Inquiry into regulation of care for older people

Scottish Care

Overview

1. Scottish Care is the national representative body for Care Home, Care at Home and Housing Support providers in the third sector and independent sector. Our aims are:

- to develop positive partnerships with all key stakeholders including service users and carers
- to support members in key areas of business and professional activity
- to effectively and constructively lobby, negotiate and represent the sector, and
- to develop the providers’ ability to deliver sustainable, high quality, outcome focused, personalised care services.

We welcome the opportunity to provide evidence for the enquiry by the Health and Sport Committee into the Regulation of Care for Older People addressing the key issue: Does the regulatory system ensure care services for older people are providing good quality and appropriate care?

2. Scottish Care has over 350 member organisations, delivering care and support services across 1,000 registered services, including residential and day care services, care at home and housing support.

Currently 85% of care home places and over 50% of care at home and housing support provision is delivered by the third and independent sector. This trend of outsourced provision is likely to continue and the required future expansion to meet demographic demand is likely to come mainly from private and voluntary providers. Evidence suggests that there has and will be limited capacity building within the public sector, as the development of new provision will be driven in large measure by the urgent need for greater cost efficiency, savings, and best value.

3. The social care workforce in Scotland has 54,150 care home workers with 36,400 located in the private sector and 10,010 in the voluntary sector. The care at home and housing support workforce has 63,750 workers with 43,820 workers located overall in the independent sector. In total, 38% of the social care workforce is located in the private sector and 26% in the voluntary sector; making this the largest social care workforce in Scotland. Quality of care depends on the quality of the investment in the workforce as well as the quality of training they can access. You can only attract, recruit and retain quality workers if you can offer a fair rate of pay. If councils enforce low charge rates, quality of staffing is and will continue to be an issue. Regulation has to be matched by investment in services.

4. Since the passing of the NHS and Community Care Act and more recently the Reshaping Care for Older People agenda, the crucial role of care
services in shifting the balance of care from acute and long stay institutions to the community has been acknowledged. Unfortunately reality has not always followed rhetoric and we are hopeful that this enquiry will add weight to the desire for change in the way our public care services are planned, commissioned, delivered, inspected and evaluated in the round. Scottish Care members continue to support the aspirations for personalisation and improved outcomes with a desire to be fully involved in developing practical responses and innovative service models. Members’ experiences of regulation to date demonstrate the emergence of a general positivity along with some concerns all of which interlink into the main overarching theme under review.

5. In our view, it is not possible to consider the regulation of care without an accompanying focus on the commissioning and resourcing of that care. For quality care to be realised, public care services must be resourced fairly and adequately to support the delivery of good quality care. Older people’s services have, as we know historically been under resourced. Care homes have enjoyed some degree of security through the National Care Home Contract (NCHC), although levels of funding have still been on the margins of viability. Care at home and housing support services however, have no agreed national contracting or funding framework. Public services delivered by statutory, voluntary and private sector continue to be resourced at varying levels but inspected to the same standards and with the same high level of performance, improvement and public expectation.

6. Previously the Care Commission was not tasked to look at the impact of poor commissioning or care management by local authorities on the quality of care. Historically this function rested with Social Work Inspection Agency (SWIA), who had no actual enforcement powers. The hope was that the new body Social Care and Social Work Improvement Scotland (SCSWIS) would be able to look at the service user’s care journey and experience in the round, covering assessment, commissioning, funding and support, as well as the direct service delivery by care providers. Despite the rationale for change, this level of integration still seems a long way off and SCSWIS still, does not have any enforcement power in relation to commissioning practices. SCSWIS can now make recommendations and publish reports were they see commissioning practices impacting on the quality of care. Disappointingly they still cannot not take enforcement or regulatory action in the way they can with providers who, have no control over the resourcing aspect of the services they are registered and tasked to deliver.

7. Scottish Care would suggest that in general the current regulatory system does ensure a basic level of quality and acts as a reasonable guarantee against poor practice being identified and appropriately addressed. However, regulation on its own may be more of guard against poor performance rather than a guaranteed route to high standards. More needs to be done to encourage and incentivise service improvement. The Care Commission published a number of reports, reviews and introduced the current grading scheme, all of which have been instrumental in driving up the visibility of standards. The regulatory annual return and the self-evaluation
process has provided access to useful information on core services and seeks to capture key workforce data which aids both analysis and improved planning. There is still some duplication in data collection and non-compliance due to system frustrations that have been identified by providers and systems have continually been improved by the regulator. We have equally seen benefits from the consultancy and advisory roles maintained by the regulator, coupled with a positive track record of offering support, open dialogue and advice to members within the limited and now reducing resources available.

8. In terms of doing what it says on the tin, SCSWIS was to have a higher profile on improvement and partnership working. Unfortunately, SCSWIS has had its resource base cut and is under pressure to focus on the core regulation aspects. This may conversely mean that they actually have less scope to engage with services specifically on improvement. There is a danger of being all stick and no carrot.

9. Over the past 4 years Scottish Care has been able to impact on quality and improvement by hosting the Independent Sector Workforce Initiative. The Initiative has delivered development resources such as ‘Tell Someone’ and ‘Care about Rights’. Funding to Scottish Care to sustain its work force function has now ceased due to the reprioritisation of government funding creating challenges on how we will deliver key work in progress for Palliative Care and Outcome-focussed Care Planning. These two resources are close to completion and aimed at supporting quality improvement. Again, workforce regulation on its own is unlikely to deliver the skilled and qualified workforce required for the future of older people’s care.

10. Following the publication of the Crerar Report, the emphasis was meant to be on reducing the overall burden of scrutiny and avoiding unnecessary duplication. Sadly, from a providers’ perspective, there is still considerable confusion and overlap, particularly between the role of the regulator and the contract monitoring function of the local authorities. All aspects of scrutiny and regulation have to operate within an overarching strategic framework, nationally determining the standards that we want to see, and which are affordable within the public purse.

11. Given the constraints of time at inspection, the focus can tend to be on the paper chain of evidence rather on direct observation of practice. How well a service does at managing the paperwork may become a proxy for the quality of care. SCSWIS has to remain committed to the triangulation of evidence from all sources. The perception of providers in relation to the first few months of the new SCSWIS operation is reported as more of a nit-picking and fault finding approach with less time being spent trying to understand where a particular service is, in its development. Good regulation and certainly quality care and continuous improvement depend first and foremost on maintaining a positive partnership between the regulator and those being regulated.
To inform the inquiry committee please find below written responses to the additional 4 questions posed:

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

   It is very important that the regulation of care supports service delivery and does not become an industry in its own right. Regulation needs to be proportionate to the care being delivered and flexible enough to respond to changing patterns of service delivery rather than becoming an obstacle to service development. Providers welcomed the potential of the new regulatory body, *Social Care and Social Work Improvement Scotland* (SCSWIS) to develop a fresh approach to regulation which looks at the experience of service users in the round, from referral and assessment to care delivery and review, ending the artificial divide which emanated from the Care Commission and Social Work Inspection Agency division. We believe SCSWIS required more time and resources at the outset to establish its new approach and that it should not simply be delivering more of the same.

   That said the current system of regulation and grading is overall welcomed by providers. There is merit in maintaining the independence of regulation, although it needs to respond to contextual pressures on the sector and also be open to challenge. Identifying services where quality is poor is the one thing it does well. However, equally, if there is a rapid deterioration in service quality due to unexpected circumstances, the regulator may and can be caught out. Increased confidence, partnership and support for improvement can help reduce such risks. On the whole regulation and inspection along with the early Regulatory Support Assessment (RSA) has managed individual service risk adequately and has sought to tackle resulting issues robustly. There is both room and a will to progress it further but this will only be achieved with an increase in the improvement and partnership roles and functions.

   **In December 2010 Scottish Care surveyed providers on their experience of regulation.**

   *Scottish care members were asked if they were aware of their current RSA level. 167 members responded. The majority (59.3%) answered low; 8.4% said high; 18.0% answered medium and 14.4% said they didn’t know. Those that responded with a high RSA were asked to explain what circumstances had led to this. Reasons given included complaints; outstanding recommendations; management changes and low inspection grades.*

   *Members were asked whether they agreed with the statement: “The current complaint system is working and will improve services.” 159 people responded.*

   *The majority (56.6%) agreed; (26.4 %) disagreed; (6.9%) strongly agreed and (10.1%) strongly disagreed.*
Comments tended to centre on the following issues; lack of appeal process; the unfairness of anonymous complaints. Comments included:

- "The lack of opportunity to appeal to the regulator is extremely frustrating and leads to a strong feeling that it is often a very one sided process."
- "Disgruntled staff has an open door to fictitious complaints."

2. Are there any particular weaknesses in the current system?

Separate systems for regulating care and commissioning care continue to undermine real progress; you simply can’t have a body driving up standards in services when those very services are not then sustained by adequate resources. The trend in commissioning and procurement has been to reduce care delivery to the minimum time and task-focused transaction possible. As a Care at Home provider recently commented: “often the root cause of issues is the time allocated by the local authority - 15 minute visits are being used in an attempt to drive down the cost of care and not necessarily used because a 15 minute visit is appropriate”

The danger here is that quality of life and desired quality of care outcomes become secondary considerations to cost. Finding creative solutions rather than succumbing to short-term, financially expedient, non-strategic courses of action is the real challenge. The current fiscal position means that providers are being forced to take cuts in revenue streams that are already the lowest in the sector. Increased standards clearly have an on-cost and accordingly there is no point of having robust regulation if the public purse can’t afford the funds to meet the standards aspired to. Providers are and will continue to go out of business and/or fail in the delivery of quality care if these issues are not addressed. We need open dialogue about the drive for continuous improvement along with an open review on sector and service neutrality in respect of costs. The regulator has argued, rightly, that increased resource is not in itself a guarantee of improved performance, leadership, ethos and creativity are all crucially important. However, the lack of resource below certain minimum thresholds is a serious impediment to the delivery of quality care.

Inconsistency in regulation is repeatedly raised by our members: increased confidence, less subjectivity and more consistency are required going forward. SCSWIS inspections are often perceived to be overly judgemental and subjective. We have experiences of organisations that operate in different parts of the country being graded as 6 in one service area outlet and as a 3 elsewhere, when the same corporate policies, procedures and practices are used. Further development of the original RSA process is required; it is currently carried out in isolation from both services and providers and at times, open to a higher level of subjectivity than is helpful or necessary. The consequences of a high RSA in response to minor variations can impact negatively on services, damage viability, and lessen staff morale.

With regards to the current grading system potential weaknesses include:
• High performing services with grades of 5 & 6 receiving less attention. The challenge is ensuring that the corresponding lighter touch regulation does not miss any reduction in quality.
• On the other hand, there can be a self-fulfilling prophecy, whereby providers with low grades receive increased and continuous scrutiny, resulting in a counter-productive level of pressure.

There is some concern that providers with low grades have also struggled to get re-graded and consequently this has had negative effects on their ability to sustain and bid for new business, overall lowering staff morale. Continued duplication of scrutiny by Local authorities through contract monitoring, whilst the regulator and service providers are experiencing a reducing resource base, must be addressed going forward.

Scottish Care members agreed that grading has shown evidence of improvement; (64.4%) of 160 respondents said they were “satisfied” with their current grades. The majority of 173 respondents graded their own service “higher” (51.4%). (45.1%) graded it the "same" and only (3.5%) “lower”.

Differences in grading - 153 members answered the question: “Do you feel there is a fair process to resolve any differences in grading?” The responses were split fairly evenly – (47.7%) answered yes and (52.3%) answered no. Comments included: Services not wanting to challenge the Inspecting Officer in case it affected their relationship with the regulator; Depends on the relationship between the Inspecting Officer and service – if there is a good working relationship in place then it can be easier to discuss; Lack of consistency between Inspecting Officers – grading based too much on personal opinion and can be subjective; There should be a formal appeals process; Inspectors should rotate.

Specific comments: “I feel this rounding down of grading can be demoralising and crush the incentive to perform well. Basically prospective residents appear to be only influenced by the overall grade of the theme.” “Feel individual inspectors are fair but there is a lack of standardisation.” “There is no formal appeals process, this is outrageous!” “Totally contrary to common law in every respect.”

Members were asked whether they agreed with the following statement with regards to regulation: “There should be an appeals process. 175 people responded (98.3% agreed / strongly agreed. The responses were split as follows: the majority (56.6%) strongly agreed, (41.7%) agreed, (1.1%) disagreed

Scottish Care Members were asked whether they agreed with the following statement: “Overall presentation, professionalism and conduct for Care Commission Officers are satisfactory.” 167 people responded. The majority (62.9%) agreed, or strongly agreed (25.1%); (8.4%) disagreed and (3.6%) strongly disagreed.
Other areas that Scottish Care feel the committee may wish to consider include:

2.1 **Registration;** the current ‘care service’ registration process is cumbersome; it discourages service innovation and flexibility. The system requires providers to carry multiple and costly registration types to deliver services across a range of needs and outcomes. We have a system that expects users to fit into fixed silos of care provision as opposed to services that can flexibly respond to individual people who use services. This all adds to the burden of management, administration, and cost of scrutiny. A solution would of course be to register the ‘organisation’ given its prime function, ‘wholly or mainly’ with the added flexibility to respond to individual need.

2.2 **Self-evaluation;** this is core to the future of self-assessment proportionate scrutiny. We would support self-evaluations becoming continual live documents available in the public domain. This would complement any development of the RSA, inspection methodology and inspection reports.

2.3 **Grading;** review the negative aspects of the rounding down of grades in particular circumstances and linked to a risk benefit approach.

2.4 **Variations and changes;** in a limited number of situations variations can bury both good and bad news on providers, consider developing links to previous reports of interest following e.g. acquisitions until updated reports become available.

2.5 **Inspection Officers;** review the effects and importance of both long term and frequently changing inspection officers on services as an identified factor on grading, improvement and quality outcomes.

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

Yes, but as with any system, it is those who are motivated or more able to engage, who get heard most. The regulator has sought to encourage the participation of people who use services. Providers are graded and judged on how well they solicit and make use of service user feedback and the regulator asks to see evidence of this, services are downgraded where service user engagement is judged to be low. Providers welcome such an inclusive, open approach but it can be weighted in favour of the more vocal service users, or more commonly relatives, and can be open to misuse by anonymous, vexatious complaints which often result in regulatory action. The majority of complaints are partially or fully upheld as often the regulator will find something that is not always related to the primary complaint. Like other sources of evidence, it is the balance of service user experience that needs to be tapped into.

*Scottish Care members were asked whether they agreed with the following statement: “The self-evaluation and grading scheme promotes greater involvement of people and carers who use services.” 167 people answered this question. The majority (55.7%) agreed or strongly agreed (25.1%); (17.4%) disagreed and (1.8%) strongly disagreed.*
Respondents were then asked whether they agreed with the statement: “The participation of people who use services enhances care provided.” 168 people answered this question. The majority (51.8%) agreed, or strongly agreed (38.1%). (8.3%) disagreed and (1.8%) strongly disagreed.

Asked if they agreed with the statement: “The participation of lay assessors enhances care provided. (44.9%) agreed, (9.5%) strongly agreed, (38.1%) disagreed and (7.5%) strongly disagreed. A significant proportion of respondents who commented had no experience of a lay assessor at inspection. The majority of respondents who had experienced a lay assessor at inspection and commented were not positive. Comments made include:

- “My experience is that they often do not have the skills or understanding regarding the service.”
- “This is not for amateurs.”
- “My only experience of a lay assessor was not a positive experience and a service user found it intrusive and inappropriate. The lay assessor appeared to be emotionally needy and this alarmed some of the service users.”
- “Lay assessor who inspected our home made inappropriate statements and lead to unsatisfactory judgements.”
- “Lay assessors are beneficial in the inspection process but they do not enhance the care provided in any way.”

Some members commented
- “Inspectors appear mainly to be interested in policies and paperwork.”
- “Too much emphasis on paper trails and not enough on observation or taking resident/family opinion into account.”

Other comments made, again suggested that regulation experiences are very much dependent on the individual Inspecting Officer:
- “Some officers are very open and supportive, some give the impression that they are ‘out to catch you out’.”
- “We have an excellent professional rapport with our inspector”.
- “My previous officers could occasionally have an attitude but we did have a good relationship, present 2 officers are fantastic – they offer support and advice.”

4. 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?

No, this needs to be improved as the care of older people has and will become more complex requiring effective, flexible regulation across all its component parts. The options are: one large body to do it all or more is collaboration between the various regulatory bodies e.g. SCSWIS, MWC, HIS, NMC, SSSC etc. We need to ensure there a holistic approach which tracks the experience of service users. For example, there is no point in SCSWIS looking at the use of medication in Care Homes, if this does not include the
simultaneous examination of the role of GPs who do the prescribing. The danger otherwise is of meaningful regulation falling between the different regulators.

At present we still have a disconnection with the acute sector, primary care, GPs, the end user and providers. The regulatory system needs to look at the full range of inputs. Health and Social Care integration will require a more joined up approach to regulation in line with new emerging models of care delivery such as reablement, step up and step down care and virtual wards. The more we create integrated care the more we will require the development of integrated regulation with effective partnership across multiple agencies.

Information sharing between all the partners needs to be addressed through, for example, the interlink proposals. This would be assisted by a single unique identifier for people who will increasingly use the integrated services of today and the future. There are concerns around the differing and poor levels information sharing. Absence and duplication of assessment and associated risks could be better managed if partners provided detailed information regarding the service user and the service required from the outset. Far too often providers report that they are given the very minimum details and have unacceptable time lines from the initial referral until they receive full information. Again, any judgement about the quality of care being delivered has to take account of the part played by all the relevant parties.

Final comments

Scottish Care can advise the committee that members believe in regulation and are committed to driving up standards and achieving better outcomes for service users, albeit in line with the resource envelop available. Providers in general are also keen to see poorly performing services brought into line. However this needs to be based on working with the sector to across all the aspects of service planning, commissioning, funding and delivery. Regulation on its own, however robust, will not produce the quality of care we all aspire to for Scotland’s older people. To that end, Scottish Care is happy to participate in oral evidence sessions and a number of providers have offered to facilitate visits for members of the Health and Sport Committee to a cross section of Care Homes, Care at Home & Housing Support Services.

Link to Scottish Care Manifesto:

http://www.scottishcare.org/docs/CCB_(Scottish_Care_Manifesto)_A4_Low_(2).pdf

Ranald Mair
CEO
Scottish Care
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