Inquiry into regulation of care for older people

North Lanarkshire Adult Protection Committee

This submission from North Lanarkshire Adult Protection Committee is based on the premise that regulation of care relates to both care at home, and care within a residential setting.

We are aware that North Lanarkshire Older Adults’ Partnership Board is submitting evidence. This submission will focus on regulation of care in conjunction with adult protection.

We would also wish to comment that any concerns or issues raised are likely to be relevant to the regulation of care for younger adults.

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

We recognise that ensuring the quality of care provided in any setting is the responsibility of a range of agencies which have particular responsibilities. This would include:

i. Local authorities and NHS – through both commissioning and contracting with services, and also under care management responsibilities

ii. Service providers – in working to ensure they meet the National Care Standards as set out in their registration agreement

iii. SCSWIS and other regulatory bodies.

iv. Adult Protection Committees – who have a responsibility to call to account the robustness of agency procedures and processes.

Service users and their families should also be able to contribute by having an awareness of the mechanisms whereby they can raise matters and contribute.

It would be anticipated that having an array of mechanisms in place, all of which should be responsive to any evidence of poor quality of care, should provide a robust overview. However, it is apparent from a range of reports, including reports by the Mental Welfare Commission and recent media reports, that there can be failures in the responsiveness of these systems.

There is a concern that having such a range of responsibilities, sitting across a number of agencies, could contribute to some confusion in roles and responsibilities when responding to allegations of poor practice.

The Adult Support and Protection (Scotland) Act 2007 (ASPA) clearly sets out duties and responsibilities for public bodies when it is known that an adult may
be an ‘adult at risk of harm.’ Within North Lanarkshire, procedures have been produced which seek to clarify the various roles and responsibilities when the adult at risk is in receipt of a registered service, either at home or within a residential setting.

This has led to fuller consideration of:

i. The linkages between poor standards of care and adult protection, and the management of processes when Social Care and Social Work Improvement Scotland (SCSWIS) has responsibilities under the National Care Standards and the local authority under ASPA, and

ii. the local authority, in carrying out its duty to enquire under ASPA, having a greater responsibility for responding to poor quality care across a range of settings, which includes hospitals.

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

Areas within the regulation of care which could be seen as weaknesses within the system include:

i. A number of registered care services are registered as offering ‘specialist’ services for people with different conditions, including dementia and alcohol related brain damage (ARBD). At times it is not apparent what ‘specialist' means as there does not appear to be any additional or altered service requirements from those provided in general care settings. If a care setting is awarded a specialist categorisation, this should be reflected in both the regulation and inspection processes.

ii. The current methodology of inspection could perhaps be improved by including a focus on a thorough review of all aspects of the overall service to individual service users.

iii. The inspection process can take an extended period to report. For people wishing to access inspection reports, such delay in the publication of inspection reports can significantly diminish the value of such reports.

iv. Areas subject to inspection may require to be reviewed. It is not clear that inspectors are taking an overview of a service’s responsibilities under Adults with Incapacity legislation. This would include ensuring S47 certificates were in place, and that the service was aware of the powers contained within Power of Attorney and Guardianship arrangements.

v. Another area that should perhaps be subject to review is the balance of social and nursing care within those services that provide both social and nursing care. It is known that following the Regulation of Care (Scotland) Act 2001, there was an increased focus on inspections
identifying the social care element within care settings, but there is concern that perhaps the focus on the nursing care provided has diminished.

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

Whilst there are required to be complaints mechanisms available within all registered services, it is known that both service users and their families can be reticent about using such processes. One reason identified for this is concern that the person in receipt of care may be fearful of the impact of complaining.

Service user surveys can be used as a means of gathering the views of people using services. These can be initiated by the service provider, commissioner or regulator. There is a concern that whilst all these bodies are proactively seeking views, it would benefit from a more integrated approach and sharing of information if survey fatigue is to be avoided.

There is also a concern that information produced from such surveys will be very general, and not identify any real concerns. Sampling across the range of people using services, and completing more detailed face-to-face questionnaires may provide a more comprehensive account of the views of service users. An increased focus of surveys on outcomes for people using the service would be more helpful in identifying the difference a service makes to them.

**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?**

Following the recent reorganisation of regulatory bodies, SCSWIS and Health Improvement Scotland (HIS) have been formed. The Healthcare Associated Infection (HAI) Task Force was set up in April 2009 to undertake announced and unannounced inspections in each acute NHS hospital in Scotland. The Mental Welfare Commission (MWC) has a responsibility to visit people with a mental disorder, to investigate any concerns regarding care and treatment and will produce reports on enquiries carried out.

As stated above local authorities now have a duty to enquire into situations where an adult may be an ‘adult at risk of harm’ and the authority may need to intervene to protect the person’s wellbeing, property or financial affairs.

Similarly, the Office of the Public Guardian (OPG) is tasked with investigating any circumstances made known to it in which the property or financial affairs of an adult appear to be at risk.

The registration bodies for professional groups also have in place requirements for professional staff to report any matters of concern regarding practice.
As previously stated, there is a concern that despite a range of mechanisms in place which should identify when the quality of care is poor, it is evident that at times all mechanisms can fail.

When an organisation does become aware of a concern and responds, again there can be confusion regarding the roles and responsibilities of the various agencies. Though good practice and legislative responsibilities do require agencies to share information and work together in their response.

At this time, it is not clear that there is a properly integrated regulatory system for the regulation, inspection and enforcement of social and NHS care in the community, either for people at home or resident within care homes or hospital.

Rab Murray
Independent Chair
North Lanarkshire Adult Protection Committee
26 August 2011