Inquiry into regulation of care for older people

Lothian NHS Board

NHS Lothian has a track record of working collaboratively with local authority partners and other agencies to achieve our ambition to be one of the world’s leading healthcare organisations and this includes developing joint plans and strategies to reshape care for older people and to ensure the highest quality of care is provided across the whole system.

Through our joint directors in West Lothian Community Health and Care Partnership (CHCP) and Edinburgh Community Health Partnership (CHP), there are key opportunities to deliver services on a more integrated basis, with East and Midlothian councils working towards a single social care directorate and in turn an aspiration across councils and NHS Lothian to see the development of a single Community Health Care Partnership in East and Midlothian.

In developing the response on behalf of NHS Lothian, views have been sought from a wide range of professionals who deal with the care of older people on a day-to-day basis such as chief nurses, general managers, key practitioners, including clinical nurse managers and general practitioners. Discussions have also taken place with our local authority partners, which has added value to the process.

Can we be confident that the regulatory system is picking up on care services where the quality of care is poor?

One of the key issues is the way in which reviews are currently undertaken and the mechanism for informing statutory authorities of any change in grading of the environment but also in the delivery of care.

The Committee will be sighted on a recent case within Lothian, where a care home which initially had a very good rating, within six months was then deemed to be delivering care at such a level that the home required to be closed and the residents transferred to alternative accommodation, including NHS care.

Within the current systems and processes there is a need to ensure that where the ‘health’ care needs of individuals are not being met that appropriate NHS personnel are informed timeously and also receive a hard copy of the Scottish Care and Social Work Improvement Scotland (SCSWIS) feedback reports. This would be an area where improvements could be achieved.

An example of good practice locally is where Edinburgh community health and social care colleagues now meet monthly with SCSWIS, to review all care home inspection reports that score 4 or below, with a view to a positive and proactive approach being taken with these areas, in an attempt to support staff to deliver high quality services and prevent crisis situations occurring.
Similarly, our other partnerships in Lothian have quality assurance frameworks in place, which include Memoranda of Understandings with SCSWIS to be informed of inspections that show improvement is required, as well as annual social work reviews, which adds to the development of the continuous improvement culture.

Although SCSWIS has been developing good practice guidance for care homes, it is unclear about the extent to which care homes ‘must’ adopt these. The commissioning of care through contractual processes would be key to ensuring the expectation to improve quality of care through best practice was achieved, with expectations indicated in contracts and service level agreements.

Feedback indicates that inspection visits, in care homes for instance, seem to concentrate more on the existence of systems, processes, and the physical environment as opposed to the application of these i.e. the appropriateness to ensuring good quality personalised care.

**Are there any particular weaknesses in the current system?**

Building on the comments provided above, one of the key issues is the timeliness of information being shared and with whom. Early warning that a home or a system might be starting to fail could then have the appropriate level of support and expertise put around it to prevent further deterioration. Other partners beyond SCSWIS have a role to play here. The quality dimension is one which organisations such as Health Improvement Scotland (HIS) have a role to play.

We know that there is a close relationship between these two bodies. Perhaps there needs to be greater clarity of purpose and function and how they not only relate to and communicate with each other but also how they support partners in social care and healthcare to deliver a framework around care homes to improve standards on a continuous basis as is the case within hospital environments.

A key element within hospitals is the clinical governance and quality improvement framework that exists against which evidence is gathered as part of the HIS programme. The requirement to have a similar framework in care homes would be beneficial and would aim to demonstrate continuous improvement.

One action that could lead to early detection is that an increase in the number and/or frequency of unannounced visits by SCSWIS may go some way to addressing some of the qualitative issues within care home environments.

Previous inspection agencies used to spend time in an area being inspected, on some occasions for up to a working week reviewing the quality of care, systems and processes in order to fully understand the workings of the care environment. Perhaps one way of strengthening the inspection assessment of the quality of the provision within care homes, should be a focus on
observation within the care delivery environment over a longer period of time, including different times during the day and night and when key activities are undertaken, like meal times.

This approach would also provide an opportunity to observe staff interactions, behaviours and approaches to service users, families and each other, which is considered a key indicator of quality provision. Some of these observations should occur on an unannounced basis to add strength to this element.

Another area of care which may require consideration is in relation to care ‘at home’. There is lack of clarity around how the regulatory system can confidently detect poor quality associated with care provision in someone’s own home. As there is a growth in the number of older people with more complex needs being cared for at home, and with the market share moving from local authority in house to commissioned services from third parties this may require further thought.

A positive development which is to be welcomed has been the recent inclusion of a rehabilitation consultant as part of the development process as is the service user involvement as advisors. Lay person involvement in the inspections for care homes will undoubtedly add benefit. Although professional medical and nursing opinion may be sought in individual cases by SC SWIS, this is often only as a result of a problem being identified. Therefore, the inspection process could be strengthened further through the involvement of qualified senior nurses who work in the field of ‘older people’ and that they should routinely be members of inspection teams.

It is helpful that from April 2011, Health Improvement Scotland, (HIS) now has a role to regulate independent healthcare services in Scotland, including regulating independent hospitals, voluntary hospices and private psychiatric hospitals. The element of nursing care provision within care homes, based on recent experiences would benefit from a similar level of scrutiny that is applied through HIS.

Additionally, an element of scrutiny that may alert regulatory bodies to potential problems would be the inclusion of a financial summary being provided for the care home business. As this will be considered commercially sensitive, there would require to be consideration about how this is reported. Within the contracting process there is often a clause indicating that there is a desire for the provider to have a certain level of ‘reserve’, which provides assurance that the business would be viable for a period of time, which would allow alternative arrangements to be made, if financial challenges were experienced.

**Does the system adequately take into account the views of service users?**

Unfortunately, it is often the case that service users are not capable of providing feedback on their own care/experience, owing to cognitive impairment or communication difficulties. That said, it is important that views
of service users are sought where possible but also that views from families and wider circles of support are sought and encouraged. In addition, there should be freedom for care staff to comment as they may know the service user better than most.

Views from staff should also include the support they receive to continually improve quality of care through ongoing education and information updates. A balanced view therefore requires to be obtained to complement more detailed observations to build a picture of the quality of service delivery and behaviours.

We would also recommend that the views of staff supporting the functioning of a home should also be sought, including where appropriate contracted general practitioner(s), community nurses and social work staff, which could add value to the inspection process and to the overall view of quality of care being provided.

In NHS Lothian we have a mechanism of capturing feedback through the contractual arrangements with general practitioners for providing primary medical services into care homes through a ‘locally enhanced service’. If this is not universally available, this may be worth considering as an option in relation to sustaining high quality care and also ensuring that there is a wider perspective on the quality of the environment and care.

**Does the registration and regulatory system provide an appropriate basis for the regulation, inspection and enforcement of integrated social and NHS care in the community?**

The ‘integration’ agenda is an evolving area. NHS Lothian can point to many examples of integration such as jointly appointed staff; joint service strategies, resources being utilised collectively and work around the development of the integrated resource framework (IRF) which is being used in three out of four partnerships locally to drive improvements in the care for older people. NHS Lothian and its partners are driving forward, through the joint plans and strategies for older people, the reshaping care of older people agenda, with the ‘change fund’ helpfully acting as a catalyst for whole systems changes to occur. The IRF tool will over time, allow these rebalancing of care changes to be clearly demonstrated in both activity and resource terms.

Further improvements could be made if the relationship between SCSWIS and the NHS was formally strengthened and appropriately resourced, to add value to the qualitative elements of care for older people in non-hospital settings.

Similarly, the SCWIS relationship with local authorities should be further strengthened as the predominant relationship is currently with the care provider. This often means that routine reports of inspections are only available to councils via the SCSWIS website, unless there is a negotiated agreement through the memoranda of understanding indicated in section 1.
In the longer term, the relationships with SCSWIS, HIS, local authorities and community and hospital health services should be strengthened as the purpose of HIS is to support healthcare providers in Scotland to deliver high quality, evidence-based, safe, effective and person-centred care; and to scrutinise those services to provide public assurance about the quality and safety of that care. Through the HIS framework, our local clinical governance and quality improvement mechanisms, we do ensure that high quality services are delivered within hospital and community health environments. There are cross cutting elements of healthcare through nursing in care homes for instance which should perhaps undergo a consistent standard of scrutiny, with equal access to improvement provided.

Again as highlighted previously, thought should also be given to how standards of care for older people with more complex needs are cared for at home are regulated.

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