



**The journey from first inspection to quality standards
(1857-2016): Are we there yet?**

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Abstract

This paper is a qualitative analysis of areas of the inspection and regulation of care for people with learning disabilities and mental health problems in Scotland, in two time periods.

The paper uses comparative historical research, drawing on primary sources from 1857 to 1862 in the form of Annual Reports of the General Board of Commissioners in Lunacy for Scotland and associated papers, to compare inspection methods, quality standards, and to identify persistent challenges to effective inspection.

Political, clinical and public awareness led initially to criticisms of existing care and eventually to the development of the “*The Lunacy Act*” of 1857. This Act resulted in the first attempts to set minimum standards of care for individuals at risk, with enforceable regulation. Some factors recur as challenges to effective practice in the inspection and regulation of care today.

There are problems of definition, reliable monitoring of quality standards and adequate, independent inspection of services that respond to unacceptable standards of care.

There is a growing evidence base about best methods of inspection of services for people in care who are most at risk. These methods attempt to strike a balance between evidence-based and value-based judgements. Perspectives from history may help focus resources most effectively.

This paper identifies common themes and common challenges in two time periods to investigate what can be learned about the development of policy and practice in inspection and regulation of care.

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Keywords: Safeguarding, Inspection, Historical research, Learning/Intellectual Disabilities, Mental Health, Regulation of Care.

Paper type: Conceptual paper

Introduction

There are some common themes in the principles underpinning legislation and care standards in the 1850s and in the early part of this century, and there are also some recurring, persistent challenges to effective inspection and regulation of services in both periods.

There is well detailed literature on the history of care in Scotland, (for example, Campbell, 1932; Anderson & Langa, 1997; Atkinson, Jackson, & Walmsley, 1997; Bartlett & Wright, 1999; Barfoot, 2009). This paper is not an attempt to summarise this work, nor to comment on it. Instead, some parallels will be drawn between inspection policy and practice around the time of the introduction of The Lunacy Act in 1857 and now, with use of illustrative examples, in a qualitative analysis.

Common themes will be identified in this paper, but it is necessary at the outset to highlight some fundamental *differences* in the context and the terminology used in the two periods. Many of the terms used in the 19th century to classify individuals are today shocking and derogatory, e.g. lunatic, imbecile, idiot, maniac, mad and insane person. This was the medical and political terminology of the day and the classifications on which policy was based. A comparative historical approach has been used in this paper. Although primary sources (1857-62) have been used, accessed in public archives and quoted where appropriate, the content and emphasis in these sources will inevitably reflect the views of the original authors. So although the factual content may be accurate, the *selection* of facts may be influenced by social and political attitudes of the time. For example, issues of capacity and consent, or clinical interventions assessed as least restrictive of the adult's freedom, now central now to care policy and practice (Campbell & Martin, 2009; Faulkner, 2012), were issues never considered in the Act for the "*Regulation of the Care and Treatment of Lunatics, and for the Provision, Maintenance, and Regulation of Lunatic Asylums in Scotland 1857*", known in short as the Lunacy Act (1857). It was assumed that if a person had a mental disorder they would, by definition, be incapable of making any decisions or of managing their own affairs.

The 1857 (Scotland) Lunacy Act, and the English Lunacy Act 1845 which preceded it, did not differentiate fully between people with a mental illness and those with a learning disability. There was an acknowledgement of different *classes* of lunatics, and there were some differences in treatment, but specific legislation for people with learning disabilities only came later, in *The*

1 *Mental Deficiency and Lunacy (Scotland) Act, 1913*. There were some early attempts to
2 differentiate types of learning disability, as idiocy and imbecility.
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5 The 1857 Lunacy Act defined those covered under the Act as:
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7
8 *“persons who by reason of mental unsoundness are unfit for the*
9 *management of themselves or their property are termed (1) furious or (2)*
10 *fatuous persons and (3) lunatics, the first of these terms applying to*
11 *maniacs the second to imbecile persons and idiots and the last to insane*
12 *persons generally”* (p3, Royal Lunacy Commission, 1857).
13

14 Four “classes” of lunatics are distinguished: dangerous, pauper (including fatuous paupers),
15 criminal, and foreign paupers. A further distinction is made, which is relevant to people with
16 learning disabilities:
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19 *“Weak minded persons (under Poor Law Amendment Act) are a different*
20 *class from fatuous persons classed with the insane as proper subjects for*
21 *confinement in madhouses”* (p24, Royal Lunacy Commission, 1857).
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24
25 In 1857, legislators reviewed the available evidence and were confident that building regional
26 asylums would improve the quality of life for lunatics in Scotland and place them, *“in a position of*
27 *comfort and protection”* (Commissioners in Lunacy (Scotland), 1859). The 3rd Annual Report of
28 the Commissioners in Lunacy for Scotland (1861) noted that:
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31 *“an asylum becomes the best security for the provision of humane and*
32 *appropriate treatment, by facilitating their removal from the influences of*
33 *unfavourable circumstances whenever, through the ignorance or*
34 *callousness of parochial authorities or the perverse conduct of relatives”*
35 (p181, General Board of Commissioners In Lunacy For Scotland, 1861).
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39 More than 150 years later, in the early part of this century, Scotland developed a system of
40 integrated regulation and inspection. This was built on existing legislation and to take account of
41 previous gaps in inspection activities (Campbell, Hogg & Penhale, 2012).
42

43 Historically, policy and practice has been used to regulate and improve services in two ways, by:
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- 45 • inspection agencies and inspectors to visit, observe and comment publically on services,
46 and;
- 47 • setting quality standards against which quality of care and quality of service can be
48 measured.
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51 These two components will be explored in turn in the following sections, followed by an
52 identification and analysis of persistent and ongoing challenges to each.
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Inspection agencies and inspectors

Between 1855-57 an inquiry by Royal Commissioners produced the *Report into the State of Scottish Lunacy, Lunacy Law and Lunatic Asylums* (Royal Lunacy Commission, 1857). This was the main political and social driver to the reforms introduced in the Lunacy (Scotland) Act, 1857.

A previous Act, in 1815 (Act to Regulate Madhouses in Scotland: 55 Geo. III c. 69), had established the right of Scottish Sheriffs to order the inspection of any public asylum, hospital or poorhouse in which lunatics were kept. These inspections were to be done twice a year, by the Sheriffs, accompanied by a doctor. In addition, this 1815 Act made it necessary for annual licences for, “*for the reception and the care and confinement of furious and fatuous persons and lunatics*”, kept for profit in private madhouses containing more than one person (Barfoot, 2009). The Royal Lunacy Commission report of 1857 recommended that any establishment with more than 100 patients should have a resident “*medical man*” (doctor) and houses with between 2-100 patients must be visited twice weekly by a doctor.

There was a number of factors that shaped the policy and practice of the first regulation and inspection services. Political and public acceptance of the need for inspection was first required, and public confidence that inspection would lead to improvement. However, both the value base and the evidence base of the Commissioners in Lunacy for Scotland were very different from what we now consider best practice. Financial considerations played a crucial role in the introduction of new legislation. The development of “lunatic wards” within poorhouses, as a temporary measure, and the building programme of larger, district asylums in the longer term, proposed in the 1857 Act, were both seen as savings to the costs being paid by local parishes for care of people at risk to themselves or to others. This was the main driver for change in most cases, rather than any humanitarian or evidence-based rationale. There was a shift from local to “regional” services, with an anticipated saving based on economies of scale.

In Scotland on 1st January 1858 the total number of insane persons was recorded as 5748, consisting: 2380 in Public Asylums, 745 in Private Asylums, 839 in Poorhouses, and 1784 in private houses (General Board of Commissioners in Lunacy for Scotland, 1859). The building of public or “district” asylums proposed in the 1857 Act was *in addition* to the existing private and charity-funded royal asylums, which housed patients from upper social classes.

Nineteenth century beliefs about causes and effective treatment of lunacy also shaped the design of inspection services:

“...a population of 79,887 paupers yielded more than one-half of the whole number of insane in the kingdom, showing the powerful affinity that exists between poverty and mental disease. Each is reproductively

1 *productive of the other, and alternatively cause and effect.”* (p37, General
2 Board of Commissioners in Lunacy for Scotland, 1859).
3

4 This is recognised today as an understanding of contributory factors; experiences of
5 poverty can increase the risk of mental illness and vice versa.
6

7 The method chosen for inspecting care conditions across Scotland was developed by the
8 Commissioners in Lunacy over a number of years. There were some local variations in how this
9 was done, as schemes of inspection improved. For example, the second annual report of the
10 Inverness District Asylum 1866 (Cox, Browne, Lyon-MacKenzie et al. 1866) gives an overall
11 inspection report, further separated into individual reports by the Medical Superintendent, the
12 Visiting Board and the Commissioner in Lunacy.
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17 Attempts to increase effectiveness of inspection activity have continued to the present day, and
18 improvements in the quality of care and quality of service are recognised measures of such
19 effectiveness.
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23 Social Care and Social Work Improvement Scotland (SCSWIS) began operating on the 1 April,
24 2011 following the Crerar Review (Scottish Government, 2007), created by the Public Services
25 Reform (Scotland) Act 2010. SCSWIS took over the functions of the existing inspection and
26 review agencies; The Social Work Inspection Agency, the Care Commission and Her Majesty's
27 Inspection of Education (child protection and the development of children services inspection).
28 These changes were part of a wider project known as Regulation for Improvement.
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33 SCSWIS had an initial budget of around £35 million and approximately 600 staff and the
34 organisation is now known as the Care Inspectorate. On 1 April, 2011 another new body,
35 Healthcare Improvement Scotland (HIS), operating a new integrated approach to the
36 improvement of health care services, replaced NHS Quality Improvement Scotland and took over
37 the regulation of independent healthcare services in Scotland. These were previously regulated
38 by the Care Commission. The Mental Welfare Commission (MWC) for Scotland is not a scrutiny
39 body *per se*, as they do not inspect or regulate services. The MWC operate independently, with a
40 focus on protection the rights of individuals, principally those with mental illness, learning
41 disabilities and related health conditions. This system of multi-agency inspection has evolved
42 from earlier models.
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49 The Care Inspectorate employs 611 staff, HIS 375 staff and The Mental Welfare Commission 55;
50 a total of 1041 (as of August 2016). Workforce and professional regulators form an additional
51 layer of inspection activity. The size of current inspection agencies contrasts with the original
52 plans for regulating care in Scotland in 1857. The Lunacy Bill (Scotland) 1857 caused concern
53 when it proposed, “*One commissioner and three subordinates*”, or, “*one commissioner and a*
54 *medical inspector*” (p7, The Glasgow Herald 1857) to inspect services across Scotland.
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1 When The Lunacy Act came into operation on 1st January 1858, it was with a recommendation
2 for a General Board of Commissioners in Lunacy for Scotland, consisting of three Commissioners
3 (two paid, one unpaid). The legislation allowed however, for the appointment of more
4 Commissioners, "*if they thought their duties necessary*". When it was set up, the Board had five
5 Commissioners: Chairman, William Elliot-Murray-Kynynmound, third Earl of Minto; two physicians
6 Dr.J. Coxe and Dr.W.A.F. Browne; and two non-medics, George Moir and George Young. Two
7 Deputy Commissioners were later added, Dr. A.W. Cockburn (in 1866) and Mr Arthur Mitchell (in
8 1870). The Board was responsible for the biannual inspection of every lunatic in Scotland, and for
9 producing an annual report. These individuals were the "professional regulators" of their time. Dr
10 Browne had worked at two large asylums (Montrose and Crichton Royal) and had been innovative
11 in both suggesting and implementing humane improvements in regimes and activities (Browne,
12 1837).

13 By 1877, twenty years after the Act was introduced, Commissioner Dr. Mitchell, estimated that
14 there was an average of one Commissioner for every 4,400 lunatics in Scotland.
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19 **Setting Quality Standards**

20 The Care Inspectorate Scotland currently use a 6 point grading scale (excellent, very good, good,
21 adequate, weak, unsatisfactory) to rate the quality of services (Care Inspectorate, 2013, 2015)
22 under themes of:
23
24

- 25 (1) Care and support
- 26 (2) Environment
- 27 (3) Staffing and
- 28 (4) Management and leadership.

29 Not all themes are covered in every inspection.
30
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32 Using these themes as a framework, the beginnings of quality standards can be traced to the first
33 report by the Scottish Lunacy Commissioners (General Board of Commissioners in Lunacy for
34 Scotland, 1859) and even earlier, to the 1847 Further Report of the Commissioners in Lunacy to
35 the Lord Chancellor (HMSO, 1847). In each of these four themes the evolving differences
36 between the individual or the institution as the "unit of inspection" should be noted, remembering
37 that "biannual inspection of every lunatic in Scotland" was the original intention. In modern day
38 inspection, for example, the individual is still the focus of Mental Welfare Commission work,
39 whereas the institution is the unit of inspection for the Care Inspectorate.
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- 56 (1) Care and Support
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1 Recommendations for what we now regard as “care in the community” or “ordinary housing”,
2 under care and support were made at an early stage in development of care services in Scotland.
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4 In the Second Annual Report of the Lunacy Commissioners there is an innovative
5 recommendation for:
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8 *“cottages or separate buildings of a simple character...in which patients*
9 *would enjoy an extended degree of liberty from being in circumstances*
10 *much more closely resembling those of ordinary life”* (p83, General Board
11 of Commissioners in Lunacy for Scotland, 1860).
12

13 The Report advocates a maximum of four people per cottage, with likely benefits of, *“more liberty,*
14 *more domestic treatment, more thoroughly recognised individuality”*
15

16 One year later, the Third Annual Report the Commissioners predicted:
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19 *“the time will come when it will be regarded as right, safe, and humane, to*
20 *leave many insane persons at the firesides of private houses, whom at*
21 *present we think it kind and judicious to confine in asylums”*(p112,
22 General Board of Commissioners in Lunacy for Scotland, 1861).
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25 In the same report there is an appeal for care and support based on individual need to be taken
26 into account:
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29 *“The features of insanity are so variable, and so dependent for their*
30 *expression on the circumstances in which the patients may be placed,*
31 *that it is extremely desirable that the law should afford every reasonable*
32 *facility for varying the manner of their disposal”* (p118, General Board of
33 Commissioners in Lunacy for Scotland, 1861).
34

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36 The merits of a, *“cottage system of management as practised in Scotland”* were praised. Again,
37 the rationale for improvements was influenced by financial, as well as clinical considerations, with
38 smaller scale accommodation, *“regarded by many as the only remedy for the increased demand*
39 *for Asylum accommodation, for the reduction of expenditure”* (p519, Tuke, 1870).
40
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42 Sadly, the early aspirations for more domestic style accommodation were not realised until many
43 years later. Instead, larger and larger institutions were built.
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46 47 (2) Environment 48

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50 In Appendix C of General Board of Commissioners in Lunacy for Scotland (1859) report, there are
51 *“Suggestions and Instructions issued by the Board of Commissioners in Lunacy in Scotland”*.
52 Although there is no systematic scheme in the form of grading scales for inspection, there are the
53 first attempts to regulate the environment. For example:
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- The site of the asylum, "*should be as central as possible to the mass of population in the county or district Convenient with respect to easy access to railway or other public conveyance, in order to facilitate the visits of friends*"
- Under "Plans of Lunatic Asylums", a maximum of 350 patients is recommended. This figure was based on the premise that the individual treatment of more than 350 patients was impossible, but also on the consideration that there was an increase in institutional costs for anything above that number (Wilkins, 1871).
- The Royal Lunacy Commission, 1857, which led to The Lunacy Act, made recommendations that features of the environment should be, "*calculated to inspire feelings of hope and confidence, soothe the irritable and encourage the helpless*". Similarly in the Third Annual Report of the Inverness District Asylum 1867, (Cox, Browne & Aitken, 1867) the importance of environment in treatment is acknowledged: "*Experience has clearly shown that their habits improve with every improvement made in their accommodation.*"

The recommendations about the environment from the time of these reports recognises improvements in this area are necessary, but not sufficient, to improve quality of care and quality of service:

"...little good will come result from mere improvements in the accommodation. We accordingly recommend that well-trained attendants should be procured, and that more method and order should be introduced." (p101, General Board of Commissioners in Lunacy for Scotland, 1862)

(3) Staffing

The main difficulties experienced by care service employers in the mid-19th century were similar to those of employers today; namely the recruitment and retention of suitable, trained staff.

"The importance of selecting humane and trustworthy attendants for the care of the insane." (p491, General Board of Commissioners in Lunacy for Scotland, 1860)

"One of the greatest difficulties under which proprietors of asylums labour is that of securing intelligent and trustworthy attendants, with characteristics of intelligence, good temper, firmness, forbearance, honesty and sobriety, with high moral qualities." (p87, General Board of Commissioners in Lunacy for Scotland, 1861)

One notable difference in focus of quality standards then and now is the requirements for staff conduct. In the mid-19th century, there was an emphasis on what staff should *not* be doing. The

1 original Inquiry Report (1855-57) into the standards of care was prompted by detailed accounts of
2 abuse and organisational incompetence, observed and reported to the British Government by
3 Dorothea Dix, an American campaigner who had visited the existing royal asylums and private
4 madhouses in Scotland (Tiffany, 1890; Gollaher, 1995; Campbell, 2016).

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7 For example, in specifying staff conduct that was unacceptable, there are references in reports to:

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10 *“no scolding, shouting or loud talking will be permitted”... “attendants will*
11 *be dismissed without notice for cruelty, drunkenness, acts of*
12 *insubordination, or the use of harsh, threatening or profane language or*
13 *any improper act “...“attendants gossiping regarding what takes place*
14 *within the Asylum, or the habits and peculiarities of those committed to*
15 *their care may at once be dismissed” (p35, Inverness District Asylum –*
16 *General Rules for Attendants, 1868).*

17
18 In contrast, today’s quality standards are based on recognised good practice, i.e. what staff
19 should be *doing*, rather than not doing. There are examples of good practice quality standards for
20 staff to be found in the early reports, but these are less numerous and less specific.

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23 *“Attendants shall at all times be careful that their manner to the patients is*
24 *kind and conciliatory ...and promote the happiness and comfort of those*
25 *under their care”. ” (p12, Inverness District Asylum - Patients Book,1875)*

26
27
28 The need for quality monitoring of staff competence in care services was acknowledged, as early
29 as 1861:

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32 *“the proper care of patients in asylums is greatly dependent on the*
33 *number and qualifications of attendants. We call for the return of their*
34 *numbers in every asylum and poorhouse with lunatic wards as on 1st*
35 *March 1860.” (p92, General Board of Commissioners in Lunacy for*
36 *Scotland, 1861)*

37
38 This need for specialist training was recognised early, but it was not until 2001, however, with the
39 introduction of the Regulation of Care (Scotland) Act, that this recommendation became a reality
40 across Scotland. The setting up of the Scottish Social Services Council (SSSC) led to the
41 establishment of a register of “Social Service Workers” in 2003. Employers (and employees)
42 were obliged to meet a code of practice for standards of professional conduct, and minimum
43 approved qualifications were set and reported to SSSC annually. As of 2014, there were 60,000
44 Social Service Workers registered with SSSC.

45 46 47 48 49 (4) Management and Leadership

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51
52 Management and leadership in care services are, perhaps, the areas in which quality standards
53 have been most improved by inspection and regulation of care services, although they also
54 remain the areas with the greatest ongoing challenges.

1 Before the 1857 Lunacy Act was implemented, the Royal Lunacy Commission (1855-57) looked
2 at care provided in run-for-profit licensed houses and private and charity funded asylums. There
3 was evidence of abuse and organisational incompetence in both (Tiffany, 1890; Gollaher, 1995).
4 One significant finding was that:
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8 *“the great difference between the licensed houses and the asylums arose*
9 *because the former were driven by economic gain for the proprietor, while*
10 *the latter were motivated chiefly by providing for the welfare and benefit of*
11 *the patient.”* (p112, Royal Lunacy Commission, 1857)
12

13 Some asylums were also run for profit.

14
15 *“In commenting on the condition of this asylum on former occasions, we*
16 *have expressed an opinion that pecuniary profit to the proprietor is*
17 *permitted to influence in too great a degree the comforts of the patients.”*
18 *(p54, General Board of Commissioners in Lunacy for Scotland, 1862)*
19

20 Prioritising financial gain over patient care remains an issue in modern day services.

21
22 *“Some [private hospitals] have up to 100 places. There has been*
23 *copious research showing that this is a model that just doesn’t work.*
24 *Over time it’s almost inevitable that the system leads to*
25 *institutionalisation and in the worst cases abuse.”* James Churchill,
26 Chief Executive, Association for Real Change. (Community Care
27 2006)
28

29 In 2011, a BBC Panorama investigation led to a serious case review, a number of government
30 reports (Dept. of Health, 2012a; South Gloucestershire SAB, 2012; Bubb, 2014), the closure of
31 the private hospital Winterbourne View, and a significant change in government policy. One of
32 the main criticisms of the company running the private hospital, was that it was *“putting profits*
33 *before humanity”* (Guardian, 26th October, 2012) a phrase more commonly associated with
34 unscrupulous drug companies, or, perhaps, factory farming.
35

36 The consequences of running a service for profit is that such services are accountable primarily
37 not to service users, or to the public, but to shareholders.
38

39
40 The competence of managers running care services is crucial to the quality of service provided,
41 and ultimately to the quality of life of service users. In comparing management and leadership of
42 services in the 1860s and now, the introduction of agreed, quality standards has led to significant
43 improvements. In the early inspection and regulation of care in Scotland, the “character” of
44 managers (and of inspectors) was seen as a major influence in the quality of services. For
45 example:
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48 *“With some exceptions, the proprietors are, as a class, totally unfit for*
49 *their duties... Condition of patients is determined partly by rate of*
50 *payment but still more by character of proprietor.”* (p95, General Board of
51 Commissioners in Lunacy for Scotland, 1859)
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54 *“The condition (of people) in individual parishes depends in no*
55 *inconsiderable measure on the character of the inspector, and the amount*
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1 *of energy he displays in correcting the abuses to which his attention has*
2 *been directed.”* (p118, General Board of Commissioners in Lunacy for
3 Scotland, 1861)

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6 What is described here as “*character*” might today be recognised in reports as the “value base” of
7 staff or managers (BPS/RCP, 2007; CSCI & HCC (2006).

8
9 Whilst there is little evidence in the original inspections of recommendations for what we would
10 understand as strategic leadership, focussing on agreed outcomes, core elements of inspection
11 services today, there is an acknowledgement that more than just good accommodation, or staff,
12 or managers is needed to provide good quality care:

13
14 *“... we feel that the principal change should be in the spirit in which the*
15 *establishment is conducted...”* (p85, General Board of Commissioners in
16 Lunacy for Scotland, 1862)

17 18 19 20 **Ongoing Challenges**

21
22 Compare the two summaries below. Both come from inspection reports for residential care
23 services. The first report is from 1862, the second from 2015.

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26 *“The Commissioners regret that they cannot speak in favourable terms of*
27 *the condition of this establishment. The Commission have so often*
28 *commented on this state of matters without producing any improvement,*
29 *that they have little hope of better success, so long as the present*
30 *management remains unmodified.”* (p129, General Board of
31 Commissioners in Lunacy for Scotland, 1862)

32
33
34 *“We did not find evidence that improving outcomes for guests was a*
35 *feature of the service, or understood by senior staff as being important...*
36 *Unfortunately overall, we found evidence of senior management lacking*
37 *sufficient drive, overview, clear direction or commitment to improvement.”*
38 (p4, Care Inspectorate, 2015)

39
40
41 The similarities in these extracts illustrate recurring themes that can be seen in a comparative
42 historical approach to inspection and regulation of services then and now. A number of difficult
43 challenges to improving services that faced inspectors in 1859 still persist today and are notable
44 by their longevity.

45
46 In reading the early reports, the “*zeal and assiduity*” (General Board of Commissioners in
47 Lunacy for Scotland, 1862) with which inspectors discharged their duties is evident. The small
48 number of commissioners covered vast geographical areas of Scotland, on a demanding
49 schedule of visits to all type of asylums, poorhouses and individual homes. They produced very
50 detailed reports, based on observation, describing the quality of service, care and life for
51 individuals, in an effort to highlight and improve all of these.

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58 *“It may possibly appear that we have described an unnecessarily large*
59 *number of cases, but we consider it of great importance that the extent*

1 *and magnitude of the evil should clearly appear.*" (p447, General Board of
2 Commissioners in Lunacy for Scotland, 1859)

3
4 The "*unstinting commitment and dedication to the organisation and its work*" (Care Inspectorate,
5 2015) of modern day inspectors is no less than that of their predecessors, but they have the
6 advantage of far greater numbers, coordinated strategic objectives based on gathered
7 intelligence, and a sophisticated "*outcomes-focused risk assessment that underpins new scrutiny*
8 *and improvement methodologies*" (Care Inspectorate, 2015).

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14 The ongoing challenges to inspection are identified by the organisations themselves in two ways:
15 (a) by individuals involved in inspection activity, and (b) by external review by independent
16 bodies. In the mid-1800s, only method (a) was available, whilst in 2016 (b) is the favoured
17 method.
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21 What follows is a few examples of difficulties reported by commissioners in early inspections. All
22 of these have modern day parallels.
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25 *"No one seems accountable, unless in those exceptional cases where*
26 *there is such gross neglect as to call for the intervention of the common*
27 *law... When treatment does not amount to a crime although it may come*
28 *close to it, you have no power whatever.*" (p191, General Board of
29 Commissioners in Lunacy for Scotland, 1859).
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32 The parallel here is the difficulty for inspectors defining abuse criteria and obtaining enough
33 evidence for a formal Adult Protection investigation or a criminal conviction under the Adult
34 Support and Protection (2007) Scotland Act (Campbell, Hogg & Penhale, 2012; Campbell, 2013).
35

36
37 *"No license has ever been recalled, notwithstanding flagrant abuses. No*
38 *penalties have ever been exacted though infringements of the [Lunacy]*
39 *Acts are incessant. Penalties for cruel treatment of patients and for*
40 *evading the Statutes are never enforced...their [patients] condition is*
41 *frequently most deplorable; and we (Commissioners) were too often*
42 *painfully conscious of our inability to improve it.*" (Appendix E, General
43 Board of Commissioners in Lunacy for Scotland, 1859).
44

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46 "Recall of license" (closure of service) and enforcement of a range of "penalties", including
47 Improvement Notices, are part of the remit of the Care Inspectorate, but this process can still be
48 lengthy and frustrating in relation to individual services:
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52 *"Our inspection team identified serious concerns last year, and we*
53 *recently reported on some limited improvements at the start of the year,*
54 *but the pace of change has been frustratingly slow. We remain concerned*
55 *that even where improvements have been made, they may not be*
56 *sustained.*" (Care Inspectorate, 2014)
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58 This service was subsequently closed.
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“the difficulty or rather the impossibility of disposing of the patients elsewhere has forced us to continue our licence to some houses which we would gladly see closed” (p462, General Board of Commissioners in Lunacy for Scotland, 1859)

Again, this is an ongoing challenge for inspection services today. The decision on whether a service is inadequate or has unacceptable quality standards should not, in an ideal world, be influenced by the resource implications of closing it, but inevitably it is. The problem of finding alternative, and better services for those displaced by any closure does affect judgements.

In setting up the new model for inspection services in Scotland in 2011-12, the Care Inspectorate was conscious of the Care Quality Commission (CQC) in England, which had been established in 2009. The CQC had been subject to a number of criticisms and subsequent reviews of performance, including a statement from the Chair of the CQC that the inspection service was *“not fit for purpose”* (House of Commons, Health Committee, 2014). Other reports had also been critical (Benbow, 2008; National Audit Office, 2011; House of Commons Health Committee, 2011, 2014; Public Accounts Committee, 2012; Dept. of Health, 2012).

Keen to learn from any lessons of the CQC, the Care Inspectorate and Health Improvement Scotland (2012a) analysed these critical reports and came up with 33 recommendations for the Scottish model of quality monitoring and inspection. Despite this, gaps remain. For example, the Care Inspectorate in Scotland do not have responsibility for inspection of in-patient services; a notable gap in external review of services for people with learning disabilities.

In 1857, Scotland also took its lead from England, where a Lunacy Act and a system of Lunacy Commissioners and inspection had been introduced in the 1844 English Commission and the 1845 Lunacy Act. The English legislation acted as a catalyst for later reform in Scotland:

“the principles of the treatment of the insane poor embodied in the lunacy legislation of the last twelve years, and evolved in the successful efforts of the English Commissioners in Lunacy to apply those principles to practice.” (p225, General Board of Commissioners in Lunacy for Scotland, 1860)

Summary

This paper reviews some of the changes in inspection methods and in quality standards, tracing the origins of inspection and regulation of care in Scotland. It also highlights ongoing challenges that exist in monitoring and improving the quality of service for those in care. The first attempts to set minimum quality standards came as a result of The Lunacy Act of 1857. The appointment of

1 Scottish Lunacy Commissioners, which resulted from the 1857 Act, was the first step to setting
2 minimum standards of care for people at risk of harm.
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5 Time period comparisons have been made in this paper between the four themes used currently in
6 grading scales by Scotland's Care Inspectorate (Care and Support, Environment, Staffing,
7 Leadership and Management) and the beginnings of these quality standards.
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10 The 19th century standards focussed more on environmental aspects of care and the *site* of
11 asylums, perhaps because that was where most evidence was available to justify decisions made.
12 Care and support standards focussed more on the *type* of asylums and smaller scale
13 accommodation, recognising the importance of the therapeutic setting in which care and support
14 was delivered to individuals. Early quality standards in relation to staffing highlighted the need for
15 particular staff "characteristics" and, only later, the need for specialist training. The importance of
16 strong leadership and good management to ensure the fidelity of patient care was also evident in
17 early inspections.
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24 Challenges to inspection of care for Commissioners in the 1850s persist in present day inspection
25 activity in Scotland. These include problems of adequate definition and identification of evidence, the
26 frustrations of trying to improve poor service standards and enforce the relevant legislation, and the
27 influence of resource considerations in responding to unacceptable standards of care and
28 sanctioning or closing poor services. A move away from "profits before humanity" has been
29 gradual, and there is evidence that this is a perennial problem.
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35 **Future developments**

36 Inspection practice is still evolving. In July 2016 the Care Inspectorate Scotland introduced a new
37 inspection methodology which:
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40 *"gives inspectors the flexibility to provide a more proportionate,*
41 *intelligence led and risk-based assessment of services, based on both*
42 *evidence and the inspectors' professional judgement."*(p3, Care News,
43 2016)
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45 New National Care Standards are also being developed by the Care Inspectorate in Scotland
46 (Care Inspectorate, Health Improvement Scotland, Scottish Government, 2016; Care
47 Inspectorate, 2016a).
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51 The drivers for these developments are the need for an optimal balance of evidence based and
52 value based judgements, combining the modern day quality standards with some of the original,
53 Lunacy Commissioners' judgement on what good services looked and felt like. Coupled to this
54 there is, in common with all public services, pressure to ensure best value for funding of
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1 inspection services. There is a danger however, that in new “lighter touch” inspections, replacing
2 more traditional “feet on the ground” inspections, good service is *assumed* in some services.
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5 *“..the inspection report for good-performing care services, where there are*
6 *no known concerns about the quality of care, will be more concise.” (p2,*
7 *Care News, 2016)*
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9 Inspection of services is largely *secondary* prevention. One of the premises on which inspection
10 services are based is that individuals at risk of harm will benefit from increased protection (Kalaga
11 & Kingston, 2007; Scottish Government, 2008; Faulkner & Sweeney, 2011). There is evidence to
12 support a number of methods of inspection, but no ideal format or comprehensive system of
13 inspection of services as yet. An independent review of how inspection data was collected and
14 related to quality standards was conducted by the Nuffield Trust (2013). This evaluated the
15 possible benefits of introducing ‘Ofsted-style’ performance ratings for hospitals, care homes and
16 other adult social care providers in the UK.
17

18 Examples were identified of initiatives in selected countries to improve the availability of publicly
19 reported data on the quality of health care.
20

21 *“analysis suggests that a clear gap has arisen in terms of the provision of*
22 *comprehensive and trusted information on the quality of care of providers*
23 *to inform the public and improve accountability.” (p10, Nuffield 2013)*
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25 The report concluded that a publically available ratings approach was more likely to be successful
26 for social care and less so for hospital care, because of the way ratings in hospitals were used
27 previously in the UK.
28

29 **Conclusion**

30 What conclusions can be drawn from a comparison of practice, then and now, in the inspection
31 and regulation of care in Scotland for people with learning disabilities and mental health problems?
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33 A pessimistic review of the evidence might conclude that despite improvements over 150 years,
34 inspection activity still fails to prevent harm to people with learning disabilities, those with mental
35 health problems and older people in managed services.
36

37 But is it the case that we don’t *know* how to effectively protect those at risk of harm through
38 inspection, or is it that we *have* the information, gathered over the years of analysis and the
39 numerous, post-abuse inquiries, but lack the political will to adequately resource care services, to
40 ensure the highest quality? i.e. that we have “*defiantly failed to learn lessons*” (Benbow, 2009).
41

42 There is a growing evidence base about best practice in inspection of services for people in
43 service settings who are most at risk of harm and inspection methods have had some success in
44 *reducing* this risk. Some problems recur as challenges to improving quality and a critical analysis
45 of inspection services may help focus resources most effectively.
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1 There are difficult decisions to be made about which methods of inspection and regulation of care
2 are most effective and the balance of effectiveness between primary or secondary prevention.
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4 The main implication for practice, from this historical analysis, is that we should make no
5
6 assumptions about the effectiveness of current systems of adult protection.
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