The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 13 September 2011

Session 4

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HEALTH AND SPORT COMMITTEE
5th 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)
Noni Cobban (United Kingdom Homecare Association)
Dr John Gillies (Royal College of General Practitioners Scotland)
Martin Green (Community Pharmacy Scotland)
Annie Gunner Logan (Coalition of Care and Support Providers in Scotland)
Ellen Hudson (Royal College of Nursing Scotland)
Dr Donald Lyons (Mental Welfare Commission for Scotland)
Ranald Mair (Scottish Care)
Dorry McLaughlin (Viewpoint Housing Association)
Peter Ritchie (Unison)
Mark Smith (Chartered Society of Physiotherapists)
Ruth Stark (Scottish Association of Social Work)

CLERK TO THE COMMITTEE

Douglas Wands

LOCATION

Committee Room 4

Scottish Parliament

Health and Sport Committee

Tuesday 13 September 2011

[The Convener *opened the meeting at 10:12*]

Decisions on Taking Business in Private

The Convener (Duncan McNeil): Good morning and welcome to the fifth meeting of the Health and Sport Committee in session 4. I remind those present, including members, to turn off their BlackBerrys and mobile phones. Agenda item 1 is the decision on taking item 4, which is the consideration of a list of candidates for the post of budget adviser, in private. Do members agree?

Members *indicated agreement.*

The Convener: I invite the committee to consider its approach to the draft budget 2012-13 in private at future meetings. Do members agree?

Members *indicated agreement.*

Regulation of Care for Older People

The Convener: I welcome our first panel witnesses: Ranald Mair, chief executive of Scottish Care; Annie Gunner Logan, director of the Coalition of Care and Support Providers in Scotland; Dorry McLaughlin, chief executive of Viewpoint Housing Association; and Noni Cobban, vice-president of the United Kingdom Homecare Association. Welcome and thank you for coming.

Gil Paterson (Clydebank and Milngavie) (SNP): The scare caused by Southern Cross has raised major concerns about financial viability in the care sector. To what extent should Social Care and Social Work Improvement Scotland be involved in the financial scrutiny of providers, big and small?

Ranald Mair (Scottish Care): Perhaps I should kick-start the discussion. SCSWIS has a responsibility to ensure the basic financial viability of an individual service. The difficulty with the Southern Cross scenario was that it involved the collapse of Southern Cross as a publicly listed company, not the collapse of individual care homes. It was less to do with the delivery of care end of things and more to do with the company's financial modelling. To that extent, it is not a scenario that applies generally across Scotland, where only a small number of such companies involve shareholders. Only one, Southern Cross, was listed on the stock market. There is a danger in identifying an issue that needs to be addressed in that regard and looking to SCSWIS to address it, as such a solution would not be applicable to the majority of care homes in Scotland.

10:15

However, I think that there needs to be a joined-up approach to financial regulation. SCSWIS plays a part in that, but the financial authorities must also look at all large corporate United Kingdom-wide or multinational care organisations—of which we do not have many in Scotland—from the point of view of how we secure and ring fence the viability of their care home services. As you will be aware, the majority of Southern Cross's care homes in Scotland were and remain viable, and they will transfer to new operators, despite all the anxiety that has been created by the collapse of Southern Cross as a company. There is a limited amount that SCSWIS can do beyond ensuring the immediate viability of a service.

Noni Cobban (United Kingdom Homecare Association): I represent home care providers who provide care in people's own homes.

A situation similar to the Southern Cross situation arose in Scotland with Choices Care, which also went into administration. The UKHCA represents a membership that, as Ranald Mair says, largely consists of individual home care providers and small groups of home care providers. We have a concern about venture capital in relation to care services and, in particular, care at home, which does not lend itself well to large, high-volume block contracts. Such contracts cannot provide care to people who live at home that is truly personalised and which meets their needs during the course of a day.

However, if block contracts are needed—I am sympathetic to that from the point of view of business modelling and providing assured income—having a larger number of smaller block contracts would put the purchasing authorities at less risk. I think that SCSWIS, which now has a role in relation to local authorities and care providers, could bring together the strands of procurement and service provision. Often, a provider of care at home services will have very short periods of contact with the person for whom they provide care and will have limited scope to have an impact on the quality of that individual's life, because they are driven by how the contract or the spot contract has been specified to them. They cannot take over responsibility for an individual's care to the same extent that a care home provider can. If someone is admitted to a care home, they live there and the care responsibility transfers from the care manager to the manager of the care home. From then on, their daily life is managed by the service provider. That is not the case with home care, which is extremely difficult in a large, high-volume block contract.

Dorry McLaughlin (Viewpoint Housing Association): It is quite difficult to separate completely an organisation's standards of care from its financial viability, whether that is based on the level of resources that it gets from commissioning or whether it is to do with the business model that has been chosen. I ask the committee to think about the role of SCSWIS from the point of view of organisations' business model and financial viability, as well as from that of the specific levels of care that they provide in care homes or in people's own homes. A comparator regulator might be the Scottish Housing Regulator, which is concerned not just with inspection of social housing and standards but with the governance and viability of housing associations and social landlords, and which carries out that role quite effectively.

Annie Gunner Logan (Coalition of Care and Support Providers in Scotland): We made the point in our written submission that the regulations that applied under the Regulation of Care (Scotland) Act 2001 required providers to demonstrate their financial credentials to the regulator. That was dropped in the regulations for SCSWIS. In our consultation response, we asked the Scottish Government why, given that, in the current climate, when there is severe downward pressure on care costs, the potential for more collapses and exits from the market is heightened. If it is not SCSWIS, some other body must look at the longer-term sustainability, stability and viability of care services and at the pricing models and business strategies they adopt.

A few years ago, we had a major third-sector organisation collapse—One Plus, a childcare organisation. I remember ministers being exercised about that because a significant amount of public money had been put into the organisation's delivery of service. On the collapse of that organisation, the Office of the Scottish Charity Regulator instituted an investigation into what had gone wrong and the Social Work Inspection Agency initiated a major programme of activity on the governance of third-sector organisations delivering public services. In the third sector, we accepted that as an entirely reasonable response to a major collapse of a third-sector provider. The question is whether the same process will be gone through in the case of the collapse of private sector care providers because, if it is not, we will not learn anything from what has happened to those organisations.

Gil Paterson: The panel has raised a number of issues, which interface with one another. The first point is that, if some form of scrutiny was put in place, we could not come up with a solution to the existence of the big and the small providers—we would need a system for the slow ship in the convoy. At what point would we determine whether a care provider was big or small? That is the first practical problem and we need to seek solutions.

However, to take the example of a large company such as Southern Cross, driven by shareholders and a board, the most difficult problem to which we need solutions is the question of who governs the service. Is it the shareholders and the board or those who receive the service in return for payment? Those are the imponderables that we must consider. If we are to pass on this responsibility to SCSWIS or another body, we must formulate a solution to those points. I would be grateful for the witnesses' comments on those areas that might help us to look at this in a practical way and to see the end result.

Ranald Mair: In the Scottish context, Southern Cross is a one-off. There are no other care organisations operating at the same size and with the same structure, owned by shareholders and listed on the stock market. The majority of private

care providers in Scotland are individual, owner-run care homes.

It is entirely proper to ask what we learned from the Southern Cross situation and what we should do about it. The interesting thing is that, right now, as the Southern Cross homes are being transferred to new operators, there is quite a bidding war among people who want to take on the homes. It was not the basic delivery of care but the company structure of Southern Cross that was not viable.

I do not know whether there are parts of financial regulation that could remedy such problems. As I said, Southern Cross got into some of the same issues that banks and financial institutions got into before the collapse of the banking sector. The model of sale of property and leaseback was quite widespread in the public sector—the Government, the national health service and local authorities all used it—as well as in the private sector. It was not a case of a particular operator using a discredited model; the model was probably deemed to be sound at the time. There is a danger in saying that what we want to do is avoid another Southern Cross situation, given that that was atypical and is less likely now that we have witnessed the departure of Southern Cross.

The Convener: The committee is interested in the Southern Cross experience, given that other large operators—Four Seasons, I heard someone say—might come in to take on groups of homes. We are interested in considering what recommendations we can make to SCSWIS about how it might identify risk in future, when care is being delivered by a bigger organisation. When there is a financial crisis, bigger sometimes turns out to be better. The committee is concerned not just about the current situation but about how care will be delivered in future by biggish groups.

Annie Gunner Logan: One of the challenges that we face in placing such a role with SCSWIS is its level of expertise in understanding the business models that are in operation. However, other organisations could assist with that, such as the Chartered Institute of Public Finance and Accountancy, which has significant expertise in that regard.

In the context of the discussion about viability of care services, SCSWIS, with CIPFA or other expertise, might be able to look at the rates that are being paid for care and consider whether it is conceivable that a quality service can be attained for some of the rates that are on offer. That is not to say that the issue is entirely about poor rates for care—it is not; there is potentially poor management and all the rest of it. However, we are increasingly worried about the matter. There is nobody who can call time on the downward slide in care costs—we think that there should be.

Ranald Mair mentioned a bidding war to take over services. I am concerned about that. Our organisation is committed to personalisation, choice and control and is very much behind the proposed bill on self-directed support that was recently announced. There is a conundrum in that regard: where is the choice for individuals in who provides their care? The convener knows that we have been very exercised in the past, in meetings of the Local Government and Communities Committee in the previous session, about the way in which social care procurement removes choice from individuals and treats people like commodities. It is worth mentioning that at this stage.

Dorry McLaughlin: I agree with Annie Gunner Logan.

It is not just large organisations such as Southern Cross that get into financial difficulty. There has been an exodus from care during property booms, when people sold off care homes to become residential properties. That might have been positive for the companies or organisations that were selling, but it meant a move for residents and it had an impact on them. A small sole provider or charity can find itself in financial difficulties, which has an impact on residents. Just because the business model that Southern Cross chose went wrong, that does not mean that other business models might not go awry in future. I do not know the answer, but I agree with Annie Gunner Logan that we need to find a way to get proportionate regulation of providers rather than just services. It should be proportionate for the 30,000-bed provider as well as the 20-bed provider.

10:30

The issue with Southern Cross was not just to do with its leaseback model; it was to do with the rates that it was getting from commissioners. With SCSWIS regulating and inspecting the commissioning side of care, there is an opportunity for it to do as the energy regulators do when they look not only at the price that we pay for energy but at quality in terms of whether there is choice and how complicated it is. I am not suggesting that that is the answer to care regulation, but I think that there is a role for SCSWIS in monitoring the market in its broadest sense.

Noni Cobban: I agree to a large extent with what Annie Gunner Logan and Dorry McLaughlin have said about the issues. However, care at home is a different issue from asset-based businesses such as care homes. Although they

are not floated on the stock exchange, there is a growing trend for them to have shareholders. The capital market is moving into care at home, buying up smaller businesses and taking a fast route to growth. They have slick skills in delivering against tenders, in that they will go for a loss-leader, which pushes the price down and can rule out good local providers of services. I have personal experience of that in an area where a good, sound and effective operator failed in a bid because an outside, venture capital-funded organisation came in to take over the contract. However, that organisation has failed to deliver against the contract and has been causing anxiety and a problem in the local area, as well as difficulty in the employment market. Such operators have a direct impact on the labour market and the already poor wages that people are paid in the care sector.

SCSWIS needs a particular sophistication—Annie Gunner Logan's suggestion of drawing on the skills of CIPFA is important in this regard—because venture capital funds are complicated instruments. I know that they exist, but I do not understand them. They want out in three years with their return. They are not in the business of providing care to older people in their homes; they are in the business of running businesses. I have worked in the private sector for many years and I do not have a problem with it, as it gives opportunities for innovative practice and doing things your own way. However, when it is big business and the business is about running businesses and not about providing care to older people, that is a problem.

SCSWIS should draw on the skills of CIPFA to understand the complicated financial models that people use to make businesses grow fast. There are no huge returns in care at home, nor will there be. There is no asset value in the businesses. It is therefore about the difference between the wage that you pay someone to do the work and the money that you receive for delivering it. You cannot cut staffing costs, because there are no economies of scale in one person going to one person in their house. You can only have one person; you cannot have less than one person going to deliver an hour or, indeed—as we are now being pushed into—15 minutes of care.

Because of the financial modelling and, as Annie Gunner Logan said, the downward slide and pressure, the high-value, high-quality providers are being forced out of the market. They will not go that low and will withdraw from a tender rather than agree to such conditions. If SCSWIS has a role in regulating the quality of care for older people, it has to be at the link between the financial models.

The Convener: Mr Mair, you can come back in briefly before I open up the discussion.

Ranald Mair: I will try to brief.

On the make-up of the sector, Southern Cross had 95 care homes. Its disaggregation will probably mean that Four Seasons, which has 50-odd homes, will pick up about 20, so it will have around 70 care homes and will be the largest provider in Scotland. A group called HC1, which is a new player on the block, is taking on a chunk of the Southern Cross portfolio consisting of about 40 homes. BUPA, with 30 care homes, is the third-largest player. It has a different financial model. As members might be aware, it has no shareholders and profits are reinvested. It is a very different form of financial modelling that is more like the John Lewis model of retailing.

The Church of Scotland's CrossReach is the largest voluntary sector provider of care homes, with just under 30 homes, so it is the next biggest provider. The next one after that is the Balhousie Care Group, with 22 homes. We then go into much smaller organisations. As I say, there is a large chunk of individual owner-run care homes that are owned by nurses and doctors who have got out of the health service and invested money in providing care. When we are considering regulation, it is important that we consider the make-up of the sector in Scotland and regulate for what we actually have.

I agree with my colleagues that we cannot regulate care delivery separately from commissioning and funding.

The Convener: That is a good point at which to move on quickly. Mary Scanlon has a bid in for a question. I saw her becoming engaged when we were talking about rates. I hope that we can deal with commissioning, capped rates and quality outcomes in the next round of questioning.

Mary Scanlon (Highlands and Islands) (Con): I have two brief questions supplementary to Gil Paterson's question. First, I note from the figures from March 2010 that the difference between the number of places in care homes and the number of residents was 5,209. I appreciate that this might be oversimplifying but, with 5,209 empty places, is it possible for care homes to be financially viable? Are we missing a resource that should be used more?

Secondly, I submitted a freedom of information request to councils during the summer. Although the information is not perfect—I got varying responses from councils—it shows that some councils charge £474 per week for a self-funder and others charge £843, which is 78 per cent more. It also shows that some council-run homes on the mainland—I have excluded the islands—have a unit cost per week of £474 while others

have costs of £904. So there is a real postcode lottery for people who are saving for care. In some parts of Scotland, it is 80 per cent cheaper than in others. How do those figures contribute to financial viability? One witness mentioned financial viability and quality. If a care home is receiving 78 or 90 per cent more funding, it can afford to up the quality a bit compared to those that are working away at £474 a week.

The Convener: We should remember that our inquiry relates to the role that SCSWIS can play in monitoring rates and their impacts and whether it can use them to identify risk.

Dorry McLaughlin: I could not agree more with Mary Scanlon; she makes a good point. The national care home contract is standard across Scotland, but in some more expensive areas people might argue that it does not fund the cost of care. Obviously, the biggest costs for a care home are staff costs. It is therefore fair to say that, in Edinburgh, it is potentially slightly more expensive to run a care home than it is in other areas. That depends on local markets. Mary Scanlon is absolutely right that it is difficult to justify that differential between £800 and £400. If a care home is being paid much more, it should be able to deliver better quality. However, it depends where the benchmark is. It is arguable that the higher charges might get you to a base level, but everybody else is providing a lower level, because the funding of care is just not aligned.

Mary Scanlon: Just to keep you right, Edinburgh is one of the cheapest areas—it is about £400 cheaper than Angus.

The Convener: What can SCSWIS ascertain if there are such variations? How can it apply any rationale to whether a certain price is appropriate in a certain area and whether that would impact on the quality of care outcomes?

Annie Gunner Logan: It depends on which end of the spectrum one looks at. With the national care home contract, there is a fixed rate for local authority-placed individuals, although certainly not for self-funders. We found that many third-sector providers will put in their own resources to top that up, rather than charge more and then take money off the top for the shareholders. As colleagues mentioned, a lot of that involves putting adequate resources into staff terms and conditions specifically.

If we look at services that are not bound by the national contract—for example, care at home—we find the most enormous variation. Care at home is usually governed by an hourly rate, so some organisations come in at less than £10, whereas others—local authorities' in-house services are particularly expensive—are over the £20 mark.

SCSWIS and the care commission before it—and any other regulator, in fact—have never taken an interest in the financial point at which it becomes impossible to deliver something reasonable. We have had a little footle around some of that, but it is difficult for an organisation such as ours to access pricing models, particularly for organisations that are not CCPS members, because that information is commercially sensitive and people are not necessarily giving it out.

There is a job to be done by the regulator, now that it has responsibility for commissioning. It did not have that before and now it does, so it can draw that together and correlate some of the rates that are paid for services that are not bound by a standard contract price against the quality that is attained.

I do not think that any of us would argue for a second that chucking money at a service will make it better—that much we know—but there is a point at which removing money risks making it very poor. There is now a legitimate role for SCSWIS in making those connections that the care commission did not have.

Ranald Mair: I will address the two points briefly. There has been a reduction in occupancy, which relates fairly directly to the position of local authority budgets: councils are having to gatekeep very diligently and that may be reducing the flow. The irony is that at exactly the same time there is again an increase—a spike—in bed blocking in Scottish hospitals. People are remaining in hospital not only beyond six weeks, which is the target that the health boards have been encouraged to meet, but from day one to six weeks, often beyond the clinical need to do so.

The constraints on spending at the local authority end mean that we are not able to make full use of our capacity, but I do not think that the regulator can address that; it is a wider policy matter.

With regard to the rates that are being charged, there has not been a level playing field in relation to local authority provision and third sector or independent sector provision. By and large, local authority costs are higher across the whole range of services, not only because of terms and conditions—although that plays a part—but because of the central services component that local authorities levy against their services.

10:45

If you pay for a place in a local authority care home, you are partly paying for the cost of running the council as well as the cost of the direct service delivery. I have no explanation for the variation in local authorities' costings, but the points that have been made are the correct ones.

As has been said, we have a regulator that combines the functions of SWIA and the care commission. Our hope was that we would be able to start looking at an individual's care experience in the round: Mrs Smith's care experience starts with referral to the social work department. She is then assessed, a package of care is determined, funding is allocated and a resource commissioned. Then follows the delivery of the service and its review.

We do not, however, regulate that way. We do not look at Mrs Smith's care experience in the round; we regulate the care delivery end separately from looking at the local authority's functions. That is unhelpful, because ultimately care providers can deliver only what they are commissioned and funded by the local authority to deliver. We must encourage SCSWIS to adopt an holistic approach to regulation that looks at all aspects of and contributions to the care of the individual, not only the bit that falls to the registered care provider.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I thought that I was getting the arrangements clear but I am now confused.

SWIA previously inspected local authorities. Did it not inspect the commissioning process? Was that not part of its function? Now that SWIA and the care commission have been put together, does SCSWIS not have not only the power but the duty to examine commissioning? That is surely part of the whole process. Indeed, the CCPS submission states that SCSWIS should look at homes that are graded 1 and 2 and ask why local authorities are commissioning from them.

The CCPS submission also states that you are

"extremely concerned that some authorities are now capping the price they are prepared to pay for care at a level which is in our view entirely inadequate".

The commissioning process seems to me to be fundamental.

One last point is that the Royal College of Nursing submission refers to there already having been quite a substantial reduction in the number of fully-qualified trained nurses at a high level. The whole point of the care commission when we introduced it was to raise standards and to increase the number of trained staff and the qualifications that staff had. If that situation is reversing when we are only just going into a period of austerity, there are real problems.

Given Ranald Mair's last comment, why is there not an end-to-end regulatory process? Should we have one? Is the commissioning bit of the process not already in there?

Annie Gunner Logan: SCSWIS has got those powers and it has the potential to do what we want. Ranald Mair's point is that we have not yet seen any evidence that it is doing that.

Dr Simpson: Can it enforce it?

Ranald Mair: It cannot. The powers are different.

Annie Gunner Logan: It cannot enforce it.

Dr Simpson: SWIA was just advisory.

Annie Gunner Logan: SWIA had no powers of enforcement similar to those of the care commission. It did not even have powers to investigate complaints from individuals. We tried to bring it out in our submission that the new body brings together the two functions in terms of its ambit and scope, but its powers are significantly different in relation to the teeth that it can apply to these situations.

Dr Simpson: I will give a specific example that you might want to comment on. In the previous parliamentary session we were very concerned about the process of reverse tendering, which seemed to us to be utterly immoral. No one from any of the regulatory bodies stepped in and said, "This is not right."

Annie Gunner Logan: To be fair, I think that SWIA was critical of that but it had very limited powers to enforce a change. It was the Scottish Government's social care procurement guidance that eventually made it very clear that that was not acceptable.

SWIA certainly had powers of inspection and was able to report—in fact, I am sure that a lot of local authorities will tell you that many of its performance audit reports were pretty cutting—but it did not have the power to go in and force through specific changes. In our submission, we make the point that SCSWIS still does not have that power, even though during the passage of the Public Services Reform (Scotland) Bill we argued strongly that it should. In the end, such a move was not deemed appropriate. Ranald Mair's point is that because its powers are so variable SCSWIS can come down much harder on service delivery than on procurement and commissioning. I hope that that clears things up.

Bob Doris (Glasgow) (SNP): I am seeking a bit of clarity. Some interesting points have been made about giving SCSWIS more power in this area and we might well mention that in the report. Can you give an example of the type of enforcement power that you want it to have?

Ranald Mair: I think that it should be able to challenge local authority practice that it feels is not contributing to commissioning and funding packages.

Let us leave care homes aside for a moment and look at the care at home issue that Noni

Cobban mentioned earlier. The reduction in blocks of time has meant that many people are getting 15-minute visits. Basically, someone comes in for 15 minutes to see whether a person is up, is well, has had their morning medication and has eaten. The danger is that SCSWIS might say, "Mrs Smith isn't getting the care service she needs" and be critical of the provider in that respect. Actually, the issue lies with Mrs Smith's assessment, what she has been deemed to need and the commissioning and funding process that has then been put in place. SCSWIS needs the power to make requirements and to ensure that they are enforced.

It is also worth mentioning that, despite the fact that two organisations have been brought together to form SCSWIS, the resource base has been reduced. Not surprisingly, because of the public profile of care, the organisation might be concentrating its reduced resource base on the regulatory end of care delivery and might have less time to devote to examining local authorities' commissioning and support agendas. The very joined-up approach has not yet been achieved in any manifest way and giving SCSWIS some enforcement powers with regard to commissioning would create a better balance.

Bob Doris: I feel that I am repeating myself—I apologise if I am just not getting it. I understand everything that you say, but what if SCSWIS goes into a care home and thinks, "All's not well here", and then goes back through the procurement process and finds deficiencies? Can you give me a brass-tacks example of what sort of power it should have to address that issue?

Dorry McLaughlin: My only response is that SCSWIS might trigger but not make such an intervention. I do not know the technical side of this, but with a failing school or a failing social services department, for example, there might be powers to intervene and take over the running of the service. I draw the analogy with schools probably because they are buildings within which a service is being run.

Annie Gunner Logan: I can give you a concrete example. You might have a social care procurement exercise going on. When you consult the guidance, you find that it says that the individuals in receipt of the service being retendered need to be consulted, their views taken into account and so on. If that does not happen and the individual using the care service wants to complain, he or she cannot complain to SCSWIS because it has absolutely no power to investigate such a complaint. We could give it the power to do so and, consequently, the power to go back to the local authority and say, "If you're going to do this, you need to consult people properly. In fact, you can't proceed with this exercise until you have done so".

Another issue that involves commissioning in a more global sense—we raised this in our submission—is that there are some extremely poorly performing services. Happily, there are fewer than there used to be—the care commission's statistics show that, overall, quality is improving—but there are some services that have consistently failed to achieve anything better than a 3, which is "adequate" in grading language. Indeed, some have failed to achieve even a 2, which is "weak". I think that SCSWIS could legitimately go to authorities and ask them why they continue to buy care from that provider and why they continue to fund that service. It would be good if, eventually, it had some teeth to stop that happening. Of course, the corollary of that is the issue of why commissioners are doing that and where their responsibility is. From our perspective the responsibility for the quality of care rests with the service provider, but if the provider is not assuming that responsibility, the commissioner and the regulator need to step in.

Ranald Mair: The issue of the regulation of care starts with having agreed national standards of care that SCSWIS can regulate against. At the moment, the commissioning end of things involves guidance rather than national standards. We might need to give status to the guidance that applies to commissioning. That might be extremely important as we move into an era in which there is greater joint commissioning of care by health boards and local authorities. We have to say, "Here are some national commissioning standards that set out what we think is right and appropriate." If we do that, SCSWIS will be able to criticise the commissioning body because it has not stuck to those nationally agreed standards.

The Convener: To turn that on its head, are we able to establish best practice through the regulator? That might help to address some of the issues that Mary Scanlon raised about the variability of payments, quality and outcomes. If we do not simply focus on the negatives, is there a role for SCSWIS to focus on the more positive side and help to establish guidelines that describe good procurement practice, commissioning strategies, good engagement with people and so on?

Annie Gunner Logan: A lot of that material is available already. SWIA produced some excellent material on commissioning, including a self-evaluation guide for local authorities. Material on good practice is available—the social work procurement guidance is, in effect, a good practice document. The difficulty is how to call to account the public bodies that are not following that

guidance. The issue is, who has the teeth to stop the problems?

Fiona McLeod (Strathkelvin and Bearsden) (SNP): I am concerned that, because of our demographics, there will be an increasing amount of care at home rather than care in homes. With regard to national commissioning standards, which Ranald Mair mentioned, how do we ensure that the regulator is fit not only for the job that it is doing now but also for the regulation of the increasing amount of care at home?

Noni Cobban: Care at home has been regulated for a number of years. The care commission invested a great deal in understanding how care at home works and evolved means by which it could sample not only service users, which it does through questionnaires as well as individual visits, but also the lone workers who go out and work on their own and are not, at the moment, qualified to do that work—they are not a mature workforce. The good things that go on happen despite the system, not because of it—they happen because of the efforts of the individuals who commit themselves to this sort of work.

11:00

Good work is going on in the regulating of care homes. I am sorry to say that I am not up to speed with the new plans for unannounced inspections. Because of the nature of home care, unannounced inspections of care at home are more difficult. If SCSWIS is going to make contact with service users, it will need to contact the provider to find out who the users and staff are. There would therefore need to be contact prior to engaging in inspection, unless, of course, the inspections were done through the commissioning route through the local authority—I am thinking on my feet now. If SCSWIS asked the commissioners who they are buying care for, it could start the process by focusing on the service user rather than starting with the care provider.

The United Kingdom Homecare Association recently did a commissioning survey that might be of interest to the committee. In local authorities that are under financial pressure, the frequency of and time given to visits has been reduced. The local authorities pay only for contact time, not for people to get from A to B. The committee does not need me to explain how tough that can be in rural districts for not only the organisations that are running the services, but the workers.

It is critical for the regulator—SCSWIS—to have some view of models of delivery of care in people's homes and to understand the complexities of the changing nature of care at home. It changes every day. People go into hospital, families are around, people's cars break down, we have had two terribly bad winters and so on. A huge number of things can get in the way of the safe and competent delivery of care at home.

I have been in home care for a good number of years and I think that there is still an impaired understanding of the precise day-to-day activities of a home care organisation. Taking into acount the complexities of the delivery, the timing, person-centred needs and matching a dispersed workforce to a dispersed client group is continual and hard work and there needs to be an understanding of how it works. Because it is difficult, there is a danger that people will concentrate on the bureaucratic minutiae of doing it rather than on the experience of the service user and—a very important measure—the experience of the care worker.

Annie Gunner Logan: The point is really important. It is about not just the shift to care at home, but the shift to self-directed support and personalised services, where we are talking about very different and not necessarily easily inspectable ways of supporting individuals.

In our submission, and during the passage of the legislation that created SCSWIS, we raised the idea that, rather than registering and inspecting services, the new body could take a slightly different approach and license providers for entry into the market. At the moment, someone who registers a service must produce various credentials relating to the manager being a fit and proper person and the existence of a suite of appropriate policies and so on. That is not a test of a provider's capacity to deliver quality, and perhaps it should be. If the role of licensing providers was given to SCSWIS, it would be looking not just at qualification levels and the policies that are in place, but for clear evidence that the provider is able to evaluate its own quality and that it is able to act on the issues that arise from those processes. SCSWIS would want clear evidence that an organisation understands what personalisation is and what person-centred planning means and that it is able to provide evidence for mechanisms for user involvement and engagement.

You would then begin to test out what kind of animal you were dealing with. Existing providers now have a track record of gradings, so you could throw that into the mix, too. You would then be able to take a view about whether a provider ought to be in the market. If the answer was yes, the need for inspections that come and duplicate all those processes would reduce. The counterargument to that, which you might get from local authorities, is that they see all those things as their job, which they do through the commissioning process. Our view is that that is not

necessarily an adequate process and we have seen the results of that in a number of procurement exercises. We would get into another squabble about whose job it is: the job of the regulator or the job of the purchaser of care. From our point of view, it is really worth exploring that whole issue of the licensing of providers, rather than registering services on the basis of paper evidence and then dealing with problems that arise afterwards.

Ranald Mair: I want to return to the question that Fiona McLeod asked about the qualifications, if you like, and competence of SCSWIS staff to carry out their task. The feedback that we get from providers is interesting. They clearly feel more positive when the inspector is somebody who has a practice background and who knows and understands the work that they are looking at. That makes it easier for a provider to accept criticism and to take advice—given that we are looking at the combination of regulation and improvement. If SCSWIS staff who have had limited practice experience and have been trained only in regulation are used, the danger is that the process becomes a tick-box exercise rather than an interactive process of engaging with the people on the front line. We would probably expect that people inspecting schools would have a background in teaching. In order to be able to do the regulation, you have to have sufficient understanding of what that task is about. People certainly do comment at times if they feel that the inspector has come in and is simply looking at the inspection as a kind of paper exercise and does not appear to have sufficient understanding of the intricacies of the care practice involved. There are some issues for SCSWIS to look at in relation to the skill mix and experience of its staff.

Fiona McLeod: Licensing might be worth looking at. One of the issues that came out of what Annie Gunner Logan and Noni Cobban said was whether, when we are looking at regulation, we should be looking more at the outcomes of, rather than the inputs to, a service. By regulating the outcomes, we actually regulate what the service is doing. Do we therefore need to make a much more focused attempt to involve the users and the carers of those users in the whole process of regulation?

Noni Cobban: Yes.

Annie Gunner Logan: Yes.

Dorry McLaughlin: Yes.

Jim Eadie (Edinburgh Southern) (SNP): My colleagues have successfully teased out a number of important issues, which we can reflect on and pose to SCSWIS when it appears before us later in our inquiry. I am thinking specifically of financial viability, which Annie Gunner Logan mentioned, and of Ranald Mair's important point about the need to ensure that we regulate care in the round and not just at the delivery end.

Mr Mair, you state in your evidence:

"Quality of care depends on the quality of the investment in the workforce ... Regulation has to be matched by investment".

If the regulatory function is to be as effective as we all want it to be, it appears that that will come down to resources, at the end of the day. I am interested to know how the panel thinks we might bring about the shift in the balance of care from acute and long-stay institutions to the community, notwithstanding Ms Cobban's point about the particular challenges of providing services at home. How do you see that shift taking place?

Ranald Mair: Again, we must accept that regulation will deliver only so much. Other things will entail clear policy. The Scottish Government has the reshaping care policy framework, and processes are under way to move towards pooled budgets so that it is clear that health and local authorities have a shared responsibility for delivery of care. We should ensure that a person's care is located in the right setting, whether that is a hospital setting or a local authority setting.

At the moment, there is a disincentive for local authorities to keep people out of hospital because that would cost them, even though it would save the health service money. We need to create a pooled budget framework that is about being clear about an individual's needs, ensuring that all the options are available for that person, and that they are in the right setting for us to deliver the outcomes that we want for them—and that they want for themselves—at the best possible cost to the public purse. There are a number of things that we want to achieve on the shifting the balance of care agenda, and some of that dialogue is under way.

There is a dilemma about the extent to which the regulator should be directly involved in such processes. The care commission always stood back from the funding agenda and said that its task was to assess independently the quality of care, regardless of the level of funding that a provider was receiving. It studiously emphasised that its role was separate from commissioning and funding, but I do not know whether that is the role that we want the regulator to play in the future.

We are certainly moving into an era of integration of health and social care and joined-up commissioning and funding. In some cases—in Orkney, for example—we are already seeing joined-up service delivery from a single health and social care delivery body. The boundaries are being redrawn. I think SCSWIS and Healthcare Improvement Scotland will have to get their act

together to establish whether people are receiving a health service or a social care service. Some of the boundaries that were clear in the past will be less clear in the future, so we may need to take a fresh look at how the regulator interacts with the changing pattern of service delivery.

Dorry McLaughlin: This is an area that I am quite passionate about. I think that the change fund has a role to play here. Ranald Mair is absolutely right about the need for joint budgets, but just pooling budgets is not necessarily a panacea.

There is a question about the extent to which having a regulator that is focused on delivery, rather than on outcomes, would stifle creativity; I do not know the answer. There are many practical things that can be done to shift the balance of care from the acute sector to the community. I will give a couple of examples that I have been involved in. Care homes that provide nursing can provide intermediary care services—step-down services for people who have been in the acute sector before they return to the community and, more important, step-up services that prevent people from going into hospital in the first place. Those services might look slightly different, but they do not have to cost a huge amount of money. Care homes have an extremely important role to play in that regard.

Another initiative that I have seen involves using the supporting people grant—SCSWIS has a role in regulating those services—to pay for someone to sit in accident and emergency departments so that when an elderly person comes in who has had a fall, they can start to think about whether adaptations could be made to the person's home to facilitate their going home much sooner, or even to avoid their having to stay in A and E.

Sometimes, we need to have that imagination and to take a punt. Perhaps SCSWIS needs to balance regulating the processes with accepting that we sometimes need to try more creative measures to get the outcomes, and with giving us the space to do that.

11:15

Jim Eadie: In that process, what role—if any—does the regulator, SCSWIS, have?

Dorry McLaughlin: The regulator has two roles. If we want to change a service a little bit and do something a little bit different, the regulator can provide flexibility in the registration categories and work with providers to facilitate such changes. SCSWIS has no regulatory role in relation to health service commissioning, but it has a role in relation to local authorities. That takes regulation from being strictly about inspection to being almost a facilitating role.

Noni Cobban: I will follow what Dorry McLaughlin said. The Regulation of Care (Scotland) Act 2001 listed the registration categories, which packet people into categories such as day care, day opportunity and home care. If a home-care worker takes a person out to a shop, is that a day opportunity or home care? People who provide community care support services might therefore be required to register in four or five categories and to pay significant fees for that, which can be quite expensive. Many home care providers are also nurse agencies, so they must register as nurse agencies, too. Instead, providing community care services for an individual and doing what that person wanted during the day—the person would be living in their home but their care might not take place there—would be a great improvement.

Mr Eadie used the term "investment". We have not discussed regulation of the workforce. Service users' experience relates directly to the quality of the worker with whom they are in contact day to day. Through some of my activities, I became a member of a working group, with the care commission, that covered children's services. That is not my field, but I found the meetings interesting, so I continued to attend them.

After children's legislation was passed, significant investment was made in developing the workforce's childcare qualifications. I was hugely impressed by the sophisticated knowledge about and professionalism in their tasks of people who are involved in childcare. That does not yet apply to care of older people, particularly in home care. To an extent, the care-home world is more sophisticated, but the care-at-home world is still very much a cottage industry that uses underqualified and underdeveloped workers.

Limited investment has been made in developing the home-care workforce for providers in Scotland, as opposed to England, where Skills for Care invested considerably in helping providers to upskill the workforce. The relationship between the workforce that delivers the care that we all ask it to do and the investment in developing that workforce involves a regulatory function. The relationship between the Scottish Social Services Council and SCSWIS will continue to be critical.

Realistic investment is needed to address the demographic change in terms of older people. On shifting the balance of care, the perception is still that home care is cheaper than care in a home—but in some cases it is not. Some care can be very effective, but in other cases, if care is to be really meaningful to the service user, it is not a money-saving exercise. The system as a whole, which includes the workforce, still needs to be taken into our regulatory function.

Annie Gunner Logan: I have just a couple of quick points in response to Mr Eadie's point about the shift in the balance of care and where SCSWIS or any other regulator would come into that. The challenge is to take demand out of the system at the acute end. That is what colleagues on the Finance Committee looked at in their inquiry into preventative spending. The Christie commission also considered it.

The work that the third sector organisations are doing is taking demand out of the system because they are supporting people in the community who might otherwise be in acute psychiatric care or whatever.

The issue for us, however, is that we do not have access to the NHS budget—the budget in which the savings that accrue from our activity are made. If you start looking at pooled budgets and joint commissioning, that is clearly the answer. The role of SCSWIS, HIS, the Mental Welfare Commission and everybody else must be in measuring progress. We do not want to go down the single outcome agreement route again, because it was difficult to tell whether progress had been made, and even if we could tell that it had not been made, it seemed that nothing happened about it. That goes back to my point about who is doing the measuring, who is calling people to account and where the teeth are.

The Convener: I have a request for a brief supplementary question. It must be very brief, Mary.

Mary Scanlon: I want to use my question as a supplementary question on an issue that Noni Cobban raised. I understand that only about 50 per cent of staff in care homes are currently trained or are training to Scottish vocational qualification level. That is very worrying. It is also worrying that more than 75 per cent of people in care homes are taking one or more psychoactive medications. I do not know about care-at-home staff: we do not know the training levels or opportunities for those staff. Do you think that there is a connection between the lack of training, the lack of understanding and the lack of support for staff in care homes and the high level of psychoactive medication that is being given?

The Convener: I do not think that that was a very brief supplementary.

Mary Scanlon: That was my question.

The Convener: I need brief answers. Richard Lyle was going to be next with his question, and that was not a supplementary. We need very brief answers, please—given that we are in the last 10 minutes of this session.

Annie Gunner Logan: Earlier this year, we conducted some research with the University of Strathclyde that suggested a clear link between the quality of care provision—not just in care homes, but across the board—and the ability of a provider to maintain a healthy training budget. It was small-scale research, but it needs to be looked at. From our point of view, there is definitely a connection.

Ranald Mair: I think that there is a link with the level of psychoactive medication. With the dementia strategy, standards are being introduced in relation to training and service delivery, which will be important.

We have to make care an attractive occupation and career. We must offer terms and conditions that will encourage people to come into and remain in the sector, because turnover is too high. Down the line, we will have trouble, given demographics, in recruiting the number of people that we need to deliver care at home and care-home care. We have to get the skills mix right, which requires investment in training. We must also make it an attractive and rewarding occupational sector for people to come into. If we do not, we will, in the not-too-distant future, hit a crisis of not having enough people with the right skills mix, as well as the right values and attitudes, to deliver the care that we are going to need.

Richard Lyle (Central Scotland) (SNP): Noni Cobban made a comment about the level of care in the home depending on the package that has been decided for the person. I could go on and on. As a local authority councillor, I came across many of the circumstances that have been spoken about this morning. We have bed blocking in hospitals and a lack of discussion between social work, housing and hospitals with regard to people. Last week, I dealt with a case in which a quick phone call to an officer solved the problem for my constituent.

Basically, we need to sort out bed blocking. The council has to regulate. Although we have care in the community and although we are trying to keep people in their homes as much as possible, we have to understand that as they move through their lifespan they will have to go to a nursing home.

This country has some excellent nursing homes; indeed, I have had experience of what my father-in-law used to call "a seven-star nursing home"—and we must ensure that they have sufficient staff. However—and I apologise to Annie Gunner Logan for saying this—as Mary Scanlon has pointed out, care costs are tremendously high and should be regulated.

People are also proposing that we have a standard of care. When you buy a car or buy something in a shop, you know what you are buying; when you go into a care home or nursing

home, you are not told the level of care that your parent or relation will receive. Should that, too, be regulated to ensure that people know what they are going to get for their money? A range of £400 to £900 a week for care at a council-run home is absolutely horrendous, but the fact is that people out there are paying extra to ensure that their relations get more day-trips or whatever. We have touched on quite a lot of this already but, as a local authority councillor, I could go on and on.

As I say, we need care in the community. Sadly, some people are only getting 15-minute visits because staff have to run between everyone that they have to see.

I feel quite passionate about this and, as I have said, I could go on and on. Before I finish my question, though, let me just say that I have actually met the health service and council co-ordinator lady in Orkney. In my past life I was the chair of social care for the Association for Public Service Excellence and she was able to tell me about Orkney's excellent services.

Should SCSWIS regulate fees for the standard of care and ensure that we have quality staff—which, as I have already said, we already have? Again, I commend the good homes that we have in this country. Should we, as was mentioned earlier, ensure that training is upgraded? Finally, should we ensure that councils, the health service and nursing home providers start to work together?

The Convener: Can we have brief answers, please.

Annie Gunner Logan: I do not think that we are at cross purposes here. When I said that care costs are low, I was not talking about self-funders. You mentioned costs of £900 and above—for my father, the figure was £850, which made us all raise our eyebrows a few years ago—but that is the figure for the people who are over the threshold and who therefore have to use their own money. I am talking about local authority rates for care of the people whom they place; I largely agree with you about self-funding.

With regard to quality of staff, I guess that it all depends on what you mean by quality. If you are looking only at qualifications, I have to say that that is quite a narrow issue and is only one aspect of what should be considered. We have always been very keen for regulators to look at development, pay, reward and terms and conditions, all of which are part of the mix.

Was that brief enough, convener?

The Convener: Yes.

Noni Cobban: Richard Lyle asked whether the price should be regulated. In the case of home care, I would have to say that it should absolutely not be regulated. After all, you could be looking after someone with moderate dementia who might simply need some help to structure their day and to keep going. On the other hand, you could be looking at hospital at home, which requires significant intervention and the use of ventilators that need a high level of skill and sometimes more than one person to operate. Transferring a person who has suffered a dense hemiplegia as a result of a stroke from chair to bed also requires skills that will not be required by someone else. If we are sticking with personalisation and focusing on the service user, it is all about that person's needs and what those needs are going to cost.

Richard Lyle: But—

The Convener: I will let you back in, Richard, after we get the other responses to your questions.

Ranald Mair: I agree with Noni Cobban that you cannot regulate the price; however, you can regulate how the price is arrived at. That is not just a subtle distinction: it is saying that what is allowed within the price may be important for a contract. For example, does it allow for staff training and a range of other things? Pricing will vary according to the needs of the individual and the location. That is not because of a postcode lottery, but because it costs more to deliver services in some parts of the country than it does in others—it is not just variation at a whim.

11:30

It would therefore be hard to regulate the price exactly, but we can regulate the process by which prices are arrived at. The regulator—SCSWIS—is rightly being more demanding about providers' transparency regarding the service that is provided and any related costs. For example, greater demands are being made about the brochure-type information that service providers must give. Such demands were made initially by the Office of Fair Trading and are echoed by local authorities in their contracting. SCSWIS, as the regulator, is saying that providers must set out their stalls so that people know what to expect from the service that they receive. There has therefore been progress in that area.

Dorry McLaughlin: I agree with Ranald Mair's point about the quality of staff. In that regard, Annie Gunner Logan is right that it is not just about qualifications, but about the whole package of terms and conditions. However, there is a huge responsibility on you and on me, as a provider, to increase awareness of the potential for care as a profession and to say that it should be a rewarding job and career to go into. It is incredibly sad that in the choice between working in a care home or working for Tesco—I mean no disrespect to

Tesco—the latter so often wins out for the same pay rate. Knowledge providers have responsibilities in that regard as well.

Richard Lyle: The price for home care cannot be regulated, because it depends on what the individual requires and every case is assessed differently. My point is that we need a minimum standard of care that everyone knows they will get.

The Convener: Mary Fee is next.

Mary Fee (West Scotland) (Lab): I will be brief.

The Convener: Then it will be the long-suffering Malcolm Chisholm, who has been very patient with us.

Mary Fee: I want to pick up on Noni Cobban's point about investment in the workforce. I whole-heartedly agree that there should be real investment, particularly in home-care workers. However, will the increasing use of direct payments have a detrimental effect on the people who do home care? Who would regulate their standard? Who would put the investment in? Would it drive out the smaller companies that often provide high-quality care simply because they are small companies? Who would you like to see being made responsible for investment in the workforce?

Noni Cobban: That is a difficult question for me to answer, because I know that our membership is concerned about the coming of personal assistants and the lack of regulation around that. At a personal level, however, I think that it is the best outcome for a service user, who can work together with someone on what they need. Having experience of its working very well, I believe in self-directed support and people employing their own assistants.

We do not have time to cover it here, but I did some research at the University of Stirling and developed a model that I think would have solved the problem. However, nobody picked it up, so I retired. If anybody is interested in that, I am happy to talk about it because I still think that it is a relatively simple idea that could be taken forward.

If we developed the system and the workforce as a whole, there would be a critical mass of people who would be appropriately experienced, qualified and developed from whom the individual could recruit, which would be good. Someone who employed a driver would make sure that the person had a driving licence. If they employed a nurse, they would make sure that the person was on the nursing register.

I am between a rock and a hard place on personal assistants. I think that it is the ultimate in personalisation, but it potentially threatens the businesses of home-care providers. However, there is plenty for us all to do; there are plenty of older people out there. People should not feel threatened by the approach.

Dorry McLaughlin: I sound a note of caution for us all. We do not want to alienate the vast swathe of carers who provide care, informally and unpaid, to relatives and friends, and who largely do a good job. I guess that there are two challenges in that context. If we completely regulate the market, we might flush out more demand than we can afford to meet. Equally, many people provide informal care—I have done it myself—with absolutely no regulation at all. Families do that all the time.

Annie Gunner Logan: There are so many layers. The issue is not necessarily the direct payment, because a person can use their direct payment to buy support from a provider who employs qualified staff and all the rest of it, or they can use it to employ a personal assistant—the difference being that personal assistants are completely outside the regulatory regime, whereas qualified staff who are employed by agencies are not.

We are very supportive of self-directed support and personalisation, which is the direction that is being taken. The issue, for me, is that the pressure on the individual to make their money go further might well lead them to choose a cheaper option, whether or not that delivers the outcomes for them. Whether their outcomes are delivered is ultimately for the individual to judge. That brings us right back to the point about the responsibility of commissioning authorities. There is significant support among our membership for self-directed support, but we recognise that there is a major and critical regulatory anomaly, which someone will need to look at sooner or later. I have to say that we have been saying that for quite a long time, but we are still not there.

The Convener: I will bring in Malcolm Chisholm.

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): The meeting is overrunning, so I will put just one question to Annie Gunner Logan. I have enjoyed hearing the evidence, which has been very useful, and I am particularly interested in commissioning and quality. I remember that Annie Gunner Logan promoted an amendment to the Public Services Reform (Scotland) Bill, which some of us supported, to require commissioners to take account of the grades that SCSWIS gives. However, you implied in your evidence that not much is happening on that. What is the position? It seemed like a good idea in principle.

Annie Gunner Logan: I can give a shining example of the approach—so far, I think that it is the only shining example. The City of Edinburgh Council, which some years back had major issues

to do with care and support tendering, has put before its elected members a commissioning strategy that stipulates that the council will not buy or commission any new services from a provider who falls below a grade 4 from SCSWIS—grade 4 is "good"—and that over time it will work towards eliminating services that it has purchased that do not meet that standard. I think that the council's approach is a direct result of the amendment to which you referred. If the City of Edinburgh Council can do that, I do not see why other commissioners cannot do it. The question for the elected members is whether the approach has cost implications, which they will have to deal with.

Malcolm Chisholm: Is the provision in the Public Services Reform (Scotland) Act 2010 couched in general terms? What requirement does it place on local authorities?

Annie Gunner Logan: The requirement in the 2010 act is that authorities must take account of SCSWIS information when making decisions about commissioning. The 2010 act does not say what decision authorities must make; it is for authorities to make their own decisions. Edinburgh has decided that it will no longer purchase anything that is graded "unsatisfactory", "weak" or even "adequate", and it should be applauded for that. We would like to see more commissioning authorities take such an approach.

Ranald Mair: It makes infinite sense that there should be an agreement about the level at which a service should perform if it is to have a contract from the council. There are, however, difficulties in the practical application of the approach. Grades fluctuate. Providers might find themselves downgraded then regraded. How do we manage that? Do we immediately withdraw all the residents from a care home because a grade has gone down to 2 on a particular aspect? There are four quality themes rather than a single one, so must all four themes be maintained at grade 4 or above if a home is to continue to be able to take council residents?

For the most part, we have tried to address the matter through the national care home contract. If a provider receives low grades—certainly 1s and 2s—the local authority is required to review the position and a robust plan for addressing poor performance must be in place. The awarding of a low grade will not necessarily immediately trigger the withdrawal of residents, but it might well lead to no new residents being placed until the matter is remedied. We are beginning to see a link between gradings and how councils administer contracts.

Probably the biggest issue that providers raise about SCSWIS—and raised in the past about the care commission—is the lack of consistency. Providers who run homes in different parts of the country might think that they are providing exactly the same standards, but they are getting one grade in one area and a different grade in another area. If we are to have a system under which the awarding and maintenance of contracts depend on grading, we must strive for as much consistency as possible in the grading process, if that is to be our benchmark.

The Convener: I thank all the witnesses for their interesting evidence. I am sorry that we kept you a bit late and I apologise for the delay at the beginning of the meeting.

11:42

Meeting suspended.

11:49

On resuming—

The Convener: In the interest of saving time, I welcome our second panel collectively. I am sorry that we have kept you a bit longer than expected. You might not be aware that we had to move committee rooms earlier, which delayed us, and we had a long first session. We will try to keep to the schedule.

I thank you all for giving us your time this morning. I will not introduce and welcome everyone individually. When you speak, you might wish to introduce yourself and the organisation that you represent. I hand over to my deputy convener, who will describe what we hope to get from the discussion today.

Bob Doris: Thank you to everyone for coming along, and for your patience with the slight overrun of the earlier session.

This round-table discussion will enable the committee to take evidence from a number of witnesses all together. The idea is that the format should provoke more discussion between members and witnesses, and between the witnesses themselves. If one witness wants to ask a question of another witness, they should not feel constrained by waiting for members—just catch the convener's eye and that can happen. The session is not about us talking at you; it is intended to be much more informal than that. Given that there are so many of us, everyone should speak through the chair, but we will try to keep the conversation going as much as possible.

The convener has allowed me to throw in the first question, which is very kind of him. Much of the earlier session looked at the tendering process. Another aspect, which we did not consider earlier, is the move to the less frequent and more risk-based self-assessment with which SCSWIS is involved. I am interested to hear what

our witnesses think are the risks and opportunities within that. I would like to tease out some of those issues.

Dr Donald Lyons (Mental Welfare Commission for Scotland): I am the chief executive of the Mental Welfare Commission for Scotland.

Members will remember that proportionality and risk-based assessment were a key recommendation of the Crerar review. It is amazing how it takes only a few cases to see a change in policy. I suppose that we are as guilty of that as anyone with our report on Mrs V; although that was not a care home case but a hospital case, it revealed the same issues.

The MWCS has been doing proportional and risk-based assessment for a few years now, and we generally support the model. The issue is not whether it is right to do proportional and risk-based assessment, but how the information on risk is collected. If we just keep going back to the same services that we thought were not very good the last time that we visited them and do not visit somewhere else, the danger is that we might miss care standards slipping and care becoming poor. It is very important that all the organisations that are doing risk-based assessment have a wide net in which to catch risk. That could be done through complaints and the expression of general concerns by members of the public and relatives; whistleblowing is also an important way of doing it.

Generally speaking, the MWCS supports the model, with caution around how it is implemented.

Dr John Gillies (Royal College of General Practitioners Scotland): I am a general practitioner in Selkirk and chair of the Royal College of General Practitioners in Scotland. I also work for NHS Education for Scotland as a training programme director, training young GPs for the profession.

The model of proportionality and risk-based assessment is used within the health service as well as within social work. For example, we use it in assessing our training practices. That is a different situation, but it allows us to target resource to where we feel that it is most likely to be of benefit.

I agree with Donald Lyons that it is important to collect information about risk from a wide variety of sources, including formal submissions and informal sources. One difficulty of risk-based assessment is that people tend to regard the gathering of information as something of a tick-box exercise. It is critical to the success of SCSWIS that it has its ears and eyes open for information from a wide variety of sources.

Ellen Hudson (Royal College of Nursing Scotland): I am associate director of the Royal College of Nursing Scotland.

I agree with Dr John Gillies and Dr Donald Lyons. The essence of what we need to capture is information on the organisational culture within which individuals are receiving care. That plays a part in risk-based assessment. A provider might have a very good assessment the first time round, but things might change. That could be because of recruitment and retention of staff or leadership in the organisation or provider. Those are important factors that can impact on the quality of care that is provided.

The regulatory process is all about providing assurance that quality care is given. The process involves examining staff training and development needs, leadership in the provider and other aspects that could have an impact. Sometimes, impacts can happen fairly quickly. In a six-month period, significant changes could occur that affect the care that is being provided. That is an important issue.

Peter Ritchie (Unison): I am the former branch secretary of Unison's regulation of care branch. The care commission always carried out risk assessment, but to a lesser extent than SCSWIS now does. The major concern about the approach, to which colleagues have alluded, is that it can become a paper-based exercise. Its big weakness is that it sometimes relies on other people's opinion. For the front-line inspector, nothing beats feet on the ground and being in a home. As Ellen Hudson said, something can go badly wrong in six months. I have personal experience of a care home going from excellent to disastrous in three months. A home can deteriorate extremely quickly. If a risk-based assessment says that a service is performing well, the inspectors might not be in for a year or two years. We regard that as a pretty risky situation.

Bob Doris: I apologise to Ruth Stark—I will let her in in a second—but, as I was having a quick chat with the convener, a question came into my mind about whether, with less frequent inspections and a risk-based system, we are capturing all the professionals who work in care homes, including external physiotherapists, GPs and pharmacists. I am keen to know about their role in the reporting process. Further, in a care home that is inspected by SCSWIS, say, once every two years, what procedures outwith the official inspections are there for related healthcare professionals to feed in general concerns—I will not use that ugly word "whistleblowing", which I do not like—that they might have?

The Convener: We must let Ruth Stark in.

Ruth Stark (Scottish Association of Social Work): One of our concerns is about how people are listened to. The skills of the inspector are important in listening to how relatives or direct service users convey their concerns. People need to be protected if they make a complaint. I accept that Bob Doris does not like the word "whistleblowing", but one big issue for people who use services and for some staff is that, because of the culture of an organisation, it is sometimes extremely difficult for them to make a complaint or to report what they see as bad or harmful practice.

12:00

There is a big difference between the harmful practice that comes from poor staff working conditions and the neglect that can fester because of it and, at the other extreme, someone who is employed in an organisation and who from the outset is set on harming individuals. There are two ends of the spectrum and we have to be careful about what we are inspecting, who we are inspecting for and what we are trying to listen out for. There is a big difference between staff who are in a poorly supported work situation and those who are in there to do outright harm. We should make that distinction.

Martin Green (Community Pharmacy Scotland): My background is pharmacy and I am the chairman of Community Pharmacy Scotland. Pharmacies provide quite significant support to care home providers and services but, with regard to the question about how the regulator engages with other professionals who provide support and services in the care home, the regulator does not engage with us at all. We are not asked to comment on the services that we are involved with in the care home and we receive no direct feedback on the input that we have into any given care home. If we hear anything, we hear it at second hand, through the care service, and there can be a dramatic change between what is said at the time and what is reported back through a third party.

The Convener: Mark Smith might have a view on aspects such as the management of medication not being considered by the regulator.

Mark Smith (Chartered Society of Physiotherapists): I represent the Chartered Society of Physiotherapists in Scotland. The way in which allied health professionals—a category that includes physiotherapists—engage with the care industry is interesting. We are regulated by the Health Professions Council and there is a rigorous process of meeting standards and on-going assessment of individuals at random, as well as continuing professional development to ensure people's fitness to practise. That is well established in the health sector.

There are interesting issues around the pathway of an individual who goes from the community into hospital and, potentially, into care. The ways in which SCSWIS interacts with HIS around regulating the delivery of health and social care together are interesting, too.

We are looking at having to deal with not only many more older people, but more older people who are less well than old people are at the moment and who are living with long-term conditions, and it will be a considerable challenge to maintain their health and wellbeing on an on-going basis. I know that this has been discussed before, but I would like there to be more on-going partnership so that care services can be delivered in a single-system way that involves greater partnership with health services in the community.

Dr Gillies: As far as I know, I do not think that the care commission has ever asked me for an opinion on either of the two homes in my area that our practice serves. Because we have close relationships with the homes, we hear the outcomes of the commission's visits and inspections—we hear that from the homes, not the commission.

This information is anecdotal rather than evidence based but, having been a GP for a long time, it seems to me that there are fewer qualified staff in some care homes than there were 10 or 15 years ago. In one of our excellent homes, there used to be a registered mental nurse looking after a dementia unit all the time, whereas that would be unusual now. We no longer have, on a regular basis, a registered mental nurse with expertise in the management of people with mental health and dementia problems, despite the fact that the needs have increased considerably. The demographics mean that we will have an explosion in the number of elderly people—mainly those over 85 years of age—over the next 30 years. That is a cause for celebration and we should not be too gloomy about it; most of us want to reach 85 years and beyond and be reasonably healthy. That is a measure of success.

However, the way in which we provide care for those people when they need it has not kept pace with the obvious demographic shift. I agree with one of the witnesses in the previous panel, who said that more people will need more care at home over the next 30 years. Even now, it is striking that people are more frail when they go into nursing homes than they were 10 years ago because they are supported at home for longer. That is a good thing, but their care needs in nursing homes are substantial.

I work in a rural area; some of our patients are as far as 30 miles away. Social work departments have the greatest difficulty in finding providers for care at home for individuals 15 or 20 miles from

where I live in Selkirk. There seems to be no funding for transport, which may take as long as the visit. We have many remote and rural areas in Scotland and it seems they are not proportionately provided for.

The Convener: Transport may be a topic that we get to, but in this inquiry we are looking primarily at the role SCSWIS could play in helping to identify risks. Fiona McLeod is next, followed by Mary Scanlon and Gil Paterson.

Gil Paterson: May I ask a quick supplementary question before that? It is fundamental to these issues. Dr Gillies has offered an opinion on the nature of the qualified staff and his view is that it is deteriorating. Can he offer an opinion on why that is the case and why, 10 years ago, we had a qualified psychiatric nurse on hand but now we do not? I think that I know the answer.

Dr Gillies: I would qualify that by saying that my view is based on my experience within the practice. There might be national statistics that show that it is more generally true. There is great difficulty in recruiting a registered mental nurse to work in a nursing home. That may be a function of wage rates, terms and conditions, training and other available opportunities. Sometimes, the homes are not a very supportive environment for the nurses to work in. The point has already been made about getting the right organisational culture within a home to support not just the patients and clients, but the staff. That is critical.

The Convener: Does Fiona McLeod wish to introduce a new theme?

Fiona McLeod: No, I want to ask a question before moving away from risk-based assessment.

As Dr Lyons said, most regulators are moving towards the initial phase of risk-based assessment being done by the organisation. Martin Green and another witness made comments that tie in with my theme of involving the users much more. If risk-based assessment is to be anything more than a tick-box exercise—"I've got the paperwork on COSHH regs, I've got this, I've got that"—it must be available at an early stage for users and their carers to comment on. Such comments should be given not to the care provider, but to the regulator. As Martin Green said, there must be a route back to the people who make such comments to let them know that the risk-based assessment of the care provider came out as X, Y and Z and that their input helped to inform the regulator's decision.

Dr Lyons: I completely agree with that statement. The Mental Welfare Commission for Scotland's role is not as a service regulator; our role is as an individual safeguard for people with mental disorders.

One of the issues is that many people with mental disorders would not spontaneously be able to comment in that way, and some people do not have family, friends or carers who can do it for them. That is where we have a crucial role. Over the past year, we have ensured that all our reports on individuals whom we see on visits to care homes and hospitals go to the regulator for that service. We send those reports, and flag up issues of concern that we have raised, to SCSWIS for registered care providers, or to Healthcare Improvement Scotland for hospital care. That is one way in which all that can tie together.

May I make a quick point about pharmacy?

The Convener: Yes.

Dr Lyons: At the Mental Welfare Commission, we have great respect for the input of clinical pharmacy into people's care. The care commission as was, and SCSWIS as is, has pharmacy advisers who are heavily involved in some inspections. If there is a disconnect between the pharmacy advisers and the pharmacy services, I am sure that you would find a sympathetic ear from David Marshall and Alison Rees at SCSWIS to try to bring that together.

The Convener: It is interesting that Community Pharmacy Scotland confirmed in its written evidence and at the committee today that it does not see that connection on the ground. That is an interesting area, which perhaps we can pursue with SCSWIS when its representatives come to give evidence.

Martin Green: I am familiar with the individuals concerned and we have a relationship with them, but only because of my experience at a political level within pharmacy, rather than my experience at the coalface in the provision of services.

Dr Lyons: It is something to build on, though.

The Convener: Dr Lyons, we have lots of evidence but, as I recall it, you identified in your submission the crossover of the roles of the MWC and SCSWIS and suggested that the national care strategy might have to be revisited. Can you expand on some of the things that would help to address risk?

Dr Lyons: The national care standards are getting a bit long in the tooth; I think that they were developed in 2003, but forgive me if I am wrong—they may have been updated since then. The reason for saying that—I think that SCSWIS said the same in its submission—is that things have moved on since then.

We co-ordinated the work on the dementia standards that were published earlier this year, which are very much rights based. The national care standards are very cleverly written from the perspective of the individual service user and

outline what they should expect, but that could be expanded on. The national care standards could be more specific in terms of expectations; some of the content can be a bit loose and woolly. The dementia standards have general overarching statements, but they include specific statements on what has to be delivered to meet the person's right. That approach could be drawn on as part of the revision of the care standards.

Ellen Hudson: If we are looking at the national care standards, another tool that the inspection team uses is quality themes and statements. In SCSWIS's system to pick up healthcare need, health and wellbeing are the focus of only one quality statement in the entire framework that is used to inspect services. It states:

"We ensure that service users' health and wellbeing are met".

It is very ambiguous in terms of how that will be delivered. Providers submit a self-assessment, but it is not mandatory for the inspector to go in and pick up on that particular field.

The RCN has concerns that the unmet healthcare needs of people living in care homes might not be being picked up, because health has a low prominence within the quality themes and statements. That is indicative of the fact that a number of regulatory bodies have to work together. The regulatory bodies that regulate the services that are being provided are mixed in with the regulatory bodies that regulate the workforce, so there is the SSSC; within nursing there is, for example, the Nursing and Midwifery Council; and there is SCSWIS.

12:15

We are concerned about where care home monitoring is being picked up in the care home sector. To return to Dr John Gillies's point, we know that people are having increasingly complex healthcare needs and that they are living longer with long-term, life-limiting conditions in the care home sector. So, the health needs component is increasing. Added to that, almost 70 per cent of people who live in care homes have dementia, and we know that that is about to double in the next 25 years. There are concerns about the national care home standards.

The report by the Mental Welfare Commission and the care commission, "Remember, I'm still me", was published in 2009. It found that, although people going into a care home had very good assessments, the pick-up was not so good thereafter. According to the national standards, they should get six-monthly checks, but the report found that that was not happening. We are concerned about that potential gap, although there are some fantastic examples, to which Dr John Gillies alluded.

In my previous role I was associate director of nursing in NHS Greater Glasgow and Clyde, and we had fantastic care home GP services with a liaison nursing team that provided dedicated services out to the care home sector, looking at the geography of Greater Glasgow and Clyde. As you can imagine, that is quite a big area. It is about looking for economies of scale and getting the best GP services and nursing care out to support those who are already providing excellent care in a number of care homes out there.

Jim Eadie: You have identified an issue of unmet healthcare need that the committee needs to consider. Is part of the solution, as set out in your written evidence, that the non-registered nursing workforce should be regulated by the regulatory body where nurses delegate care to healthcare workers?

Ellen Hudson: That is an RCN position that we feel strongly about. People who undertake work that is delegated by a registered nurse must have support and supervision. They are the ones who are delivering hands-on care in the care homes, and they must be skilled and competent at what they are doing. Given the complexity of care needs, it is a hard job to care for individuals in a care home and to meet all their individual care needs. We need a really skilled workforce working in that environment like never before. That is why the RCN feels strongly that there must be the right skill mix and the right balance between registered nurses and the workforce. It is not about one taking priority over the other; it is about getting the right complement to meet the individual needs of people who live in care homes.

Demands change on a day-to-day basis, as people often have more complex care needs from one day to the next. How can the workforce be fluid enough to respond to the nature of those needs? Contracting for services and getting in additional staff can sometimes be a complex process for the provider, requiring back payments and recouping of costs from the local authority. In the meantime, to meet the instant health needs of the individuals, they must get in those additional staff.

The Convener: I will take comments from the witnesses and will then open the debate for questions again. Mary Scanlon will open up a new theme.

Peter Ritchie: I want to ensure that the committee is clear about this. A colleague mentioned the process that we go through in terms of quality themes and assessments. You are right that it is not mandatory to look at any particular area, but inspectors take a sample of

care plans and if a need is picked up that is not being met they are obliged to go in and explore that further. What starts out as one quality theme or statement can quickly expand into much wider areas. We trust that someone would pick up such issues and carry them through properly. So, I am not sure that the notion that there are grey areas of healthcare need not being met is an accurate picture of what happens.

It has also been suggested that the care commission and SCSWIS do not report back to other healthcare professionals, but the converse is true: there are historical difficulties with getting input into inspection processes from other professions. The situation is not new; there have been difficulties in all sorts of fields for years. Childcare is the most obvious example: when things go wrong with childcare, whether or not people are talking to one another is always identified as an issue.

The Convener: We have reached a point that I am glad we have reached. We have a slight difference in interpretation, or a different view. Do any of the other witnesses want to enter the debate?

Dr Lyons: I agree that the care commission and SCSWIS have probably done more in looking at unmet healthcare need. I suppose that we have always thought that a potential weakness of the split between the regulation of health and the regulation of social care would be that there would be a divide. SCSWIS is predominantly a social care regulator and HIS is predominantly a healthcare regulator, so there will be a disparity in what is assessed by whom.

The converse is that SCSWIS would have closed yesterday long-stay hospital wards for people with dementia that we visit if they were in the regulated care sector, as they do not come anywhere near any standards for individual privacy and dignity. Let us be clear. There are huge disparities across the care sector, and one of the big regulation tasks for SCSWIS, HIS and us is to try to bring those areas together and get greater uniformity. That is what dementia care standards were about.

Dr Gillies: I want to follow up on what Ellen Hudson and Peter Ritchie have said.

We cannot overemphasise the major change that the demographic shift in the next 20 years will bring to the sector. On regulation and a provider being assessed by self-assessment, the turnover of clients in a nursing home, say, is now quite fast, as many people enter nursing homes towards the end of their lives. That means that whatever process is put in place must look quite critically and regularly at information from that home. There are also the increased numbers and the increased healthcare needs of those individuals, which will continue to produce quite big challenges for commissioners and the regulator to meet over the next 10 years. The situation is not static.

Ruth Stark: A witness on the first panel talked about people's choices. In a sense, it does not matter where a person is being looked after: they still have an element of choice. I agree with Donny Lyons. There must be a balance between, on the one hand, nursing care, health standards and people being well looked after, and, on the other hand, people's personal choices about what they want to happen to them. They may not want an intrusive health service coming into their end-of-life experience. We have to respect the dignity of the person in whatever setting they are in.

Ellen Hudson: I want to go back to the point that Peter Ritchie made. I appreciate that inspectors sample, but the process is about how SCSWIS can get things right, make the approach of inspectors not arbitrary and perhaps select certain things. A number of other agencies are calling for a review of the national care at home standards. If that can be incorporated, and we can be far more explicit about determining health needs so that the approach is not arbitrary, that would go a long way towards a solution. That goes back to Jim Eadie's point.

The Convener: We are keeping the argument going.

Mark Smith: There is an issue with the resource available to support people in a rehabilitative way in the long term in nursing home care and home care. We see a lot of people with severe stroke who will require to be in a care environment but who are potentially still recovering to some extent and, therefore, whose performance, health and wellbeing could be improved. Historically, there has been a lack of resource available for that part of the pathway.

I note that SCSWIS has specialist advice in a number of different areas. Is there an argument for having more advice around people's longer-term rehabilitative needs?

The Convener: Do you wish to come back in, Peter?

Peter Ritchie: Yes. I am not getting into a debate here—or perhaps I am.

The Convener: We have very helpful written evidence, so it is important that we hear the differences around the edges.

Peter Ritchie: It is about process. The selection is not arbitrary; the quality themes and statements are picked for a year or six months and they are what everyone is expected to inspect against. If inspectors pick up on other stuff as they go, they are obliged to look further.

Ellen Hudson: But you have only one quality theme for health; I think that that is a bit of an omission.

Peter Ritchie: You and I might disagree on that, but I entirely agree that we need to review the national care standards, because they are getting a bit long in the tooth and creaky at the edges.

The Convener: I call Mary Scanlon. I am depending on you to start another debate, Mary.

Mary Scanlon: I do not know whether this will start another debate, but the four areas of inspection, which Ellen Hudson has mentioned, are quality of care and support, quality of environment, quality of staffing and quality of management. The main one that I am concerned about is quality of staffing. Generally speaking, on one visit, SCSWIS will look at one area, so if it looks at one area every two years and there are four areas of inspection, the quality of care and the quality of staffing might be looked at once in eight years—if you are lucky. I do not think that that is good enough.

While Donny Lyons is here, I will put a question to him, which I do not apologise for asking again. It is really about the quality of staffing. Less than 50 per cent of support workers in care homes are trained to SVQ level 2 or are in training. They do not need to register until 2015. The "Remember, I'm still me" report by the MWC and the care commission highlighted that there is very little evidence that medication was reviewed and that very few people in care homes had annual health checks from GPs. Seventy-five per cent of people in care homes are on psychoactive medication. Is that being used and abused to control people, if you like, in the absence of having good training, support and care and valuing the staff that we have?

Dr Lyons: As Mary Scanlon will know, her question could start me on a rant until midnight. The simple answer is probably yes. You cannot look at the prescribing of medication in isolation; you have to look in the round at what is available for that person. On what we and SCSWIS are doing about that, if we go in and find somebody who is being prescribed medication for so-called challenging behaviour—we could talk for hours about what that means—we ask what the care plan is to support that; what steps are put in place before medication is thought about; what interventions people are trained to use; and whether there are training gaps. One of the other issues that we brought out in "Remember, I'm still me" was the lack of training available. As members will know, that is a core part of the dementia strategy; the two main planks are standards and training. I know that I am talking about dementia here, but I think that if we get it right for people with dementia, we will get it right for everybody.

Medication is an interesting issue and it brings me back to a point that I wanted to make earlier. A care home might have two, three or four separate units. Unit A in the care home might be excellent and offer a really good standard of care, but unit B might be appalling. It all depends on leadership: how good the manager of the unit is, and how well they are supervised.

12:30

To pick up on a point that John Gillies made earlier, one of the issues about plonking down an RMN in a care home is the degree of supervision that that person has. They might not be supervised by someone who has the knowledge and skill to know what an RMN's role, responsibilities and professional expertise should be in that situation. We have a huge training agenda; coupled with better adherence to good prescribing guidance, training will bring that 75 per cent down to, we hope, less than half.

We have focused a lot on antipsychotic drugs for people who have dementia, but we have broadened that out because we were concerned that, if we stopped prescribing drug A because of worries about its side-effects profile, there would be a danger in supplementing drug B, which might be just as bad. We have seen a fair amount of that in our travels.

The Convener: We will give the others an opportunity to respond to Mary Scanlon's question, but—this is for Dr Gillies—are there risk factors that SCSWIS should be looking out for in relation to local pharmacies and the type of medicines that are going into a home? We are looking at what should be on the risk register.

Dr Gillies: I am grateful to Mary Scanlon for bringing up annual health checks and psychoactive medication for elderly people in nursing homes, which is a really important and complex issue.

We have already discussed in various ways the importance of having the right organisational culture and leadership in the care home so that training is an intrinsic part of the organisation's plan. GPs are often placed in quite a difficult situation, and I hear from colleagues that sometimes people who exhibit quite challenging behaviours have to be assessed and dealt with by staff who do not have adequate training. I reinforce what Dr Lyons said about that. There is a risk of drugs being used not because they are really needed but because it is a quick fix in a complex situation. The answer is to ensure that our workforce has the skills and training to meet

the complex physical and mental health needs of such residents.

Recently, there was an interesting paper in the *British Medical Journal* on dealing with challenging behaviour by elderly people in nursing homes. The researchers discovered that it often helps to give such people paracetamol because a lot of challenging behaviour happens as a result of unrecognised pain. Sometimes simple answers come if we go back a few steps and ask why a person might be presenting challenging behaviour. An antipsychotic drug will not sort that, but a simple analgesic might. However, not all such problems can be dealt with in that way, unfortunately. If paracetamol was the answer to the problems of nursing homes, we would have sorted them by now.

I go back to the need for cultural and organisational leadership and training to reduce the amount of medication that is administered. As an aside, I sit on the delivering quality in primary care group of the Scottish Government's health department, which is looking carefully at this area. We have geriatricians, psychogeriatricians and GPs looking at how we can safely reduce the amount of medication that some of our elderly people are on. We have also initiated some joint work with the Royal Pharmaceutical Society to see how some of these issues might be addressed.

The Convener: Richard Lyle wants to come in, but I am consciously giving the witnesses precedence over members.

Ruth Stark: Looking at staff training needs, it occurs to me that, in social work and social care, we have centres of excellence for residential child care, for criminal justice and for people who have dementia, but we have nothing for residential care of the elderly.

To meet training needs, we need to invest in training staff who are not even at SVQ level 2. Some such leadership must come from political investment in training staff. It cannot all be left to SCSWIS to try to regulate in that regard; it is not the body to do that. We must address proportionately issues that can be addressed, one of which involves looking seriously at the training needs of care home staff.

Mark Smith: I am a member of the national advisory committee on stroke. The better heart disease and stroke care action plan, which the Scottish Government published last year, highlighted knowledge about and skills in managing people with stroke across the board and made that part of the implementation plan. In partnership with Chest, Heart and Stroke Scotland, eight health boards are trying to achieve improvements. Health and social care staff from all levels can access training programmes to gain knowledge about and skills in treating stroke. That could be a good model to develop.

Martin Green: Statistics can be a little dangerous at times. The startling figure that 75 per cent of people were taking psychoactive medicines knocks people off their chairs, but the term is broad. Many medicines that are considered psychoactive are not necessarily used to deal with aggressive or challenging behaviour. Psychoactive medicine is rarely the first solution to tackling a patient's aggressive and challenging behaviour, although it will be prescribed for the patient. The committee needs to look more closely into the statistics before being too startled by the figure.

As for clinical input in potentially reducing patients' use of medicines and establishing whether medicines are appropriate for them, a chronic medication service to support patients in the community is being developed through our national contract. Patients in care homes are excluded from that service, which greatly disappoints us, because including them would facilitate a platform from which such input could begin.

Mary Scanlon: The figure that I quoted came from the Royal Pharmaceutical Society's submission and was based on the report "Remember, I'm still me" by the Mental Welfare Commission and the care commission. I would think that the Mental Welfare Commission would know a psychoactive medicine if it saw one.

Dr Lyons: May I respond to that briefly?

The Convener: I knew that Mary Scanlon would not let me down.

Dr Lyons: I will argue with my pharmacy colleague, too. I return to what I said about one medication substituting for another. It is right to say that various classes of psychoactive medication were being prescribed. Quite a few people were on antidepressants, the commonest of which was trazodone. In many cases, trazodone was clearly being used not for antidepressant purposes but for its sedative effect—including being given as required, which is a completely inappropriate prescription. More clinical pharmacy involvement in nursing homes to nip such practices in the bud would help.

Another class of drugs that was used was anxiolytics and night sedation. I understand that research shows that, on balance, giving somebody with dementia a sleeping tablet does twice as much harm as good, because that person could experience drowsiness the next day and falls in the morning, although their sleeping pattern might improve.

Given that information, we deliberately took a broader approach. We saw that much medication

was being used not for improving mood, which antidepressants can help with and might be underused in care homes, but for sedation and behavioural control.

Martin Green: The committee needs to examine the statistics closely.

The Convener: Yes. I will give a simplistic view. Care homes have no connection with local pharmacists and questions have been raised about how and by whom medicines are administered and about what outcomes are expected.

Could SCSWIS, the regulator, examine the management of medicines and prescribing generally? Perhaps this is simplistic, but if a lot of a medicine of the type that we have discussed is prescribed for use in a home, does that indicate a problem and that medicines are being used to manage people because of understaffing or a lack of knowledge and skills? I do not know; I am trying to focus on what areas SCSWIS could examine that would indicate a risk.

Peter Ritchie: I will start another fight.

The Convener: Good. That is the round-table format.

Peter Ritchie: I remind the committee that it is not care home staff who write prescriptions for medicines but medics. That is always done by doctors. I saw a report the other day that said that, although the UK Government has been trying for years to reduce the prescribing of benzodiazepines, such prescribing has gone up. The only people who prescribe benzodiazepines are doctors.

Mary Scanlon: It is all their fault.

Dr Lyons: We tried to nip that argument in the bud after the "Remember, I'm still me" report. We get into an unhealthy and unhelpful situation in which care home staff blame doctors for what they prescribe and doctors blame care home staff for the pressure that they put on because they cannot manage the people whom they have under their care. That is not a helpful argument. The helpful argument is to consider in the round everything that improves prescribing practice and behaviour management in care homes.

Dr Gillies: The buck always stops with the medic. That comes with the territory.

I agree with Dr Lyons that it is about finding the right solution in each individual care home. I also agree with my community pharmacy colleagues that more pharmacy input would be really helpful. Perhaps joint visits between GPs and pharmacists might help to address the issue. However, we also need better training standards and standards of care.

If there were an easy answer to the problem, it would have been found by now.

The Convener: We are going into the last 10 minutes. One member whose hand has been up and down is Dr Richard Simpson, to give him his full title. I had better let him in as well.

Dr Simpson: I have learned something today: I did not realise that the chronic medication service—which I thought would help with the problem a lot—excluded care homes. That is a big flaw. The service is just rolling out and has a way to go, but the committee will need to examine it.

One of the big issues that we have been considering is financial stability. We have not really got into it with this panel of witnesses, although I understand why. However, as Peter Ritchie is here, I will ask about the impact of clawback on SCSWIS—the substantial reductions in its funding over the next year or two. Will that have a real effect or will it be accommodated through savings made by merging the operations?

I ask that because, as we have discussed, the care home population will get older and have more complex needs, there will be more dementia to deal with, and more palliative care will be used. We do not want to move people into hospital. We do not want them to die in hospital and they do not want to die there; they need to die in their own homes or in care homes. The increasing step-up and step-down and the integration of the health service with social care are also part of the picture. There are all those elements, and then we have a substantial reduction in funding. Will Peter Ritchie comment on that?

12:45

Peter Ritchie: The reduction in funding over the next four years is cumulative and amounts to 25 per cent. In the last financial year in which the care commission existed, it had to run a voluntary early retirement and redundancy scheme because the number of staff who were technically eligible for transfer into SCSWIS far exceeded what the budget could handle. Around 70 staff, which included more than 50 inspectors—boots on the ground—were lost.

The care commission had an establishment of around 330 inspectors. SWIA had around 20, but it also employed sessional people. As I understand it, the staff from Her Majesty's Inspectorate of Education moved in as well, by and large, but I do not know the figures. SCSWIS currently employs 289 inspectors, so there has been a drop of about 60 to 70 people. We do not need to be financial experts to work out that that means that people are not able to spend the amount of time on inspections that they used to spend.

Partly because of that situation and because it is looking to make efficiency savings, SCSWIS has shifted its structure. Before, care commission officers inspected, registered and investigated complaints. Occasionally they were involved in enforcement, too. Now the functions are split; we have registration teams, an inspection team and a complaints team. With such an approach, there is the risk of the usual information not being exchanged.

I grant that systems are still in development and I would not want to say that they are not working. However, as I understand it—this is anecdotal—the number of complaints that have been made against SCSWIS staff has jumped massively since the start of the year, when we started taking the risk-based approach and inspecting mainly high-risk homes. That fits with my experience in the care commission. High-risk homes retaliate by attacking the inspector and trying to undermine the report's validity. There are complaints along the lines of, "I didn't like his attitude"—people say that to me all the time, but I do not get upset about it and it does not affect what I do. To be fair, not all care homes take that approach, but some do. Some care homes attempt to slow down or undermine the process.

It was ironic that the witness from Scottish Care said that care homes would appreciate inspectors having a background in the field that they inspect. I think that most inspectors would appreciate providers having some background in what they provide.

The Convener: Ouch.

Peter Ritchie: Oops, yes.

The Convener: I do not know whether you will get the last word on that. Is nobody in the mood to respond? I can see that Dr Lyons is—sorry, I see that Ruth Stark wants to come in, too.

Ruth Stark: Peter Ritchie raised a critical issue about how complaints are handled and what happens to the people about whom complaints are made.

I think that it was SWIA that observed that many complaints that it received came from care managers who had visited their clients and service users in care homes, and that many such complaints were made anonymously, because people did not want to be victimised. Behind that is a subtlety and a culture that means that we do not hear complaints in a positive way and we do not protect the people who make statements about the quality of care that they see. The people who see deterioration in a care home are often the people who visit residents—the friends, relatives and social workers.

We must look at the system and think about how we protect people who make complaints. We have recently discussed exactly that subject with the Mental Welfare Commission. The current system does not work.

Dr Lyons: I am grateful to Peter Ritchie for making the point that he made and I applaud SCSWIS for involving service users, carers and lay inspectors in visits. I, too, want to challenge what Ranald Mair said—I did not get a chance to speak to him but I will make the point when I meet him. Sometimes, service users and lay inspectors pick up things that professionals miss, because we get inured to things that are bad practice but have always been done in that way.

The Mental Welfare Commission has used lay people, service users and carers for some time and it is an eye-opener for me to visit with a service user and find that they regard as completely inappropriate something that I was used to because it was always done. That has challenged my perspective, and we should all be open to such challenge.

Fiona McLeod: I am very conscious that we do not have much time. All our discussion—great as it has been—has concentrated on the regulation of care in homes. We want to find out whether the existing system of regulation will allow us to regulate care at home, which is where most care will be given. Dr Gillies's point about the changing demographics was interesting, and we have talked about people going into care homes later, so the care that is provided at home in the next five to 10 years will have to be of a much higher level than today's already high level. More people will get care at home and the care that they get will be of a higher level. Will the current regulatory system cope with that? What do we need to do to ensure that we regulate care at home?

The Convener: Are there any comments on the future and the shift?

Ellen Hudson: There has to be far greater integration with health services that are already provided in the community. Integrated team working will be essential in the future. There is already a great deal of sharing of expertise. Specialist nurses will not necessarily work for every care home provider, but they should be a resource that can be tapped into easily by all the care home providers and by people who live at home who have independent packages of care—they should have access to the same expertise, advice and support that anyone else would get, whether in a hospital, a care home or wherever.

Fiona McLeod: But how will regulation ensure that that happens?

Ellen Hudson: There will have to be more integrated working between HIS, which regulates

NHS services, and the other regulatory bodies that regulate the people who provide care services. They will all have to work together.

Ruth Stark: The complication with regulating everyone who provides home care will be the cost. We do not have a mechanism for doing it cheaply. That is a political thistle that the committee will have to wrestle with.

Dr Gillies: Fiona McLeod's point is extremely important and is perhaps the most important consideration for the future. Care at home can be done well only if we have integrated working; at some level, that might mean integrated regulation as well.

Dr Lyons: We have had discussions with the care commission, and we have opened discussions with HIS, on having a tripartite arrangement for looking at care-at-home services. Were the committee minded to make a recommendation on that subject, it would be music to our ears, because we are keen to adopt such an approach.

The Convener: You got that in at the end.

There are seven minutes remaining. People may have come to the meeting with an issue that they wanted to put on the record, which is always difficult to do, so you each have a minute to identify the issue that you feel the committee needs to recognise in making its recommendations and producing its report.

Peter Ritchie: I should have done this earlier, but I want to flag up the fact that the cumulative budget reductions are likely to mean that SCSWIS will lose more staff—I understand that it is talking about another 30 inspectors going in this financial year. All that I ask is that people stop expecting too much from the regulator when we are in the situation that we are in with the public sector finances.

The Convener: That is a relevant point, as the list of things that SCSWIS should do grows longer. Capacity issues will be taken into consideration.

Ellen Hudson: There is no agreed national standardised approach for determining staffing levels in care homes. We know that an awful lot of work has been done to develop different tools and indicators of relative need and so on, but one recommendation from the committee's inquiry should be to agree a national approach, to meet the fluctuating needs of residents of homes. Such an approach would ensure a baseline for providers, as we already have in the NHS, where a lot of workforce planning tools are used. That would determine the workforce required in the care home sector.

Dr Lyons: A key plank in implementing the dementia strategy will be mobilising expertise so that it can be taken to the people who need it; and a key part of regulating and respecting the care home sector will involve determining whether care homes have access to all the expertise that they require in order to cater for people's needs.

Ruth Stark: Whatever system is developed will have to take into account the flexibility required to deal with the diversity in people's capacity to make their own choices and decisions. If there were too much regulation, it would not allow for choice and flexibility.

Dr Gillies: Experience in other sectors—such as services for children—tells us that things can often go wrong when there is a gap between regulators. This session has been very useful, and the risk of such a gap developing between the healthcare regulator and the social care regulator has been brought home to me. People in care homes need high-quality healthcare and good-quality social care, and their mental health needs must be met as well. In Scotland, we are fortunate in having the Adults with Incapacity (Scotland) Act 2000, which has been a tremendously useful piece of legislation and preceded the English act by a number of years. However, the possibility of a gap will be a key area to consider in future.

Martin Green: I may be repeating what I have already said, but I would call for closer working between providers of care services and the regulator, and for care services to make better use of existing platforms. I have mentioned the chronic medication service; the minor ailments service is also available to patients in the community, but patients in care homes are not allowed access to it. If they were, it would resolve many of the issues experienced in care homes.

The Convener: On behalf of the committee, I express our appreciation for this session, which has been good and insightful. The committee received extensive written submissions, but it was important to have this round-table discussion to build on those. I also express gratitude to my fellow committee members, who have exercised an unusual level of patience—politicians are used to speaking, not listening. I thank everyone who participated in the session.

After a brief suspension, we will get on—quickly I hope—with the remaining part of our agenda.

12:58

Meeting suspended.

12:59

On resuming—

Petitions

Deep Vein Thrombosis (PE1056)

The Convener: I thank committee members again for their patience. We move now to agenda item 3. We have two petitions before us; we will consider PE1056 first.

I am sure that members will have had the opportunity to read through the information. The committee is invited to consider whether it wishes to write to the Scottish Government to request an update on the progress of all three strands of the petition, to close consideration of the petition, or to propose an alternative approach.

Mary Scanlon: The petition has never been before this committee. I appreciate that Trish Godman did tremendous work on the issue in the past. I have read the papers that we have today and I would welcome our writing to the Scottish Government to get an update. That is my proposal.

The Convener: Is that agreed?

Members *indicated agreement.*

The Convener: Thank you.

Silicone Breast Implants (PE1378)

13:00

The Convener: The next petition is PE1378, in the name of Mairi Johnston. It, too, has received much focus. The committee is invited to consider whether it wishes to write to the Scottish Government and/or the Medicines and Healthcare products Regulatory Agency to seek additional information, to close consideration, or to propose an alternative approach.

Mary Scanlon: In this instance, Rhoda Grant has done the considerable work. Again, the petition has not been before this committee. I am concerned by what the petitioner has included in her submission to this committee, and I would welcome an update from the Scottish Government on the issue.

The Convener: I should say that Rhoda Grant intended to speak to the committee this morning in support of the petition. With the disruptions, she has had to leave as she is now chairing the Labour group meeting.

Do we agree to write for additional information before we consider how to progress further?

Dr Simpson: We should also recognise as a committee that the health technology assessment of items rather than drugs has come in for considerable criticism recently. There may be a broader issue to which the committee might want to return later in this session of Parliament.

The Convener: Thank you for that, Richard. Taking those comments into consideration, do we agree to write to the Scottish Government and MHRA to seek additional information?

Members *indicated agreement.*

The Convener: We now move into private session.

13:02

Meeting continued in private until 13:14.

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