The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 6 September 2011

Session 4

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CONTENTS

HEALTH AND SPORT COMMITTEE
4th Meeting 2011, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Jim Eadie (Edinburgh Southern) (SNP)
*Mary Fee (West Scotland) (Lab)
Richard Lyle (Central Scotland) (SNP)
*Fiona McLeod (Strathkelvin and Bearsden) (SNP)
*Gil Paterson (Clydebank and Milngavie) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab)
Anne Conlin (Carers Scotland)
David Manion (Age Scotland)
Henry Simmons (Alzheimer Scotland - Action on Dementia)
Lord Sutherland of Houndwood

CLERK TO THE COMMITTEE

Douglas Wands

LOCATION

Committee Room 2

Scottish Parliament

Health and Sport Committee

Tuesday 6 September 2011

[The Convener *opened the meeting at 10:00*]

Decision on Taking Business in Private

The Convener (Duncan McNeil): Good morning and welcome to the fourth meeting of the Health and Sport Committee in the fourth session of the Scottish Parliament. I remind those present to turn off mobile telephones and BlackBerrys. Apologies have been received from Richard Lyle MSP, and the committee has been joined by Malcolm Chisholm MSP. The first item on our agenda is a decision on whether to take in private items 3 and 4, which are consideration of the committee's approach to its inquiry into the regulation of care and a review of its work programme. The committee is also invited to decide whether to take in private future consideration of evidence received and draft reports on its inquiry into the regulation of care for older people.

Members *indicated agreement.*

Regulation of Care for Older People

10:01

The Convener: Item 2 is our first oral evidence session on the committee's inquiry into the regulation of care for older people. I welcome Lord Sutherland as the first witness—we are pleased to have him along. Lord Sutherland chaired the 1997-99 Royal Commission on LongTerm Care of the Elderly which, along with making recommendations for funding of long-term care, concluded that a national care commission was required. This morning the committee has the opportunity to consider what was envisaged by the royal commission compared to the current regulatory framework. Lord Sutherland would like to make an opening statement. We will take that before moving to questions.

Lord Sutherland of Houndwood: I thank the convener for the invitation. I keep an interest in all this and I have a particular attachment to the Scottish Parliament because of the positive response to many of the matters that our committee worked on.

I will say two things. First, there is an unexpected tension in devolution. I should be preparing for the Scotland Bill debate in the House of Lords but am here instead, so there you are. That is a tension none of us envisaged.

My second point is a health warning in that many committee members are more expert in this than I am, as I expected. A broad sense of direction and the matters that we hoped would be picked up remain at the forefront of my mind. I have been arguing the case with the Dilnot commission south of the border, as well as what is happening here.

I was shown a suggestion of points to discuss and I can make two or three general remarks to begin. It was suggested that a long-term care commission, which the report recommended, was something that the committee might want to consider. The intention behind that began from the obvious premise that we are all fallible. Members of the commission knew that we might get some things right and that it was quite possible that we would get things wrong or that circumstances would change. The speed of change of demography and advances in health science mean that the matter should be re-examined in terms of quality of provision and cost. We modestly suggested that after five years it would be time to examine how matters were developing.

The Scottish Parliament asked for a mini version of that examination so a number of us sat down after five years and prepared a report responding to the teething troubles. I hope that it was also positive about what had been achieved. I have tried to carry the message south of the border that much has been achieved. Money is involved, but the Parliament and Executive in Scotland have 10 years of experience of dealing with an issue that, south of the border, has hardly been defined. Otherwise, the Dilnot commission would not be running down the same tracks that we went down.

The Scottish Parliament has 10 years of experience, which is not to say that you have solved all the problems; indeed, there are big problems ahead, which you all know about. However, it is still the case that local authorities talk to the Executive up here, whereas at one point 18 months ago down south they were communicating through the letters columns of *The Times*, which is no way for a discussion about the future of such an important issue to take place.

I have been very positive about your understanding. The short interchange that I had with the Cabinet Secretary for Health, Wellbeing and Cities Strategy and her colleagues about 18 months ago covered the question that we had commented on, which was; “How far should health and social services be integrated?” I made what I hope was a pragmatic suggestion by saying that given that you have a lot of experience, that integration is happening informally very well in some places, tentative steps are being taken in other places and you have had the Arbuthnott report on local authorities combining services and so on, given there is a lot that could be put into practice as pilot studies. My understanding is that that is going ahead, so I hope that you will take due note of what is working and what is not working, which is very important.

I believe that the integration of health and social care services is, in the medium and long terms, one of the essentials for ensuring quality and sustainability of care. We all know the size of the demographic problem and the financial position that, by and large, all European Governments are in. I strongly recommend that looking at integrating those services be part of the focus of how you begin to address quality and sustainability.

Additional factors have come in. We recommended in our five-year review that there be a national agreement on eligibility criteria, entitlement to an assessment and portability of benefits, which were all issues about which difficulties, niggling problems and sometimes real problems had arisen for individuals. Again, recommendations have been made on that and I think it is important that we see that they are carried through.

There are two or three basic principles. One is to ensure the best quality of care, which I know is the committee’s concern. A second is to ensure that there is fairness of provision so that no particular group is disadvantaged. The third, which is a means of moving towards that, is to spread the risk. The risk—this is still the case in England and will be until something is done about it—is that if you have Alzheimer’s, the danger financially and in terms of the quality of care is much greater than it would be if you have lung cancer or need a liver transplant. That is not an adequate position. I commend what has been achieved here in terms of spreading the risk.

The Convener: Thank you very much. The first question is from Mary Scanlon, who will be followed by Richard Simpson.

Mary Scanlon (Highlands and Islands) (Con): I actually have two questions, convener. Does the implementation of the report of the Royal Commission on Long Term Care for the Elderly meet, exceed or fall short of your expectations?

Lord Sutherland: I am always an optimist and if you are an optimist things always fall a little bit short of your expectations. However, one of the huge changes is in the financial position of this nation and other nations in Europe. I foresee some major problems resulting from that, which is why I am stressing the importance of the national spend on health and social services. That spend is very great. The Dilnot figures are very informative: only 8 per cent, or possibly less, of the public money that is spent on health and social services and so on for retired people is spent on care, while the other 90-plus per cent is spent on health, housing and benefits of various kinds. That really needs further inspection. Looking at how best you spend the money is priority 1.

Yes—I would like to see better provision in a number of ways. I noted in your very good briefing paper the statistics in tables 3, 4 and 5 about the quality of the activity of various people in the care system. The assessment scores of those in care homes tended to be systematically lower than those in other areas of care, which is a concern. If you are looking for places where prodding needs to be done, that is one. Perhaps the questioning will develop that.

Mary Scanlon: You have taken me very easily to my second question by raising the issue of the quality of care.

On the issue of the lead authority, I am pleased that NHS Highland and Highland Council are leading the way, with NHS Highland being the lead authority on care of the elderly. However, my second question concerns the quality of care. The framework and the mechanics are in place, but in almost all of the submissions there are shocking figures on quality. I would like to give you one or two figures before asking you what can be done.

Some 11 per cent of care homes are graded 1 and 2, which means that they are weak or unsatisfactory. I do not think that they should exist as care homes. I was shocked to see that, in East Ayrshire, 35 per cent of care homes are weak or unsatisfactory. Last week, the ombudsman told us that 42 per cent of NHS complaints were upheld. Some 82 per cent of complaints about care homes were upheld. Only 17 per cent of our care homes were top graded.

Another thing shocked me as I was doing a bit of homework for today's meeting. The Scottish Social Services Council was to be the vehicle for training staff with regard to dementia treatment and so on. When I sat on the Health and Community Care Committee with Malcolm Chisholm and Richard Simpson in 1999, I did not appreciate that staff in care homes for the elderly would have until 2015 to register. What is even more shocking is that support workers for care at home have until 2020 to register. They will have been able to have had a 20-year career without even registering. I feel quite passionate and angry about that. We are talking about quality, and those are not the quality standards that I was led to believe would be in place. I understood that staff would be trained and would understand elderly care. Most of the scandals over the years—at the Elsie Inglis nursing home and so on—have involved the standard of care. Have we been less robust than we should have been by allowing people 20 years to register and by allowing many of them to work without having any training? Is that good enough?

Lord Sutherland: I saw in the briefing the figures that you are referring to, and I was surprised about how long it would be before there would be a requirement for registration. That should be looked at.

If there is a problem with staffing, we must ask why. There are two obvious answers: one is training and the other is pay. I hear that, in Edinburgh, some of the care homes have a problem during the summer because the workers can get better pay taking up casual jobs during the festival. If that is true, it tells us something about the value that we attach to the rewards that we give to people who work in care homes. Quality of staff is fundamental to your main point, which is the quality of care provided. That involves issues of training and reward.

In terms of inspection, there are issues about how much information has to be provided about recruitment and retention of staff. If you go into a care home or any other place of employment and find that retention of staff is bad, it is a sign that something is wrong. That will show through in terms of the quality of staff, which feeds into the quality of care.

There are a lot of detailed points to be considered but, on your general point, I was surprised when I saw how long the registration process will take, and I would like to ask why it will take so long.

Mary Scanlon: Could I make a final point on the quality—

The Convener: We are now nearly 15 minutes into the session. Richard Simpson has a question.

10:15

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I want to move us on to an area that we discussed when we originally considered the Regulation of Care (Scotland) Bill. If you remember, Lord Sutherland, one of my concerns was that the local authority would be, in effect, a monopoly purchaser under the free personal care system. On the one hand, we had a monopoly purchaser and, on the other, a care commission that determined the quality of care. One of my concerns was financial viability. I am sorry if my fears have been fulfilled in the Southern Cross business.

Do you have any comments or suggestions on how we move forward on that? If Social Care and Social Work Improvement Scotland wants a provider to increase the number of trained staff, reduce the number of double rooms or improve this, that or the next thing, that all has a cost. If the local authorities turn round and say that they will not give the providers any more money, it could be that the Southern Cross homes are just the first in a long line to go out of business. We know that that has happened to quite a lot of homes anyway.

Do you have any suggestions or comments to make on financial risk, financial viability and monitoring?

Lord Sutherland: There are different strands to that. The fact that the local authority is, in effect, the monopoly commissioner is a reason why it would be helpful to consider combining commissioning in health and social care. That, at least, would provide a different perspective and the opportunity to open up some of the questions to which you referred.

You also implied that it is important to monitor the financial viability of the big operators in particular. I have a specific suggestion on that. It is from an amateur, so you would have to test it out with them as knows.

In inspections, SCSWIS might reasonably have access to trained accountants who could examine business plans and report on the long-term financial sustainability of the big operators in particular. I do not think that Southern Cross will go belly up completely, because steps have been taken, but picking up the bits for a big operator that went belly up would be a major imposition on public funding and confidence.

I am not suggesting that you appoint a battery of accountants to work with SCSWIS. There is a model that you could use without employing lots of additional people: as part of its business, Audit Scotland could supply SCSWIS with expertise on X number of person days a year. That model operates quite well in other public and Government services, so the committee could pick it up. An examination of the financial sustainability of a provider's long-term plans could be a specific point in an inspection, especially if there was reason to believe that there might be difficulties.

Dr Simpson: That is helpful.

Bob Doris (Glasgow) (SNP): If I read it correctly, table 3 of our briefing shows that 78 per cent—nearly 79 per cent—of all care homes for older people sit in the private sector. I am thinking about the strategic approach to provision of care. Is that percentage too top heavy? Should local authorities and the health service look for a greater spread of providers for that form of care, such as more voluntary sector and local authority providers? Have we got it a little bit wrong and let the private sector run away too fast with this?

Lord Sutherland: Voluntary sector providers were the first to lose some of their care homes. I am strongly in favour of the voluntary sector being involved centrally, but we must pay a reasonable rate when we commission care. They are not in it for profit. Was the Church of Scotland not the first that had to get out?

Mary Scanlon: It was the Salvation Army.

Lord Sutherland: It is tremendously important that we consider how that could be reconstructed. I am not in favour of the local authority being commissioner and provider. That distorts what can be done. If it were to continue or be enhanced, there would have to be a revelation of full costs in the kind of financial inspection that I suggested, so that we would know whether the local authority was subsidising the cost of care and, therefore, paying a lower rate to private sector providers who were not able to sustain the situation. There are complicated questions in that, but it needs to be examined.

The Convener: I will ask about the private sector and about crashing a business that is too big or important to fail. If we discovered worrying news about finances and business planning, the concern is that that might crash the business and put people out of a home. Some suggest that that can sometimes mean that private sector providers have an easier ride in terms of inspection and action against them. Given Bob Doris's point, is it a big worry that people can crash a business and that such businesses are too big to fail?

Lord Sutherland: We saw what happened when that appeared on the banking front—when banks were considered to be too big to fail. That cannot be repeated in other forms of public provision.

I will pose a question that perhaps the committee could ask. If a big power supplier crashed, for example, the chaos would be huge, unless the business could be maintained and sustained. What structures are in place to monitor that? I do not think that any organisations will crash, but we would have said that about Southern Cross in its previous incarnations five and 10 years ago.

What monitoring exists? Bank monitoring—how we check whether the banks are viable—will obviously have to be looked at again. Perhaps monitoring must be probed. Otherwise, the risk is that some big contractors might say, "Well, we'll be bailed out anyway." I do not think that that will happen to Southern Cross, but if such a risk existed, what emergency and reserve plans locally or in the Executive would deal with it?

Jim Eadie (Edinburgh Southern) (SNP): A strong theme in your introduction was the need to integrate health and social care and the positive impact that that would have on quality and sustainability. Can that be achieved without major structural change? If such change took place, what would be its impact on service delivery?

Lord Sutherland: Some of that change has been achieved informally in parts of Scotland and England, where well-meaning, well-versed and sensible chief executives in local authorities and the health service have got together and said, "We can't go on with this. We really need to pool our resources because you have needs and we have needs." Such integration can happen, and Scotland has shown how it might happen—there are key examples of it. In the Highlands that approach is being pursued more formally.

Any such change in structure will be resisted—perhaps for bad reasons and occasionally for good reasons. However, unless we deal with the perverse incentives that still arise in the system by bringing together the two budgets that relate to a single old person who could have Alzheimer's and infirmity that affects their getting around, and who lives on their own in a rather unfortunately designed house that was built 100 years ago, the individual's needs will not be dealt with properly. That change must take place.

Jim Eadie: Do we need a major structural overhaul, or can integration be achieved without reorganising services?

Lord Sutherland: I hope that Scotland is going about the matter sensibly now by considering ways of piloting the approach. I encourage the Government to look at different pilots and to see where arrangements work. They might work in one area but not in another because of a different set-up. The structure in an area with a string of major emergency hospitals will differ from that in a large rural area that facilities are scattered across. There is no single solution, but we must try the approach. Otherwise, money is not being spent sensibly.

Mary Fee (West Scotland) (Lab): My concern is about how self-assessment can be used to scrutinise and maintain standards of care. Which indicators would trigger a further outside inspection?

Some of the submissions that we received express the view that self-assessment can be a procedural exercise that may mask underlying problems and can be completed in such a way—intentional or otherwise—as to make the service appear to be better than it is. Self-assessment does not ask about staff turnover; it asks about vacancies, but staff turnover can often indicate an underlying problem that the self-assessment form would not be able to pick up. I am interested in hearing your views on that.

Lord Sutherland: I do not have a copy of the self-assessment form in front of me, but I am surprised—in view of what I have already said—that it does not include reference to staff retention, because that is a major factor in the health of any operation.

The good thing about self-assessment is that it is the path to self-knowledge and, as someone who was trained in philosophy, I think that self-knowledge is the beginning of wisdom. If you do it properly, you will understand things about your own operation that will be much more deeply embedded in your response than if someone from outside were to tell you about them.

There are values and benefits to self-assessment, but I agree with your underlying question: who says that that is the reality? People have an interest and are naturally inclined to paint the best picture. We all do that; it is not necessarily wickedness. That means that you must have as many other routes in as you can. One that I stress very strongly to the committee involves the use of a good statistical analyst who can look at the statistics that are coming in, ask the right questions and get the right information.

If one is an expert in the field one can often tell quite a lot about an operation from looking at the figures. If one sees a gradual decline in the amount that is spent on food over two or three years, it prompts a question. If specific questions are asked that receive factual responses, you should get someone who has statistical training that is much more sophisticated than mine to look at those statistics. Staff turnover would certainly be one of those areas. Statistics on staff training—the amount of time and money that are spent on in-service training, professional upgrading and so on—tell a story alongside the prose on the self-assessment form and the boxes that are ticked. You must ensure that you get adequate information, and undergird all of that with the principle—which is already in place—that inspections can take place unannounced.

Bob Doris: We are looking at the inspection regime and the change that has taken place, but the idea of consulting service users themselves is another important point. I hate the expression “whistleblowing”, as it seems to apply when things reach crisis point and people feel that they have no choice but to come forward. I am talking about the part of the inspection process outwith self-assessment. Is there a greater role for advocacy groups to go into residential care homes and talk to service users? They are the best advocates for a good-quality service, but they are always—I hope, if they are confident enough—the most likely people to identify service failings. Do you think that we have the balance right in that regard?

Lord Sutherland: There certainly should—not only in the cases in which self-assessment is important, but in general—be an adequate and clear complaints procedure in any organisation that is providing care. It should be straightforward, and as part of the process—whether that involves self-assessment or just inspection—questions should be asked about how many complaints there were, what the outcomes were, how they were dealt with, whether any independent voice was heard and whether large care home operators effectively have non-executive directors who take a specific interest in that area.

I will relate a memory that has come back to me. When I was head of various universities, I always chaired the appeals committee after exams. Some of the appeals were quite spurious: the number of grannies that someone had dying over the years could be well in excess of the normal quota of two. I learned a lot about various departments and different types of assessment from seeing those appeals. In the same way, it is important to look at the complaints procedure and at how it is organised and dealt with.

10:30

Bob Doris: Sometimes people do not like to complain. Making a complaint is a big thing for a resident of a home. People like to raise their concerns without making a formal complaint. Is there a role in the sector for independent advocacy in institutions, and for light-touch regulation whereby people can talk more informally?

Lord Sutherland: That is well worth exploring. Anonymous complaints are always a difficulty. There are interesting comments on that in the SPICe briefing. On one hand, there are malign people who will make complaints spuriously, sometimes because of a particular point of offence that has nothing to do with the running of the care home. On the other hand, anonymous complaints must be looked at. I was interested to see that SCSWIS has a grading system as to how it responds to such complaints. It is right that such complaints should be taken seriously and looked at within X days.

Dr Simpson: The Parliament has just passed the Patient Rights (Scotland) Act 2011, which contains the first statutory system for national health service complaints. It is a four-part system, which allows for compliments—positive feedback, in other words—and comments, which is a light-touch approach. The third level is “concerns” and is a little more significant, and only at the fourth level do we have “complaints”. In the interests of integration, uniformity and increasing the input from staff, carers and residents, I wonder whether extending the system to the care homes sector would be a reasonable part of any integrative process.

Lord Sutherland: That is an interesting idea and it is well worth looking at how it would work. Quite often a complaint might be about not simply the health care but the integration into the community when a person left hospital, or whether they were referred to the right physiotherapist or support worker. There is a seamless web, which people move through. That is an example of one of the difficulties of having two systems that are administered by two different groups.

Fiona McLeod (Strathkelvin and Bearsden) (SNP): I want to consider the stage before complaints are made. We have been asking whether the system adequately takes into account the views of service users—Bob Doris was starting to talk about that. Especially in the context of patients with Alzheimer’s or dementia, people say that it is too difficult to get users’ views. However, there are many innovative ways of doing that. As part of the regulatory and inspection system, should there be an understanding that it is not just about the inspector having a chat with the resident who can chat to them and that there should be a clear plan for assessing the views of users and family carers?

Lord Sutherland: Certainly the general point about hearing what the people who use the services have to say is very important. The approach has to be enhanced—it is the way that our society seems to be going, which is a good thing. As you suggested, there is a particular issue to do with people who have Alzheimer’s or dementia—that is not an all-or-nothing issue, as I am sure that you will hear from the next panel, because there are stages and degrees. I read what was said in the SPICe briefing about patients at risk; people with Alzheimer’s or dementia are among the most at risk, for all sorts of reasons.

I suppose that it is the task of a specialist, who has understanding beyond my knowledge, to know exactly how to assess such people’s views. We can ask our colleagues at the University of Stirling whether they have suggestions. The university has a very good dementia services development centre, which is doing much good work and research. The idea could be probed and explored; that is as much as I can say.

Mary Scanlon: I want to bring the discussion back to the quality of staffing and talk about another thing that surprised me. SCSWIS can go into a care home once every two years. When it does that, it does not look at all the quality standards—quality of care and support, environment, staffing, and management and leadership. It might look at quality of staffing once in eight years. That comes from an excellent paper by Age Scotland. I am not being critical, but I feel that as far as quality of staffing is concerned staff need more support, training and understanding, particularly of dementia. Is it not shocking that this new organisation called SCSWIS inspects the quality of staffing in a care home once every eight years?

Lord Sutherland: I did not know that that conclusion could be drawn from what has been said. I have taken what I have read about inspections every two years or so as a guideline. I understand that the Parliament can shift that. It would be shocking if a requirement that quality of staffing be inspected once in eight years had been rigidly laid down but I do not know whether that is the reality. I agree, though, that staffing is fundamental.

Mary Scanlon: Obviously if a care home were graded 1 or 2—weak or unsatisfactory—SCSWIS would go in more often. However, when it does so, it looks at only one of four quality issues, one of which is staffing. If inspections are being carried out once every two years, it follows that on many occasions staffing might be inspected only once in eight years.

Lord Sutherland: If that is the case, it is not good enough. There are two issues in this respect. First, you could go in and look at the staff in a particular care home and come up with a series of individual judgements. Secondly—and this is one of the more general points that I wanted to make—something that I think is a task for SCSWIS is the development of a research capacity. There are more general problems that are not specific to only a certain number of care homes—and one of those problems clearly is staffing. What work is being done to analyse the problems and therefore the solutions? I do not necessarily think that inspectors need to be taken off the beat to do that; there are other agencies that would happily do that work.

The Convener: I will indulge myself with a couple of questions. I am sure that we will be dreaming up or coming to a lot of conclusions about what SCSWIS could do. Indeed, already this morning, we have heard about the development of a research capability, which I am sure is a responsible suggestion and is consistent with some of the original commission's recommendations, and the creation of a financial arm that would allow more scrutiny of business plans and so on. However, a number of written submissions that we have received refer to the fact that SCSWIS is being required to make a 25 per cent saving over the next four years and a 7.6 per cent reduction in 2011-12. What is your view on that, particularly in light of the fact that we are increasing its workload?

Lord Sutherland: As they say, if you combine two operations, you will save something although, to get that saving, you will probably have to spend quite a bit along the way. To be honest, I would need to know more about the detailed figures, including where money could not be spent if it were spent on this.

However, as has been made clear in comments from a number of committee members, we need to think about what SCSWIS does, how it does it, how effective self-assessment is and what is needed alongside that. One approach would be to get a good statistician to help to identify weak points; equally on the financial side. I do not mean employing two dozen people in each area, but finding people with the expertise and getting them in, certainly on the research side.

Refining the tasks of inspection and regulation will not be a new activity. I am sure that Her Majesty's Inspectorate of Education and Her Majesty's inspectorate of prisons for Scotland have been doing it over the years; there is also a body that monitors what the police do. How much do these regulators get together and share more efficient ways of targeting the resources that are used? Of course, that is not to say that it will not need more money than has been promised, but I think that that is true of almost every part of the public purse.

The Convener: I want to raise another aspect—I will also ask future panels about this—which is that a growing number of people are being cared for at home. What thoughts do you have about that increasing number and the care that is being delivered in the home setting? We are planning for an increase in carers delivering what we might have described not so long ago as nursing care at home, and the numbers are growing. In my observation of the levels of scrutiny and protection in care at home, there are big gaps. Do you have any views on that?

Lord Sutherland: The parts of your briefing that deal with individuals who are at risk show that among those who are most at risk are those who live alone at home and who have a stranger, as they might see it, coming in once a day or three times a week or whatever.

A great deal of very good care is being delivered there; I am not suspicious of the whole system. However, there are additional risk factors for someone who is living on their own at home and they must be built in to the monitoring done by those who employ carers. Of course, not all carers are employed. Without the unemployed carers, we would be in real difficulties. Those who employ carers, be they local authorities or whoever, should assure themselves about and should be held to account for the integrity and quality of those carers who go into people's homes. That means looking at more objective factors, such as the support that those carers are being given in professional development or in dealing with particular problems. I go back to the unit in Stirling, although other units are looking at the issue. Dealing with people who have dementia is a particular skill and unless that skill is imparted when necessary and the right carer drafted in when a change has taken place in the old person's responses, the care will be more at risk, not necessarily for malign reasons but for want of the expertise. It does not just come naturally.

Fiona McLeod: Increasingly care will be provided to the individual in their own home by the cared-for person employing the carers. That is a huge area. How do we regulate that? How do self-directed support and direct payments ensure the integrity of the person that someone will employ in their own home?

Lord Sutherland: There is no magic solution. I am not against self-directed support or direct payments in the system, but the more of that there is, the more different types of risk there will be. There will be charlatans out there. They phone me up regularly to tell me that I need double glazing and soon they will be telling me that I need care services. There are charlatans out there who will devise ways of extracting money from vulnerable old people. I do not dissent from any move towards self-directed support, because some people would make a pretty good fist of providing for themselves but, if someone does so, they will need fairly regular visits from an independent professional to see what is happening. That would be one way of beginning to deal with the situation.

Dr Simpson: I have a slightly different point, although I am not sure that we have the time to go into it. It has been suggested to me that in Scandinavia, when someone reaches the point in their journey at which they become resident in a home, they will be there for a year or less, whereas they might spend three years in a home in the United Kingdom. This is a late stage at which to introduce a fundamental question, but are we using the sector appropriately? Given the coming demographic changes and the pressure on costs, are our assessment thresholds appropriate? Do we need to look at that?

10:45

Lord Sutherland: You have rightly indicated that we face different issues. One is short term and is about the specific individual in front of us and how we ensure that they get the best quality of care within the resources and structures that we have available. That is an urgent task and I am sure that the committee is well equipped to focus on it.

There is a longer term issue—judging by your question, the committee is equally interested in it—which is what the shape of our society will be. The demography is such that it will be very different. A section in the report on free personal care that some of us wrote five years after it was introduced tried to raise that question. Given the proportion of older and possibly infirm people—although not all old people are infirm; I speak as one who had a 70th birthday this year—what is required? How do we rethink? We have seen this coming for 20 years. Everyone knows the demographic trends, yet no real long-term thinking is going into what kind of society we will have. For example, what kind of transport system do we need, if any? Returning to your question, I strongly advocate looking at what kind of communities we will have from the point of view of buildings. I have seen some interesting care villages. Of course, the worry is that they are ghettos. On the other hand, though, in this city I have seen experiments involving providing sheltered housing within blocks of modern flats. We should be doing more of that thinking and looking, because that is how we will begin to deal with some of the issues that you are raising. In the longer term, we will need more homes. I do not mean care homes, but homes for individuals. Let us not build the wrong kind. Let us see what the shape of society requires.

The Convener: When the care commission was set up, now followed by SCSWIS, you said that a national care commission should have a wide responsibility that would include that capacity to think ahead, to plan long-term care and appreciate what was happening. Are you disappointed that SCSWIS does not have those responsibilities?

Lord Sutherland: I think that someone should have them. I am open on whether it is SCSWIS or whether there could be a unit within the Scottish Government's department of health and social services. The danger is that if you give those responsibilities to a body that has urgent, detailed issues in front of it, that is where it will focus. It should be more than a think tank—somebody who is commissioned to report to the Parliament, and to the minister of course, about trends and the long-term shape of society. That is critical for our future. We can compare it with global warming. There has been a huge noise about global warming. There has been lots of planning and there have been many calls for more investment. It is a big issue. An equally big issue is demographic change and we have not seized it.

The Convener: I do not think that we have any further questions for you. That is a challenging note to end on. Thank you very much for giving us your time. I am sure that the evidence provided will be helpful to the committee in its inquiry.

Lord Sutherland: If I may, I will make one little suggestion that I came prepared to give. Why not have a star system in inspections, in which you put a star on a report for particular creativity and innovation? There are individuals working in the system who should be encouraged to innovate and be creative and there should be ways of spreading those ideas. It will not all be settled by us sitting around a table like this. Such an approach might pay dividends, not least in times of change of structures and budgets and so on, and would not take an awful lot to put into the system.

The Convener: If there are any other suggestions that you came prepared to give us, please do so now. I should have asked you whether there were areas that we did not cover that you wish we had.

Lord Sutherland: I am looking quickly at my notes. I think that all my points have come up. That was my one additional little gimmick or suggestion.

The Convener: If, at a later date, you decide that there were areas that were not covered that you felt should have been, please e-mail the committee. We will be pleased to receive any additional information.

Lord Sutherland: All the evidence that you have received has just gone on the web, but as I got home at 9 o'clock last night and left the house at half past seven this morning, I have not had time to read it all. When I do, if I have any reactions I will drop you a line.

The Convener: Thank you.

10:49

Meeting suspended.

10:50

On resuming—

The Convener: Joining us for our second panel, we have Henry Simmons, the chief executive of Alzheimer Scotland; Anne Conlin, the development and training manager of Carers Scotland; and David Manion, the chief executive of Age Scotland.

To aid time and to give committee members the opportunity to ask all their questions, we will move straight to questions. If our witnesses feel that there are important issues that we have not covered, they may raise them at the end of the discussion.

Dr Simpson: When we originally discussed free personal care, I was a strong advocate of it because of the distinction between our treatment of those who had cancer and those who had dementia. I thought that a fundamental discrimination was occurring in our treatment. To some extent, it is still occurring today. Would any of the panellists care to tell us whether they think that we have adequately tackled that discrimination through the current system and whether the regulatory processes that are in place ensure that that discrimination is minimised? It is a fairly general opening question on the shape of our services.

Henry Simmons (Alzheimer Scotland - Action on Dementia): There are 82,000 people in Scotland who are living with dementia. Their main medical treatment involves four drugs—three that are taken in the early stages and one that is taken in the later stages. There is nothing else on the horizon. There are eight compounds that look promising, but there is no treatment solution coming around the corner. In many ways, therefore, what you are seeking to check by way of regulation and inspection is the treatment of dementia. Unfortunately, however, it is perceived as care, not treatment, with the result that people with dementia are put in a bracket that means that they inevitably have to pay for quite a significant component of that cost. There is still an underlying unfairness; the issue has not been solved.

Free personal care has been a hard-won and much-deserved assistance in that regard, but more thought has to be given to the process of what we mean by treatment for dementia. Treatment is not just medication or drug treatment. We would describe the social care elements of the treatment of people with dementia as being akin to chemotherapy—it needs to be administered in correct doses, it needs to be well maintained and it needs to be given early in a way that is well inspected and well supported. None of that sits too well within any of our systems at the present time. I argue that we need a complete transformation with regard to the way in which we think about dementia, from the point of diagnosis through to palliative care and the end of life. None of that is captured simply by viewing an element of the system and grading it through an inspection process. The person and their journey are apart from that and we need to get much closer to the issues of what an individual has in their life, what they want to retain in their life and what it is possible to sustain in their life, throughout that journey. We need to think about how we use all the resources and skills in our system to help that person live their life with the outcomes that they want.

Too often, we look at the 70 per cent of people living in care home environments who have dementia and think that they are happy to be there and that the system is good, so we just need to think about how to regulate that. However, the problem starts at the point of diagnosis and gets bigger until, as was mentioned, people end up in a care home two or three years earlier than they should have. That happens because not enough investment is made early on in sustaining people and preventing their lives from falling apart. Often, people end up in a care home at a point of crisis. When that happens, the care pathway is pretty poorly planned.

David Manion (Age Scotland): I have two observations. First, the contribution that free personal and nursing care makes to admission avoidance and, ultimately, transfer into care homes, is understated. The second part of the question related to whether the regulatory process is keeping pace with developments in care in the community. There is evidence before the committee, including in our submission, that it is not.

Dr Simpson: To take a specific example, we talk about the care commission looking at care, but one of the big problems is the prescribing of antipsychotic medication to people with dementia in the community and particularly in care home settings. Is our regulatory system sufficiently integrated to make it fit for purpose? That is a fairly fundamental question, but that is what the inquiry is about. With the changes that are to be made through the move towards risk assessment, will our regulatory system be more or less fit for purpose?

David Manion: There are grounds to believe that it might not be. I do not say that the whole system is completely out of kilter, but the evidence in our submission about the inspection regime in care homes certainly raises legitimate questions to which the committee needs to find answers. The first question is whether inspections should all be unannounced. The second is about the frequency of inspections. The third is about the criteria against which inspections are marked. The contention in our submission is that the current system allows for avoidance of some criteria. I do not know whether I share Mary Scanlon's interpretation of the inspection regime—I do not profess to have that much expertise—but it is certainly logical to ask whether using just one criterion on which there happened to be a high or low score at one inspection obviates the need to inspect on other criteria.

The fourth legitimate question is about whether the resourcing of the inspection regime is adequate and appropriate. It is not our job to second-guess care managers, many of whom are highly professional and motivated and do an absolutely first-rate job. It is certainly not our wish to second-guess SCSWIS, which is full of well-motivated and caring people. The question is whether the reduction in resources to the combined body equips it for the future. That question must be asked because, as members have heard, there has to be more care in the community—the case for that is compelling, so there is no avoiding it. Therefore, is it right to reduce the resources that are available to the merged institution? I speak as something of an expert on mergers.

11:00

I want to flag up something in relation to the comments about service users and the adequacy of their involvement in the inspection regime. As I am sure my colleague will agree, we do not give enough space and time to relatives in the process. They are often the people who are closest to a service user, who for a variety of reasons may be unable to advocate adequately for themselves.

Dr Simpson asked whether the regime is adequate for health and social care. That is a bit of a problem. I think that everyone here would acknowledge that, in a way, the Parliament has merged or integrated the inspection regimes before it has integrated health and social care. Everybody understands that the delivery of combined or integrated health and social care across Scotland is patchy. It is very good in some places and not so good in others. Perhaps there is a greater role for SCSWIS in trying to set a framework for what well-integrated inspection regimes in health and social care should look like.

Henry Simmons: On whether the inspection regime is fit for purpose, it depends on your conception of the purpose. If it is simply protection and reassurance that the quality of care is satisfactory, there are certainly elements of the system that work pretty well. However, if the purpose is about improvement, meeting the demands and shaping services for the future, the regime is most certainly not fit for purpose, because it tends to focus very much on the latter stages of the care journey. That is a fundamental mistake.

The inspection regime must be able to look at all the commissioning and procurement processes from start to finish, particularly for someone with dementia. The diagnosis point, for example, is a crucial time in such a person's life. If no adequate services have been commissioned at that point and that leads to a massive and rapid decline in people's lives and subsequent pressure on the care home environment, that must be considered in the round and should be fed back.

At present, the regulator cannot say to a local authority, for example, "You have not thought through the steps in commissioned services in an adequate way to meet the overarching need." If we seek to be ambitious about how we might use regulation and inspection for improvement, we need to go a bit more upstream and be more creative in giving powers to SCSWIS to influence the shape and design of the commissioning. Inherent in that is the unavoidable question about whether a service is failing because there is not enough funding to deliver on the national dementia care standards or the new promoting excellence skills framework. Those are fundamentals that will require commitment and resources to deliver.

Dr Simpson: The Government is rightly pressing primary care to achieve a much greater degree of early diagnosis, so the problems to which you refer can only get worse.

Gil Paterson (Clydebank and Milngavie) (SNP): The submissions comment frequently on inspection, and it is almost as if inspection is regarded as a silver bullet. What are your views on the diverging opinions, if I can put it that way, on the matter? Is there any benefit in looking at the quality of inspections, or should we be concentrating on the frequency of inspections instead?

David Manion: I would say two things in response. First, as our submission makes pretty clear, both elements are important. With the Elsie Inglis nursing home, there was a very dramatic drop in the standard of care over a fairly short period of time. That is not to say that within the system there is overwhelming evidence that the inspection regime is inadequate—indeed, we would not wish to go on record saying as much—but that is a very clear example of a care home where, in a relatively short space of time and for reasons that we do not know, there was a rapid decline in the standard of care. With the current regime there is at least a possibility that that problem could be repeated elsewhere and it is for the committee to get the experts in front of it and ask whether that can be avoided through having more inspections or inspections of better quality.

I want to emphasise one other point to back up Henry Simmons's comments. Many other people in the system, particularly carers and relatives, can provide a lot of anecdotal evidence and tell you what is actually going on; the question is whether there is enough room in the system to allow them to contribute in that respect. That would improve quality. In any case, I think that it is better to talk about the sophistication rather than the quality of inspection, if you get the distinction.

Henry Simmons: Although the right balance has to be struck between the process and frequency of inspection, it is only one element of the empowerment of the individual consumer. The work of the cross-party group on dementia, of which some of the committee were members, on developing a charter of rights for people with dementia was widely embraced by people across the care sector and provides a starting point in empowering individuals and making them feel enabled to complain, to make suggestions and to have their rights and needs met. Fundamentally, we must encourage and embrace the power of complaining. In that respect, there is a lot that we can learn from the Patient Rights (Scotland) Act 2011.

Our experience with people who phone our helpline to talk to us and with people with dementia who are frightened about the service that they receive is that they are frequently pretty terrified of complaining. That is not a criticism of the people providing the service; if your mother, father or family member is in an environment that you yourself are not in all the time, you will not be certain whether any complaint you make will be acted on. There is a real need to change that culture, empower people and encourage that type of thing. Of course, that will in turn require an even-handed response and organisations that try to deal effectively with complaints that they receive should be given encouragement and applauded when they do so. After all, you do not wish to hammer everyone over a complaint; you have to deal with it in a balanced way and support a creative dialogue with regard to change. That is partly about involving service users and people in families in every aspect of care. In that respect, I am talking not only about care homes but across the spectrum. As we know, people do not want to be in a care home to begin with; they want to be in their own home and we must ensure that that outcome is measured and well supported.

Anne Conlin (Carers Scotland): With regard to involving service users and carers in the quality and frequency of inspections, I was invited along partly because Carers Scotland in partnership with the previous Social Work Inspection Agency employed, recruited and trained carer inspectors for its significant programme of social care inspections over the 32 local authorities. The carers involved took part in a range of quality work, including advanced readings, inspection team meetings, focus groups and field work.

As a result of the involvement of carers in that inspection process, the reports that followed the SWIA inspections contained a range of recommendations that were for carers involved in social work, not just users, as well as recommendations for carers that came from carers who were involved at the front line of inspections. On quality, that model has been brokered and used. We are in dialogue with SCSWIS to ensure that that model of good practice continues. However, there is a difficulty, because there are different ways of using people, so to speak, as lay inspectors or care inspectors in the whole process. The care commission had a different system from SWIA. At the moment, we have to merge all that and find a comfortable way forward in order to ensure that best practice continues.

Fiona McLeod: I want to continue that theme. Age Scotland's submission states:

> "The charity feels any inspection must involve direct engagement with users as a mandatory requirement."

I feel quite strongly about that. The work that was done with the carer inspectors is one model, but how do we ensure that the views of users of the service, who can often have difficulty with communication, and the family carers and relations who are visiting are heard and acknowledged? This becomes even more important, given that, as we have heard in evidence and seen from the submissions, the demographics mean that we will be providing even more of our care in the cared-for person's home. Does the regulation system have to change quite dramatically to ensure that inspections within a person's home are of the same high standard as inspections in a care home and that the user's views are taken into consideration? Given the move towards direct payments, how does the person who is doing the employing, who could be the cared-for person or one of their carers, ensure that the person whom they are employing has been sufficiently regulated and inspected?

Henry Simmons: I will start with your last point. The social care (self-directed support) (Scotland) bill will hopefully extend the concept of direct payments away from the person simply being in receipt of the funding to their having access to a personal, individualised budget, which will in some ways remove the necessity for them to become the employer but will empower them to make choices and decisions about the type of support that they want.

The problem that we have with the current commissioning structures is that often a local authority that is faced with a dwindling budget might perceive an economy-of-scale commissioning approach to be a satisfactory way of achieving savings or meeting the budget. That neglects the massive amount of what I would describe as the natural support, or carer support, that is already part of that person's life. What we should all hold out hope for is for the self-directed support bill to enable state resources to be far better combined with the individual's resources.

There are some simple examples of that. We have run pilots on self-directed support as an alternative to residential care. When families are empowered and enabled to use their money more creatively, they match it far more effectively with the types of things that they have in their life. For example, they will organise care on a Wednesday evening so that the mum can maybe still go to the bingo. It is difficult to commission en bloc a big economy-of-scale model to do that; it is difficult to make such models that flexible.

Although there are some risks, the benefits of utilising the state resources in a far more effective way in combination with the person's natural support resources outweigh those risks. They also outweigh the risks that are associated with how we regulate that.

We can be creative enough to think about the people who are offering to provide this service, many of whom are already established providers and already registered with the commission. We all have to buy into the concept that individual outcomes—what individuals expect from their journey—are the goal that we are all aiming for. It is possible to achieve that.

If the world of people with dementia in particular and their families is entered at the right time, the type of support that they want can be comfortably designed and their outcomes can be understood. Our difficulty is that we do not talk to people until they have lost the capacity to really tell us what is needed. The earlier we do that and the more personalised we are, the more creative we can be with state resources, the better value we will get, and the better outcomes we will get for individuals. It is not outwith our ability to set a path in Scotland and be a leader in how to personalise the way in which we regulate behind that. That is not impossible. We have not done that yet, but we can do it, and there is no reason why we should not aspire to do it. In our view, that is the only way in which we will cope with the growth in demand. If we do not use what is there and what people have, we will simply have to build more care homes every month, and that is not the solution. We will never be able to afford that. We must get creative alternatives in place.

11:15

Anne Conlin: That was very well said. Personalisation would be a way forward, specifically for carers; such an approach regards them as experts and experienced in their field.

I would like to share a short story with members. A distraught carer came to our door. She was looking after her mother, had a package of care in place from the social work department, and was at the end of her tether. Basically, she asked me, "Why can't they just give me the money to do the caring? Why do I have to have an army of home helps or carers who won't do, who won't listen, and who don't care for my mother in the way I know I can care for her?" That is a small example that is replicated in millions of households throughout the country. If responsibility and outcomes were put into the hands of carers, that would be a step forward. There is an army of carers out there, and they are the experts with the knowledge, understanding and willingness to do things. That risk can be taken with the regulation.

David Manion: I agree.

Fiona McLeod: Anne Conlin has said what I have said for many years, but we will always come up against the question how we can regulate care providers who are family members or are employed as a result of an advert in the local newsagent. Henry Simmons and Anne Conlin have said that we can do that, but I need to know as a parliamentarian, not as a carer, how we can do it.

Henry Simmons: The process relating to the registration of staff that was referred to earlier is a critical component. Anyone who provides such a service would certainly be expected to be licensed and trained and to have the right level of skill; if they do not, they should not be able to provide it. That is one way of ensuring at least as satisfactory a position as we currently have. We currently have a system in which many people are not registered or trained. Our argument is that anyone who wishes to provide dementia services should follow the knowledge and skills framework and should not be allowed to support someone unless they are at the right level within it. That is not an unhelpful position.

The business of regulation is not simply about SCSWIS. We must remember that we have a very competent social work workforce out there. People often see the evolution of personalisation as the demise of front-line social work practice, but that is entirely wrong; rather, it is the empowerment of front-line social work practice. It has given social workers the ability to work much more creatively with families, but the social worker must not go away from that process. In a sense, the social worker becomes the front line of the regulation.

That is not an unhelpful position. The social worker should be monitoring how moneys are used to meet the expected outcomes for an individual, and I argue that, if there are difficulties, it is their responsibility to flag that up and start to deal with it.

That is another layer of competent regulation, and it is pretty much what a lot of care managers do at present. It is simply a question of empowering them to do it a little more effectively. We need to take some time to discuss that component and be clear, but I do not think that it is impossible or that we need a massive new raft of expenditure and funds to manage safely the evolution of our support services. We have skilled staff and the ability to do it already; we just perhaps do not have it all joined up at present in the way that we would want.

Bob Doris: I want to look at the regulation and inspection of care homes, but I am struck by the feeling in the evidence that individuals often end up in care homes that do the best jobs they can but which are not necessarily as appropriate as they could be if the care pathway was right in the first place—I think that that was the point that Fiona McLeod was making.

Taking that as a given, I want to look again at the system of care home inspection. I know that there have been anxieties with the two-yearly inspections and the risk-based aspect, but if we get the evidence and intelligence right, which is vital in getting the correct risk basis, could it be an opportunity to drive improvement in the service? Do we need full inspections for warnings to be flagged up? Have your groups received patterns of complaints—themes of service failure—that you have then been able to feed in to SCSWIS or, previously, the care commission, and have those bodies acted on your concerns rather than wait for their inspections to see whether there is service failure? I am interested to know what your experience has been in the past and how you would like it to improve in the future.

The Convener: I am sorry, but I will have to intervene and ask you to hold the question. We are having microphone problems that are causing interference, so we will pause for a short while. I will give the witnesses an opportunity to respond once we have dealt with the issue.

11:22

Meeting suspended.

11:25

On resuming—

The Convener: Sorry about that suspension. I believe that the microphones have now been put right. I ask the panel to respond to Bob Doris's questions.

Henry Simmons: First, I would describe our organisation's relationship with the former care commission and other bodies that have an interest as extremely satisfactory. We had regular and frequent meetings to highlight concerns that came through our helpline, and our members invariably got a very satisfactory response and agreement about how to tackle the issues. I do not expect anything different in the way forward with the new bodies. I genuinely believe that there is a maturity of relationship with organisations such as ours, which have a big membership and an advocating role as well as making other contributions. That is well appreciated, and our comments are often well received. We have had a very positive experience.

On the changes to the way in which inspections take place and their frequency, we have some serious concerns about the approach for people with dementia. The nature and rapidity of the decline that can occur for people with dementia, and the changes that can occur in their support needs, make them extremely vulnerable at times. I refer the committee back to the report "Remember, I'm still me", which I am sure that everyone is familiar with. I will not go through it, but it enabled us to look across social and health care provision and to consider things such as the prescription of psychoactive medication. It helped us understand that many actors are involved in the inappropriate prescribing of a psychoactive drug to a person with dementia. Changes can happen in a week or two. The recipient of the drugs, which will end their life a year or two early, may not be in a position to make a complaint, and their family may be pretty worried about making a complaint and may not know the full implications.

I mentioned earlier that we have to have a better method of encouraging people who have concerns to raise them and have them dealt with effectively. I have never had an experience in which a complaint has been made to the commissions but not dealt with—complaints are often dealt with well. The problem is that we hear lots of complaints that are not made to them, so we encourage people to make them. We have a massive problem: it would be wrong to assume that things are okay and safe if we are not in and around care environments. I do not wish to put a bigger burden on people who provide services, but we have to think about the fact that we cannot leave someone for too long and expect things to be okay simply because they were okay last month. That would be entirely wrong.

Anne Conlin: I echo that contribution: Carers Scotland's previous relationship with the Social Work Inspection Agency has continued into the new body, SCSWIS. We have been involved in a range of information and consultation exercises—so much so that I can provide the information that carers are assigned to inspections of social work services into 2012. The good practice has continued. There is a bigger body now—it is a different beast—but we still work closely with staff in the organisation on elements of work. We are happy with the continued involvement, in the knowledge that we have a trusting relationship that can continue into the future.

11:30

David Manion: We also enjoy a good relationship with the regulator. Mr Doris asked whether there are trends. We run a helpline, and we see that levels of anxiety tend to rise when events are in the public arena. For example, when the Southern Cross episode came into the media big time we were able to make arrangements with the regulator and others to refer on people who had specific concerns around the issue.

On the future, it is fair to say that the Scottish Government is set to look again at health and social care. I understand from the early indications that the Government has a pretty blank page on that. I very much welcome that approach; it is appropriate that all the options and models are looked at, aired and debated. As part of that process, the implications of more care in the community for the inspection regime need to be looked at in a way that fits into the overall model rather than in a kind of stand-alone inquiry.

The Convener: Mention has been made of the use of antipsychotic drugs and the “Remember, I’m still me” report. There is Scottish Government work on that, to establish baselines and stuff. Out of interest, where is that work at? When will something be produced and when will it have an impact?

Henry Simmons: The problem was well considered in the context of the national dementia strategy. The initial assessments of the use of such drugs are well under way. What we need now is for the strategy objectives on the provision of alternatives and targeted reductions to be delivered. There is no point in simply reducing medication without considering the impact. I chair the programme board for “Promoting Excellence: A framework for all health and social services staff working with people with dementia, their families and carers”. The board includes the SSSC and NHS Education for Scotland and has developed a second-tier initiation document, which includes proposals for quite extensive psychological intervention training and other forms of training for all staff, to help to tackle the issue of how to deal with someone who presents challenging behaviour. Often antipsychotic drug use is about challenging behaviour.

At least we in Scotland have not done what other countries have done, which is simply to set a target for reduction without putting in place actions and support measures to ensure that there are alternatives. In the second year of the national dementia strategy we should start to see real progress and results around that.

We have not done enough to tackle the fact that people who have prescribed such drugs have often done so unlawfully, without using a certificate of incapacity under section 47 of the Adults with Incapacity (Scotland) Act 2000. Such individuals require to be challenged at professional level. There is a culture that we must challenge, because it is difficult for care home providers to say to a GP, “You need to do your section 47 certificate before I can give out this medication.” We need to change that culture. The legal protection for individuals who receive antipsychotic drugs is pretty poor—we have to stop the practice.

The Convener: Do certain aspects of the regulatory system assist in the implementation of the dementia strategy and identify areas where there might be weaknesses and where the practices that you describe are going on?

Henry Simmons: The issue is the crossover between services. In the past, prescriptions in the healthcare system were not considered in care commission inspections. Until the Mental Welfare Commission for Scotland and the care commission managed to do a joint inspection we were not able to look across, but when that happened we were able to join things up and we found an extensive problem. That is a good model for the regulatory system. Any inspection regime must include the ability to look at prescribing patterns and the underlying legislation, which is an argument for doing the whole thing and not just a part of it.

Mary Scanlon: I commend Callum Chomczuk from Age Scotland on an excellent briefing paper. I say to David Manion that all our questions to Lord Sutherland came from his organisation’s submission and our SPICe briefing.

I will go over the two issues that I raised earlier. Age Scotland’s submission says that not every inspection of a service covers all four inspection areas—most inspections cover one area or perhaps two—that we need a holistic approach and that the practice that I just described

> “must end immediately ... The current fragmented approach to inspections can lead to care homes of questionable quality being under-assessed and potentially over-rated”.

Your paper raises the issue of a fragmented system, which led me to conclude that something as important as staffing quality might be inspected only once in eight years. The submission is excellent, but I want to get your concerns on the record.

David Manion: We cannot tell from the statistical information how widespread the problem might be. However, if the regime can include only one of the four criteria, it is logical to say that some time could pass before an inspection and corrective action took place. Later in the submission, we make the point that early-warning signs about a care home took quite a long time—the paper says five months, but it was nearly six months—to be corrected.

We stand by the position that, if inspection is to be done, it should be done properly. The key consideration is confidence. People must have confidence that there is no room for error, and they must have confidence in the system. In a couple of places, grounds exist for believing that confidence could be undermined.

Mary Scanlon: I will ask about confidence. Page 3 of your submission says that,

“as a matter of urgency”,

we should examine staff selection, training and retraining. On the back of Fiona McLeod’s point, how can someone have confidence in a system in which registration with the Scottish Social Services Council of support carers for care at home as trained, qualified and fit for purpose will begin only in 2017 and be completed in 2020? Staff in care homes must register by 2015. Lord Sutherland talks about charlatans. Are we allowing charlatans to operate by not fully supporting, valuing and training staff to provide a good service?

I was a member of the session 1 committee that raised the issue. I do not remember having dates at that time but, as with everything else, it was assumed that staff would be trained and registered in two or three years. I am amazed that it will be 19 years after the council was established before we can expect staff who care for people in their homes to be trained and registered. How can we have confidence in the system while that registration framework is in the background? Is that good enough?

David Manion: It is important that I say that we are not, and do not claim to be, expert in the qualification requirements of care staff—Lord Sutherland also claimed not to be an expert, so I am in good company. Our submission says that everyone understands that people with more complex needs are being cared for in the community and in care homes. As there ought to be, there has been a rise in the complexity of cases of people being cared for outside traditional settings. Ergo, it must be right that someone in the system examines the skill mix in community and care home settings. In some areas, we will need more highly qualified nursing staff and people who understand drug regimes better. It is arguable that the inspection regime and the skill mix in a number of care homes have not kept pace with the move towards care in the community. On the question whether we—or rather, you—are allowing charlatans to operate, it would surprise me to discover that people must wait such a long time between practising and registration. I am not familiar with the detail of the arguments, but it is something that the committee should examine as a legitimate question.

Henry Simmons: I want to reassure members that our experience of working with local authorities is that there are not many care at home services that are not commissioned by local authorities. Many local authorities have monitoring and standards teams in operation, which sometimes overlap with the regulation aspect. The monitoring and standards units tend to examine some of the matters about which committee members are rightly concerned. They expect reports on staff turnover and complaints and will set standards and criteria for training. The difficulty is with how a service is commissioned. With regards to people with dementia, if local authorities do not set the bar higher than simply providing a generic service for older people, which is about very basic care, people may end up receiving a 15-minute slot for a visit. That may seem acceptable on the surface, but it is only a visit, whereas we need people with a higher level of skills and training to deal with a person’s dementia. We can only commission for that—we cannot regulate it. We can regulate the outcome at the end but we must commission and procure in a more specific way around needs. Having an equitable payment for the required level of service is where local authorities have greatest difficulty when it comes to budgets. The issues of staffing, skill mix and change tend to be part of the contractual arrangement between a provider and a local authority. Often, the first port of call for those responsible for local authority funds is to ensure the contract with the provider is robust enough so that the expected services are delivered, and the provider has a responsibility to report on that. Regulation comes in at a level behind that and has a broader view. There is not much room for charlatans to operate in the current system, which is robust but needs to improve.

The Convener: Ms Conlin can respond to that point. There are a number of supplementary questions—the point raised by Mary Scanlon has sparked interest.

11:45

Anne Conlin: A comment made by a carer with whom I was involved recently was that, even when the balance and the mix are there in the staffing, that is not a caring workforce; it is a time-based workforce. It is a workforce that has to work to rule and deliver the goods within a set period of time, so what happens is that caring goes out the window. A person's slot may be from 10 to 11 or from 2 to 3, but that is not when the caring is required or needed, so as a result the caring can break down. It does not seem to be a caring workforce; it is just a workforce.

If you examined the workforce, you would see that staff are very skilled and have the qualifications under their belt but they are very frustrated, because they are not given the time and resources. They require time to do the job that they want to do and which they entered the profession to do.

Like Henry Simmons, I do not believe that there are a lot of charlatans out there providing care. There is a very frustrated workforce, who are not able to do the work that they set out to do and to care in the way that they want to care for the individuals under their auspices.

The Convener: There are a couple of quick supplementary questions on that point.

Fiona McLeod: Mr Simmons, I know that Alzheimer Scotland is a care provider. Can I take it that all your staff have all the appropriate qualifications and meet all the standards? If so, why are other workers being allowed to wait until 2020? You mentioned direct payments, as did Ms Conlin. I know that a direct payment is usually £10 an hour, on average, but your service costs £14 an hour, so people with dementia cannot afford to buy the specialist service that your organisation provides. That must be a problem in relation to the provision of appropriate care.

The Convener: The question goes beyond being a supplementary. I do not take offence at that, but it is discourteous to the person who asked the original question. By all means, please respond to the question, Mr Simmons.

Henry Simmons: The level of direct payments is variable, so £10 is not standard across the country. In some areas it is more than that—in some areas there are three or four criteria levels. Some authorities have innovative voucher schemes. The situation is evolving.

We tend to argue that it is not right to put a flat rate on a direct payment. Indeed, we work with many families who get a direct payment but who do not use it to buy our services; they use it flexibly. Someone with dementia is often offered only four or five hours of support, in contrast with someone who has a learning disability, who may get 80 or 90 hours of support at a similar risk tariff level and level of need. We contend that there is an inequality there. The argument is that a person with dementia needs only an element of specialist input. If you look at it in the round, someone who has a level of 15 or 20 hours of support and a budget of £150 might want to commission two or three hours of skilled input but does not need that skilled input for all the basic stuff. They might want to employ someone to help with the garden or other things. We are not quite there when it comes to the creativity involved in that approach and the achievement of individualisation, but I do not necessarily feel that we are discriminating against or disadvantaging people, because we are trying to use these systems to help people get what they choose.

On our staffing and skill levels, as I said the local authorities that we work with have pretty specific and clear contracts. In the 32 areas that we work in, I am pretty confident that we meet the criteria in the contracts. There will be staff who have just joined and are going through the induction process, so they will not necessarily meet all the criteria, but they will be on the way to doing so.

Our bigger aspiration relates to the new knowledge and skills framework. There are four levels within the framework and we hope to have everyone operating at the dementia skilled practice level. That is the standard that we seek to achieve and that is what needs to be built into the dementia world, if you like, as time goes on. It is not necessarily a black-or-white situation—we are seeing 32 different evolutions.

Some local authorities have a creative spirit and have made excellent progress on the issue. The Scottish Government has funded innovative pilots. We are making good progress on all fronts, and we are at the stage of trying to gather all that together. However, many people who would benefit from the approach still cannot do so. They are being denied their rights and are not being given direct payments. As with the argument about care homes, a private organisation will get a couple of hundred pounds less and the local authority will pay for it. Why is that? The cost of care of £14 per hour is a reasonable cost per hour and is not at all expensive. People deserve the right level of direct payment that equates to the level of care. The issue is about ensuring that the payment level is right for everyone; it is not so much about some local authorities setting bars that are far too low.

Jim Eadie: On the need to drive up standards across the sector and to achieve the appropriate skill mix and staffing levels, page 3 of the Age Scotland submission suggests that the best way to achieve that would be by

> "ensuring a higher minimum percentage of staff in all care homes were registered ... as nurses."

Does David Manion have a percentage in mind?

That was a specific point, but I also want to build on Mr Simmons's reference to innovative pilots in social and health care. Age Scotland's submission highlights the role that specialist dementia nurses could play in the NHS and in disseminating good practice across the home care sector. I ask the witnesses to say something more about that.

David Manion: Henry Simmons will deal with the second question and I will deal with the first.

We do not have a specific percentage in mind, because it depends on needs assessment. We are saying that it stands to reason that there would be more qualified staff than there were, say, four years ago. As a safety measure, we could demand an F grade nurse in each care setting, but it would be difficult to insist on that absolutely across the board, because in some areas it would not be appropriate and in other areas it would underegg the position terribly. In the inspection regime, we need a box that sets out the existing skill mix and a box that says what skill mix we are looking for and whether there is satisfaction that there is a match between the two.

Henry Simmons: On Mr Eadie's second point, in Scotland, we now have an understanding and appreciation of one of the biggest areas of difficulty for people with dementia, which is our acute general hospitals. Having a level of qualification and a professional background is, in some ways, helpful, but I am sure that we have all read the horrific report on the Mrs V case, which involved skilled consultants, nurses and doctors. In our acute general hospitals, in an average 900-bed unit, about 150 people will have some form of cognitive impairment, which will probably mainly be dementia.

Not a single penny of resources has been spent to tackle that issue in recent years. However, we have campaigned vigorously for the problem to be understood and we now have an understanding of it. We have created a fund, which has been supported by the Scottish Government, that will provide a nurse consultant in every NHS board by the end of the year. The new standards of care are being led by the chief nursing officer. That approach will incorporate the promoting excellence agenda, which will be backed up by an action learning network and a managed knowledge network. It will start in the acute hospital sector and will then be rolled out using a process of dementia champion training to incorporate the social care workforce and the implementation of the national dementia strategy.

That is still not enough. The funding package for that over a year is about £1.5 million to £3 million, to which we make the biggest contribution, from fundraised income. In a sense, dementia charities are starting to following the path that cancer charities took 20 or 30 years ago.

However, the really massive issue in that respect is that, in considering how to widen regulation to cover all the environments in which people, particularly those with dementia, might find themselves, if you add a cognitive impairment into the process of complaining, choice, engagement and involvement, you will find yourselves in extremely different waters. As a result, we would argue strongly that you cannot deal with dementia simply by thinking that it can be encapsulated in the regulation of the care of older people in any environment. The issue is so big that it must be prioritised and made the specific focus of regulation of any form of care. We contend that it needs a focus that sets it apart from all other long-term conditions. People might argue that it can be bundled up in some generic sense and that if they can get it right for older people they can get it right for people with dementia as well. As evidence from across the system shows, such a view is entirely wrong. You cannot capture the needs of people with dementia simply through a generic approach; you must be specific about what you are looking for and about your understanding of dementia across health and social care.

The Convener: At the end of the session, we can come back to the question of what needs to be in the inspection guidelines. After all, we are looking at inspections and improvements to the system that might complement your dementia strategy.

I apologise for coming in there, Mary. Do you wish to finish your questioning?

Mary Scanlon: Thank you.

I just wanted to wind up. A lot has been said this morning about the lack of training and support for staff, the lack of understanding of dementia and the lack of skills for caring and treating people with dementia. Are so many care homes resorting to multiple and inappropriate prescribing of psychoactive medication because such training is not in place and because that is the only way of coping?

Henry Simmons: What you say is entirely right in many circumstances. Again, this is a problem not only in care homes but in general practitioner practices, acute hospitals and accident and emergency environments. Without labouring the point, I think that it is not unreasonable to expect a person who is in an environment that they do not know and who is struggling to make any sense of where they might be, with people who do not know very basic things about them, to get anxious and agitated. If the first and immediate interaction with that individual is from a misinformed perspective instead of a calming, well-understood and well-appreciated engagement from someone who knows how to deal with a person with dementia, it is likely that things will escalate. When escalation happens and anxiety takes hold, people will get into a fight-or-flight situation. It is very basic psychology. If that is not well understood, the next step will be, “I cannot deal with this; I’ve got 25 other people to deal with. You’ll have to get someone to calm this person down.” Before you know it, a prescription will have been sought over the phone or a doctor will have been called in and the medication given.

The subsequent problem is that the situation is not reviewed and, as a result, a person can be on medication that was prescribed for a very minor incident for the rest of their life—which will be shortened by that very prescription. We argue that when any such decision is taken—and of course it might well be legitimate and there might well be good reasons for having taken it—the key is to review it and ensure that the prescription was given for a particular reason or purpose. In the culture that has been created through not using the section 47 certificate, the question whether a person should keep receiving medication is not important. Organisations that are stretched can see this as a solution, but I see it as a massive infringement of individual human rights. As we know, skilled intervention need not be that excessive; it can be about environment and other basic stuff. Very often it is about human interaction, dignity and decency but, in busy environments, such things are sometimes quite expensive commodities. We need to return our caring world back to these basics and demand them of everyone. However, you cannot train that or insert it into people; you can only lead it, supervise it, manage it and recruit for it.

The Convener: Is there anything that the regulatory system can do to assist you in that delivery? If there is, we would be very interested to hear what it is. After all, the system is what we are looking at.

Henry Simmons: You could do lots to the system, but it is all about moving away from insisting on a certain level of training to insisting on certain attributes, certain staff skills, a certain quality and how people engage in all that.

The Convener: What could an inspection of a particular environment—a care home or whatever—include that would assist with that?

12:00

David Manion: Henry Simmons used the term “human rights”. I do not know whether the committee has heard from the Scottish Human Rights Commission, which has done an outstanding piece of work.

The Convener: We have seen that significant piece of evidence.

David Manion: You have to mainstream human rights. It is a fundamental part of raising standards. The piece of work that the Scottish Human Rights Commission did recently is outstanding in that respect.

The Convener: Do the guidelines that are in place, which can be amended by the Scottish Government through SCSWIS, take account of that interesting paper on human rights?

David Manion: Not sufficiently, in my opinion.

The Convener: We are interested in how that situation could be improved.

Henry Simmons: Mrs Scanlon has touched on this issue quite often this morning. You need to consider the quality of the staff and support that are available in each environment, whether it be a care home or a person’s home in which care is provided or, indeed, whether it involves a person who is running their own organisation that provides support to individuals with direct payments. We must think about the room to provide training, support and supervision that exists in the way in which that service is commissioned.

The Convener: Is there a role for SCSWIS to review the commissioning process? Earlier, Lord Sutherland said—

David Manion: I would say that there is an excellent piece of work in the making involving the work that is being done by the Scottish Human Rights Commission and SCSWIS. If you brought the two organisations together and asked them to examine that recommendation, that would be a good start. They have already started thinking about that.

The Convener: I thought that it was interesting when Lord Sutherland said that issues such as staff turnover, pay and conditions, shifts and hours would give us an indication of what the likely outcomes might be. That goes back to the issue of commissioning.

David Manion: You hear the phrase “continuity of care”—

The Convener: I am sorry; Mr Simmons was going to respond on the issue of commissioning.

Henry Simmons: The proposal would be a worthless exercise if SCSWIS did not have the power to challenge the way in which the service was commissioned and procured in the first instance. There is no point in assessing a service that is clearly poorly funded, is not well led, is not giving the staff the right support, supervision and training and is strangled by a low-level funding agreement that must be challenged. It must extend the vision and ask why the service was commissioned in that way—if that is the problem;

there will be services that were commissioned really well but still have all those problems. However, it must be able to look at both ends of the spectrum.

For many years, it has been difficult for the care commission to comment. It sees services that have clearly not been well commissioned or procured but cannot do anything about them. I think that it would say that there should be an extension of the power to say to local authorities that a service has not been commissioned properly. SWIA's inspection processes considered all those issues in a much bigger way. There is a lesson to be learned from the way in which SWIA examined leadership, commissioning and management and brought that into the direct delivery of services.

The Convener: In response to Richard Simpson, Lord Sutherland addressed the issue of the stability of some of the financial aspects and the strength of the business. Does that play back into the whole commissioning process?

David Manion: I have had informal discussions with people in SCSWIS about Southern Cross Healthcare Services. They were pretty clear that they did not have the in-house expertise to assess the business viability of some of the larger operators. I do not think that anyone would expect them to have that, necessarily. The suggestion that Lord Sutherland made about buying in that expertise was good. You hear the expression "continuity of care", which does not mean a huge amount in itself, unless you come to understand what continuity of care is. Our anxiety is that, to some of the bigger operators, continuity of care can mean putting different faces in front of the users each day.

I do not think that there is sufficient capacity in the system. I also think that it is important to consider where the regulatory authority lies in a situation such as the one that arose with regard to Southern Cross. Does it lie with the Scottish Parliament? Does it lie with Westminster? Where is the head office registered? What are the overlaps in the inspection regime? Whose responsibility is it? For a great many providers, that relationship will be with the local authority, where there will be people who can assess the financial viability or otherwise of the business, but I dare say that most local authorities would be highly challenged to look at whether the larger providers stacked up financially. Lord Sutherland made an excellent point.

The Convener: Do you wish to add something, Mr Simmons?

Henry Simmons: I throw a word of caution into the mix, in so far as some of the most successful independent providers are not very viable businesses in the long term. In some cases, people can only just take a wage out of the business. There is a need to not exclude some of the small operators from the process. Many voluntary organisations can be quite small-scale operations that do not have a big reserve or a lot of capital. They could probably not develop an exit strategy in the event that things went wrong with their occupancy levels, but they provide an extremely high level of care. We must allow a reasonable level of proportionality when it comes to business viability.

If we do not do that, setting Southern Cross aside, the large care home providers are probably the most able to deal with how we are handling our economy at the moment. I am talking about economy-of-scale provision, which relies on large volume and large levels of self-investment, with investment coming not from local authorities but from the venture capitalists or businesses that can put the money in and which can operate over a 20-year period. We need to be careful that we do not reach a situation that lends itself to that becoming the mode of operation, because some of the best provision that we have in Scotland comes from committed, small-scale, not very financially viable organisations that are heavily quality orientated. That is why I offer a word of caution. We could end up looking to commission from some of the massive organisations that do not provide the same level of skill and quality.

The Convener: Lord Sutherland also supported the idea of SCSWIS having a research arm to look at long-term trends and shifts in elderly care. Is that a good idea?

David Manion: It always surprises me that there is not more high-quality academic research in the field. To my knowledge, no one has been able to quantify the preventative impact of funding free personal and nursing care on the system as a whole. Everyone says that of course it stacks up and that it is bound to stop people being inappropriately admitted or cared for, but there is a paucity of academic evidence. As a former university vice-chancellor, Lord Sutherland is right to point in that direction. There should be better-informed academic research. Otherwise, how do we explain why people in Scandinavia will stay in a care home for a year but people in Scotland will stay in one for three years?

Henry Simmons: It depends on where we place the focus of the research. The Scottish Government has a strong strategy for reshaping care and investing in intervention in care of the elderly, but we continually find ourselves lacking evidence on what the return on the investment might be because we have never made the investment. It is a question of where we should place the very limited resources to answer some of the key questions. I would argue that we should not necessarily put all those resources towards the back end and that we need to think about how we plan for the future early on.

I can give a clear example on dementia care. If we invested £8 million, we could give every person in Scotland who is diagnosed with dementia one year’s worth of post-diagnostic support. The best evidence that we have suggests that that would delay admission to residential care for two years. To fund one year, you would require a delay of only two weeks. If there were a body that could embrace that evidence and say that that was exactly the right way to go, of course that would be of value, but the reality is that that evidence already exists and is not utilised and not listened to. We are not getting that message through.

Again, I sound a cautionary note about where the resources should be used, what should be done with the evidence that we get from research and how real the benefits can be.

Jim Eadie: That was a helpful observation from Mr Simmons. Because of the inquiry’s specific focus on regulation, we have avoided the bigger question of how we unlock the money that is currently tied up in the acute hospital sector as a result of emergency unplanned admissions of over-65s. Mr Simmons’s point is well made and the committee has heard it.

I have a question for Mr Manion on the paucity of academic research. Given the importance that what is happening in Scotland has to the debate on long-term care throughout the UK, is there any way that he could make the case for commissioning academic research to his colleagues in Age UK?

David Manion: There is academic research from throughout Scotland, but it is a legitimate question whether the academic institutions have been brought together in focus to answer the sort of questions that the committee has raised.

We are independent of Age UK. Age Scotland is Scotland’s older people’s charity, so we determine our own research priorities. It is a field that we, as a charity, would gladly enter into.

Jim Eadie: Presumably, you are in touch with colleagues south of the border as well, though.

David Manion: Yes. They have greater research capacity.

Henry Simmons: Alzheimer Scotland is in the process of working with the Scottish clinical dementia research network to design a post-diagnostic study that will examine early intervention to try to give us enough evidence to ensure that, in five years, we are not faced with the argument that the evidence is not strong enough for investment. Along with the coming together of other academic institutions on dementia, that network is doing what Jim Eadie suggests.

On 21 September, we and the University of Edinburgh will launch a new clinical research centre led by Professor John Starr. Together, we have probably raised around £1 million to fund dementia-specific research of a clinical and partly scientific nature in Scotland to improve the translation of research findings into practice. That is a big investment that Alzheimer Scotland is making, but the university is backing it too.

That is all predicated on the fact that the Government has invested in the clinical research network. Scotland is ahead of the rest of the world in its database of people who are prepared to participate in dementia research. We are making ourselves attractive, and I think that we might start to see some bigger funding coming in from outwith Scotland to invest in some of the clinical research that is required. That is a good strategy for dementia.

Anne Conlin: I return to Lord Sutherland’s earlier evidence about the kind of society that we will have and the kind of care that it will provide. Carers UK, which is our main body down in England, is doing a survey—it is not research; it is a survey—throughout the UK on the state of caring. The evidence from that will be published later this year. So far, 10 per cent of the participants in that survey have been from Scotland, so it is perhaps representative of the whole UK. It is a fairly broad and lengthy survey and, if the committee is looking for information on what it contains, I can certainly pass that on.

The Convener: We look forward to receiving that.

We now move to the very patient Malcolm Chisholm, who has a number of questions for the panel.

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): I have only a couple, and it is kind of you to let me in, convener. I am interested in the regulation of care homes and will ask two questions.

There seems to be much agreement on the importance of more direct engagement with service users—in this case, people who live in care homes. From my point of view, that should encompass the whole experience of living in a care home and how they feel about it.

Is there some deficiency in the care standards because they have not flagged that up enough or can we deal with that simply by changing the inspection guidelines? At present, the guidelines say that, typically, inspectors talk to people who use the service. That does not make it absolutely central to their work of inspection. What do we need to do to change that and are there difficulties? Will it take a lot more resource and time if we really engage seriously with people who live in care homes as part of the inspection regime?

12:15

Henry Simmons: It is evident from the inspections and reports that the national care standards have not met the full requirements of people with dementia. Our view is that the new dementia care standards emanate from the human rights agenda and from our work with the cross-party group on Alzheimer's on the charter of rights. In terms of regulation, we need to find a way of fitting the standards into the next inspection regime. By doing that, we will have a better chance of ensuring that the needs of people with dementia are met.

There are many different ways of engaging with people with dementia, as not everyone is at the same stage in a care home. The most important thing for me is that, when people arrive at a care home, there is an understanding of their hopes and expectations. That requires some thinking to be done early on. We need to know what type of outcomes the person wants. We need to stop people being disconnected from the world at large and simply being stuck in a care home and unable to get out. They may have good-quality care, but it might not do anything that meets their individual aspirations or, indeed, their previous life.

We must therefore personalise the process, but we can do so only by understanding the individual's journey and their expectations, which means that we must rely on the system producing a personal plan for individuals that can then be checked and monitored. We do not have that just now. There is no sense in looking at all aspects of a care home environment without looking at what outcomes an individual wanted in their life. We must find a way of individualising the process. I do not think that it is overly complicated. We cannot do it with everyone, but we must strive to understand what a person was like before they came into care, what they did, what their life was like and how that has been maintained. We must stop the care home becoming all-encompassing for only a part of a person's life.

David Manion: First, we must integrate the mainstream human rights agenda, which could be put into the inspection regime, with training around it. However, there would be a resource question in that.

Secondly, as I hope I have tried to convey, the system as a whole does not take sufficient account of the views of relatives and carers. It is appropriate that it focuses on users, but relatives and carers obviously have a significant part to play.

Anne Conlin: It might seem that a carer stops caring when the cared-for person goes into residential care, but in reality that individual does not stop caring. I echo what my colleague David Manion said in that we need to take cognisance as well of carers' needs, wants and aspirations for the outcomes of the cared for. Carers and lay inspectors should be more involved in the inspection process, which might as a result better address issues that cannot be separated and are vital to the continued welfare of the cared for.

Malcolm Chisholm: One of the questions that I have been thinking about is how often SCSWIS misses problems and gets things wrong. Obviously, this question was thrown up for me by the Elsie Inglis situation. David Manion referred to the rapid decline in standards of care there. Equally, however, it may be that the problems were missed in October when the last inspection before the problems arose was done.

Do not quote examples, but have any of you had a sense before that SCSWIS was perhaps missing problems? The Elsie Inglis situation is the only concrete example that I know of, but there may be a different explanation even for what happened there. The committee will probably want to reflect on the extent to which problems are not being picked up, because that would be a fundamental problem of the regulatory system.

David Manion: I think that it is too early to make a judgment on that.

Malcolm Chisholm: I do not mean in reference just to Elsie Inglis but in general.

David Manion: We observed in our submission that the issue is not only the frequency of inspection but the follow-through. Perhaps you would be more reassured if the follow-through were done within a specific timescale, because that is not identified anywhere in the regulations, as far as I am aware. You could spot a problem, but it could be some months or even, as many have pointed out, years before you go back. Perhaps the issue is the follow-up action as well as the inspection regime.

Henry Simmons: Problems will always be missed. There is no way of regulating problems out of the system. The level of human interaction and intervention and the number of people with varying needs mean that at some point somewhere something will fail. The question is how rapidly that can be responded to.

We cannot have a system of regulation that will pick up on every failing element of a service. We need other parts and actors to take control within that. For example, there is no one in a care home who does not have a GP or a social worker and there is no care home that does not have a manager. Moreover, many people in care homes have families who have a voice in the process.

The issue is how we structure a process behind all that to pick up on instances of failure and react quickly to them. Obviously, people do their best to avoid such instances, but the system at some point will not work for everyone. Regulation cannot necessarily pick up on that and react instantaneously. We must encourage a culture that searches for system failures and ensures that we respond to them. Regulation can inspect how such failures occur and what organisations do to improve their quality, find out what the issues are and deal with them. However, the only guarantee that most providers would give is that although, at some point, something will not work right, they will do their best to find it and rectify it. As a society, we must embrace and work with that as a cultural value and ensure that people have a voice in that process.

Anne Conlin: It is probably too early to say whether SCSWIS will produce the information and the regulatory support. However, we can ask that examples of good practice from the care commission’s and SWIA’s operation of inspection processes are put together and are not lost to the new body.

The Convener: Thank you very much for your attendance here this morning. We appreciate it very much. I believe that we have gathered important evidence here that should influence the eventual report and outcomes.

12:23

Meeting continued in private until 13:10.

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