Inquiry into regulation of care for older people

Royal College of Psychiatrists in Scotland

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

Does the regulatory system ensure care services for older people are providing good quality and appropriate care?

The present system is seen as helping with this but by no means ensuring the same. The system appears firmly focused on checking standards do not fall below an arbitrary minimum rather than seeking continuous improvement. Even a very limited emphasis on “avoiding scandal” is only just making its presence felt in relation to community services, as distinct from care homes, and again a quality improvement ethos would appear preferable.

The capacity of care services to meet the bravely aspirational standards for dementia care currently being consulted upon is likely to serve as a litmus test for overall quality and appropriateness in terms of regulation.

The ability of existing arrangements to survive scrutiny, legal or otherwise, in terms of unjustified age discrimination will also be a challenge for any regulatory system. One simple example is the impression that unofficial resource “ceilings” exist for community care packages for older people prior to their being institutionalised, in contrast to younger people with learning disability or complex physical care needs. Given the scale of the issue(s) under consideration the overall lack of cost effectiveness data, or even research, is deeply troubling.

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

We can perhaps be reasonably confident that very poor care is being picked up but not that more modestly substandard care is readily detected. Uncertainty exists as to whether care homes which make lots of referrals, and frequently seek hospital admission for their residents, are functioning well or poorly in the eyes of regulatory authorities. The difficulties faced by regulators in truly grasping quality of life, or care, issues are readily acknowledged as analogous to those faced by clinicians in relation to the behavioural complications of dementia. Similar challenges in terms of conceptualisation and measurement justify an increasing emphasis on research into hitherto relatively neglected aspects of service delivery and its inspection / regulation.

Attention to proper implementation of AWI legislation falls well short of that in relation to the Mental Health (Care and Treatment) (Scotland) Act. Under the latter, individuals are identified, recorded and monitored.
leading, it can at least be surmised, to higher standards of care. The seeming tendency to focus on Welfare Guardianship more over the short term is perhaps a further weakness in terms of longer term care of older adults with mental illness. Difficulties demonstrating any advantages of “specialist” over generic care homes compound the issue further and it is to be hoped the inquiry will also pay due attention to the English experience in this regard.

Are there any particular weaknesses in the current system?

The dependence on self-reporting and paperwork, rather than direct inspection, was felt to be double-edged with anecdotes about the ability of some care homes to present this facet particularly well relative to the direct care experiences of their residents. The loss of bodies such as SHAS was commented upon though the seeming increase in the scope of MWC activity in relation to older people has been favourably received. It would seem illogical if hospitals, whether general or psychiatric, were excluded from the scope of this inquiry.

The overall profile of the Care Commission was seen, rightly or wrongly, as relatively low in terms of older people with mental health issues and some uncertainly existed as to the extent and effectiveness of their interactions with local authority supervisory systems in this regard. Clearer understanding of what are considered adequate staffing numbers and skill mix for care homes (e.g. numbers of RMNs in establishments supposedly specialising in dementia care) as well as more explicit requirements to be able to deliver ALL aspects of community care (e.g. interval night care) would be helpful.

The profile and consequences of a poor review, or perhaps a sequence of poor reviews, should arguably be higher. Unannounced visits were felt to be of particular potential benefit and similarities with hospital wards, where nursing colleagues frequently appear to face a choice between delivering care and writing about it, were readily acknowledged.

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

Probably not, though the difficulties of doing this when so many have significant cognitive impairment are not to be under-estimated. Issues such as independent advocacy for care home residents and ability to challenge Welfare Guardianship arrangements are probably beyond the scope of this inquiry but nonetheless still germane. The particular vulnerabilities of those living alone in the community are of special importance as this is the generally quoted “direction of travel” for future service delivery.

As a smaller and smaller percentage of older people enter care homes the challenges faced by these more “difficult” populations will intensify and the importance of truly appreciating their experiences of care will
continue to increase. It is debatable whether the NHS provides enough support for people who would previously have been long term inpatients. Trends towards specific general practices providing GMS input to specified establishments appear helpful but await evaluation. The importance of both commissioning and regulating integrated approaches from geriatric medicine and psychiatry of old age, as well as primary care, appears worthy of further study.

Many care providers worry about how regulatory bodies deal with complaints, perceiving a bias towards complainants rather than a truly balanced view. Certainly, an undue prominence often seems to be given to even minor complaints which might reasonably have been referred back to the care provider. While older people still probably complain less than they should, proper responses take a lot of time and effort which ideally could be put into improving care and it would be helpful if regulatory bodies put a greater emphasis on broadly based and constructive dialogue, not least when carrying out inspection visits.

**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?**

Levels of integration were felt to vary widely across the country in this context and may require to be a focus for central guidance or even legislation before the notion of *enforcement* can be usefully explored. Few examples emerged of this appearing to be a priority for current regulatory systems and again, fairly or unfairly, the Care Commission seemed to have a relatively low profile when viewed from the perspective of NHS staff involved with older people in general and their mental health in particular. Ideally, multidisciplinary community teams who are providing training and support for care home staff as well as individual reviews of complex patients would liaise with both commissioners and regulators.

Integration of social work and primary care systems does not, in general, appear to have been carried forward particularly effectively in relation to the mental health of older people within current CHP arrangements but that may be because it was made not an explicit priority for these struggling organisations. A good case can be made for regulatory bodies having some commonality of agenda and commissioning guidelines within whatever level of integration is considered achievable. One area of attention might lie in reviewing and comparing the percentages of both those whose needs are not being met and those who no longer require the level of care being provided.

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