process and was intended to support participants' reflection (Von Der Gracht 2008).

The co-productive phase was undertaken from 21st January to 15th February 2019. The follow up survey ran from 18th to 22nd March 2019. Participants' responses to the follow up survey are discussed in section 6.5.

6.2 Findings

Several key themes emerged which will be discussed in further detail:

Themes arising	Sub themes
Purposes of regulation	Educative/developmental Protection Assurance Accountability Value for money
Critiques of regulation	Inconsistency in regulatory processes Anxiety Defensiveness Lack of understanding
Models of regulation	Compliance-based Responsive Self-regulation/voluntarism Anticipatory
Confidence in regulation	Inspectors' visibility/professionalism External oversight of care Tangible improvements Negative impact of poor regulation Inspection as a 'snapshot' Interpretation of findings
Inspection or improvement?	Difference Targeting improvement

6.2.1 Regulation as protection, assurance and accountability

Participants were asked to consider the purposes of regulation highlighted in the literature (Boyne, Day and Walker 2002; Tuijn 2011; Alsop 2013; Ehren 2016; Leistikow 2018). These were assurance and accountability, public safety and protection, value for money, compliance, identifying and learning from failures, regulating risk and supporting change and improvement.

Protection, assurance and accountability were the purposes most favoured by participants, although several said they agreed with all the purposes outlined.

"All the aspects of regulation above are totally relevant and obviously have subsets which involve more specific aspects of maintaining the care experience. Ideally a positive life experience of the care end user should be stressed as being the imperative of all regulatory literature. Thus 'accountability' would be my first choice as most important" (CP5).

The role of regulation as developmental or educative, as well as promoting a focus on human rights, was also felt to be important. One participant recognised the purposes may be viewed differently, depending on perspective:

"I would imagine that views about the core purpose of regulation would differ depending on the perspective of the stakeholder - as a 'service provider' I see it sometimes as being about surveillance and monitoring although from a 'regulator' perspective I would see it as maintaining accountability and maintaining standards. As a service user, I see regulation as protective and ensuring quality" (CP8*).*

Participants stated that the legislative framework and associated powers for regulators, combined with registration, inspection, complaints and enforcement activities, supported the identified purposes of regulation. Working alongside people and building positive relationships was also believed to achieve these aims.

Participants stated that the purposes of regulation were not achieved when those being regulated displayed fearful or defensive attitudes to regulation or misunderstood regulation. One participant commented:

"I think attitudes towards regulation get in the way of people perceiving the noblest aspects of regulation. Managers can genuflect towards a no blame culture but, in fact, because of their views about regulation and targets, not adhere to this. Defensiveness and fearfulness do not make for easy working relationships or openness" (CP1*).*

Some participants highlighted issues with the regulatory process which they believed restricted regulation, including jargon, over-use of a compliance model, vexatious complaints and a perception, on the part of service providers and services, that the funding of services was linked to inspection grades.

6.2.2 Value for money

This was the most controversial of the purposes cited. Some participants stated they did not believe that regulation could - or should - determine value for money and did not believe this could be the purpose of regulation, in a social care context. They viewed this as either a role for others, for example, service commissioners or bodies such as Audit Scotland. As regulators, they did not feel themselves qualified to evaluate whether a service was, or was not, achieving value for money. Comments included:

"Many local authorities services have a duty to provide and they have to do this without consideration to value for money... Again, if it's a private provider it is not our call today whether they are offering value for money" (CP2).

"In my own experience I cannot say that charging an elderly person with advanced dementia well over £1,000 per week for care, represents value for money" (CP6*).*

"Demonstrating value for money is an area I would question in relation to regulating care services. I am aware of the need for accountability and sustainability however, the inspection guidance does not lead me to explore how well managers and leaders perform in this area" (CP1).

Participants expressed a view which reflected that competence in one aspect of regulation was no guarantee of translation into another type of regulation and saw this as a micro political process (Power 2000; Alwardat, Benamraoui, Rieple 2015).

6.2.3 The inconsistency of regulatory processes

Participants were asked to consider some critiques of regulation in which regulatory processes were felt to be inconsistent (Clark and Newman 1997; Ashworth, Boyne and Walker 2002; Tankebe 2009; Black 2014; Palsson 2018). One participant agreed there could be inconsistency, however, stated:

"There will always be a degree of inherent inconsistency in regulation. The regulator cannot be in all services 100% of time and so needs to target and focus inspection activity. This means that service A may get closer inspection than service B in some regards. The process may be inconsistent, but the expectations are not, i.e. expectations of services A and B are same but for this inspection (for clear reasons) we are looking more deeply at service A" (CP2).

While another argued *"If the regulation process is followed correctly that should make regulation consistent so I disagree"* (CP8*).*

Another stated *"whilst striving for consistent practice, there needs to be recognition that consistency does not mean uniformity. Uniformity stifles creativity and innovation"* (CP5*).*

Although there were mixed views, all participants stated they recognised these critiques, however, these were not necessarily negative: inconsistency in the process was felt to be acceptable and not the same as uniformity, provided that there was no inconsistency when it came to expectations or standards to be met. Participants did accept that the interpretation of legislative frameworks could be subjective and, therefore, inconsistently applied.

6.2.4 Mimicking of practice

One critique that regulation supports the mimicking of practice was put to participants. Ehren (2016), in discussing regulation in schools, concluded that it legitimises practice in schools deemed to be better performing and it is this which encourages other schools to mimic this practice. She gives the examples of the publication of performance league tables, benchmarking or publicising good practice which lead schools to mimic other schools, replicating elements of what works elsewhere without analysing the impact on their own school. When this was put to participants, one participant stated that "*Services cannot mimic as the scrutiny of their processes would pick this up"* (CP10).

Others, however, recognised this view but felt it was a positive critique:

"When considering raising standards, best practice should be shared. Maybe this is mimicking practice but if by doing so people who use services get to experience good or better outcomes, that's a result" (CP9).

"If services 'mimic' 'best practice' then that would be a positive interpretation of the processes" (CP4).

"I would argue that regulation now has a significant improvement agenda which supports the sharing of innovation and best practice. I do not see this as 'mimicking', more an 'embracing' of continuous improvement" (CP6).

Participants, therefore, echoed the negative points made about regulation encouraging the mimicking of practice (Ehren 2016) and positive points that mimicking can engender new norms for excellent practice which become internalised and change behaviour for the better (Sauder and Espeland 2009).

6.2.5 Regulation as anxiety-provoking

Participants stated that fear or anxiety was the response with which they most identified and had experienced this from services. Participants acknowledged that regulation could be anxiety-provoking, however, also suggested that building positive professional relationships was integral to overcoming these perceptions and that, for the regulator, a move to focussing on outcomes for people was a journey. Participants also

acknowledged that the personal approach of the inspector was key in developing relationships.

"Without doubt, regulation and scrutiny cause anxiety, particularly where there have been failures which have led to increased need for scrutiny. In my experience those anxieties can be well managed through open and improvement focused conversations and regulatory practice between the inspector and those she works with" (CP4).

"I do agree regulation can create anxiety - that is human nature, no one likes being judged" (CP9).

Some participants highlighted that the regulator's approach had developed over time so, while many of the critiques may have been true in the past, they felt they were less true now. One participant summed this up as follows:

"Even the best performing services get anxious at the thought of being regulated as they are striving to provide the best possible care and know the outcome of any regulatory activity can impact on them, whether that be positive or negative. That said, despite the anxiety, many who are regulated welcome regulation and see it as an opportunity to get recognition for the good work they do. Regulation of care services has progressed over the years and now is much more of a partnership approach rather than services feeling as though regulation was being 'done' to them" (CP3).

Although participants recognised that regulation could provoke anxiety, they felt this would be lessened if the approach of regulation was better understood and the focus was on people's outcomes or experiences. There was a strong sense, however, that the application of regulation still had some deficiencies.

6.2.6 Models of regulation

Participants were asked to consider models of regulation (Healy and Braithwaite 2006 and 2011; Baldwin and Black 2008; Cayton and Webb 2014; Connolly 2017; Singh and Singh 2018). These included compliance-based, responsive, smart regulation, self-regulation / voluntarism and anticipatory models of regulation.

While participants saw a value in each model, most responses favoured compliance-based processes. Comments included:

"(a compliance approach) can be clear, everyone knowing the standards and consequences of not applying" (CP8).

"a benefit (of compliance models) is everyone is working to the same standards therefore grades can be compared" (CP7).

"A 'one size fits all' structure may assist compliance on an equal basis across all areas" (CP4).

"Compliance based regulation can be of benefit as it enables consistency and transparency about what the regulator is scrutinising and on what basis. This model ensures that minimum standards are achieved and provides a clear evidence base for enforcement action to be taken" (CP2).

It was felt that a compliance-based model sets clear standards to be achieved and gives an ability to benchmark services. The language used by participants focussed on protection for people who use services, more so than simply compliance to standards.

Responsive models were recognised for their ability to ensure regulation remains targeted, to enable more creative approaches to service delivery and to ensure developments could be more service led:

"Responsive regulation benefits include the ability for a more targeted approach by the regulator, more time can be spent focussing on areas which require more improvement and will further enable the service to demonstrate strengths. This model enables the regulator to be more focussed on capacity for improvement in relation to making requirements or recommendations which in turn can enable more opportunity for creativity in developments" (CP3).

Participants felt that a move to self-regulation / voluntarism was either impractical or could not be achieved without some complementary degree of external regulation:

"although perhaps fine in principle, (this approach) would be very much local management dependent. Although the theory here would lend itself to tailored interpretation of regulations and standards, with potential benefits for the care end users,

a strong and durable management structure would be required to ensure the service maintained a high level of performance" (CP5).

One participant commented on the ability for this model, however, to create a reduction in public spending, thereby establishing its purpose and intent. The National Audit Office recorded the annual expenditure of all 90 regulators operating in the UK at £4 billion, with £980 million of this allocated to regulators in the health and social care field (National Audit Office 2017b). Given the high cost involved and the decreasing public purse (Butler, Campbell and Siddique 2019), any future discussion about regulation must take the impact of cost into account.

All participants recognised disadvantages in each model. It was felt that compliance-based models could stifle innovation, be over-prescriptive, encourage a focus on minimum standards and restrict responses to legislative or policy change. Responsive models were felt to value subjectivity over objectivity, were perhaps not robust enough and could encourage different models and associated standards for different services. Self-regulation was felt to need robust external oversight and an independent overview, acknowledging that services may have their own vested interests in this. Some participants also commented that this model would rely on strong, consistent management and leadership to succeed.

The majority of participants placed a weighting on the compliance end of the regulatory spectrum, however, stressed the need for this to be applied in such a way as to maintain the best interest of those using services at its heart.

6.2.6.1 Participants' own models of regulation

Participants, when asked to design the key components of their own regulatory model, cited the following: clear standards; trained regulators; independent advice; clear reporting; relationship building; benchmarking; seeking people's views; making observations; and sharing learning and good practice.

One participant set out a 4-stage process:

1. *"Regulatory framework to check practice and procedures.*
2. *Intelligence gathering from staff, service users and families.*
3. *Observations of how care is delivered.*
4. *Discussion regarding improvements and sharing of good practice"* (CP5).

All these aspects are currently part of the methodology of regulation as applied by the regulator in Scotland, suggesting participants' general acceptance of the efficacy of this model. Participants did recognise the need for a whole systems approach to regulating a service, for example, stating that an inspection should involve the evaluation of health, safety, people management, staffing, service user outcomes, medication procedures etc. Some participants also highlighted the importance of regulation in adapting to changes in legislation, societal and community needs. No participants cited an assessment of value for money as part of this approach.

6.2.7 Perspectives of regulation

Participants were asked to consider responses to Inspection Satisfaction Questionnaires (ISQs) completed by those using services, relatives or visitors 2013-2017. These gave overwhelmingly positive responses to statements made about their perceptions of the process of inspection, the inspector's approach or the impact they believe the inspection had on the service either improving, or maintaining its already high, quality.

Most participants felt this confidence in inspection was attributable to the visibility and professionalism of inspectors. Some participants said that the existence of an independent regulator engendered this confidence as it offered external oversight of the quality of care. Participants also commented that those using services may well have seen improvements in care which they attributed to the inspection.

"In my opinion it is the fact that there is a body who will help to improve or maintain the standard of service that their family member or friend is experiencing. An inspection process can almost be viewed as a safety net and that gives reassurance to all involved" (CP9).

There were several comments made about perceptions: that those receiving care services, and their families, wanted to believe in inspection because they perhaps saw from other sectors the negative consequences of no, or poor, regulation and because they wanted to see the best care for their loved ones and believed that inspection contributed to, drove or assured the quality of this.

"This reflects more on the people completing the ISQ than it does on the inspection process. People want to believe inspection will help because they instinctively know from other sectors and news headlines the consequences of lack of regulation, where lack of

oversight causes problems" (CP3).

Participants were asked to consider findings from the literature review which suggested that not all writers displayed confidence in the inspection process to achieve its aims. Most participants commented on the differences between what individuals receiving care services and individual writers were looking for through regulation.

"Are writers still looking at inputs rather than outcomes...I would query whether researchers are focusing on different aspects of what gives service users confidence in the process" (CP4).

"The research often looks more at processes which can be more easily quantified rather than the important interpersonal and organisational relationships which are much more difficult to measure" (CP1).

Some participants commented that writers may not be focussed on the experiences of those using services, that they may be more focussed on evaluating tangible aspects of the process.

Participants also felt they may not see the whole process of regulation, perhaps only focussing on the inspection. Participants acknowledged this was a 'snapshot' in time and, consequently, open to interpretation as to its longer-term outcomes. This was felt to make it difficult to pinpoint the exact direct impact of regulation. Some participants also commented that it was difficult to quantify the intangible aspects of regulation, for example, the interaction between individuals which leads to the relationship through which improvement is attained.

6.2.8 Inspection or improvement

Participants were asked to consider the difference between inspection and improvement (Scottish Government 2011; Francis 2013; Care Inspectorate 2017a; National Audit Office 2015b and 2017b).

This question caused some participants to state there was no, and should not be, any discernible difference between 'inspection activities' and 'improvement activities' as an inspection should be improvement focussed.

"I think stakeholders would struggle with this as may inspectors and other people in the organisation struggle. It's often argued that the very nature of inspection and other regulatory activities is about improvement, so why would we differentiate during inspection" (CP7).

Others felt, however, that there was a clear difference: that improvement activities were those which should be readily identified by the service itself, rather than the inspector, and that it was the role of the inspector to then support that improvement by suggesting targeted activities. One participant also commented on the difficulties of defining an improvement activity and stated that, internally, the regulator was still discussing ways to address this.

One participant summarised the different perspectives on this as follows:

"I believe that some stakeholders have a greater understanding then others. For example, I do not think that people experiencing the service will have a notion of the difference. Perhaps most staff involved will not perceive the difference either. Perhaps managers and providers will perceive a difference as inspectors will have communicated to them the inspection plan and what aspects of the service will be inspected, and very often the improvement work is identified by the manager of the service during the inspection. I do not think the public, reading inspection reports will perceive any difference" (CP4).

6.3 Participants' suggestions for targeted questions

The researcher asked participants to consider the questions they thought may be pertinent to ask of individual interviewees in the next phase of the research, given there may be a broad range of interest and investment in regulation. There were two core aspects suggested: influence and adaptability.

Participants felt that it may be helpful to further understand both how the lived experience of someone using services influenced regulation and how regulation itself influenced services. In an evolving social and economic environment for care services, participants felt it would be helpful to understand how regulation adapted to better support sustainable services.

6.4 Experience of the co-productive phase

Participants were asked to comment on their experiences of the co-productive phase. As a process, all participants felt it had been a positive experience. Issuing three to four questions on a weekly basis was welcomed and described as not onerous, with the format described as "*easy and user friendly*" (CP1). One participant (CP7) had felt initially anxious having never participated in anything like that format before, however, felt the process to be very manageable in time and commitment.

Some participants stated they had perhaps not been as able to contribute, given their "*lack of knowledge of regulation*" (as described by CP8), but hoped their contributions had been helpful.

Others stated they had welcomed the opportunity to reflect on regulation and the current application of regulation and felt that, although complex, the questions had been "*thought provoking and salutary*" (CP3), enabling them to consider their views against those arising from research.

One participant felt a discussion board may have offered a more focussed conversation (CP5), given the complex nature of some of the questions.

6.5 Brief follow up survey

Following the first four weeks of the study, the brief follow-up survey enabled the researcher to evaluate the perceptions and reflections of participants, after they had had time to consider others' responses.

An analysis of the survey showed a clear consensus among participants from their views and reflections (Okoli and Pawlowski 2004; Pfleger et al. 2008; Keeney 2011; Tonna et al. 2014; Martin and Manley 2018).

One month after closure of the co-productive phase, the researcher contacted all ten participants, issuing a hyperlink to a final brief survey to ascertain their views following the opportunity to reflect on the contributions of other participants. This final survey was open for a further week. The final survey opened on 18th March 2019 and closed on 22nd March 2019.

Six participants responded and indicated that, following time to reflect on the responses of the other participants, they would not change any of their own responses, however, had found others' views both interesting and thought-provoking. Several participants commented that they found the opportunity to reflect on others' views particularly valuable in both reaffirming their own views but also in allowing them to consider the underpinning rationale of regulation. One participant commented:

"I think reading other responses was very interesting. I suppose I am still musing on what I think about regulation. My original responses revealed that I valued it but had not properly considered every facet of its underpinning philosophy. The ethics of it are important to me but the construction of the whole 'edifice' never examined before" (CP2).

6.6 Limitations of the co-productive phase

The approach taken to using the principles of a traditional Delphi study and creating a series of weekly surveys could be subject to several critiques, including: a lack of guidance in many aspects including sampling of experts or group size, a lack of agreed method of data interpretation and also critiques that findings are only applicable to that one group of experts (Schell 2006; Iqbal and Pipon-Young 2009; Wheeldon 2010; Torrance 2012; Pinto, Wall and Spector 2013). However, the following sections identify how each of these areas was addressed to mitigate this:

6.6.1 Participants

As anticipated, the number of participants who agreed to take part in the co-productive phase changed over the period of the study. This could have limited the effectiveness of the study, however, the sampling process had sought to account for this: seeking twelve individuals from the beginning of the process meant that, should the number of participants decrease over the course of the study, those remaining would still be able to contribute their expert knowledge. Sample size in qualitative research is a challenge and is recognised as being adaptive and emergent (Sim 1998). As described earlier, this phase of research did not seek to replicate a traditional Delphi study, rather, the expert views of participants were sought in discussion of findings from the literature and quantitative data analysis. The numbers of participants, although small, still provided an expert view.

6.6.2 Process

The process of using an online survey could have limited the effectiveness of responses, given the time commitment and regularity of input required from participants. Feedback from the eight participants in week four, however, suggests that the process was a positive one. The process was felt to be user friendly and manageable in terms of time and commitment. Most participants felt that the study had enabled them to reflect on their own views of regulation both in a wider sense and as delivered by their organisation.

As a researcher, the use of a tool such as the Bristol Online Survey was invaluable in supporting the design and distribution of the survey and the evaluation of the responses. The process, once learned, was easy to use, accessible and offered the ability to create clear boundaries in setting timescales.

6.6.3 Themes

The themes in the co-productive phase reflected the findings from the quantitative data analysis and from the literature review. Some participants in week one demonstrated, however, that some of the language used was not accessible to them and, therefore, they felt they did not contribute to the degree they wanted, with some not responding in later weeks. In the design of this phase, the researcher had reflected the language from the findings, believing that, as these reflected current terminology in the field of regulation, words and phrases would be understood by all participants. Unfortunately, this proved to not be the case. The researcher reflected that piloting questions in advance would have supported good research practice (Silverman 2010; Fryer et al. 2012). Unfortunately, this was not undertaken, given the tight timeframe for preparation of the co-productive phase so, when issues of language accessibility were raised by participants, the researcher was unable to re-design questions. The researcher believes this led to some participants choosing not to respond in future weeks. This has been an indication to the researcher that, in any future similar study, a researcher would need to consider the audience for the study, better consider issues of accessibility and language and test this beforehand to address validity.

Otherwise, participants fed back that the questions enabled them to reflect on their role and regulation and, although some may have felt they did not contribute as they would have liked, the depth and richness of data collected by the researcher was significant.

6.6.4 Small scale study

With a mean of 7.75 respondents, the co-productive phase was small scale, however, its intention was always as a connecting framework between the quantitative and qualitative phases (Fetters, Curry and Creswell 2013). The data gathered was significant and had a richness and depth to it which further added to data previously gathered. Together with consideration of participants' own suggestions for questions, the researcher used findings from the co-productive phase to support the design of interview schedules for the next part of the qualitative phase.

6.6.5 Timescales

To ensure equity of the process for all participants, the researcher strictly maintained the boundaries established at the outset, including adherence to timescales. Two participants contacted the researcher after the survey had closed to ask if the timescale could be extended as they had not been able to complete it in time. The researcher made the decision not to extend the timescale and acknowledges that this may not only have contributed to a loss of data on that occasion but could also have impacted on participants' responses in future weeks. It was important to the researcher that timescales were adhered to, recognising that other participants could have lost interest if additional time was accrued for those who had not been able to meet pre-determined timescales, delaying feedback for all (Gerrish and Lathlean 2015).

6.6.6 The impact of the researcher

The researcher acknowledges that, although ethical practice was followed in the design of the co-productive phase and the researcher minimised any impact which her role as employee of the regulator could have had at this point, once initial communication had been made directly with participants, they would have recognised her as a colleague. It is, therefore, acknowledged that, despite attempts to reduce the impact of the researcher on this element of the research process, knowledge of the researcher may have had an impact on participants' responses.

The researcher was aware that participants could have responded from a position of social desirability: a position in which they could have been sensitive about their responses and answered in a way which generated a positive image of themselves (Krumpal 2013; Rees 2016). The researcher mitigated against this by ensuring questions were not personally focussed but based on knowledge of regulation, that responses gained via the Bristol Online Survey preserved confidentiality and gave an assurance

that participants and their communications would only be known to the researcher and not the wider group.

6.7 Areas for exploration in interviews

A thematic analysis of the co-productive data was undertaken, and several themes were identified. These are recorded below:

Theme	For further exploration
Purposes of regulation	Co-productive phase participants highlighted accountability, assurance and protection as key purposes of regulation and recognised that fear, jargon and overly bureaucratic processes could get in the way. What do stakeholders experiencing regulation think?
Experiences of regulation	Some co-productive phase participants recognised inconsistency in regulation while others did not. How do those being regulated experience this? Co-productive participants believed regulation had moved away from compliance-based models and were now more responsive and built on positive relationships. How do those being regulated experience this?
Models of regulation	While recognising the positive aspects of responsive regulation and believing this was what is delivered by the regulator, co-productive participants still identified compliance-based models as their preference. How do those being regulated experience this?
Impact of regulation on stakeholders	Co-productive participants believe positive relationships, professional inspectors, visibility of inspectors and understanding of the impact of a lack of regulation lead to stakeholders responding positively in ISQs. How do those being regulated experience this?

A thematic analysis of the data from the co-productive phase was undertaken. The themes arising from the co-productive phase supported the design of interviews. These themes were integrated with the themes arising from the findings of the literature review and the quantitative data analysis and a semi structured interview schedule developed for the next stage in the qualitative phase: the individual interviews. The semi-structured interview schedule can be found in Appendix 7.

6.8 Chapter summary

This chapter has explored the co-productive phase. It has included an outline of the process and findings gained. Finally, the chapter concludes by discussing themes for further exploration through the next part of the qualitative phase.

Chapter 7: Interview phase findings

Introduction

This chapter explores the findings from the interviews in the qualitative phase of the research, supporting the researcher to address research objectives 2 and 3.

Participants in the interview phase were identified as IP1-IP6 (Interview participant 1 – interview participant 6). These codes were applied as follows:

IP1	Childminder A
IP2	Childminder B
IP3	Day care service manager
IP4	Housing support service manager
IP5	Manager – care home for older people
IP6	Manager – care home for children and young people

Over the course of the six interviews, several themes emerged:

Category	Theme	Sub themes
Knowledge	Formal	Tangible and practical materials; knowledge through experience
	Informal	Knowledge through others' perceptions
Emotional responses	Before inspection	Unpreparedness; fear and anxiety; defensiveness; intrusion
	After inspection	Relief; validation and confidence; emotional investment
Purpose of regulation	Safety	
	Public assurance	Impact of grades
	Compliance	Standards
	What regulation cannot do	Value for money
Impact of regulation	Improvement	Improvement through regulation; improvement through other factors; status quo
	Reflection	Internal; wider arena
Regulation	What works well	Advice and guidance; involvement of service users and staff; observations of practice; time; focus on outcomes
	What could be achieved differently?	Generic approaches; competing demands of regulators; bureaucracy; inconsistency; impact on the business of the service
The inspector	Competence and knowledge	
	Characteristics	
	Authority	
Unpredictability	Of process	
	Of allocated inspector	Inspector turnover
	Of frequency	Frequency of inspection
Models of regulation		

7.1 Knowledge

7.1.1 Formal knowledge

Of the six participants interviewed, three described having some degree of knowledge about regulation prior to their first inspection (IP1, IP3 and IP4). They had worked within social care for a long period of time and described being aware of the requirement for their care services to be registered and what inspection meant for them. They described formal knowledge of the legislative requirement for their own services to be registered with the regulatory body. One childminder (IP1) described knowledge of the existence of the Care Commission (the regulator's predecessor body); one housing support manager

(IP4) described being "*in the sector a long time*", and thereby demonstrating knowledge gained over time.

The other participants interviewed were either relatively new to the field of social care, had only a basic understanding that their service was subject to registration or had begun a private care business without the initial knowledge of regulation. One childminder (IP2) who said she had no specific knowledge, stated she "*just knew it (the regulator) was around*".

Tangible and practical materials

Some participants who had not known anything about regulation talked about "*reading up*" (IP5) on the regulator's website (or those of its predecessor bodies) and trying to understand what registration with this body might mean for them. They said the information highlighted there helped their understanding of regulation, however, participants indicated that they found publicly available information in advance of regulation sparse. Participants (IP 5 and IP6) said they would have welcomed some additional written information in advance of their first inspection. Specifically, this referred to information tailored to their service type.

Knowledge through experience

One day care of children manager (IP3) (initially a practitioner, latterly in a management position) described a "*general understanding*" that the care service was registered when she was a practitioner but, had researched the regulator and its duties in more detail once she gained a management position. One care home manager (IP5) described being part of a team "*on the receiving end*" of inspections before becoming manager so she felt she had a good knowledge of what inspectors were looking for.

7.1.2 Informal knowledge

Others received verbal information from friends or peers who undertook a similar role. For instance, one childminder (IP2) spoke to friends who were also childminders for advice and information about what to expect. This participant described her peers' experiences as all being different, leaving her unclear of the specifics of an inspection, heightening her anxieties about regulation. One care home manager (IP6) stated she had learned from other team members what to expect and how to prepare. Her preparation included supporting a young person to complete a form about their experience in advance of the inspection.

7.2 Emotional responses

All participants described specific positive and negative emotions in response to the process and experience of regulation.

7.2.1 Before inspection

Prior to their initial contact with the regulator, all participants described negative feelings and emotions.

Unpreparedness

One childminder (IP1) described being "*worried*" at not knowing what to expect on the first occasion and, consequently, being unable to prepare. She felt the lack of tangible information only served to compound these feelings further. Others described their experiences when inspections were unannounced: one participant (IP5) described feeling nervous at receiving an email asking for details about the numbers of residents in her care, changes in her service and had known then that an inspection was imminent. She described the unannounced nature of inspection as something which added to her anxiety.

Fear and anxiety

The word 'inspection' was described by participants as "*intimidating*" (IP3), creating "*fear*" (IP5) and, in itself, increased already established feelings of anxiety. One housing support service manager (IP4) said: "*the word 'inspection'…it's difficult not to feel intimidated by it*". One day care of children service's manager (IP3) described the anticipation of inspection as "*high stakes and pressured*". One care home manager (IP5) gave an example of a situation in which an inspector had "*lectured*" one of her staff members on an issue of health and hygiene *"to the point that she (the staff member) was terrified*".

Defensiveness

Several participants expressed caution when asked about their emotions regarding their first inspection. One childminder (IP2) was concerned that the inspector "*would want to look round the whole house and …. it would have to be a perfect environment*". She talked about wanting the house to be its best. A housing support manager (IP4) had experienced one inspector not interacting with staff or those using the service but simply "*checking from a list*" and refusing to discuss any ways in which the service could improve. The manager stated the inspector had said it was "*up to them to find out*" (what

was needed to improve). The participant had felt this was defensiveness on the part of the inspector.

Intrusion

One care home manager (IP5) described feeling "*under scrutiny and judged*". She described the process as "*invasive*". One childminder (IP1) described experiences told to her by her childminding friends, one of whom had described the first inspector she met as "*raiding fridges*". These individuals went on to say they understood the role of inspection now but, on that first occasion, the inspector's approaches had not been helpful. One care home manager (IP5) spoke about the preparation involved for an inspection. Similar to another participant, she had received forms by post from the regulator to be completed by those using her service, indicating to her that an inspection was imminent. From her previous experience of inspection, she had found these intrusive, so had co-ordinated much preparation of the environment by the team. She described feeling that her care home was already performing well, from the outcomes of previous inspections, nevertheless, she and the team busied themselves ensuring the environment, residents and staff were ready for the inspection. She described the unpredictable nature of what different inspectors look for during an inspection, so the team had tried to prepare for every eventuality. The inspection had resulted in similar grades to the previous year, but the manager felt the time and effort had been disproportionate to the outcome of the inspection.

7.2.2 After inspection

Participants described very different emotional responses following inspection.

Relief

All participants described a feeling of relief when the inspection was over. The word *"relief"* or "*relieved*" was used by all those interviewed. One childminder (IP1) described feeling confident that her positive experience had helped "*put (my) mind at rest*". Several participants had experienced a number of inspections over a period of years. When asked whether they still experienced the same feelings when an inspection was due to take place, they all agreed they did – but the degree to which these feelings were experienced had lessened. This was attributed by them to better understanding and experience.

Validation and confidence

Participants described feeling more confident in the ability of the service to meet the requirements of the inspection, of their abilities to support staff through the process of inspection and confident in their relationship with the regulator, through the inspector. One day care of children service's manager (IP3) described a sense of validation and "*affirmation for the service of what we're doing well*".

Emotional investment

Several participants talked about the amount of time, emotion and energy which they felt they had put into the inspection, both in preparation beforehand and during the inspection. One childminder (IP2) commented "*I don't get as much out as I put in*".

7.3 The purpose of regulation

7.3.1 Safety

All participants mentioned "*safety*" when asked what the purpose of regulation was. When prompted to describe what they meant by safety, this was broadened out to describe keeping those using services safe within each environment, delivering a high-quality service and ensuring people were cared for. One housing support service manager (IP4) also described issues of health and safety.

7.3.2 Public assurance

Participants saw a value in regulation of assuring relatives that their loved ones were cared for in a regulated environment and giving affirmation that the care service was working well. One childminder (IP1) commented that "*parents want to know their child is safe here*". Another (IP2) said that "*knowing a service is regulated is better for parents*". One care home manager (IP6) felt that public assurance was also enhanced by "*checking that a service is doing what it says it is*"; the other (IP5) felt that regulation could "*assure families of residents' safety*".

7.3.2.1 Impact of grades

Most participants spoke about the grades given by inspectors following inspection. One childminder (IP1) felt, however, that grades given by the regulator were not as important in her area as reputation: "*word of mouth in (area) is important*". She described a situation in which she was one of only a few childminders when she began her service and, as a consequence, families approached her having heard about her from other

families. She was aware that many of the parents whose children she had minded had not reviewed her grades but had accepted recommendations from other parents. She accepted the public assurance role of regulation but was clear that the role of the regulator may need to be balanced by capacity for service in certain locations. Both childminders (IP1 and IP2) talked of the importance of 'word of mouth' in their service. One care home manager (IP5) was also reflective of the role of grades in giving assurance to the public. She pointed out that people recognised that inspections were "*tick boxy*" so her perception was that grades were not always considered representative of the experiences of all individuals within that service.

7.3.3 Compliance to standards

Participants described compliance to agreed standards of care as an important purpose of regulation. One care home manager (IP6) said it was important that the regulator made sure the service was "*working to the right standards and adhering to legislation*". Participants commented that compliance to standards meant that safety guidelines were being followed and, as a consequence, people using services were being kept safe.

7.3.4 What regulation cannot do

The area which participants who expressed a view queried was that of the role of the regulator in evaluating value for money. While those who expressed a view (IP3, IP4 and IP5) agreed it was important that value for money was assessed, they did not feel this was the role of an inspector. Participants questioned how value for money would be 'judged': those who commented, described the difficulty in aligning cost effectiveness with the qualitative measurement of outcomes in an individual's experiences. One care home manager (IP5) felt that the commissioner of the service (the local authority) was already responsible for assessing the service's value for money.

7.4 Impact of regulation

Participants considered there were several impacts arising from regulation.

7.4.1 Improvement

Participants recognised improvements in their care service. Some attributed these as a direct result of regulation, others felt improvements had happened as a result of other contributing factors. Some participants felt they maintained the status quo and that regulation had no impact.

7.4.1.1 Improvement through regulation

Participants recognised that the approach of inspectors had developed over time and several commented on their confidence to approach their inspector for advice or guidance, or to contact an improvement advisor to support development in an area of practice. Participants also described the role of the regulator in helping services to enhance the individual's experience. This was balanced with a recognition of the need for the regulator to enforce compliance to standards of health and safety. The safety of those using services came across strongly as not only a purpose of regulation, but as an impact of regulation. Only two participants, however, saw a relationship between inspection and improvement in their service.

One housing support manager (IP4) was clear that "*inspection helped us get to where we are now*". She attributed this to a change in the process of regulation: from a previous model of compliance to standards to a model focussed on people and one in which the inspector's role was more about giving advice. As a direct result of this, she talked about feeling confident to learn from the regulator. A day care of children service manager (IP3) was clear that one particular inspection acted as a catalyst for improvement within her service. The service had received grades of 2 (Weak) during one early inspection and had received both requirements and recommendations from that inspection. She viewed this as a turning point and instituted an action plan for change. She described this experience as "*challenging and rewarding*" – 'challenging' because of the work undertaken following that inspection and the fact that she felt she was "*on eggshells*" while awaiting the outcome of the following inspection; and 'rewarding' because the outcome was positive for the service: the service received grades of 4 (Good). These two participants demonstrated a clear link between inspection and improvement.

7.4.1.2 Improvement through other factors

The remaining four participants did not believe that improvement in their service was as a direct result of regulation. One care home manager (IP6) was clear that improvements in her service were as a result of better training for staff, a change in culture and support from her managers. One childminder (IP1) cited changes in policies which had informed how she delivered her service as being the catalyst for improvement. Another childminder (IP2) could not describe anything she had changed as a direct result of an inspection. One care home manager (IP5) was also clear that the staff did nothing differently following inspection, however, did state that the team "*sat down together to consider what (we) already do well*". She felt it was this discussion, and not the

inspection, which led to improvement. A day care of children service manager (IP3) stated that inspection did not lead to the service doing anything differently but "*helped the service clarify its practice*" and better articulate why it delivered a specific approach to that practice. One care home manager (IP5) also felt that any improvements had been as a direct result of the new Health and Social Care Standards.

7.4.1.3 Status quo

Participants commented that they recognised the advice they received from inspectors over the years, however, many felt they had changed nothing following the inspection and that they had maintained an already good standard of care. The theme of using an inspection to validate what was already felt to be working well, was common among participants regardless of whether they saw a link between inspection and improvement or not.

7.4.2 Reflection

External regulation was viewed by participants as bringing the opportunity for services to reflect on their practice and consider what could be different or better. Regulation, in and of itself, was viewed by participants as influencing services to "*make an effort*" to maintain high quality care (IP3).

7.4.2.1 Internal reflection

Participants reflected on regulation as it related to their own service. One childminder (IP2) stated that regulation enabled her to reflect on what she did well and what she could do to improve. Another childminder (IP1) commented that inspectors had helped her consider issues of safety for the children in her care of which she had not been aware. A care home manager (IP5) talked about holding meetings with staff to reflect on what the team did well. Participants, in general, reflected on any advice and guidance they felt inspectors had given them and viewed this as positive in relating this to their service. Participants spoke about the reassurance they got when inspectors confirmed, for them, that the service they were delivering was performing well. One participant, a childminder (IP1), believed she gained most validation from the parents of the children she looked after, however, described the enjoyment, achievement and pride she got from being part of the lives of children. She commented that she had been childminder to one child continually throughout his first nine years of life and this, in itself, was her validation for the job she did. In her view, although an inspection confirmed she was doing well, seeing this child grow and develop was more important.

7.4.2.2 The wider arena

Participants also recognised the role of the regulator in bringing an objective view to the care service, supporting and challenging the service to consider its practice and helping the service to see the wider context of its work. One participant (IP3) described the service as often operating in "*a bubble*" and that it was beneficial to learn about how other services in the sector operate. She said: "*regulation helps services see the wider picture and not just that of our own service*".

7.5 Regulatory approach

Participants acknowledged and appreciated the changes which they had experienced in the regulatory approach. All commented on regulation which had been "*process driven*" (IP5), "*focussed on form filling*" (IP1) and "*bureaucratic*" (IP3) to a current process which was "*more focussed on people*" (IP4).

Participants were able to describe aspects of regulation which they felt worked well and aspects which they felt could, or should, be improved.

7.5.1 Advice and guidance

Several participants commented on the advice and guidance they received from inspectors and from information disseminated by the regulator itself. Inspectors were described as offering information on practice or standards to service providers which were valued for bringing new insight from practice. One childminder (IP1) spoke about advice she had received about food hygiene and changes in policy which affected her service; another (IP2) spoke about the "*top tips*" she received. One housing support service manager (IP4) described information which she regularly sought from the Hub – the electronic portal used by the regulator to disseminate good practice, policy updates or information for the social care sector. She said she regularly downloaded articles for the staff notice board or for discussion at team meetings.

7.5.2 Involvement of people

Taking the time to speak to those using care services and their relatives was overwhelmingly appreciated by participants as the most important element of the inspection process. Participants whose services employed staff also acknowledged the importance of inspectors gaining their views as much as possible. One care home manager described the inspector now as "*always on the floor*" (IP6) and described this as a change from her previous experiences when inspectors took a different approach.

The childminders (IP1 and IP2) both said the inspectors took time to speak with the children present or collect their views in advance. One childminder (IP1) spoke about the forms she used to gain the views of parents about the service which she presented to the inspector. The positive aspect of the inspector "*spending time talking to people*" (IP5) was a consistent theme from all participants.

7.5.3 Observations of practice

Several participants commented that they valued the fact that the inspector took time to observe practice as a means of seeking assurance. One childminder (IP1) felt that the inspector observing her interactions with children she minds was "*more valuable than just talking about (what she does)*". One care home manager (IP6) talked about the "*transparency*" associated with an inspector observing what staff do, rather than reading about it.

7.5.4 Time

Participants, although acknowledging efforts associated with inspection, welcomed the amount of time an inspector spent in services, particularly larger services. One care home manager (IP5) commented that inspectors spent two days in her service to ensure they had the opportunity to speak to as many individuals and staff as they could. This time was spent both during the day and also at night, talking to staff who worked evening or night shifts. One day care of children service manager (IP3) also commented that inspectors of her service spent two days there and she felt it gave the inspector "*good oversight of the whole service*".

7.5.5 Focussing on outcomes

Participants described the current process as focussed on the outcomes and experiences of those who used their service. All participants stated that, during every inspection, inspectors spoke to those using services and their relatives. One housing support service manager (IP4) commented that inspectors wanted to know "*about our residents' experiences*" and a care home manager (IP6) commented that inspectors clearly wanted to know from those using services "*what's working*".

7.5.6 Generic approaches

Inspections were still experienced by participants as a "*one size fits all*" (IP5) approach which was not felt to take on board the nuances of each service setting. Participants felt it was vital that the inspector understood the service in detail and described positive

changes in inspection when teams changed from being generic inspection teams to being sector specific. Inspectors in these teams were viewed as being attuned to the needs of the sector and the service. Despite this, their approach to inspection was felt to be too generic and not tailored to each service.

Participants commented that inspection was a rigid, uncompromising experience which did not fit their service's needs. Within this, while participants understood the need for a systematic approach, they also recognised the need for responsiveness. Participants variously described their experience of inspection as:

"*box ticking*" (IP1)
"*one size fits all*" (IP5)
"*broad brush strokes*" (IP3)
"*form filling*" (IP2)
"*lack of consistency*" (IP4)

One day care of children service manager (IP3), whose care service uses a particular approach, felt that inspectors had not always understood this approach. She felt that inspectors' judgements were based on traditional service delivery models and inspectors were not open to considering newer approaches to practice. One child minder (IP2) described her service as operating on a very part time basis with only two or three children, yet the inspection still involved the same process, paperwork and procedure as when she was operating a full-time service with more children. She found this "*cumbersome*" and challenging for her relationship with parents, as she was still required, by the regulator, to complete the same amount of paperwork, share it with parents and seek their feedback as regularly with fewer children as she had been with many children. This participant recognised the value of feedback forms but wanted them to be more tailored to each service's functions. One housing support service manager (IP4) described repeatedly having conversations to define the boundaries of her service with colleagues and questioned whether, perhaps, the regulator could have a role in supporting these conversations. Participants agreed that checking compliance to standards should be part of inspection but that it was important to remain responsive, not just to a service type, but to individual services. One day care of children service manager (IP3) suggested that a return to 'themed' inspections would be welcome. Themed inspections were those which focussed on one area of practice at a time and reported only on this aspect for every service inspected. One care home manager (IP5)

commented that "*not everyone offers the same service, so (every inspection) should be more tailored*".

Participants described feeling there was added value when the inspection felt tailored to the service, with one participant (IP3) commenting: *"(inspection) enables you to consider and reflect on what you do, think about how you can improve, continually make the effort".*

7.5.7 Competing demands of regulators

Several participants were providers of services which were subject to different regulators at the same time, each of whom were described as focussing on different perspectives, using different language and often, these regulatory roles were not felt to be aligned. Participants described the challenges involved, not least in time and effort, when multiple regulators were involved in their regulation. Participants (IP4 and IP6) had experience of regulators which included the Care Inspectorate, the Scottish Housing Regulator, Education Scotland, Healthcare Improvement Scotland, Environmental Health and the Scottish Fire and Rescue Service. The role of the different regulators and the different focus of each was described as a "*conflict*" (IP6) at times. A day care of children service manager (IP3) felt that her staff were having to adapt and "*think on their feet*" to ensure they meet the different expectations of each. The different requirements made on services by different regulators was a source of frustration for participants. From the perspective of these stakeholders, the attempts by regulators to be proportionate and responsive were overshadowed by the volume and complexity of seemingly disconnected demands of different regulatory functions.

7.5.8 Bureaucracy

All participants described a process which, although it had evolved, was felt to be "*overly bureaucratic*" (IP5). Participants noted that the requirement for the completion of forms, the need to keep written records within the service and the expectation of maintaining forms for specific purposes had become more streamlined over the years. They felt, however, that this was still an area on which too much emphasis was placed.

Participants also commented that there should be more creative ways of demonstrating how people's outcomes are being met. Suggestions included providers producing videos, photos and storybooks which could be used for inspections. One participant (IP5) described a situation in which the inspector expected the content of all care plans

to follow a similar format, but that individuals' needs and wishes did not always correspond to this format. One childminder (IP1) commented that she was expected to show inspectors the contracts she held with parents but that parents, who were asked to complete forms for school or nursery, often did not want to complete additional forms for a childminder. She described some of the forms she was asked to complete as "*unnecessary*". Another childminder (IP2) commented that she kept records "*solely to produce as evidence (for inspection)*".

7.5.9 Inconsistency

Participants all felt they had experienced inconsistency in the inspection approach and its focus, leaving them often unsure of what to expect. One childminder (IP2) commented that, when she was registering and about to experience her first inspection, she had sought advice from friends who were childminders. Their experiences, however, had been so varied that she was unable to gain a clear picture of what to expect. One childminder (IP1) stated that there were differences in the expectations and focus of inspectors: "*what they looked for and their attitudes*". This led her to feel that she did not know what an inspector considered during inspection "*or why*". One day care of children service manager (IP3) described differences in how different inspectors interpreted guidance and, therefore, differences in how they graded her service. She felt that inspectors must decide "*what is a required standard to be met and what is best practice, as policies can change a lot*".

7.5.10 Impact on the business of the service

One care home manager (IP5) acknowledged that inspections were now more focussed on individuals, with inspectors spending more time speaking to people, often over a two-day inspection. While this included visits to speak to night staff, the manager felt this was not always sensitive to the duties of night staff whose jobs were often busier than day staff. One care home manager (IP6) described trying to facilitate an inspection at a time when staff were addressing a very challenging situation with a young person. One day care of children service manager (IP3) spoke about the challenges inherent in accommodating inspectors at different times of the calendar year: for instance, busy periods such as school holidays were particularly challenging for staff in some services and inspections during this period were described as "*putting different pressures on the service*" (IP3).

7.5.11 The Inspector

All participants talked about their experience of inspection as closely aligned to their experience of individual inspectors, both positive and negative. Positive experiences of inspectors meant that participants perceived positive experiences of inspection, regardless of the inspection outcome.

The level of knowledge held by the inspector about the sector and the service was felt to be very important. One childminder (IP1) felt her inspector was very knowledgeable: "*she obviously knew (her) stuff*". The change to sector-specific teams rather than generic teams was viewed as a positive development in increasing the individual knowledge of inspectors. Another childminder (IP2) felt that inspections need inspectors "*with the relevant service background*".

Participants described the characteristics they valued in inspectors and their experiences of individual inspectors. Words used to describe what they valued included:

"*approachable*" (IP6)
"*communicative*" (IP3)
"*sensitive to the needs of the service*" (IP5)
"*friendly*" (IP1)

One childminder (IP1) stated that her first experience of an inspector was a positive one – the inspector "*put (her) at ease*", was "*engaging and sympathetic*". Another childminder (IP2) said she'd found the first inspector to be "*very good at talking through the inspection process*". One care home manager (IP5) described a negative first experience in which the service "*had poor relationships*" with the inspector. She felt this had been because the inspector was focussing on "*very minor issues and was very critical of the service*".

One housing support service manager (IP4) stated that inspectors "*need to recognise skills and not just failings*". She described experiences when inspections, she felt, had been more process-driven and in which, she felt, inspectors were overly critical and not encouraging. She had seen a change in approaches but was clear that the relationship between a service and the inspector was pivotal in achieving positive outcomes. She commented that "*when organisations are fearful, they don't share information.* One

participant (IP4), whose service had had the same inspector for a long period of time, felt the quality of their relationship now enabled staff to be more confident at not only taking on board the inspector's suggestions, but in also knowing when to say that a particular approach would not work in their service.

All participants displayed an understanding of the authority inherent in the role of the inspector. For some, this authority was used positively, for others, their experience was a negative one. One participant (IP1) described feeling "*fearful*" that, if her inspection was not a positive one, this might negatively impact on her business as a childminder. Participants recognised they worked hard to build relationships between the service and their allocated inspector but still had a clear understanding of the authority inherent in the regulatory role, something which is reflective of others' views (Barwood 2000).

7.6 Unpredictability

Participants all variously described situations associated with unpredictability – of the process, of the allocated inspector and of the frequency of inspection.

7.6.1 Unpredictability of the process

Even within the same service types, participants described experiencing different inspection processes. One childminder (IP2) had received an email from an inspector asking if she was childminding at a certain period and requesting that she ask parents to complete forms seeking their views, thereby alerting her to the fact that an inspection would be imminent. Another childminder (IP1) experienced an unannounced visit from an inspector with no prior contact. One care home manager (IP5) also received forms in advance asking her to seek the views of residents, also alerting her to the fact that an inspection was due. She commented that, while this "*worked for her, maybe other homes would pull together*" only after they had received notice of an inspection in this way. Participants described experiencing different approaches during inspections.

7.6.2 Unpredictability of allocated inspector

Inspector turnover was repeatedly mentioned as an issue which led to unpredictability. Relationship building between the allocated inspector and the service was viewed as especially important and, when inspectors frequently changed, this relationship was felt to be disrupted. All participants commented on experiencing a turnover of allocated inspector and comments included:

"*the inspector doesn't get to know the service and the service doesn't get to know the inspector*" (IP6)

"*it feels like we're taking a step back*" (when a new inspector is allocated) (IP5)

"*a change in inspector always resets relationships and rapport*" (IP3)

"*the service has experienced several different inspectors, all with different views, sometimes on the same topic*" (IP4)

One childminder (IP1) described two different approaches she experienced from two different inspectors: one was described as more "*paperwork oriented*" and the second was "*more focussed on the children and the environment*". Inspectors were also described as "*difficult to get hold of*" (IP4).

7.6.3 Unpredictability of frequency

Some participants felt that inspections were not frequent enough and that the differences in frequency of inspections between services was "*unfair*" (IP5) and unclear. Better performing services which received less frequent inspections were viewed as risky by one care home manager (IP5): she felt there was potential for these services to "*slip*" and for issues with care not to be addressed due to infrequent opportunities for inspection. One childminder (IP2) commented that, as she was inspected only every four years, it was a different experience for her every time.

7.7 Models of regulation

Participants who commented on models of regulation saw the benefit of both compliance-focussed and responsive models of regulation, with most expressing a preference for more responsive models. For one childminder (IP1), the current model was "*just right…a mix of observing the children, reading records and looking around the environment*". One day care of children service manager (IP3) felt that "*regulation needs some element of compliance, but it is important to be responsive*". One housing support service manager (IP4) said she would like to see models of self-regulation, however, recognised there remained a need for some form of external oversight to "*ensure everyone is doing their job*". All participants had also expressed a preference for tailored inspections specific to each service, not just a service type.

7.8 Limitations of the interviews

7.8.1 Gatekeeping

The researcher's original approach, using a 'gatekeeper' to access potential participants for interview was not effective in this study and could have potentially dissuaded potential participants from becoming involved (Davies and Peters 2014; Collings, Grace and Llewellyn 2016). After two rounds in which a gatekeeper was used as a conduit between the researcher and potential research participants, the researcher decided to contact individuals directly to ascertain their interest in participating in the study. This direct approach was more successful and elicited seven positive responses, six of whom were interviewed. Despite clarity regarding the voluntary nature of participation, the directness of this approach, could also, conversely, have unduly influenced participants to take part in the research.

7.8.2 Gender

All six participants were female, as is the researcher. This research was never intended to explore gender perspectives in regulation. As participants self-selected, it was by chance that all participants were female. According to 2017 Scottish workforce data for the sector, out of a registered 202,090 employees, 85% are female and 15% are male (Scottish Social Services Council 2018). The field of social work and social care is described as a "female majority, male dominated profession" (McPhail 2004 p. 325) so, statistically, it was likely that the majority, if not all, of a small group of participants would be female. Although participants were few in number, their views very much echoed findings from previous stages of research. In any future research, a broader contingent of participants may allow an exploration of relevant contributory factors, including gender.

7.8.3 Power imbalance

There may also have been a perceived imbalance of power between the researcher and the interviewees (Etherington 2007; Kvale 2007). The researcher was clear in both her introductory email and at the beginning of the interview that she was acting as an independent researcher and not as a member of regulatory staff. Leaflets outlining her purpose and issues including confidentiality were developed to ensure these issues were thoroughly addressed, and this was outlined at the start of each interview and informed consent was gained. Despite this, the subject of power can be difficult to assess in an interview process. The researcher may deliberately take a less powerful role or abandon

some of his or her power, however, those being interviewed may still have perceived an imbalance in power (Karnieli-Miller, Strier and Pessach 2009).

7.8.4 Care service performance

After conducting the interviews, the researcher reviewed the last inspection grades for all six care services from which participants volunteered their views. All services had attained ‘Adequate’, ‘Good’ or ‘Very good’ grades. As these services were, generally, performing well, it is interesting to consider whether participants from services which were not performing well would have given similar responses.

7.8.5 Stakeholder involvement

Not all care service types were represented in the interviews. In the random sampling of active services within the criteria, several different care service types were contacted. Of the six interview participants, four different care service types were represented and these covered local authority, voluntary sector and private sector providers.

Similarly, this stage of the research involved care service providers and no other stakeholders. This will be explored in the comprehensive limitations of the research in Chapter 9.

7.9 Chapter summary

This chapter has outlined the findings from the qualitative phase of the research through individual interviews with six participants. These individuals represented different care service types, different local authority areas and different provider types. Despite this, their views remained broadly consistent, both between the group of participants and with comments made through findings in both the literature review and the co-productive phase.

Chapter 8: Discussion of research findings

Introduction

This chapter will review and discuss the findings aligned to all research phases and to the review of literature.

The overarching research question was: 'How do stakeholders involved in social care service provision experience regulation as delivered by the regulator in Scotland?' The research aim was to explore the views and perceptions of a range of stakeholders involved in care service regulation in Scotland. The specific research objectives were:

1. To describe the performance of all care service types regulated in Scotland over an identified period (1st April 2013-31st March 2017).
2. To identify knowledge, understanding and perceptions of regulation among those receiving care services, among those providing care services, and other stakeholders.
3. To identify stakeholders' perceptions about the process, delivery and framework of care service regulation in Scotland.

The integrated findings from the quantitative and qualitative phases were designed to achieve all three research aims.

The quantitative phase established five sub questions which supported a descriptive analysis of the data in addressing the above overarching research question. Themes arising from an analysis of the quantitative data, as well as those arising from a review of the literature, supported the development of the first part of the qualitative phase – the co-productive approach. Themes arising from the co-productive phase then supported the development of semi structured questions for the second part of the qualitative phase – the individual interviews with service providers.

The themes arising from an integration of findings from the literature review, the quantitative data and the two phases of the qualitative data were as follows:

Theme	Sub Theme
The performance of care services	Evaluations and the impact of complaints, requirements and enforcements Improvement and regulation
	The perception of stakeholders
Knowledge, understanding and perceptions	Formal and informal knowledge
	Purposes of regulation
Experience of being regulated	Emotional responses
	Bureaucracy
	The inspector
	Critiques
The impact of regulation	
The framework of regulation	Models of regulation
	The involvement of those using services

8.1 The performance of care services

Across the period 1st April 2013-31st March 2017, most care services in Scotland were evaluated as having performed well (87%). In the year 2015-2016, for example, the Care Inspectorate had 13,929 care services registered nationally and reported that 92% of services were evaluated as 'Good' or better. Of those high performing services, 96% maintained or improved their high grades (Care Inspectorate 2016b). The question was what role, if any, did regulation play in driving, supporting or maintaining this high level of performance? Or is regulation, as some writers assert, simply a means of governmental control over society and, in particular, those organisations providing public services? (Selznick 1985; Lewis, Alvarez-Rosete and Mays 2006; Foucault 2014; Harrison and Sanders 2014).

8.2 Evaluations and the impact of complaints, requirements and enforcements

A descriptive analysis of the quantitative data demonstrated that the majority of registered care services – across all care service types – were evaluated by the regulator as performing well. There were, however, a minority of care services – again, across all care service types – which did not perform as well. From quantitative data analysed, the regulator reported a significant amount of work to support these services to improve. Across the four years of the quantitative data reviewed, the majority of services receiving one 'Adequate' or less had improved to receive at least one evaluation of 'Good' or better.

The services which improved were across service types, provider types, geographical areas and all had experienced some requirements or enforcements or received some complaints over the period of time reviewed.

During the period of study, a descriptive analysis of Inspection Satisfaction Questionnaires (ISQs) showed that the views of those using services who had been involved in care service inspections were consistently positive, across a variety of different care services. Arguably, positive feedback given to questions about individuals' views of the inspection process in ISQs could be influenced by social desirability bias – the individual's desire to say what he/she believes the researcher wishes to hear or to appear to be a 'good person' (Brenner and De Lamater 2014; Rees 2016). Regardless of motivation, positive feedback remained high with a mean of 93.9% over the four-year period of the research.

Participants in the co-productive phase had experience of regulating a variety of care services, across Scotland and delivered by various provider types.

Interview participants also came from a variety of service and provider types and were spread across different local authorities. There were no discernible differences in responses from participants across geographical areas, care service types or aligned to the performance of services. An analysis of the six services from which participants were identified, made after interviews took place, demonstrated that they were, generally, performing well. These services had been sampled from the 844 care services which had shown improvement from the original larger sample in the quantitative data phase. At their last inspections, these six services had received grades ranging between 'Adequate', 'Good' and 'Very good'. The six services were based across four different local authority areas, with some services commissioned by several other local authorities. This demonstrated that, despite the performance, provider type or service type, the experience of those being regulated within these services was broadly similar.

8.3 Improvement and regulation

A review of the literature demonstrated that improvement is one accepted principle, and purpose, of regulation (Parker 2013; Scottish Government 2017a; Ouston, Earley and Fidler 2018; Furnival, Boaden and Walshe 2018). Improvement is understood in the literature as a systematic approach based on specific methodologies for improving care and the regulator makes a distinction between inspection and improvement (Ross and

Naylor 2017). Participants within the co-productive phase, though, stated that the boundaries between these were blurred and that, even within the organisation, there remained ongoing discussion of the two as distinct, yet related, functions.

Interview participants discussed the added value which they felt regulation brought to their service and the wider field of social care, however, only one participant could give an example of how her service had improved as a direct result of regulation. This service had been given a poor evaluation by the regulator and had received several requirements as a result. Arguably, the service, therefore, had to demonstrate improvements to avoid further regulatory intervention and had exhibited expectations of preferred behaviours. This mirrors findings from the literature review which reflect the role of regulation as having a greater emphasis on a performance culture (Webb 2001; Harris 2003; Harrison and Sanders 2014).

Interview participants cited different examples which had led to improvement in their service, but none stated that, following inspection, they had specifically changed anything. In fact, one service provider stated:

"*I feel we are always striving to achieve the best for our residents and just because the (regulator) comes, we do not do anything differently than we would normally be doing*".

This is a view shared by others who have experienced inspection: in an analysis of the impact of OFSTED inspections on primary school teachers, Case, Case and Catling (2011) found that teachers felt the inspection had had little or no impact on their practice, although they felt the experience had undermined their confidence and commitment.

From this research, acceptance of, or resistance to, the outcomes from regulation appears to have been the catalyst for reflection, in most cases. Braithwaite (2011) recognised that some degree of resistance to regulation can create the best opportunities for improvement because it can engender dialogue. Of the participants who offered examples of an improvement in their service's evaluations, they all cited their initial response to the inspector as being resistant in some form. In other words, their initial resistance to the regulator's input led to a process of internal dialogue which, they felt, supported their own service's improvement. It can be argued, therefore, that, from participants' views, the improvement of care services can be more directly influenced by the dialogue between the regulator and the service than as a result of any specific action or outcome prompted by the intervention of regulation. The link between inspection and

improvement was not easily quantified, as demonstrated through this research, supporting the arguments of some commentators that the role and impact of regulation requires a more sophisticated understanding (Harris 2003; Waine 2004; Davis, Down and Martin 2001 and 2004; Walshe and Boyd 2007).

8.4 Knowledge, understanding and perceptions

The aim of research objective two was to identify knowledge, understanding and perceptions of regulation among those using care services, and among service providers and other stakeholders.

8.4.1 Formal and informal knowledge

Interview participants said they knew very little about regulation prior to their involvement in social care. Their knowledge, if any, came from peers or their own research into the regulator and what regulation might mean for them. One participant discussed the influence of the media in sharing knowledge about regulation, particularly in the role of failings in care. This view had prompted her anxiety, prior to inspection, about ensuring she was as prepared as possible for the first inspection of her service.

Perhaps it is not surprising that participants expressed little understanding of regulation, as the literature review highlighted complexities in defining and sharing an understanding of it. These complexities were well-recorded and included differences in the language of regulation, challenges in defining its core purposes, difficulty in specifying its impact and a lack of clarity in linking regulation to outcomes (Ayers and Braithwaite 1992; Harvey and Newton 2004; McKitterick 2015; Professional Standards Authority 2015a; Drahos 2017). This mirrors findings in the above section, which demonstrated that the impact of regulation, on improvement, was not easily understood or defined.

8.5 Perceptions of regulation

When citing the core purposes of regulation, participants reflected definitions evidenced through the review of literature: providing assurance and accountability; public safety and protection; compliance and supporting improvement (Boyne, Day and Walker 2002; Tuijn 2011; Alsop 2013; Spencer-Lane 2014; Ehren 2016; Palsson 2018).

8.5.1 Safety and compliance

Throughout research phases two and three, participants highlighted safety as the primary purpose of regulation and discussed it within the broader context of providing assurance; public safety and protection; compliance and supporting improvement.

For participants in the co-productive phase, it is perhaps unsurprising that these principles were cited as the most important, given their roles as both employees and inspection volunteers with the regulator. The regulator's vision is that "every person in Scotland should receive high quality, safe and compassionate care that reflects their rights, choices and individual needs…" and the stated purpose of the organisation is to contribute to this vision by "providing assurance and protection…; delivering efficient and effective regulation…; supporting improvement…; acting as a catalyst for change…; and working in partnership…" (Care Inspectorate 2019). Assurance, safety and improvement, therefore, are arguably most influential in the thinking of these participants in carrying out their day to day roles.

Participants did identify additional purposes of regulation which they felt the literature, as presented by the researcher, did not specifically address: education and development; influencing innovation and focussing services on human rights and choice. Again, given the roles of participants, it is perhaps not unexpected that these aspects were chosen. The regulator launched 'The Hub' in 2013 to support improvement in the social care and social work sectors (Care Inspectorate 2017a). The Hub is a web page dedicated to identifying practice resources, up to date knowledge and legislation and signposting viewers to relevant training opportunities, events or seminars to enhance practice. The Hub contains information on aspects of development, innovation and sets the regulator's work in the context of human rights. Given their involvement with the regulator, co-productive participants were familiar with these. Interview participants, i.e. those receiving regulation, were unaware of these elements.

Interview participants, when asked to describe examples of how regulation supports 'safety', gave examples related to health and safety. In one example, an inspector had advised a participant to remove a pressurised can from a room in which a child was playing; in a second example, another inspector had given advice about safe play areas and in a third example, a care home had been given advice about safe storage of medication. These participants all agreed that compliance to standards was a core element of their experience of regulation. Affirmation of their compliance to relevant

standards was felt to enable them to maintain a level of validation which, in turn, supported the confidence of staff and those using services and their families. Walshe and Boyd (2007), however, suggest that in some services which merely practice compliance with the regulator, standards drive mediocrity and effectively act as a limit on, rather than a stimulus for, improvement. The challenge for regulation, then, is in identifying services which merely comply with standards to appease the regulator and identifying those which genuinely promote improvement. As cited earlier, the services from which interview participants came were from the group of services which had shown improvement in performance over the course of the four years of the research. Within these services, however, only one participant gave a tangible example of how the regulator had directly affected this improvement. All other participants were unclear as to the specific impact of regulation on improving services, with some citing external or internal service factors as being more of a driver.

8.5.2 The business of care

Interview participants all recognised the importance of attaining positive standards but cited different reasons: to give assurance to those using services and their families that services were being delivered appropriately and safely; to drive development of the service and staff; and to be as attractive as possible to service commissioners and potential 'customers', as described by some participants. These participants recognised that their services operated in the worlds of both business and care and, at times, this caused some degree of tension. Rogowski (2012) comments on this and explores the impact of a quasi-business system on the social care environment, concluding that this places the needs of those using services as subordinate to those of the competitive social care marketplace. This reflects the challenges expressed by participants and their desire for positive evaluations from the regulator to attract future business or sustain their place in the market.

Elements of current care policy, including increased regulation, greater managerial control and certain changes in workplace practice, derive from the business sector and can contribute to these tensions experienced by care providers as explored by some writers (Harris 2003; Zwetsloot and Pot 2004; Germak and Singh 2009). The neoliberal values underpinning policies applied by the UK coalition government from 2010 contributed to an increase in market competition and the promotion of private business within the social care sector and it is the impact of these initiatives which may have contributed to the participants' views of operating both in a business and a care world, as

reflected by some researchers (Calabrese and Sparks 2004; The King's Fund 2005; Smith 2009; Pownall 2013; Johnson 2015; Gallagher 2017; Cummins 2018). Service providers operating in the spheres of care and business are increasingly aware that they deliver care services within an environment which is competitive and complex. In the drive to secure increasingly scarce funds, services are showing more enterprising and entrepreneurial behaviour (Dees and Anderson 2003; LeRoux 2005; Germak and Singh 2009). From the comments made by some of the interview participants and cited within this study, despite this evolving environment and the responses of service providers, the response of regulation has remained the same.

8.5.3 Value for money

The only purpose of regulation cited in the literature which caused disagreement between participants was that of value for money, specifically whether assessing this was the role of a social care inspector.

In recent years, austerity measures have led to a diminishing role of government in the delivery, financing and regulation of public services and the changes brought about by these measures have impacted negatively on social care provision and been widely commented on (Berry 2011; Asenova and Stein 2014; Lewis et al 2016; Heald and Steel 2018). There are continuing challenges faced by local authorities in delivering services to local communities in a climate of reducing budgets where value for money is almost certainly a consideration (Audit Scotland 2018b).

Assessing value for money is cited as one of the core purposes of the role of a regulator (Smith 2009; South West Joint Improvement Partnership 2010; Glasby 2011; Leistikow 2018; Audit Scotland 2018b). As a Non-Departmental Public Body, the Care Inspectorate is accountable, not only to the public, but also to Scottish Government. Accountability extends to giving assurance that public monies are being spent effectively and efficiently (Scottish Government 2011, Audit Scotland 2018b). Indeed, efficiency is cited as one of five of the regulator's values in the sense of providing public value in its work (Care Inspectorate 2018). The regulator interprets this role as evaluating the quality of care delivered to individuals but does not specifically evaluate the ways in which the service discharges its expenditure of funds.

The National Audit Office (NAO) views value for money as the optimal use of resources to achieve the intended outcomes and demonstrates its three criteria of economy

(spending less), efficiency (spending well) and effectiveness (spending wisely) in the figure below, adding a fourth criteria of equity (spending fairly) in some circumstances (National Audit Office 2009).

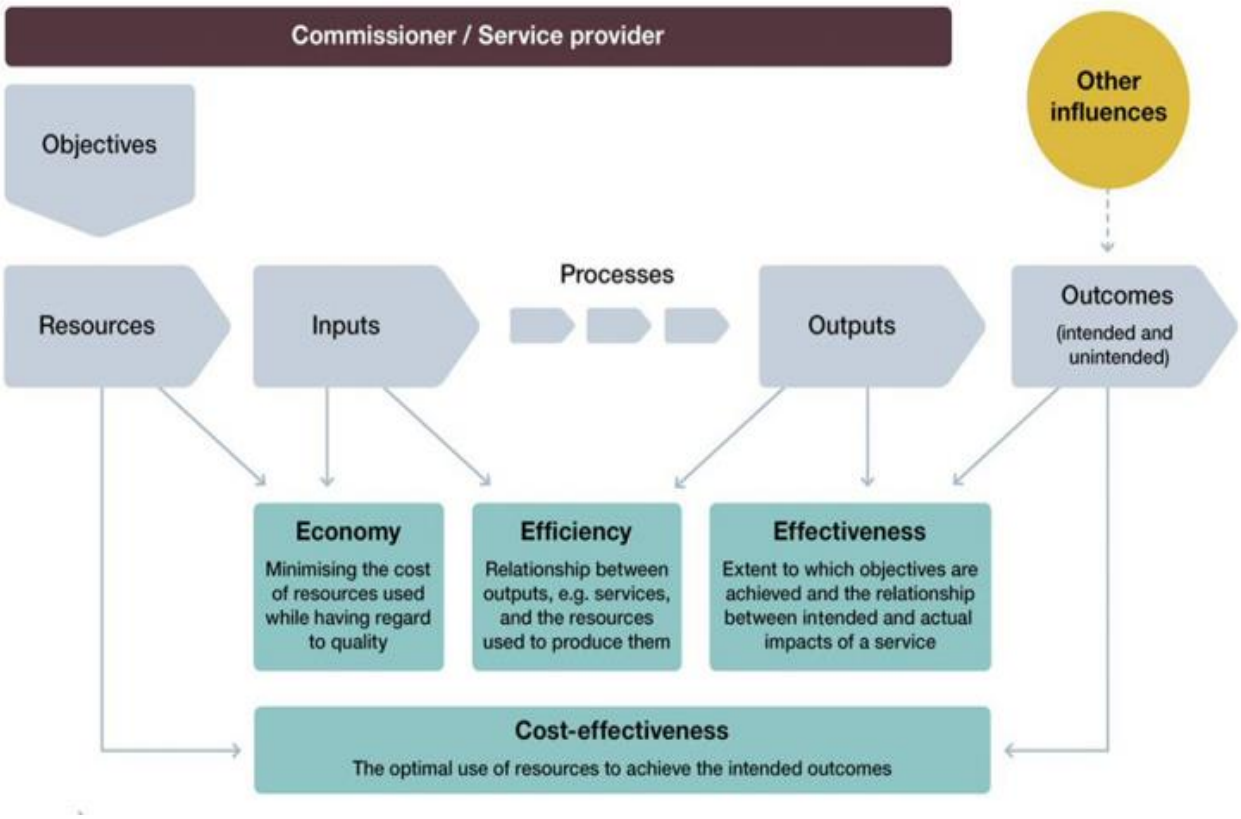

Figure 23: Assessing Value for Money (National Audit Office 2009)

The regulatory role of assessing value for money is one stated purpose of regulation and this principle is reflected through government and policy expectations (Scottish Government 2011, Audit Scotland 2018b). Participants in both the co-productive and interview phases, however, were not clear how this role could be undertaken by a care service regulator.

Participants stated that the duty to provide care services lay with local authorities and that evaluating value for money was a role for others, for example, service commissioners, rather than regulators.

Through the co-productive phase, participants felt that high quality care was something regulators were focussed on, however, were unable to describe any potential link between high quality care and value for money. Participants in the co-productive phase

commented that the social care environment had changed as a result of the impact of austerity measures. They recognised that services were under increasing pressure to deliver high quality care but with less financial resource. Some questioned the role of regulation in relation to supporting services to deliver and sustain high quality care in this challenging environment. These are questions also reflected by commentators who have explored the tensions inherent in public service delivery in times of austerity (Berry 2011; Asenova and Stein 2014; Lewis et al 2016; Heald and Steel 2018). These writers argue that austerity measures have a disproportionately negative impact on caregiving and that further work needs to be completed to comprehensively understand this impact, particularly on outcomes for people receiving services.

Value for money is viewed as one of the purposes of regulation; the state requires assurance from regulators that services are effective in their delivery; the regulator interprets its accountability to the state as evaluating the quality of care provided by services but does not specifically evaluate value for money; and those being regulated do not view the evaluation of value for money as the role of a care service regulator. The discussion about whose role it is to evaluate value for money within social care remains to be had, leading to calls by many commentators to ensure the future of regulation lies in the development of closer relationships between the regulator and those being regulated (Case, Case and Catling 2011; Davies, Nutley and Powell 2002; Morgan 2005; Walshe and Boyd 2007). The positions of the state, the regulator and those being regulated, therefore, were contradictory in relation to value for money.

This remains a very live issue for both the regulator and government: in the current Independent Care Review in which the system of care for children and young people in Scotland is being reviewed, the Review group has published some recommendations from its work to date. One recommendation to the regulator is that “regulatory bodies must scrutinise any presence of profit to ensure that funds are properly directed to the care and support of children” (Independent Care Review 2020). This will necessitate dialogue between the regulator and relevant stakeholders about the ways in which this will be progressed during scrutiny going forward.

8.6 Experience of the process of regulation

8.6.1 Emotional responses

Interview participants acknowledged that their experiences of regulation had changed over the years as the regulators' approach had evolved. From feelings of fear, intimidation and anxiety, all participants acknowledged they were now more confident and comfortable with the process of regulation, and what was expected of them, albeit a degree of anxiety about being inspected remained. These experiences closely reflected those highlighted within a review of the literature (Perryman 2006; National Advisory Group on the Safety of Patients in England 2013; Moloney 2016). The literature highlights that staff undergoing inspection often feel professionally compromised, stressed or even intimidated during the process of regulation and several case studies explore this further (Brimblecombe, Ormston and Shaw 1995; Case, Case and Catling 2011; Hopkins 2000; Lloyd 2006).

While the responses of interview participants indicated feeling fear and anxiety (albeit this lessened over time), participants in the co-productive phase – who were all involved in the delivery of regulation – acknowledged this but were clear that, through relationship-based practice, this could be mitigated and that collaboration was key. Despite the regulator's evolved approach, those being regulated still experienced negative feelings about being regulated and this remains a clear finding from literature (Male 2006; Drahos 2017; Hanberger, Nygren and Andersson 2018). There remain challenges if the regulator, and its inspection staff, believe they are creating the environment for effective regulation through relationship building while those being regulated still describe negative experiences and relationships. Many comments made by participants indicate that some of this anxiety is driven by a lack of knowledge of the role of the regulator, so it is clear that better promotion of the role and function of the regulator – by the regulator – would have some positive impact in this area.

8.6.2 Bureaucracy

Participants reflected clearly the findings from the literature review when it came to addressing what worked well in regulation and what should be improved. The focus on processes, paperwork and completion of relevant required documentation was cited by all interview participants as overly bureaucratic, time consuming, not always relevant, as well as cumbersome for services, staff and those using services. Participants felt this was more about the creation of an environment in which risk assessment and

management had taken priority over the assurance of safety and improvement of services. The policy context, shaped by neoliberal values of market competition, a reduced role for the state in service delivery and a focus on the needs of the individual, may have contributed to these views, with a focus on the bureaucracy involved in regulation, as reflected by some commentators (Domberger and Jensen 1997; Webb 2001; National Audit Office 2015b and 2016). In a period where the regulators of social care claim to focus on outcomes, participants felt this instead created a focus on outputs, as reflected by several writers (Clarke and Newman 1997; Ashworth, Boyne and Walker 2002; Harvey and Newton 2004; Fenech and Sumsion 2007; Palsson 2018). These contradictory perceptions serve to add to the complex nature of the relationship between the regulator and those being regulated and support a call for greater clarity about the role of the regulator, as identified above.

8.6.3 The inspector

The importance of the approachability of inspectors and an open, trusting relationship between an inspector and a service were cited by all research participants as pivotal, although not all participants had experienced this. There are numerous examples of research which comment on individuals' experiences of being regulated (Boyne, Day and Walker 2002; Ashworth, Boyne and Walker 2002; Perryman 2006; Case, Case and Catling 2011; Bailey and Cavanagh 2014), however, very little is written about the nature and importance of the relationship between a regulator and regulatee. Rhetoric from the regulator cites relationship building between inspectors and services as a core element of supporting improvement (Care Inspectorate 2018b) and this was supported by findings from participants in the co-productive phase, however, findings from interview participants demonstrated that positive relationships were not universally or consistently experienced by those being regulated.

8.7 Critiques

In examining critiques of regulation, all participants reflected and acknowledged the points made in the literature, with the two critiques most commented on being inconsistency in regulation and regulation's encouragement of mimicking of practice. Regulation, as a practice delivered by, and focussed on, human beings will inevitably be inconsistent (George and Dane 2016). As one co-productive participant commented, "*inconsistency of process is acceptable, inconsistency of expectation is not*". In a time when personalisation of care is expected, regulation must be responsive and bespoke, while maintaining expected standards (Glasby 2011; Scottish Government 2017b). Co-

productive participants rejected the mimicking of practice as a critique, instead viewing it as something positive and to be encouraged, and mimicking, in this sense, was interpreted as disseminating learning and good practice.

Co-productive participants felt that confidence in regulation as a process was due to the visibility and professionalism of inspectors as well as those using services, or their carers, seeing improvements being made and aligning these to inspection. Conversely, participants felt that lack of confidence in regulation, as expressed in the literature, was due to a difficulty in seeing tangible outcomes as a result of an inspection process which only gained insight as a snapshot in time.

The literature review highlighted several themes which impact on the confidence and trust demonstrated in regulation as a process. Research demonstrated that regulation was process-focussed; a reaction to failures in care; failed to promote personalisation; of limited effectiveness; was subjective; resulted in unintended consequences; engendered fear and questioned motivation to comply (Clarke and Newman 1997; Tankebe 2009; Norton 2009; Bowman 2010; Bailey and Kavanagh 2014; Berwick 2016; Abbott, Levi-Faur and Snidal 2017; Leistikow 2018; Palsson 2018; Pope 2018).

Confidence in regulation, and inspection, is itself subjective and dependent on the perception and standpoint of the individual involved: those using services, and their carers, state they recognise improvements as a direct result of inspection while researchers are challenged to find direct cause and effect (Ashworth, Boyne and Walker 2002; Drakeford 2006; Furness 2009; Norton 2009; Tuijn 2011; Palsson 2018). As outlined above, in this research, most interview participants could not define the link between regulation and improvement and had, in fact, experienced inconsistency in regulatory practices and approaches, leading to a described lack of confidence in regulation.

8.8 The impact of regulation

Findings from this research demonstrated the challenge in determining the impact of regulation and participants' views on its effectiveness varied. Understanding the interaction between regulation and other key factors is important (Walshe and Boyd 2007). Norton (2009) argues that inspection uses a rhetoric of service user expertise, but it is "hamstrung by a particular form of management values and practice" and is increasingly focussed on audit (Norton 2009 p. 1), reflecting again the neoliberal values

behind the regulatory policy context (Munro 2011; Asenova and Stein 2014; Lewis et al. 2016; Heald and Steel 2018). Some views were shared by interview participants about the positive impact of regulation being the opportunity for reflection and dialogue within the service; other participants spoke about the inconsistency and bureaucracy inherent in the generic inspection approach. For them, this meant they did not view regulation, as they had experienced it, as being effective.

A review of literature reflected these views: some writers argue that, while some improvement in care services may be due to the regulatory system and the work of the regulator, some will also be due to external and contributory factors which include market competition, increasing expectations from those using care services and their families, and renewed vigour on the part of staff in advance of an inspection (Braithwaite et al. 1993; Davies, Nutley and Powell 2002; Waine 2004; Morgan 2005; Grol et al. 2007).

Indeed, interview participants expressed that improvements made were due to both internal and external changes in practice and influences, rather than regulation.

In Figure 24, Walshe and Boyd (2007) highlight both positive and negative effects of regulation from their study across different regulatory sectors:

Positive effects	Negative effects
Specific changes and improvements in services resulting from regulatory attention	Temporary rather than sustained performance improvement which disappears after regulatory intervention
Causing organisational reflection and comparison with regulatory standards and with the performance of others	Pointless conformance behaviours in which things are done solely to satisfy regulators which have little or no value for service users or the organisation
Giving important or longer-term issues greater organisational priority than they would otherwise receive	Defensive or minimal compliance in which standards effectively act as a limit on, rather than a stimulus for, improvement
Providing leverage for change for groups or individuals within regulated organisations	Creative compliance in which organisations appear to comply with regulatory requirements by making superficial changes
Driving continuing improvement as regulatory standards are continually updated and improved	Prevention of innovation or improvement in which regulatory standards discourage or prevent change
	Distortion of organisational priorities as organisations respond to issues raised by regulators instead of dealing with internally identified issues
	Opportunity costs as organisations invest considerable resources, particularly managerial time, in interacting with the regulator

Figure 24: Positive and negative impacts of regulation (Walshe and Boyd 2007 p. 29)

Figure 25 demonstrates how responses given by research participants in this study reflected the points highlighted in Figure 24:

Positive effects	Negative effects
Supporting reflection on practice	Imbalance of power between regulator and those being regulated
Changes in regulatory approaches leading to service improvements	Bureaucratic and generic system
Services review priorities	Disproportionate investment of time and resources to support regulation
	Little or no changes as a result of inspection

Figure 25: Positive and negative effects (adapted from Walshe and Boyd 2007 p.29)

Participants in this research reflected all the above points made by Walshe and Boyd (2007) as being the effects of regulation as they variously perceived them, namely:

Positively, participants stated that regulation had supported their reflection on their practice which had led to changes in the service. This reflection was both inward and outward focussed. Services were then able to review their priorities and focus on these, supporting small and large changes to occur within services. Some participants also acknowledged that changes in regulatory approaches had supported some improvements.

Despite two of the interview participants expressing a confidence to challenge the regulator when they believed that suggested actions would not work in their service or say that the approach of certain services were not understood by the regulator, most participants did not express this confidence. This lack of confidence contributed to a feeling of a power imbalance within the regulator-regulatee relationship, something which is well-documented in literature (Makkai and Braithwaite 1994; Lonsdale and Parsons 1998; Tankebe 2009; Ehren 2016).

Interview participants also described their experience of being regulated as being part of a bureaucratic and generic system which did not support innovation. Some stated that being inspected took tremendous investment of resources in time and effort. The review of literature reflected these experiences and demonstrated that the reliance on a 'one size fits all' process of regulation was short sighted (Walshe and Boyd 2007; Alsop 2013; Ehren 2016; Palsson 2018).

8.9 The framework of regulation

Research objective three was to identify stakeholders' perceptions about the process, delivery and framework of care service regulation in Scotland.

8.9.1 Models of regulation

Interview participants expressed a preference for responsive models of regulation. Responsive regulation implements a state endorsed regulatory function with more proportionate regulatory approaches (Baldwin and Black 2008; Braithwaite 2011; Connolly 2017; Singh and Singh 2018). Participants who had experienced more compliance-based regulatory approaches were clear that the current approach of inspectors was much more focussed on outcomes for those using care services and they appreciated this shifting dynamic. Most felt this supported more positive, trusting and open relationships between the service and the inspector. One participant commented that "*when organisations are fearful, they don't share information*". While most

participants felt that responsiveness in models of regulation worked best, one participant felt that self-regulation was the preferred option. This service, part of a national organisation, felt its staff had the professionalism, integrity, skills and responsibility to hold their own service to account in adhering to relevant standards and to seek relevant advice from an appropriate authority in any development work. This view echoes a government drive towards a more self-regulatory approach which encourages organisations to use their internal quality assurance frameworks and their own internal regulatory processes to promote better outcomes (O'Dwyer 2015; UK Government 2017; Booth and Hennessy 2018).

Despite the plethora of regulatory models proposed in the literature (Reed and Stanley 1999; Walshe 2003; Healy and Braithwaite 2006; O'Dwyer 2015; Schweppenstedde et al. 2017; Ajay and Gregg 2018) and the evolving focus on regulation which is responsive and adaptable within the social care regulator in Scotland (Care Inspectorate 2018), there were contradictory positions demonstrated by research participants. Despite the regulator using the rhetoric of responsive regulation, co-productive phase participants (those involved in the delivery of regulation) demonstrated preferences for models which were closer to compliance in nature, while interview participants (those being regulated) expressed a preference for more responsive and individually tailored models. Literature suggests a complementary approach works best (Milligan and Conradson 2006; Gunningham and Sinclair in Drahos 2017).

Self-regulatory models and voluntarism were the least favoured by all participants. The legislative framework of regulation very clearly places statutory responsibilities on regulators in carrying out their duties, yet the regulation of social care in Scotland attempts to operate in a dynamic environment and adopt a position of responsiveness which arguably relies on trust and transparency between all stakeholders. Participants' responses about the different models of regulation and confidence in these seem to suggest that trustworthiness depends on acceptance of external accountability and transparency in performance, echoing points made by some writers that trustworthiness in regulation and regulators remains within a political orthodoxy that hierarchical regulation works (Scott 2001; Walshe and Boyd 2007; Healy 2011).

8.9.2 The involvement of those using services

The one area which all research participants were positive about was the involvement of those using services and their relatives in regulation. This was widely reflected in the

literature as pivotal in supporting processes which demonstrate best practice (Ross et al. 2005; Brodie, Nottingham and Plunkett 2008; Beddoe 2011; Beresford and Carr 2012; Cayton and Webb 2014). All participants in this research had experienced the involvement of those using services in inspections and cited this as a very positive evolution in social care regulation in Scotland. The involvement of those using services in regulation, from these participants' experiences, however, had extended only as far as gaining their views on services received, i.e. as "selective consumers" or "informed patients" at a service level (Drahos 2017 p.616). Participants had not experienced the involvement of those using services in the designing or shaping of a regulatory framework itself, something which has been repeatedly criticised, particularly in high profile instances of failures in care (Department of Health 2012; Francis 2013; National Audit Office 2017a).

8.10 Proposed model

In Chapter 3, the researcher proposed the following model:

Figure 9: an integrated model of regulation

Findings from this research demonstrated the importance participants placed on the experience of being regulated and the relationships inherent in the regulatory role: relationships between those regulating and those being regulated, as well as the

relationship between regulation and better outcomes for those using services. This model suggests a way for regulators to consider outcomes for people as being at the heart of the eight core purposes of regulation and supported within a cycle of regulatory models which offer a framework of responsive options. Findings from this research further reinforce the need for regulation to be more relationship-based. Stakeholders involved in delivering regulation discussed the need to develop positive working relationships with those delivering care services and believed this had evolved over the course of regulation in the social care sector. Nevertheless, stakeholders experiencing regulation felt this fell far short of the type of professional relationship they expected or viewed as optimal in supporting the achievement of best outcomes for those using services. A model of regulation which maintained the importance of outcomes for people at its heart, therefore, is pivotal in moving the conversation about regulation forward.

8.11 Chapter Summary

This chapter has discussed findings arising from the literature review, the quantitative phase and the qualitative phases and has demonstrated how these phases, when analysed together, achieved all three research aims.

Chapter 9: Summary, conclusions and recommendations

Introduction

This chapter will identify a summary of the research study, the conclusions from this research, discuss the impact of the research, highlight its strengths and limitations and outline recommendations for future research, practice and policy in this area.

9.1 Summary

This research aimed to add to the limited existing body of knowledge about stakeholders' understanding of regulation. The research used a sequential explanatory design within a mixed methods approach. Firstly, the existing literature was reviewed to analyse the key themes arising. Then an analysis was made of quantitative performance data in relation to services over a given time period. Then, beginning the qualitative phase, a co-productive approach was taken which involved ten individuals – five regulatory employees and five inspection volunteers. Their views then informed the second part of the qualitative phase which involved individual interviews with six service providers.

Participants – both those regulating and those being regulated - reflected many of the principles of regulation cited in literature. The research, however, demonstrated contradictory views between regulators and those being regulated in terms of their experiences of the regulatory approach as it applied to social care regulation. They described both positive and negative experiences of regulation. Regulators described the importance of building positive relationships with service providers within a model of responsive regulation. Service providers described experiences of regulation which focussed on compliance, within relationships in which the power imbalance often led to feelings of anxiety and fear.

In the current environment in which high quality care is expected by both public and government alike, despite the impact of austerity measures, this research recommends that further dialogue needs to take place to ensure the impact and outcomes from regulation are better understood and explicitly articulated.

9.2 Conclusions

The key messages arising from this research are noted in Figure 26:

Key message 1: Participants felt it was the dialogue inherent in the regulatory process between the regulator and the service being regulated which influenced reflection in the service and, as a consequence, gave regulation its value.
Key message 2: There were contradictory views between those regulating and those being regulated about their experiences of the application of regulation and their preferences for specific models.
Key message 3: There was clear consensus between participants about which aspects of regulation worked well or not so well.
Key message 4: Little has been written about the pivotal nature of relationships in relation to regulation, yet both the regulator and those being regulated recognised its importance.
Key message 5: Regulation within the social care sector was viewed by participants as particularly challenging given the nature of some social care services operating in both a care and business context.
Key message 6: The role of a care service regulator in assessing value for money elicited contradictory views between participants, researchers and policy makers.
Key message 7: Given the significant investment in social care regulation, and an expressed lack of clear understanding by those being regulated of the role, function and purpose of this investment, more needs to be done by the regulator to support better understanding and articulation of the role, function and impact of regulation.

Figure 26: key messages from the research

This research demonstrated the complexity of regulation in social care in Scotland: its role, the perceptions of stakeholders and its impact.

Most care services in Scotland were found to perform well (92% were evaluated as ‘Good’ or better in 2015-2016), with consistently positive evaluations from those receiving care services. There was no discernible difference across care service types, provider types, geographical location or other identifying criteria. Of those which did not perform well, the majority of these which continued to operate did improve their performance. From this research, it was difficult to define the impact of the regulator on

care service performance, given the additional impact of external factors influencing the social care environment in Scotland and the disparity of views from research participants as to the impact of regulation. Most participants did not see any specific outcome from regulation, with only one participant perceiving a causal relationship between regulation and service improvement. Broadly speaking, **participants felt it was the dialogue inherent in the regulatory process between the regulator and the service being regulated which influenced reflection in the service and, as a consequence, gave regulation its value**.

Social care regulators remained clear about their perceptions of their impact and influence, however, and promoted specific models of improvement to support this position, varying from models of compliance to those which were more responsive. **There were contradictory views between those regulating and those being regulated about their experiences of the application of regulation and their preferences for specific models**. The interview participants (those being regulated) had experienced regulation which they described as being about compliance to standards. They had expressed a preference for being regulated within a more responsive and tailored model. The co-productive phase participants (those involved in the delivery of regulation) spoke about delivering more responsive models of regulation but, when asked to describe their preferred models, described the elements of more compliance-based approaches. Despite the regulator's stance of responsiveness, this was not reflected in the experiences of service providers.

There was, however, clear consensus about which aspects of regulation worked well or not so well: an over-emphasis on bureaucracy and a 'one size fits all' model of regulation were not welcomed; the involvement of those using services during inspections was universally welcomed, although participants perceived that it could have gone further and better involved individuals in designing the framework of regulation. The research demonstrated mixed knowledge, understanding and experiences among interview participants. Prior to their involvement, interview participants (service providers) found it difficult to find out information about what was required of them as service providers and relied on the experiences of peers, or written materials, to enhance their understanding of regulation. This inconsistency of knowledge led to feelings of anxiety about the role of regulation. Feelings of anxiety, although lessening with experience and familiarity, remained present for those being regulated. Despite evolving approaches by the regulator to focus on relationship building as a means to

support regulation, relationships between inspectors and services were not always experienced by participants as positive or open**. Little has been written about the pivotal nature of relationships in regulation, yet both the regulator and those being regulated recognised its importance**.

Regulation within the social care sector was viewed by research participants as particularly challenging given the nature of some social care services as operating in both a care and business context. Interview participants were aware of an imbalance of power inherent in the regulator-regulatee relationship and understood their services required positive evaluations from the regulator to continue as a viable business entity. These participants felt this position was not always understood by the regulator. The wider impact of regulating within a complex and evolving marketplace is a dialogue necessary between the regulator and those providing and/or commissioning services. The primary purpose of regulation was widely understood by participants as 'safety': the safety of individuals using care services, the health and safety of individuals and staff and wider public assurance about the safety of care services. Those involved in regulation were able to articulate safety within the wider concept of the role, i.e. giving assurance and accountability about the effectiveness of care services, supporting improvement and ensuring respect for choice. **The role of a care service regulator in assessing value for money elicited contradictory views between research participants and policy makers:** while assessing value for money was an accepted purpose of regulation within the literature, and an expectation of policy makers, none of the research participants felt this was a role for care service regulators. They accepted this was a key part of regulation, however, felt this role would be better carried out by other bodies, such as service commissioners or auditors. This element of regulation bears further dialogue and understanding, particularly given the challenging environment in which social care operates.

Despite this lack of universal understanding of the role of regulation, it still plays a pivotal role in the care service delivery landscape in Scotland. Policy makers believe it is key to improving care services and the regulator employs a significant resource to deliver its legislative function. **Given this significant investment in social care regulation, and an expressed lack of clear understanding by those being regulated of the role, function and purpose of this investment, more needs to be undertaken to better understand and articulate the exact impact of regulation**.

9.3 Research impact

The impact of social science research, in particular, “plays a key role in framing the major societal questions which need to be addressed and identifying ways in which these might best be tackled” (Research Council UK 2020).

The primary aim of this research was the creation of new knowledge which provided an evidence base with which to support the consolidation of, present a challenge to, or lead to a change in the framework of, the regulation of social care services as currently delivered in Scotland. The social care sector operates in an increasingly challenging environment, which means the regulator must respond to this effectively. New knowledge of the experience of regulatory stakeholders will impact on, and support, ongoing dialogue about the evolution of regulation in this field.

The secondary aim of this study was to address an existing gap in research in the field of social care regulation. As outlined in the study, much of what has been written about stakeholders’ perceptions was in relation to their experiences of individual services and less so in relation to regulation in and of itself. This research, therefore, addressed this gap in knowledge and made a real difference to what is actually known and understood (Sheppard 2004; Bastow, Dunleavy and Tinkler 2014; Denicolo 2014; Higher Education Funding Council for England 2016).

The findings from this research will support the regulator to reflect on its methodology for care service regulation and work together with stakeholders and partners to support best practice in this area.

9.4 Strengths and limitations of the research

9.4.1 Strengths

The research used a mixed methods approach to ensure the findings were triangulated and, therefore, robust. The involvement of stakeholders in research is accepted as good practice (Tomer 2012; Resnik 2018). To ensure the involvement of stakeholders in the design of the research, a co-productive approach was applied involving experts by experience: those involved in regulation as employees and volunteers. Prior to initiating the co-productive phase, the researcher used a control measure to test the questions – by seeking the input of one of her tutors (Creswell 1998; Marshall and Rossman 2016).

The views of those involved in the co-productive approach helped to shape the design of interview schedules in phase three.

Some stakeholders involved in this research were those not commonly featured in the literature, namely inspection volunteers. This, therefore, brought different and unique perspectives to this area of research.

Once interviews had been conducted, the researcher issued interview notes to participants for clarification and to give them the opportunity to expand on their views. This was also incorporated into the co-productive approach.

The researcher maintained an ethical approach throughout the research: seeking ethical consent from Robert Gordon University; designing and providing information leaflets and consent forms; seeking informed consent from participants and maintaining confidentiality throughout the research process. The role of the researcher as both regulatory employee and independent researcher was clarified both at the beginning of this doctoral thesis and in conversations with all participants at every stage in the research process.

9.4.2 Limitations

It is important to outline the limitations of this research. The research design had several limitations in internal validity. The quantitative data analysis phase analysed publicly available data in relation to the performance of care services between 1 April 2013 and 31 March 2017. The scope of the research did not allow for an analysis of the variables which could have impacted on service performance, including both internal and external factors. Despite strengths in involving stakeholders in supporting the design of the interview schedule, the construction of this was the researcher's own and subject to her values.

The qualitative phase of this research explored the views of stakeholders within a very specific context, time period and approach. Ten individuals were involved in the co-productive phase and six individuals were individually interviewed. In external validity, while readers can transfer learning to their own setting from this relatively small sample, the findings themselves cannot be extrapolated and applied more widely.

Convenience sampling was utilised during the qualitative phase and, therefore, it is possible that, with a different group of research participants, different perspectives would be gained.

9.5 Recommendations

9.5.1 Recommendations for further research

The field of regulation in relation to social care is a complex and dynamic one and there are many areas in which further research would be important. Already, the framework of regulation described within this research has evolved over the course of the study in response, in part, to the complex and dynamic field of social care in Scotland. It would be pertinent for further research in this area to consider the dynamic social care environment when undertaking research into regulation.

9.5.1.1 Relationships

The relationship between a regulator and those being regulated was cited as very important to research participants and this is an area which would benefit from more detailed research. Between a regulator and regulatee, there exists a balance of power. Participants in this research who delivered regulation believed they were undertaking their role by developing positive and open relationships, however, this was not the consistent experience of participants who had experienced regulation. Any further research would benefit from exploring the dynamic inherent in this relationship.

9.5.1.2 Impact

In this research, the impact of regulation was not explicitly or consistently articulated by all participants. A review of literature also upheld this position. Walshe and Boyd, in their review of regulation, found that regulatory agencies should do more to share ideas and innovations in regulation and demonstrate more clearly the impact of regulation to stakeholders (Walshe and Boyd 2007 p.2) and this position was borne out in this research. It is suggested that further research be undertaken, particularly within social care, to better understand and articulate the impact of regulation. While this research focussed on the regulation of registered social care services, the social care regulator in Scotland also carries out joint inspections of children's, adults' and justice services as delivered by community planning partnerships and health and social care partnerships. Any future research in regulation should identify the regulation of services provided and commissioned by these partnerships to add further understanding of social care regulation in its broadest sense.

9.5.2 Recommendations for practice

9.5.2.1 Models of regulation

While the regulator states it has developed responsive models of regulation, the process of regulation is still experienced by those providing care services as a generic, 'one size fits all', bureaucratic process. It would be of benefit for the regulator to work together with those being regulated to develop a framework for regulation which is more tailored to individual services, but which still achieves its core purposes. The researcher recommends her own 'integrated model of regulation' for consideration in regulatory practice.

9.5.2.2 Promotion

Given the challenges found in this research in defining the purpose and impact of regulation, it would be important for the regulator to work together with partner agencies to better define and promote its role, function and impact. Participants commented that they had found information prior to regulation very limited, therefore, the regulator may wish to consider the ways in which it can better promote the importance of regulation to all stakeholders.

9.5.2.3 Regulation in times of austerity

All participants commented on the environment in which care services currently operate as being particularly challenging and this is borne out in the review of literature. Given the views expressed by participants of their operation in both the business and social care worlds, it is suggested that, together with relevant stakeholders, the regulator should further consider how it carries out its regulatory role and supports service improvement in times of austerity, recognising the impact of tis decisions on services and the wider marketplace.

9.5.2.4 Involving those using services in the design of regulation

While regulation has evolved during the period of this research project, participants overwhelmingly agreed that the involvement of those using services was a key element of regulation and one which was universally valued. From participants' experiences, this extended only as far as giving their views of individual services and this reflected literature in the field. It is suggested that the regulator work together with those using services to support the design of the regulatory framework itself, mirroring a truly co-productive approach.

9.5.3 Recommendations for policy

9.5.3.1 The role of the regulator

As demonstrated in this research, most services deliver a high quality of care, with the regulator significantly supporting those which do not. The current regulatory framework involves the inspection of all regulated care services, albeit with different degrees of frequency of input. With increasing expectations of government that care services will always be held to account, it will be vital to have a dialogue to further define the role of the regulator in the current challenging climate. It will be important to understand how the regulator should maintain its role in giving public assurance about the effectiveness of care while delivering a regulatory service which is more proportionate, focussed on services with greatest need for support and which uses its own resources more effectively. This dialogue must also address how the regulator could better support the sustainability of care services.

9.5.3.2 Assessing value for money

Policy makers will be interested to note the discussion about the role of the social care regulator in assessing value for money in care services. Within the literature, there was a consensus that assessing value for money is a core principle of regulation, however, research participants demonstrated mixed views in this area. Particularly in the current environment where the impact of austerity measures continues to be felt in the care service sector, it will be important for there to be further dialogue about this area.

9.5.3.3 Centrality vs locality of regulation

Regulation currently operates from a centralised model. In an environment in which governmental rhetoric supports an increase in self-regulation and in which stakeholders expressed a preference for more tailored models of regulation and greater understanding about individualised local services, it will be important to consider the ways in which the regulatory role can be delivered effectively while incorporating these two elements.

9.6 Concluding remarks

This research has demonstrated the difference in experiences between those delivering, and those receiving, regulation within the social care sector in Scotland. This difference leads to a disconnect between the regulator's intentions and the perceived impact of regulation in meeting those intentions.

Given the complexity of regulation within the field of social care, as demonstrated within this research, and the increasing expectations of the public and of government that social care services will continue to offer the highest quality of care, even in times of austerity, it is imperative that there is a dialogue between all stakeholders about the exact expectations on a social care regulator within this evolving environment. This dialogue should explore how the purposes of regulation can be achieved within a system of both internal and external quality assurance, informed by the views of stakeholders, which effectively puts the needs and outcomes of those using care services at its heart.

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Appendix 1: Definition of Care Inspectorate evaluations (at the time of the study)

Excellent

All aspects of the quality theme/quality statements are met or exceeded. The service is exemplary. The service's performance is a model of its type. The outcomes experienced by service users are of very high quality. The outstanding performance is likely to be worth disseminating beyond the service. This grade implies these very high levels of performance are sustainable and maintained. Services graded 'excellent' are rigorous in identifying their areas for improvement and implementing action plans to address them. There will be strong evidence that the service consults service users and carers regularly and appropriately about service quality and performance and acts upon their views.

Very good

All aspects of the quality theme/quality statements are met. The 'very good' grade applies to performance characterised by major strengths. Identified areas for improvement represent improvements to be made on already very good performance and not on weak performance. This grade represents a high standard of performance which should be achievable by all services. It implies that performance does not require significant adjustment. However, there is an expectation that the service will take opportunities to improve and strive to raise performance to excellent.

Good

All aspects of the quality theme/quality statements are met. Areas for improvement are identified but performance is basically good. The 'good' grade applies to performance characterised by important strengths which have a significant positive impact. Identified areas for improvement will not call into question this positive impact. This grade implies that the service should try to improve further the areas of important strength and act to address the areas for improvement.

Adequate

Most aspects of the quality theme/quality statements are met. Aspects which are not met may be subject to recommendations but don't cause concern. The 'adequate' grade applies to performance at a basic but adequate level. This grade represents a standard where the strengths have a positive impact on the experiences of those using services. While weaknesses will not be important enough to have a substantially adverse impact, they are constraining performance. This grade implies the service should address areas of weakness while building on strengths. This is likely to be reflected in

recommendations for improvement in respect of relevant National Care Standards.

Weak

Aspects of the quality theme/ quality statements are not met and this gives cause for concern. A quality theme or quality statement is evaluated as ‘weak’ where, though there may be some strengths, there are important weaknesses which cause concern. The weaknesses will, either individually or collectively, cause concern about the performance when measured against the quality theme or quality statement. This grade implies the need for structured and planned action by the service. Services graded as ‘weak’ will be likely to have recommendations or requirements made that reflect the concern about performance on that quality theme or quality statement.

Unsatisfactory

Aspects of the quality theme/ quality statements are unmet in a way which gives cause for significant concern. The ‘unsatisfactory’ grade applies when there are major and or widespread weaknesses requiring immediate remedial action. There is likely to be significant concern about the experience of those using services. Services graded ‘unsatisfactory’ will be likely to have requirements made against them and there will be a possibility of formal enforcement action.

Appendix 2: Participant Information Leaflet

1. What is this research about?

This research is an exploratory study of how those involved in social care service provision experience regulation as delivered by the Care Inspectorate in Scotland. It will explore the performance of regulated care services over a specific period of time and seek views about regulation from people receiving care, providing care and other relevant stakeholders.

2. Who is carrying out the research?

The researcher is an employee of the Care Inspectorate, however, she is undertaking this research independently in fulfilment of the requirements of the Doctorate of Professional Practice degree, with supervision by a team at Robert Gordon University (see contact details below for any queries).

3. How could I be involved and how will my information be used?

You could be involved as an individual in a face-to-face interview with the researcher. Interviews will last no more than 1.5 hours. A final dissertation will be produced by the researcher following completion of the research and the findings may be used for purposes of publication in academic or professional journals. You may also request a summarised version of the findings.

4. Do I have to participate?

Participation in this research is entirely voluntary. There will be no negative consequences for choosing not to participate and there will be no rewards, financial or otherwise, if you do choose to participate. You may withdraw from the study at any stage and you may request that any information gathered from you not be used. If you agree to take part in the research, you will be asked to sign a consent form which will be maintained during the research.

5. How will you ensure what I say is kept confidential?

a. Information gained from interviews will be used only for the purpose of the research.
b. Written records of interviews will be kept by the researcher.
c. All participants will be asked to sign consent forms.
d. Individuals will be referred to anonymously.
e. Specific people, roles and/or organisations will not be identifiable in the research.

f. All data will be recorded, stored and used within the guidelines of the Data Protection Act 2018.

6. Who will know about my participation in the research?

You have expressed an interest in being involved in this research through your care service. However, what is discussed in an individual interview will remain confidential, as in section 5 above. You will not be identified in this research.

7. How will you record and store information?

All data will be recorded, transcribed and stored in a password-protected computer, within the University's data management system, complying with its data management policy. Only the researcher and supervisory team will have access to it. In line with University guidance, links to personal identity will be destroyed. Raw data (audio recording, interview transcripts, statistical tables and questionnaires) will be kept for a minimum of ten years following publication of the dissertation, then destroyed.

8. What will happen if a child or adult protection concern arises?

The researcher is registered with the Scottish Social Services Council and must adhere to its code of practice. This means that any issues or allegations of harm, child or adult protection arising during the research study will be reported to the relevant body and, where necessary, interviews or groups will be terminated at that point.

9. What if it becomes clear that I have a right to complain about a care service?

If, during the research study, an issue arises with regard to the level or quality of care being provided by a care service, you will be made aware of your right to make a complaint, initially to the service for resolution, or directly to the Care Inspectorate or another appropriate body. This will remain independent of the research study.

10. Will I be paid for my time?

No, participation is voluntary.

11. Should you have any further queries about the research, please contact:

Gill Pritchard, student of Doctorate of Professional Practice, School of Applied Social Studies, Robert Gordon University, Aberdeen. Email: g.b.pritchard@rgu.ac.uk

Principal supervisor: Dr Linda H Smith, School of Applied Social Studies, Robert Gordon University. Email: l.h.smith@rgu.ac.uk

Appendix 3: Co-productive phase programme – Bristol Online Survey schedule

Week 1

Page 1: Introduction

This study supports the wider research which is a study of the views of stakeholders about the regulation of social care in Scotland. This study is to ask your views on key points which have resulted from research to date. Following the end of the study, a consensus of everyone's responses will inform the next phase of the research. As outlined in the participant information leaflet, your participation is voluntary, you will not be identifiable through your response and your responses will only be shared with the researcher and her supervisory team at Robert Gordon University. Data is collected and stored under the terms of the University's relevant policies and as outlined in the participant information leaflet.

In completing this survey, you are confirming your consent to participate.
Thank you for your participation.

Page 2:

1. A review of literature identifies the purposes of regulation as providing assurance, maintaining accountability, assuring public safety and protection, demonstrating value for money, maintaining compliance, a means of identifying poor practice, supporting improvement and sharing learning/good practice. From your experience, which, if any,

   of these purposes would you disagree with or question? Please say why.

2. From your own experience, are there any additional purposes of regulation you would want to add to the above list. Which ONE purpose would you see as most important? Please say why.

3. From your experience, which parts of the regulatory process help achieve the above purposes and how?

4. From your experience, which parts of the regulatory process get in the way of achieving the above purposes and how?

Thank you very much for your responses.

Once the first survey closes, the researcher will analyse all responses and will issue a second set of statements/questions at the beginning of next week.

Week 2

Page 1: Introduction

Thank you for your responses to the questions from week 1. This next set of questions again come from a review of literature to date, this time focussing on what critics of regulation say. Please can you complete your answers by 5pm on Thursday 31st January 2019?

Page 2: Critiques of regulation – processes

Some critics of regulation comment on the processes. They believe that the regulation of services is inconsistent and that it focusses on the performance of services and encourages services to mimic practice. What are your views on these comments?

Page 3: Critiques of regulation – perceptions

Some critics of regulation say it does not promote personalisation in care; it is distant from the point of care; it creates anxiety and that a tightening of regulation is often a response to failures in care. What are your views on these comments?

Page 4:

In your role with the care Inspectorate, which (if any) of these criticisms are you aware of/do you acknowledge the most? (If you are not aware of any, which do you agree with the most?)

Page 5: Additional critiques

If you were to offer a critical comment about the regulation of care services, what would you add to the list of what some critics say?

Page 6: Thank you

Thank you very much for your participation in the second week of the study. The study will close at 5pm on Thursday 31st January 2019. After this, the researcher will analyse all responses and create a set of questions/statements for week 3. These will be issued on Monday 4th February 2019.

Week 3

Page 1: Models – Benefits

A review of the literature highlights 3 basic models of regulation. These are:

1. Compliance based: the regulator sets standards and enforces these using a framework of legislative powers to support this.
2. Responsive regulation: the regulator uses a mix of approaches, dependent on the requirements of regulation, or the issues raised.
3. Self-regulation or voluntarism: the organisation/service being regulated monitors itself against agreed standards, makes a judgement then applies its own changes.

What are your views on the benefits/advantages of each of these approaches?

Page 2: Models - Disadvantages

What are your views on the disadvantages of each of these approaches?

Page 3: Your model

From your experience, if you were to design an inspection of a care service from scratch, what would you want the key component parts of your inspection to be? (i.e.

consider who you think regulation is for, what you think would help achieve the aims of regulation and what tools you would apply to achieve this?)

Page 4: Final page

Thank you very much for your contribution to week 3 of the study. All responses will be analysed once the survey has closed. The final set of statements will be issued on Monday 11th February 2019.

Final week

Page 1: This final set of questions is based on findings from literature and from a review of data held by the Care Inspectorate for regulated care services between 2013 and 2017.

1. From responses to Inspection Satisfaction Questionnaires (ISQs) completed in the above period, those using services (and their relatives and/or visitors to the service) give very positive responses to statements made about the process of inspection, the inspector's approach or about the impact they believe the inspection will have on the service either improving or maintaining its already high quality. From an analysis of ISQs, there are no differences in responses by service type, service provider, geography or other criteria. Whether those responding are in a service evaluated by the inspector as highly or poorly performing, those responding give, on average, 94% positive responses about the inspection itself, potentially demonstrating a high degree of confidence in inspection. What do you believe it is about inspection which gives those using care services such a high degree of confidence?

2. From a review of literature, however, there are many writers who do not place such confidence in the inspection process to achieve its aims (as discussed in previous weeks of this study). What do you believe accounts for this difference in expressed confidence in inspection between those using care services on an individual inspection basis and those reviewing regulation in its entirety?

Page 2: Improvement activity

From 2015, inspectors have recorded specific time spent on improvement work during an inspection. This averaged 1.4 hours specifically spent on improvement per inspection. How do you believe stakeholders in that inspection understand the difference between ‘inspection’ activities and ‘improvement’ activities?

Page 3: Views of stakeholders

The core purpose of this wider research is to explore the perceptions, knowledge and understanding of stakeholders about care service regulation in Scotland. Stakeholders include those using care services (their relatives and carers), service staff and managers, service providers, service commissioners, policy makers and members of the public. With such a broad range of interest and investment in regulation (and to varying degrees), what 3 questions do you think the researcher should be asking people in the next stage of research?

Page 4: Your views of this study approach

Finally, the researcher would be interested to hear what your experience of being part of this study has been like. Can you comment on how you have found the experience?

Page 5: Final page

Thank you again for your responses and for your participation in the study. Every comment has been very valuable in supporting this research. This final week closes on Thursday 14th February 2019 at 5pm. The researcher will, following the closure of the survey, analyse all four weeks' responses and compile a brief summary which will be issued to you by the end of February 2019.

Many thanks once again for your contribution and participation. Best wishes.

One month follow up survey

Page 1: Introduction

This is a final follow up survey to ask if your views have changed in light of reading the combined responses of all participants in the study.

Page 2:

Week 1 of the survey asked for participants' views of the purposes of regulation. Having read the summary of responses, please comment whether your views of the purposes of regulation have changed or whether you wish to add any comments.

Page 3:

Week 2 of the survey asked for participants' views of the processes of regulation. Having read the summary of responses, please comment whether your views of the processes of regulation have changed or whether you wish to add any comments.

Page 4:

Week 3 of the survey asked for participants' views of the different models of regulation. Having read the summary of responses, please comment whether your views of the models of regulation have changed or whether you wish to add any comments.

Page 5:

Week 4 of the survey asked for participants' views of confidence in regulation and about the distinction between improvement activity and inspection activity. Having read the summary of responses, please comment whether your views of these have changed or whether you wish to add any comments.

Thank you very much for your participation in this follow up survey.

Appendix 4: Email to potential interview participants

Dear

Re: Expressions of interest to participate in a research study

I am undertaking research to explore the views and opinions of those who have experienced care service regulation as carried out by the Care Inspectorate in Scotland. Although I am a strategic inspector with the Care Inspectorate, I am carrying out the research independently of my job and am supervised by a team at Robert Gordon University.

Your care service is one of several which have been randomly selected from a list of those currently registered with the Care Inspectorate.

There is no obligation for you, your staff or service users to participate. There are no negative consequences should you decide not to participate. Your involvement is entirely voluntary. You, your staff or service users will not be identified, or identifiable, in the research.

I would be grateful if you could advise me if:

- You would be interested in speaking with me as a care service manager in either a focus group or individual interview
- If any of your staff would be interested in speaking with me in either a focus group or interview
- If any of your service users would be interested in speaking with me in either a focus group or an interview

I have enclosed a participant information leaflet which gives further details about the research.

I have contacted several care services and, once I receive expressions of interest, I will randomly select care services on a ‘first come, first served’ basis for further follow up. If you, your staff or service users have expressed an interest but are not randomly selected, I will contact you to advise you of this.

If you, your staff or service users are interested in participating, please contact (business support assistant) by (date) and confirm that you are happy for your contact details to be shared with me.

If you, your staff or service users wish to ask further details about the research before deciding to participate, please contact me directly on g.b.pritchard@rgu.ac.uk .

May I take the opportunity to thank you for considering this request?

Yours sincerely
Gill Pritchard

Appendix 5: Consent forms

'An exploratory study of the views of stakeholders about the role of regulation in social care service provision in Scotland'.

This research is about how those involved in social care service provision experience regulation as delivered by the Care Inspectorate. It will explore the performance of care services over a specific time period and seek views about regulation from people receiving care, providing care and other relevant stakeholders.

By signing this form, you consent to be a participant in the research project

Your responses will be kept strictly confidential. If, at any time during the study, you feel unable or unwilling to continue, you are free to withdraw – your participation is voluntary. If you do not wish to answer any particular question, you can decline. Your name will not be linked with, or identified by, the research materials, and will not be made public in the dissertation.

The participant information sheet outlines many aspects of the research and will answer some of your questions about this research, however, if you require further information, please contact:

Gill Pritchard, student of Doctorate of Professional Practice, School of Applied Social Studies, Robert Gordon University, Aberdeen. Email: g.b.pritchard@rgu.ac.uk

Principal supervisor: Dr Linda H Smith, School of Applied Social Studies, Robert Gordon University. Email: l.h.smith@rgu.ac.uk

By signing below, you are confirming the following:

- I have read and understand this form and the participant information leaflet. I have had the opportunity to consider the information, ask questions, and have had these answered satisfactorily.
- I understand that my participation is voluntary and that I am free to withdraw from the study at any time without giving any reason and without penalty.
- I give permission for my data collected during the study to be reviewed by individuals from the research team where relevant. I understand research data will be kept for a minimum of 5 years following publication of the dissertation.
- I understand that in the published dissertation no data will be identifiable as my own.
- I agree to take part in this study.

Participant's Name	Participant's Signature	Date
_____	_____	_____
Researcher's Name	Researcher's Signature	Date

Appendix 6: Responses to ISQs 2013-2017

ISQs from those using services, relatives and visitors 2013-2017

Statement	2013-2014 Agree or strongly agree	2014-2015 Agree or strongly agree	2015-2016 Agree or strongly agree	2016-2017 Agree or strongly agree
1. Inspector suitably involved me in the inspection	97%	96%	98%	99%
2.Inspector appeared to be well prepared	98%	98%	100%	99%
3.Inspector tried not to disrupt the normal running of the service	97%	96%	98%	99%
4.Inspector was polite and treated me with respect	99%	99%	99%	100%
5.Inspector had the right level of contact with people using the service	67%	73%	77%	78%
6.I am satisfied with how the inspection was carried out	99%	99%	98%	99%
7.I believe service quality will improve as a result of the inspection	87%	88%	95%	96%

ISQs from staff and managers 2013-2017

Statement	2013-2014 Agree or strongly agree	2014-2015 Agree or strongly agree	2015-2016 Agree or strongly agree	2016-2017 Agree or strongly agree
1. Inspector suitably involved me in the inspection	97%	97%	96%	97%
2.Inspector gave clear feedback on inspection findings	96%	95%	96%	96%
3.Inspector appeared to be well prepared	98%	97%	99%	98%
4.Inspector tried not to disrupt the normal running of the service	98%	98%	97%	99%
5.Inspector was polite and treated me with respect	98%	99%	98%	99%
6.Inspector had the right level of contact with people using service	92%	89%	88%	89%
7.The draft report was written clearly	98%	99%	99%	99%
8.The reasons for recommendations and requirements are clear	96%	98%	97%	97%
9.I am satisfied with how the inspection was carried out	97%	97%	96%	97%
10.I believe service quality will improve as a result of the inspection	93%	93%	98%	98%

Appendix 7: Semi structured interview schedule

Knowledge:

- Can you describe what you understand by the term ‘regulation’?
- Can you describe what you understand by the term ‘inspection’?
- What do you believe the purpose(s) of regulation/inspection is (are) and why?
- What purpose, for you, is most important and why?

Experience:

- Do you have experience of regulation or inspection?
- Can you describe your experience of and your involvement in regulation/inspection?
- What information (and from whom) had you been given beforehand?
- What were your expectations of regulation/inspection?

Models of regulation: Compliance-based; Responsive; Self-regulation/voluntarism

- Which of these models do you feel will achieve the purpose of regulation best and why?

Advantages and disadvantages of regulation/inspection:

- From your current experience, what works well about regulation/inspection and why?
- From your current experience, what doesn’t work well about regulation/inspection and why?
- From your current experience, what should change about regulation/inspection and why?
- In regulation/inspection, what is the most important aspect for you and why?

Impact:

- What, from your experience, have been the positive impacts of regulation?
- What, from your experience, have been the negative impacts from regulation?