Inquiry into regulation of care for older people

Mental Welfare Commission for Scotland

The Commission is happy to make comment on the questions posed by the committee. We are only in a position to comment on matters pertaining to the care of older people with mental disorder as defined in the Mental Health (Care and Treatment) (Scotland) Act 2003.

The Mental Welfare Commission has several important duties in relation to people receiving registered care services. These largely stem from our authority under the Mental Health (Care and (Treatment) (Scotland) Act 2003 (the 2003 Act) and the Adults with Incapacity (Scotland) Act 2000 (the 2000 Act). They include, in relation to people with mental disorder:

- The authority to raise matters of concern with Scottish Ministers and others
- The authority to raise matters of concern with Healthcare Improvement Scotland (HIS) and Social Work and Social Care Improvement Scotland (SCSWIS)
- The authority to investigate abuse, ill-treatment, neglect or other deficiency of care or treatment
- The duty to give advice relevant to our functions (with specific reference to the duty to give advice to persons with welfare proxy powers under the 2000 Act)
- The duty to visit people in a variety of care settings (including care homes and people in receipt of community care services) and/or who are subject to welfare guardianship under the 2000 Act or various orders under the 2003 Act

The committee will be aware of the joint report “Remember, I’m Still Me” (published jointly by us and the Care Commission). We think this report raised awareness of many issue relevant to the care of people with dementia in care homes. Many of these lessons could be transferred to other services, e.g. hospital and community care services.

These provisions give us the opportunity to comment of the care of individuals in receipt of registered care services. Our responses to the consultation questions are as follows.

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

We do not regulate care services but we do comment on the care of the individual people we see. We conduct visits to persons receiving care in

1 http://www.mwcscot.org.uk/web/FILES/Publications/CC__MWC_joint_report.pdf
certain places, e.g. hospitals, care homes and prisons. We provide summary reports to service providers after our visits. All our reports to registered care services are sent to SCSWIS. Usually, we raise issues specific to the operation of mental health or incapacity legislation and undertake follow-up work to ensure that services act on our recommendations. We also raise matters of concern about, for example, privacy, dignity and quality of life for the individuals we visit. We would alert SCSWIS to more general issues on quality of care. We ask SCSWIS to alert us to individual cases where we may need to investigate abuse, neglect, deficiency of care or treatment or unlawful detention.

Are there any particular weaknesses in the current system?

We do all we can to minimise the risk of duplication between us and SCSWIS. The above division of responsibility addresses this, but there is the possibility that the two organisations will take different views of a service given that the focus of visiting/inspection may be different. We are clear that SCSWIS is the regulatory organisation for care services.

One possible weakness, identified when developing standards of care for people with dementia (work coordinated by the MWC), is that National Care Standards may need to be revised. These were written several years ago. More recent work, including dementia standards and “Remember, I’m Still Me,” have provided recommendations and new standards. We recommend a revision of the National care Standards.

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

We know that SCSWIS makes determined efforts to obtain the views of users and carers. The MWC’s work is entirely focussed on the individual. Many people who receive registered care services are unable to give their views. Sometimes, individuals and their relatives can be reluctant to complain for fear of consequences. Independent advocacy is especially important. There is a need for collective advocacy for people in care establishments when those people have difficulty giving their own views or are unable to express any views. We would draw attention to guidelines on “Non-instructed Advocacy” published by the Scottish Independent Advocacy Alliance. It is important that NHS Boards and local authorities ensure that advocacy is available for people with mental disorder who receive registered care services. Also, for people who cannot express their views, we collate information from a variety of sources including case records, talking to staff and carers and observing the care the person receives to build up a picture of that person’s experiences.

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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?

We visit people subject to welfare guardianship and community compulsory treatment orders in the community. We are therefore in a position to see the totality of the person’s care. We have had concerns that, when things go wrong with an individual’s care, there is a lack of a joint approach to identifying what went wrong and why. Procedures under adult support and protection legislation are helpful but even then there can be problems, especially relating to primary health care. Our investigation reports often highlight poor interagency communication when individuals suffer deficiencies of care and treatment.

We hope this response is helpful to the committee. We would be happy to expand by giving oral evidence if requested to do so.

Donald Lyons
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