The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 4 October 2011

Session 4

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HEALTH AND SPORT COMMITTEE
7th 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)
Geoff Huggins (Scottish Government)
Jacquie Roberts (Social Care and Social Work Improvement Scotland)
Nicola Sturgeon (Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy)
Gordon Weir (Social Care and Social Work Improvement Scotland)

CLERK TO THE COMMITTEE

Douglas Wands

LOCATION

Committee Room 1

Scottish Parliament

Health and Sport Committee

Tuesday 4 October 2011

[The Convener *opened the meeting at 10:01*]

Regulation of Care for Older People

The Convener (Duncan McNeil): Good morning and welcome to the seventh meeting in 2011 of the Health and Sport Committee in the fourth session of the Scottish Parliament. I remind those who are present, including members, that mobile phones and BlackBerrys should be turned off completely.

I welcome Malcolm Chisholm MSP, who has for the past few weeks been attending the evidence sessions on regulation of care for older people, which is the first item on the agenda. This is our fourth and final oral evidence session for our inquiry.

I welcome our first panel of witnesses. They are Jacquie Roberts, who is the interim chief executive, and Gordon Weir, who is the director of resources, from Social Care and Social Work Improvement Scotland.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): We have received evidence that there is concern not so much about routine or even unannounced inspections as about how things can change quite rapidly. What would trigger an inspection? Your written submission mentions some things.

I have two subsidiary questions. First, do you take into account the Scottish patients at risk of readmission and admission—SPARRA—data on emergency readmission rates? Management in care homes of conditions such as chronic obstructive pulmonary disease, and other long-term conditions that can lead to emergency admissions if they are not properly managed, is important. Secondly, do you measure how often care home residents have expressed a wish to remain in their place of residence rather than go into hospital at the end of their lives? Is there a system for recording whether patients have pressure sores when they are admitted to hospital, and how much use is made of bank staff?

Those are three or four specific issues, but perhaps you can begin by outlining the general trigger mechanisms. I might come back with a quick subsidiary question on whistle blowing.

Jacquie Roberts (Social Care and Social Work Improvement Scotland): I apologise on behalf of Professor Clark, who is the chair of the care inspectorate. He could not be here today because he had already booked to be out of the country.

On triggers, we receive a lot of information and request information from services. Are you talking about care homes for older people in particular?

Dr Simpson: Yes.

Jacquie Roberts: We receive information in annual returns and notifications. Any notification of concern about the quality of care in a home would be acted on. Notifications could come from district nurses, from admissions to hospital departments, including emergency departments, or from general practitioners. We do not analyse all that information systematically at the moment, but the care inspectorate, with its duty of co-operation, has the opportunity to work alongside Healthcare Improvement Scotland on the data.

We can receive any form of notification from any health or social care professional. It is likely that we would, on the basis of such information, undertake a more intensive inspection to investigate concerns.

We routinely receive very positive statements about the quality of end-of-life care in care homes and I regularly get letters from very thankful relatives and family members about the service. However, in the past five or six years, what was formerly the care commission put a lot of emphasis on the quality of end-of-life care and the standards that we should expect.

We now have an opportunity to move forward and to collect and examine more systematically research data from across the country. As I have said, however, we not infrequently receive phone calls and notifications from hospital staff, at which point we respond and carry out an investigation.

Dr Simpson: I do not disagree with the move towards a risk-assessment system, but as your submission suggests, good intelligence and proper statistical analysis will become absolutely necessary. In that respect, SPARRA data, data on the number of patients who have to be admitted for terminal care and so on are important because, although a home might well admit people to hospices for pain relief or pain control, or seek advice from hospices, a really good home should not be admitting patients to hospitals. If the percentage of terminal or emergency admissions from a home is high, that indicates that the quality of care is not particularly good. It is vital that, with the shift to risk assessment, we have good intelligence and data that are not received through notification. After all, notification is a passive process that requires a general practitioner or district nurse to have a concern about a home that might not be in the mind of a single patient.

Jacquie Roberts: We now have the opportunity to do that. Moreover, we are collecting information on notifications from NHS 24.

As for your question about bank staff, we routinely examine the proportion of such staff who are used in care homes' staffing schedules.

Dr Simpson: Is there an anonymous telephone line for whistleblowers? If so, have all staff been informed of it? I realise that it might lead to inappropriate, misleading or vexatious complaints, but we need nevertheless to err very much on the side of ensuring that staff are able to complain. At the moment, staff in some homes would fear for their jobs if they had to make a complaint internally.

Jacquie Roberts: Yes. Unlike in other parts of the United Kingdom, we have a system that allows people to make anonymous complaints. Moreover, in our inspections, we interview members of staff privately.

However, as you have pointed out, this is not just about staff members in the service in question; other visiting professionals also have a responsibility. We intend in the next few weeks to launch a local-newspaper campaign to ensure that members of staff are fully aware of their responsibility to report poor practice. That is one of the strengths of our close alignment with the Scottish Social Services Council, which has codes of practice for workers and expects people to tell the care regulator of concerns about the quality of service. We must ensure that visiting GPs and district nurses, those who receive patients from care homes and everyone else involved fulfil their full responsibility to be alert to problems in a particular service.

I believe that, in a previous evidence session, a representative of the City of Edinburgh Council talked about a pilot that we are undertaking to try to get the whole system around care of older people to share assessments and concerns about the service, and to try to get each part of the system to contribute to individuals' care histories, plans and pathways in order to ensure that they get the right assessments and service allocations. That is the way we should be going; we should consider more than just the quality and standards of the individual registered service; we should also consider the whole professional system around individuals.

Dr Simpson: You have not mentioned pharmacists. In previous evidence, we heard that the long-term conditions approach that is currently being rolled out will not include care homes. It seems to me that it is an extraordinary exclusion that patients who are registered in care homes will not be allowed to register as part of the management of long-term conditions. In the light of concerns about antipsychotic medication being abused in care homes, it seems to me that one would wish to change that. From your regulatory point of view, do you want the pharmacists to be more engaged in things, because they monitor medication? I am talking not just about the supply side—I know that you have had discussions with one of the main suppliers—but about management of the pharmaceutical side in care homes.

Jacquie Roberts: I do not quite understand the concerns that the pharmacists have expressed, as we have very strong links with community pharmacists and we report back on management of long-term conditions and systems. We ensure that we report back to pharmacists if we have any concerns, and we have two expert pharmacy advisers to do that. We have meetings booked with the Scottish Government's pharmacy adviser and the community pharmacists to ensure that we are pursuing every possible route and that we have good links with them.

The Convener: I think that the evidence from the pharmacists and others—even the general practitioners—was about reports and inspections. They feel that they are not connected to the inspections or that they were not asked for their views. If you think that that is not the case, that is fine.

Jacquie Roberts: We have given you a bit of supplementary evidence on that.

The Convener: Yes, I see that.

Jacquie Roberts: We even put such things in inspection reports. I suspect that in one or two cases the service provider has given to the pharmacist incomplete information that has not necessarily reflected the information from the pharmacy adviser. However, my pharmacy advisers have given me information that shows that they are regularly in communication with community pharmacists. There are hundreds of e-mails each month.

The Convener: It may be that we have been given evidence that the inspection regime is patchy and that it may not focus on areas that would require the input of the pharmacists.

I want to follow up on complaints. We seem to have opened up the issue of whistleblowing and triggers. I think that everyone recognises the importance of wider engagement with service users, pharmacists and people in and around residential care. Is there a phone line that the public can use?

Jacquie Roberts: Yes. That is one of the big changes since we became the care inspectorate. There is a national inquiries line and a national complaints team that can take anonymous complaints. Now that we have an understandable

everyday name, we will move forward and ensure that members of the public know more about what they have a right to expect from care services for older people, and that they know that they can make complaints to the care inspectorate. The experience in the care commission means that we know only too well that residents of care homes for older people and their relatives fear repercussions if they complain. They need the capacity to speak to someone in order to work out exactly how they can give us worrying information, which we can investigate.

10:15

The Convener: We will probably ask how you handle capacity issues later.

In respect of complaints, your website helped me. Perhaps you can help us. According to your figures, 426 complaints were upheld. How many complaints were received? Were 50 per cent of complaints upheld?

Jacquie Roberts: The figure is usually more than 50 per cent. I do not know what timescale you are talking about.

The Convener: I think that the number was from March. I put it to you because there seems to be unmet need. If 426 complaints were upheld in the system, I presume that a greater number of complaints was made—I do not want to misrepresent the position. However, 4,236 people hit your website to inquire how to complain, and 1,000 people—I might be double counting—looked at the complaints procedure. We would not necessarily add those figures together, but I presume that about 5,000 people thought, "I'm going to complain because I'm not happy." If 426 complaints were upheld, that means that a big gap exists and that we need to get the system right.

Jacquie Roberts: I am not sure what figures you refer to. Are they from the care commission?

The Convener: I am looking at your website figures. Your website—which is not the easiest to manage, but that might just be me, so I do not condemn it—provides the helpful information that the leaflet entitled "How to complain" had 4,236 hits and that the complaints procedure had 1,000 hits. The figure of 426 complaints upheld comes from your submission to the committee. I understand that the number of complaints would be higher, but even if it is 800, when that is set against 5,000 people who were at the point of complaining, is that not a big gap?

Jacquie Roberts: You assume that people's finding out about the complaints procedure means that they are on the point of complaining. In a sense, it is a success that so many people access that information. I am not sure whether the 426 upheld complaints link to the period of the hits.

All registered providers—particularly good-quality ones—want to investigate complaints themselves and to put right what families or residents complain about.

The Convener: So, the 5,000 hits are just from providers.

Jacquie Roberts: No—not necessarily. We do not know where all the hits are from. I am pleased that so many hits about complaints have been received, so that people are aware of the procedure and can pursue a complaint if they are really concerned.

The Convener: The point that I am attempting to make is that people did not pursue their complaints for one reason or another. We all know that complaining about the care of someone who is in a residential setting is difficult, because of the fear that their situation will worsen.

Jacquie Roberts: I believe that people think that, but I do not know whether we can make that assumption for all 5,000 hits.

Bob Doris (Glasgow) (SNP): I will return briefly to the pharmacy stuff. I point out that the convener added to the number of hits when he visited the website.

The Convener: I just added one to the figures. I and, I am sure, a whole lot of other people are interested in the procedures.

Bob Doris: I will ask for clarity about pharmacists' involvement. We have pursued several issues. It is encouraging that you are discussing with pharmacists how they can better and more proactively inform you of concerns, but I have one little question. You did not put on the record whether, when an unannounced inspection is to take place, you ask pharmacists as a matter of course what their concerns are, what they think of a care home's ethos and what the issues are. Whether you do that or wait for them to go to you proactively was not clear from your evidence.

Jacquie Roberts: Our approach depends on the information that we have received, which is risk assessed. If we have no concerns about medicine management, we might not ask pharmacists whether they have any concerns. However, we now tell pharmacists routinely of our unannounced inspections and ensure that they come to us.

Bob Doris: The disagreement with Community Pharmacy Scotland related to that.

Jacquie Roberts: That organisation thinks that we should routinely ask pharmacists about issues before every visit.

Bob Doris: It came across very strongly in evidence that it would make sense, if you were doing an unannounced inspection, to go to various allied health professionals that engage directly with the care home. Just for the record, can I confirm that you do not do that? That is a potential gap.

Jacquie Roberts: We do not do it 100 per cent routinely, but at this very moment we are creating questionnaires for all visiting health and social care professionals who might have an interest in a service. We will ensure that we send the questionnaires out so that we will, as we develop a more risk-based system, routinely get information about their concerns. That should fill that gap.

Richard Lyle (Central Scotland) (SNP): I refer to your supplementary evidence on the national care standards. It states:

"The National Care Standards (NCS) for care homes for older people describe expectations prior to moving in and information that should be available to help decide. They also describe expectations on service delivery and when moving on from a care service."

Do you agree that most care homes require to improve their information to prospective clients and their families on the level of care that they should receive in a particular care home? What would you do to improve that information? Do you believe that all homes meet the established national care standards?

Jacquie Roberts: From the original evidence that we gave about the gradual improvement in the quality of care in homes for older people, I would say that a smaller and smaller proportion of care homes are not delivering the standards. A general problem for us all—it is probably one of the reasons for the committee's inquiry—is that perhaps all of us do not expect enough and do not have high enough expectations of the standard of care for older people. The national care standards are very good from that point of view, because they are aspirational and want the rights and uniqueness of each individual who receives a service in a care home to be promoted. I do not think that they are reached in every single case, but there are definitely signs of improvement.

I point out that the care commission's final report in March 2011 found that, when compared with other areas, the standards of management and leadership, of staffing and of care and support in care homes for older people were the poorest performers. What I am saying in my lengthy answer to your question is that not in every case do homes meet the national standard.

Richard Lyle: You are saying that

"The Care Inspectorate will take these NCS into account when inspecting."

Do you?

Jacquie Roberts: Yes, we absolutely do.

Richard Lyle: If we find that something is wrong and that the minimum standards are not being met or that the standards are not being met at all, what would we do?

Jacquie Roberts: If the standards were not being met at all, it is highly likely that we would give a very low grade—totally unsatisfactory; a grade 1—and move to an improvement notice, which is an official enforcement notice. If that did not bring improvements within a certain period, we would move to cancellation.

The Convener: You also say in your supplementary evidence that the national care standards need to be reviewed. Can you expand on that?

Jacquie Roberts: The national care standards were produced in 2000 and 2001. They were heralded in all parts of Europe as being based on the user's point of view: the person who uses a service has a right to expect certain things. However, they were written 10 years ago and have some outdated annexes, so we need an updated and refreshed version. We also believe that they need to become more integrated with other quality indicators and standards that have been developed since, especially the national standards for dementia care.

We also believe that it is probably possible to have a set of standards that are core standards for all people receiving any type of service. There is probably an opportunity here to move from designing standards for only one particular type of service, because the social care sector in particular is undergoing significant change and we do not want the standards to be an obstacle to innovation. There should be a core set of standards that everyone has a right to expect, with some links to quality indicators and more up-to-date guidance for the service providers.

The Convener: Do you agree that the guidelines and duties around equalities and human rights should be incorporated into the national care standards, too?

Jacquie Roberts: The national care standards should always be based on rights and duties. It would be very helpful to have those incorporated. We also have to take into account the proposed incoming legislation on self-directed support. We are having a meeting with the bill team about self-directed support, too, because that will be a very important part of what people can expect.

The Convener: That is helpful.

Mary Scanlon (Highlands and Islands) (Con): We have received two submissions from you. The first, which was dated 24 August, states:

"SCSWIS believes that its regulatory system delivers robust and wide-ranging scrutiny ... the system is robust and quickly adapts to reflect changes in the assessment of risk and analysis of intelligence."

It goes on to say that the system offers

"protection to ensure care services for older people deliver good quality, appropriate and accessible care."

That submission was written before the committee started taking evidence on the inquiry. It seems that not only has your name changed, but your opinions have changed very much from stating that the system is "robust" and wonderful. You now say on 4 October—seven weeks later—that

"The registration process is not a test of a provider's capacity to deliver quality. ... The registration process cannot guarantee the delivery of a good quality service."

How much is that significant change of view a reflection of what the committee is uncovering?

Jacquie Roberts: To be honest, I do not recognise that final quotation. I will need to look back at the submission.

Mary Scanlon: It is on page 8 of the submission that we received today. It comes under the registration heading. You state:

"The registration process is not a test of a provider's capacity to deliver quality."

The other quotations are from pages 1 and 8 of your previous submission.

Jacquie Roberts: We were repeating a statement that had been made by other people, not by ourselves.

Mary Scanlon: Your statement was:

"The registration process cannot guarantee the delivery of a good quality service."

That is your statement. The other statements are also your statements.

Jacquie Roberts: I believe that the first statement was a summary of statements made by other people. We then answered that statement; we were not saying—

The Convener: Mary, can I be helpful here for the benefit of others? We welcome the additional submission. The statement in the box is a summary of the evidence and the bullet points below are a response to the statement in the box.

Mary Scanlon: The bullet point states:

"The registration process cannot guarantee the delivery of a good quality service."

That is very different to the comments in your previous paper. Why has there been such a significant change?

Jacquie Roberts: That is because we are saying that it is through the inspection process that we hold people to the guarantees. Whatever system of care regulation there is, it cannot eradicate risks; it can only minimise them. I return to the earlier statements that we made in August: we definitely have the components of a very robust care regulation system.

Mary Scanlon: It certainly does not sound as robust on 4 October as it did on 24 August.

I will move on. You picked up a lot of the issues that the committee has been discussing. First, you made a point about unmet healthcare needs.

Dr Simpson: Can we explore registration a little further, given that Mary Scanlon has quite rightly raised it?

The Convener: I will allow a supplementary, if you want to come back in, but Mary has waited patiently to ask her questions.

Dr Simpson: If she is moving on from registration—

The Convener: I will come back to that, Richard. I think that I agreed that I would let you in to ask about registration. Go on, Mary.

10:30

Mary Scanlon: Given the time that we have this morning, I will stick to my main hobby-horse. The issues include the quality of care and support, the quality of staffing and the quality of management and leadership. Over the past decade, have you raised with ministers the timescale for registration and training of support staff in care homes and care-at-home services? Given that the Scottish Social Services Council was set up in 2001, I was shocked to discover that care-at-home staff do not need to complete registration until 2020. Does that cause you concern and have you recommended that the timescale be brought forward?

Jacquie Roberts: We have not formally recommended that the timescale be brought forward. In fact, we have concentrated on the registration of managers and on ensuring good management and leadership. I give a guarantee to the committee that the sign of quality in a care service for older people will be the quality of its manager. I have no doubt about that.

We have also assessed the provision of training for, and supervision of, care staff. We always examine that in unannounced inspections. We also spend a lot of time encouraging care service providers to invest in training, particularly on the rights of older people. We embarked on a big campaign on that with the Scottish Human Rights Commission.

The workforce is extremely large, and the Scottish Social Services Council has managed the compulsory registration calendar within its

resources, but it was absolutely the right decision to start with the managers.

My understanding is that workers in care homes for adults will have to achieve registration from September 2012, not 2020.

Mary Scanlon: The Scottish Parliament information centre briefing says that there are currently 198,000 social services staff and the SSSC said last week that 50,000 have been registered. That leaves 140,000 staff of whom, according to the information that I have, around 50 per cent are trained or in training. That leaves 70,000 care-at-home staff, who I understand will have to be fully registered by 2020, and support workers in care homes, who will have to be registered by 2015. We are talking about 70,000 workers going into people's homes without the support and training that they need to do the job. We heard from the SSSC last week how beneficial the training is not only for all aspects of care but in giving care workers the confidence to look after elderly people.

If your figures differ from those that we have, I would like to see them. I quoted from the SPICe briefing.

Jacquie Roberts: I am sure that the Scottish Social Services Council can submit the details of compulsory registration. It is important to emphasise that its register is different from those in other parts of the United Kingdom in that it is qualification based. Therefore, a lot of time must be invested to ensure that these vital workers receive the training that is required to achieve a qualification in order to register. The process has definitely boosted the quality of the workforce and will continue to do so.

The other difference in Scotland is that we, as the care regulator, can inspect whether staff meet the registration requirements and can take enforcement action if they do not.

Mary Scanlon: Last week, the representative from the Scottish Social Services Council acknowledged and did not question the figures that I used. I am surprised that the care inspectorate has not raised concerns with the cabinet secretary about the support that is given to staff to carry out the jobs that they do, which means so much from the point of view of quality of care.

Jacquie Roberts: I have certainly raised the issue that the workforce needs as much training, supervision and good management as possible, and that it is quite an undervalued yet extremely important workforce for Scotland. I have raised those issues.

I think that you may have been talking about workers in care-at-home services rather than workers in care home services.

Mary Scanlon: I am talking about both.

Jacquie Roberts: I have in front of me the list that relates to workers in care home services. I believe that there is concern—which I share—about the number of workers in care-at-home services who are not on the timetable for registration. That has been raised.

The Convener: Is there as much focus on the importance of the management and leadership role in care-at-home services as there is in the residential sector? I see from some of the evidence that, in a residential setting, a change of manager or team leader is quite a significant trigger and risk factor but that there is no equivalence in that regard in care-at-home services, where managers and team leaders change all the time.

Jacquie Roberts: The importance of managers to care-at-home services is just as great, if not greater, than their importance to care home services because of the need for leadership and the fact that the services are so dispersed. Managers are a very important part of the care-at-home sector.

The Convener: Do you go in and inspect care-at-home services if a manager changes?

Jacquie Roberts: Yes, we do, and we spend quite a lot of time assessing the management and leadership of the care-at-home service.

The Convener: So that is a trigger.

Jacquie Roberts: That is an extremely important part of what we do. I have been on a care-at-home inspection, when I spent a lot of time with the manager of the service. The links between a manager, their staff and the referring agencies are vital to raising the quality of services.

The Convener: Richard Simpson has a brief supplementary on registration.

Dr Simpson: It is a very brief question. If a home has a poor rating, by which I mean that it has a rating of 1 or 2 on the scale—is that correct?

Jacquie Roberts: Yes.

Dr Simpson: Even a rating of 3 is not fantastic.

Jacquie Roberts: A rating of 3 is "adequate".

Dr Simpson: That is right. I am concerned about homes that have a rating of 1 or 2. If a company or an individual owns a home that has a rating of 1 or 2, can they still register to run a new home? Can you block the registration process because performance has not been satisfactory in one or more of their homes? If they close a home

in their group, can they automatically just expand or take over other homes, as happened in the Southern Cross situation, or can you block that?

Jacquie Roberts: It would very much depend on the circumstances and the information that they gave at the point of registration. They might have recruited a new manager, they might have regrouped, or there might be lots of evidence that they were in a better position to deliver a quality service. Past performance would certainly be taken into account in a risk assessment, but it would be quite difficult, legally, to block a registration unless there was very strong evidence that they were not able to commit to delivering a good-quality service.

Dr Simpson: According to the last report that I read, 11 per cent of homes still have quite a low rating; in fact, in one of the three Ayrshire areas, I think that 35 per cent of the homes have a rating of 1 or 2. Are you saying that you could not prevent the people who run those homes from taking on more homes before they sorted out the ones that you have inspected?

Jacquie Roberts: We have certainly had such discussions with one particular provider in the context of Southern Cross.

Dr Simpson: But you do not have the power to be able to say no—

The Convener: This is a supplementary, Richard.

Dr Simpson: I am sorry—I will stop.

The Convener: It is an interesting line of questioning, but Bob Doris is waiting to ask a question.

Jacquie Roberts: I will come back to you on whether we have the legal powers to do that. There are ways of discouraging a registration, particularly if we feel that we have not been given enough evidence to assure us that the company concerned could be a good provider.

The Convener: That would be helpful. Jim Eadie has a brief follow-up.

Jim Eadie (Edinburgh Southern) (SNP): To follow up Dr Simpson's point, would you welcome further enforcement powers in that area? Do you want to reflect on that and come back to us on it?

Jacquie Roberts: I would like to reflect on that and come back to you. We have given you some evidence about where we think the legislation could be strengthened. The legislation is built around the concept that providers want to provide a good service and that we have to work with providers so that they move from poor service to improved service. That is very important to members of the population because many older people and their relatives do not want to lose the service—that comes first, rather than assessing the quality of the service. It is therefore very important that we do not destabilise and suddenly deprive people of services that they are very dependent on.

Bob Doris: Mary Scanlon referred earlier to your additional submission, in which you state:

"The registration process cannot guarantee the delivery of a good quality service."

I agree with that comment. For clarity about the registration process, am I right to assume that the first resident comes into the care home only after the care home owner registers? If so, registration does not guarantee the quality standard. There can be best practice on paper, but it is about what happens on the ground. How quickly after registration do you make an inspection? Is it one, two or three months, or one year? How quickly will you inspect in future? Your evidence is that registration does not guarantee quality and that only inspection does so.

Jacquie Roberts: Again, it depends on the service. For example, when the providers who are taking over the former Southern Cross homes get registered, we will inspect the homes within three months. It is important to give that guarantee to the residents and their families.

Bob Doris: Will it be a target for all future registrations to be inspected within three months?

Jacquie Roberts: I doubt it, if you are referring to the 14,000 services that we are talking about. Again, inspection of those will be based on risk assessments. For example, it might not be necessary to go in within three months of registration to a day care service for children.

The Convener: On Southern Cross, we have assurances that current staffing levels will remain in place—that was an agreement between the banks, Southern Cross and so on. Do we have any assurances on staffing levels after the new owners take over?

Jacquie Roberts: We will carefully assess that.

The Convener: If they reduce staffing levels, what can you do?

Jacquie Roberts: We can demand an improvement and give them a low grade.

The Convener: How do you measure staffing levels against quality?

Jacquie Roberts: We look at the outcomes for people and assess the number of staff on duty and the needs of the people who receive the service. There is a staffing schedule available as well. We are engaged in some quite important work that will be a first. It is about getting a much more sophisticated assessment of required staffing

levels, particularly for older people in care homes. I believe that it is not just about staffing levels but about the skill mix. Currently, only 11 per cent of staff in care homes are qualified nurses. Given the change in the population of people in care homes, the Scottish Government must look at that situation as well.

The Convener: That is an interesting answer, because we have had evidence that points us to nursing levels, staffing levels, staff turnover and so on. When will your piece of work be completed?

Jacquie Roberts: Probably in early 2012.

Mary Fee (West Scotland) (Lab): I want to ask you a bit about care at home. Given that, with the increase in self-directed support, more care will be done at home and it will not always be done by registered and trained care staff or by medically trained staff, how confident are you that care standards will be met in the home? How will you regulate those care standards? What measures can you take to ensure that the standards are met? Will there be a trigger for inspecting care at home?

10:45

Jacquie Roberts: Self-directed support raises a significant challenge over whether personal assistants should be regulated. Up to now, the policy on that has been very clear and has been driven by the independence lobby—the people who want to manage their own care package entirely independently. They do not want to be forced to have regulation of the service, and that raises significant issues. The legislation on protecting vulnerable groups gives some protection, as people who work as personal assistants will have to register with Disclosure Scotland for the new protecting vulnerable groups scheme. When it comes to people who are employed by agencies, we can give some guarantees about staffing, recruitment and the things that the manager of the service will do to ensure training and the quality of staff. However, the risks are always greater, as we do not have the capacity to visit every person's home to inspect the service as it is delivered, and I do not think that anyone would want us to be able to do that.

When we carry out an inspection, we consult the relatives of the people who are receiving the service. We also carry out surveys and telephone surveys with people who are prepared to talk to us about whether they are receiving a good enough service. When we go on visits, we shadow members of staff and feed back to the inspection report on the quality of those staff. When we follow a member of care-at-home staff as they go on their visits to people, it is striking how much we can pick up about the quality of that service, the training and supervision that the worker has been offered and the standard of service that is delivered to people in their homes. However, we are unable to visit the homes of all the 80,000 or 90,000 people who receive the service.

Mary Fee: If care at home is undertaken by registered agency staff, how often do you inspect? I have a greater concern about care that is undertaken by staff who are not registered with an agency. Should those staff be regulated? I accept that you cannot visit every person's home, but some people who receive care at home will have quite complex needs; if they are cared for by people who are not registered with an agency, how will you regulate that?

Jacquie Roberts: That goes back to the first part of my previous answer. If you asked the population whether personal assistants should be registered and regulated, 50 per cent would say yes and the other 50 per cent would say no. It is a subject of hot debate, which should be discussed in the context of the self-directed support bill. There are risks, but they are risks that some people want to take because they want to employ someone they know to deliver their personal service who is not necessarily registered. The safety net is the fact that people would expect to have to register with the protecting vulnerable groups scheme through Disclosure Scotland.

Fiona McLeod (Strathkelvin and Bearsden) (SNP): I want to follow up the point on the protection of vulnerable groups and personal assistants. I understand that it is up to the person who is employing the personal assistant to decide whether they should go through the registration process. We could end up with someone receiving public funding for self-directed support employing someone who has not gone through the PVG scheme and Disclosure Scotland. The person providing the care could be completely unregulated but be paid for out of public funds. I absolutely accept the independence lobby's argument, but self-directed support is increasingly going to be provided for people whose carers will be directing their support because they have dementia. Can you, as the regulator, give us a yes or no answer to this question: should personal assistants be regulated to ensure safety?

Jacquie Roberts: Personally, I think that there should be the safety net of personal assistants registering through the protecting vulnerable groups scheme. Certainly we as a nation need to discuss the issue more.

Fiona McLeod: With regard to achieving consistency of inspection through the training of inspectors, you have said that all inspectors are required to complete the regulation of care award.

How many of your inspectors are practising as inspectors before they have received the award?

On the issue of whistleblowing, you said that inspectors are expected to interview staff during inspections. How can you ensure the confidentiality of the information given by staff, carers or users? After all, if you subsequently say to the manager of a care home, "We have heard about certain concerns," they will be able to find out who made the complaint by looking at the staff register or seeing who visited that day.

Jacquie Roberts: My staff are very skilled and sensitive to that very issue and would do everything they could not to expose an individual member of staff. They would make things much more anonymous and try to protect staff who have given information in private by, for example, linking it to observations that they might make about the service and evidence that they might receive from others, including relatives.

As for your first question on the proportion of inspectors who have received the regulation of care award, I would imagine that most of them have started practising. Given that it is a practice-based qualification, they need to be assessed while undertaking it. I point out that we are the only care inspectorate that requires its members of staff, including those who are not on the social services register but who might be registered with the Nursing and Midwifery Council, to undertake a regulatory qualification. Gordon Weir will say a bit more about training and qualifications.

Gordon Weir (Social Care and Social Work Improvement Scotland): The last of our seven cohorts of inspectors is currently undertaking the regulation of care award. After that tranche finishes in the next year to 18 months, all the workforce will have been trained and we will then take a maintenance-based approach to new starts and other staff who come into the organisation. On top of the regulation of care award, our inspecting staff are allocated an average of almost nine days of specific training a year and we also put specialist staff through specific training courses and programmes.

Gil Paterson (Clydebank and Milngavie) (SNP): We are all acutely aware of the difficulties caused by the Southern Cross crisis. Can you outline for the *Official Report* your powers with regard to financial regulation?

Jacquie Roberts: I think that that question gives Gordon Weir another chance to speak.

Gordon Weir: We are enabled to carry out financial regulation at point of entry to the market—or, in other words, with the initial registration. Given that approximately two thirds of care homes are within the private sector, a significant element is subject to such regulation. At point of entry, we carry out what could be described as due diligence and examine cash flow projections, business plans, financial ratios, credit reports, bank references and so on and, after that initial round, we very much adopt the care regulation methodology and do not carry out financial regulation beyond initial registration.

Gil Paterson: So, something like the Southern Cross situation could be happening in the sector right now, because we do not go in and scrutinise beyond that initial period.

Jacquie Roberts: That is an interesting question. I think that we would like to come back on it.

Gordon Weir: One of the features of financial regulation is that it tends to be applied retrospectively. We tend to look at published accounts and so on, so there is an element of delay. The view that the care commission has taken, which has rolled on to the care inspectorate, is that financial issues will show up through a care overview before they show up through a financial reporting process. The complicated financial models that group structures operate make it difficult for things to appear as quickly as we might want.

Jacquie Roberts: Technically, it would be possible to put in place an annual financial check. However, we have to think about whether that is the primary thing to do, because if we did that and we found that a service was not financially viable, the end result could be exactly the one that the service users would not want—it is likely to be closure of the service.

We are working with the Scottish Government to examine the issue because of the Southern Cross example. There were 27 different operating companies under the umbrella of Southern Cross. It is a complicated field. Our absolute focus is on the quality and standards of service and the outcomes that people receive. Financial regulation is another aspect. If it is required, we will have to consider how it will be done and whether it would be right for the care regulator to do it or whether other systems of financial regulation should be put in place. It is significant that 67 per cent of the market of care homes for older people is delivered by the private sector.

Gil Paterson: I have an associated question. Most of the service providers are private companies. Do you have the powers to go into such companies and, beyond just looking at their accounts, to drill down and examine their financial operations? Do you have the power to take action to close down a private company? If not, would you like that power? How would you operate it?

Gordon Weir: The short answer is that we do not have that power. It is a complex issue and we

have to be cautious about saying that we want it, because there could be a lot of unforeseen consequences. It is possible for a provider with a weak financial regime to provide high-quality care services, and the regulator's interest in that situation might precipitate the crisis that we were trying to avoid.

The care inspectorate is a care regulator and not a financial regulator. We apply elements of financial regulation, but we are talking about something quite different and new.

Jacquie Roberts: We fully understand people's concerns about the matter, which is why we have opened discussions with the Scottish Government about what would be a reliable financial regulatory regime, should one be required. The Care Quality Commission in England is seeking help from an organisation called Monitor, which has been set up to do financial regulation of national health service trusts. It is a complicated issue.

The Convener: Should there be such a role for the care regulator? The issue has been raised. The Convention of Scottish Local Authorities has written to Vince Cable on financial matters and we have heard some additional questions about Four Seasons taking over some of the Southern Cross homes. There are about £790 million of debts to be repaid in September and net assets of £350 million. Even I can work that one out. Is it genuinely a role for the care inspectorate, or can other agencies bring something to the table?

11:00

Gordon Weir: I suppose that the important questions are: what problem are we trying to avoid, and will giving additional powers solve it? Things can change very quickly in a private sector organisation. Unless you are in the boardroom, you cannot be sighted, and it can take a long time before problems surface. There is therefore some discussion about whether the approach will in practice prevent Southern Cross-type examples in the future. That is why Jacquie Roberts said that we need to involve other parties in how we reach a solution or a better way of working across the sector. Other parties are involved.

Jacquie Roberts: We now ensure that services have contingency arrangements. The outcome that everyone fears is having to leave their home or losing the service that they value highly, so the contingency arrangements to ensure continuity of service are the most important.

It is not a role just for the care regulator; there is a strong role for the commissioners of services. Whatever solution we come to must involve COSLA and the commissioners of services. Some private providers could say that financial difficulties could arise as a result of a lack of guaranteed revenue over the next five or 10 years.

Jim Eadie: There has been some discussion this morning about extending the powers of the care inspectorate, particularly in financial scrutiny and regulation but also in commissioning and procurement. I want to ask about the funding settlement that underpins your existing powers. Do you feel that there are sufficient resources, with the projected increase in the grant in aid available to you as an organisation, to allow you to carry out the responsibilities that you have been tasked with? In other words, do you have sufficient resources with the current projected grant in aid to allow you to do the job that the Government has asked you to do?

Jacquie Roberts: You are talking about the settlement that was announced in the comprehensive spending review.

Jim Eadie: That is right: £21.4 million in 2011-12, rising incrementally to £21.9 million in 2014-15. Do you have confidence, and can the public have confidence, that you have sufficient resources to do your job?

Jacquie Roberts: My response is that the public can now have confidence that we have stability to manage the significant change from the care commission, the Social Work Inspection Agency and the child protection inspections that we have undertaken. We have stability for planning and much more confidence that we will be able to develop the work that Dr Simpson talked about earlier to undertake well-informed, intelligent and risk-based regulation of care services and to develop the actions that we need to undertake to look at, inspect and make judgments on local authorities' commissioning practices and how they arrange services in the delivery of care.

Jim Eadie: I am grateful for the answer, and I understand your point about stability. I am also conscious, as the committee is, that the cabinet secretary announced that there would be an increase in the minimum frequency of inspection. Do you feel that you have sufficient resources and sufficient staffing to fulfil that responsibility?

Jacquie Roberts: The extra funding has taken into account the extra costs of having to do the minimum inspections.

Jim Eadie: Are you looking to increase the number of inspectors in order to fulfil the requirement?

Jacquie Roberts: We will have to increase the resources to undertake that requirement. There are all sorts of ways of increasing the inspecting resources, which could include using associate

and specialist advisers and assessors as well as recruiting staff.

Jim Eadie: My final question is on the balance of income that you receive between Government funding grant in aid and fees from registration. Do you see scope for increasing the level of fees, and how would you go about reviewing that situation?

Jacquie Roberts: Our understanding is that the Scottish Government will undertake a review of the fee regime. It is a long, complex story, and I will hand over to Gordon Weir to give you the history of the fees for the care commission and care inspectorate.

Gordon Weir: I will be brief. A range of fees is charged for registration and an annual continuation fee is charged to service providers. The basis of the fees is different in the various areas of provision. Very few of our fees are set at full cost recovery rate, so an element of grant subsidy is applied to almost all our fees. Only the care home sector is at full cost recovery levels. Therefore, there is scope to increase fees in almost all other areas of our activity if that policy decision was taken. The current balance is approximately two thirds grant funding and one third fee funding.

The Convener: I seek clarity on the original written evidence that we received on the money that is available. I would also like verification of the information from SPICe that, in the spending review period, there will be a real-terms decrease of 5.3 per cent in your funding. Is that correct?

Jacquie Roberts: It depends on the starting point.

The Convener: Your written submission had a hammed-up figure of a target cut of 25 per cent, which has dominated some of the written evidence and discussions. We now know that that was hamming it up a wee bit. We have information from SPICe that, as a result of the Scottish spending review, there is a real-terms decrease of 5.3 per cent over the term. Is that correct?

Jacquie Roberts: Gordon Weir will answer that, because it is a complex issue.

Gordon Weir: It is complex, but I will do my best to be as brief as possible. I suspect that you are referring to a decrease because a deflator has been applied and an assumption made about inflation levels, hence producing a real-terms figure. On a cash basis, there is a marginal increase in funding. I have no reason to doubt that applying that deflator would result in that figure. The total potential funding that is available to the care inspectorate in the current year is just under £35.5 million, which compares to a figure of £35.9 million for the predecessor bodies. On the face of it, a similar amount of funding is available in the current year as was available in the previous year. However, approximately £2.5 million has been notionally set aside for one-off costs.

There has been a bit of complexity around how the current year position changed. Until recently, we were planning internally for a 25 per cent budget cut over four years. As Jacquie Roberts said, we now have broad stability on a cash basis for the planning period up to 2014-15. If a deflator is applied, using whatever inflation figure, I can see how a real-terms figure would be produced. However, on a cash basis, there is a gradual increase over that planning period.

The Convener: So you do not take into account inflation. When you produce a budget, do you discount inflation and look only at cash?

Gordon Weir: We look at income. We look at our projected income from the registration continuation fees and at the grant figure that is set out, which is a cash figure. As is happening in all parts of the public sector, we will strive for efficiencies to meet targets and to do more within the figures.

The Convener: You had 320 inspectors at 1 April 2010. Do you have enough funding to maintain those 320 inspectors in 2011?

Gordon Weir: I will talk only about inspectors, or the staff who transferred from the care commission. At 31 March, rounding to the nearest whole figure, we had an establishment of 312. At the end of March, the care commission had 303 staff in post. Because of the financial targets, the care commission ran a voluntary severance scheme under which 40 inspectors left the organisation. That was to get to our workforce planning figure of 263, which is broadly where we are now.

The Convener: When you gave us written evidence you said that you had an inspection staff of 320 and that you expected it to go down to 289 at 1 April 2011, but now you have 263—

Gordon Weir: We have 263 inspecting staff, and on top of that we have another 21 senior inspectors—

The Convener: Do those senior inspectors carry out inspections?

Gordon Weir: They carry out a different type of inspection, but they are inspecting staff.

The Convener: How many senior inspectors are there?

Gordon Weir: Twenty one.

The Convener: That takes you to about 289.

Gordon Weir: Yes.

Jacquie Roberts: We can give you that detailed information in writing if it would be helpful.

The Convener: It would be, but if you will allow me, I will pursue the questioning.

Given the statement from the cabinet secretary, we have now agreed that there will be an increased frequency of inspection. Is that as against an increased number of inspections? Will we maintain the same number of inspections but do them more regularly? How does that work?

Gordon Weir: The two main cost drivers in our workforce plan are inspection frequency, which is the number of times that we go out and physically inspect a service, and inspection intensity, which is how long we would spend in a particular service. We are reinstating the inspection frequency to previous levels for care homes—

Jacquie Roberts: And care-at-home services.

The Convener: What does that mean?

Jacquie Roberts: We will need increased human resources; there is no doubt about that.

The Convener: You need increased human resources.

Jacquie Roberts: Yes.

The Convener: I do not know how big a part residential homes are of the business that you carry out, but they are a small part of your business, are they not? If in cash terms the money is there but in real terms it is declining by 5 per cent, as SPICe said, and you have fewer inspectors and increased activity, what gives in your resources? Where are we taking the people from within your organisation: children's services or inspections of children's homes, for example? Where are we taking those inspectors from?

Gordon Weir: We are looking to release resource through our continued review of our estate. We have had a significant efficiency gain over the past four or five years by rationalising our property. We will be looking at other efficiency measures.

The Convener: To generate funds to employ more inspectors?

Gordon Weir: Yes.

Jacquie Roberts: Yes.

The Convener: How much did it cost you to make those inspectors redundant? Do you know?

Gordon Weir: I do.

The Convener: Please tell me then.

Gordon Weir: I can provide the figure, but I cannot find it in my papers immediately.

The Convener: Give me a ballpark figure.

Gordon Weir: It was a significant sum of money.

The Convener: Off the top of your head, you do not have a ballpark figure. Have you had discussions with Government ministers about this?

Gordon Weir: Yes we have.

Jacquie Roberts: Yes.

The Convener: You have discussed those figures.

Jacquie Roberts: Yes.

Gordon Weir: Yes.

The Convener: Why can you not give me a ballpark figure off the top of your head?

Gordon Weir: I do not want to give you an incorrect figure, convener.

The Convener: Okay. We will wait for the detail.

Gordon Weir: I am happy to provide that.

The Convener: A significant amount of money has just been spent on making people redundant.

Jacquie Roberts: Yes.

The Convener: How much are we going to spend re-employing people? How many people are we going to re-employ?

Jacquie Roberts: That depends.

Gordon Weir: It will depend how we employ them. We will need to reinvest of the order of £400,000-worth of staffing costs to service the additional activity.

Jacquie Roberts: I should say that it is not just frequency of inspection that matters; it is also about the level of intensity of inspections. We spend more time in certain services if we go into them in greater detail. The severance scheme was fully negotiated and agreed with the Scottish Government, because of the 25 per cent target.

The Convener: Yes. I understand. I presume that you have given the Scottish Government assurances that the other parts of the service that you provide—children's services, inspection of social work and so on—will all be protected. There is no diminution of the service that you provide in other areas to focus on this small area that you cover.

Jacquie Roberts: No. That is why I advised and recommended that the frequency of inspection should be reinstated not just for care homes for older people but for care-at-home services and care homes for all age groups. The other parts of the service already have a more intense frequency of inspection, anyway.

11:15

The Convener: And you insisted on that because of the fear that other areas would lose out.

Jacquie Roberts: It was based on a risk assessment of those particular sectors and where concerns might lie.

The Convener: Can the committee get in writing the detail that you could not provide this morning? It would certainly be helpful.

Jacquie Roberts: Yes.

Gordon Weir: I have found the figure that I was looking for, convener.

The Convener: Go ahead.

Gordon Weir: It is £2.4 million.

The Convener: That is how much has been spent on redundancies.

Gordon Weir: Yes, but that covers other staff in the organisation as well as inspectors.

The Convener: I understand that.

Gordon Weir: I also point out that it was made on the basis of a 25 per cent budget cut over a four-year period.

The Convener: So, with the £400,000 that has been mentioned, it has cost around £3 million or more to do all of this.

Gordon Weir: In its last month, the care commission spent a certain amount of money to reduce the staffing base that would transfer to the care inspectorate. The care inspectorate is now talking about spending from next year an additional £400,000 on staff that will be funded through other efficiencies that it has made and is planning to make.

Bob Doris: Given the challenging financial climate that has been outlined, perhaps we should also ask about the direction of travel in the medium term rather than what is happening imminently. You mentioned care pathways at the start of the session and in these evidence sessions we have been testing the idea of inspecting such pathways. What cognisance do you take of such issues when you go into homes to inspect residential care for older people? Do you pick half a dozen residents and inspect their care pathway to find out how, over the past six months, year or 18 months, they came to find themselves in that home? In examining the quality of that process, do you carry out back-tracking with other agencies and inspectorates? I understand that there might have been some forward thinking on that matter, and I would appreciate it if you could put that on the record before we finish this session.

Jacquie Roberts: We have taken such an approach to looked-after children. Indeed, in the Edinburgh pilot, we plan to do exactly as you suggest and involve, for example, our Healthcare Improvement Scotland colleagues in investigating individuals' pathways and assessing the contribution of decision making and the provision of service to those people over a period of time. Now that our senior inspectors are also responsible for assessing local authorities' performance and can link with Healthcare Improvement Scotland's assessments, various opportunities will emerge, including the interesting and exciting prospect of being able to link in with the inspection of acute services for older people in the national health service and to examine discharge and care management arrangements in local authorities. However, that work will take a year to develop.

Bob Doris: I do not want to explore the issue further—I just wanted to give you the opportunity to put that on the record.

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): I want to pick up on a couple of points that have been raised in this very wide-ranging discussion. First, you said that the main cost drivers were increased frequency and inspection intensity; indeed, those were the two main issues that were highlighted before the inquiry began. Is there any trade-off between them in the short or indeed the long run? The increased frequency element will kick in quite quickly but given, as has been highlighted previously, the number of quality themes that are inspected on any one inspection will any trade-offs be required in the short or long run with the intensity of inspections?

Jacquie Roberts: The policy is for regulatory bodies to move away from routine inspections made with routine cyclical frequency, irrespective of the quality of that service. We will ensure that the right amount of time and resources go into the services that require greater scrutiny, but we can probably take the foot off the pedal with regard to high-performing services.

However, I think that the perception of members of the public, committee members and the Scottish Government is that we cannot take the foot off the pedal too much, which is why annual frequency has been reinstated even for high-performing services.

My answer to the question is that we will want to adjust and base our activity on knowledge, information and risk. We are only at the beginning of that journey, as I pointed out in my response to Dr Simpson's question.

Malcolm Chisholm: The number of quality themes was one issue that people raised in the

early stages. I suppose that the other issue is the intensity of inspections within any quality theme. You have described in detail why you thought that the care standards should be reviewed, although you have praised them from the user's point of view and spoken about how widely admired they were when they were produced. To what extent is further attention to user focus needed in the care standards? Obviously, there are issues relating to the standards such as choice and the participation in assessing and improving services, but to what extent will inspectors be able to really engage with service users in a care home, for example? I suppose that that relates to the intensity of inspections. Getting some awareness of how those people experience the service and what their views are seems to be quite important to user focus. Is that embodied sufficiently in the care standards? Would there be time to do that in a meaningful way anyway in an inspection?

Jacquie Roberts: I think that the user focus is embodied very well in the standards, and I recommend that we maintain that approach. I know from having been on many inspections that a lot of time is spent observing the delivery of the service to the service users and communicating with them and relatives.

There is an interesting challenge at the moment. Because all our inspections are unannounced, it cannot be guaranteed that a relative will be there to interview, but there are ways around that. An early discussion that we have had in only the first six months of the organisation has been about whether we can build in even more time for inspectors to build in user focus.

There are also lay assessors who take part in our inspections. They are mostly users or carers. There have been well over 200 lay assessor inspections since the start of April.

When we grade services, we ensure that we consider whether there is a good engagement and involvement system for service users and carers. A high score cannot be given if there is no such system. That approach is embedded in everything that we do. The senior inspectors who go out to assess local authority services that engage with service user groups use service user inspectors, and the interviewing of children and families in the child protection inspections is a routine part of the multi-agency child protection work.

The user focus is very embedded in the care inspectorate's system, and it would be impossible to remove it. It is there from the top right through to the front-line services. For example, last week, we had a two-day board development event at which two service users joined us to develop the corporate plan for 2012.

It is very unusual for only one quality theme to be considered. That was done in the care commission's last year. We would look at a minimum of two quality themes, and at the four quality themes for any poorer-performing service.

Malcolm Chisholm: Would you say that, in the next six months, there will be no increase in the number of care homes that are inspected on the basis of only one quality theme?

Jacquie Roberts: It depends on when we start the increased frequency. However, approximately 170 care homes will not be expected to be inspected this year, as that is the frequency regime that we put in the inspection plan at the end of November last year.

Malcolm Chisholm: When the increased frequency starts, will more homes have to be inspected on the basis of just one quality theme for the rest of this year?

Jacquie Roberts: No—we will do a minimum of two quality themes.

The Convener: When will the increased frequency start?

Jacquie Roberts: We have yet to have that final discussion with the Scottish Government. It is clear that the answer depends on human resources.

Mary Scanlon: I will ask about unmet healthcare needs, which Bob Doris and others have raised and which Healthcare Improvement Scotland highlighted last week. I am not sure whether we have discussed that widely today.

Healthcare Improvement Scotland said:

"We think it is important we contribute to the health component".

People in care homes are not really in a position to phone to make an appointment to visit their GP, so they depend on people noticing changes. Pages 5 and 6 of your supplementary submission say that you

"employ a number of professional advisors and consultants"

who include people with expertise in a range of healthcare disciplines such as pharmacy and general practice. Do you employ pharmacists and GPs? How do they ensure that the medicine of people in care homes is reviewed regularly and that those people receive their annual GP health checks?

The main concern is that 75 per cent—in case you query that figure, I say that it is according to Age Scotland—of such people are on psychoactive medication. Healthcare Improvement Scotland is concerned that the health component

is not being examined robustly. What do you do and how does that work?

Jacquie Roberts: I am clear that considering the provision of healthcare by NHS employees—including the independent contractors, GPs—is not our responsibility. That is why Healthcare Improvement Scotland thinks that the issue is important. We need to link up with that body and its responsibilities for providing quality assurance of NHS services.

For some years, we have made it clear that we want NHS services to take more interest in and responsibility for the healthcare provision for people in care homes. As you said, such people can be very dependent. The NHS is required to take responsibility for delivering the service to those people.

I was interested to note that, in a small proportion—less than 19 per cent—of the applications to the change fund, which is being allocated to people to work on integrated health and social care, the funding is being used to allow the NHS and local authorities to consider improved provision and supervision of NHS and healthcare-provided services in care homes. It is important that NHS boards take full responsibility for the delivery of service in care homes in their areas.

Mary Scanlon: I do not want to repeat myself, but you say that you employ pharmacists and GPs. Given that community pharmacists say that they

"are not routinely asked their opinion of how they perceive a care service"

and that GPs do not always regularly visit people in care homes, have we almost lost sight of the important health needs of people in care homes in the past 10 years, although we have considered social care?

Jacquie Roberts: I would prefer you to ask GPs and NHS board chief executives that question. I do not think that we have lost sight of those needs, but it has been possible for some NHS boards to think that healthcare needs are being met in the setting of a nursing home and that they do not necessarily have responsibilities there. However, we all now know that GPs have a system of visiting care home residents. That is part of the system in NHS boards. Again, that issue needs to be looked at. It is a shared problem for Healthcare Improvement Scotland and the care inspectorate, and it is for NHS boards and local authorities to ensure that their commissioning arrangements provide the right health services for residents in care homes.

11:30

Richard Lyle: I return to Jim Eadie's point on staffing levels. Most companies have reshaped their services from time to time. Your two organisations have merged. At that time, you thought that you could lose staff through early retirement and people leaving. It has cost you over £2 million—

Gordon Weir: £2.4 million.

Richard Lyle: £2.4 million. Now you have financial savings because of property, reinvestment, selling and whatever. Quite rightly, the cabinet secretary has increased your workload because of concerns about care homes. By my estimate, you are now down 28 staff. How many staff will you re-employ?

Gordon Weir: Under the severance scheme that the care commission ran in March this year, 56 staff left the organisation, 40 of whom were care commission officers; those who remain are now called inspectors. The staff who transferred from the child protection arm of Her Majesty's Inspectorate of Education and from the Social Work Inspection Agency are designated as senior inspectors and tend to do the corporate inspections. Broadly, we are 40 inspectors below the figure that the care commission previously ran. It is not likely to be as simple as recruiting directly to full-time posts—we may get agency staff or temporary staff and so on—but we are looking at a full-year figure of about £400,000-worth of staffing costs. Again, that depends on when we start the process and whether there is scope for doing so this year.

The care commission had significant savings targets to hit in its last year. On top of that, the severance scheme was run to reduce the costs of transferring into the care inspectorate. The care inspectorate running costs budget is 8.6 per cent below the combined running costs budget of the predecessor bodies in their final year. We have therefore delivered a significant running costs efficiency.

I accept that the total funds available to the organisation for one-off transition costs held the overall figure in a stable position for this year, but we are running with 8.6 per cent fewer resources than the previous body had. That is not all made up of staff costs. We have a targeted efficiency regime that picks up on estate savings and a multitude of other, different ways of working. The organisations have never been static or stable in terms of a drive towards stable business models, because we have been driving efficiency gains out of the organisation all the time in order to direct resources to where their benefit can be maximised.

Richard Lyle: You still have not answered the question.

Gordon Weir: Apologies for that.

Richard Lyle: By my reckoning, you are 28 staff down. You now say that you are 40 staff down. How many staff will you re-employ to get to the level of inspection that we want your organisation to deliver? We continually put the onus on you and you quite rightly say that you must do that work. So, how many more staff will you employ to get back to where you were?

Gordon Weir: On full-time equivalent numbers, seven or eight—that kind of number.

Richard Lyle: Seven or eight. Thank you.

The Convener: Seven or eight, or the equivalent. I suppose the issue is also about using equivalent skills.

Gordon Weir: Yes.

The Convener: They are not just sitting around; you have a pool of people that you could use on a more flexible basis. You could use seven or eight at any one time from a pool of 40 who have just left who have all the required skills and training.

Jacquie Roberts: And not just people who have left, but other people who are employed by Healthcare Improvement Scotland.

The Convener: Yes, with the appropriate skills.

Jacquie Roberts: The most important thing to say is that we are in the middle of assessing where we might have a skills gap. We need to know whether we need to employ another pharmacy adviser, for example. We are examining the mix of people with nursing qualifications and social care qualifications. We want to ensure that we get the right resources in the right place.

Dr Simpson: Does the care inspectorate have adequate enforcement powers on commissioning?

Jacquie Roberts: We do not have enforcement powers over local authorities' commissioning responsibilities, but my experience is that we do not need them. We can review and assess commissioning practice and publish the results, which produces improvements.

I am keen to develop that in the next inspection year. The Social Work Inspection Agency had concerns about commissioning practice and published a good self-evaluation guide on social care commissioning. Audit Scotland is currently undertaking a detailed study of social care commissioning. I have arranged to meet Audit Scotland once its results are ready to plan what we could do to assess social care commissioning, not simply to describe what is not happening and what is going wrong, but to try to improve practice. I am certain that improved practice will mean joint commissioning with the NHS; that is the future.

The Convener: I thank Jacquie Roberts and Gordon Weir for being with us this morning. We appreciate their evidence and I am sure that it will be useful in our final report.

11:36

Meeting suspended.

11:40

On resuming—

The Convener: We proceed to our second panel and I welcome Nicola Sturgeon MSP, the Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy. She is joined from the Scottish Government by Geoff Huggins, deputy director of health and social care integration; Gillian Barclay, head of the older people's care unit; and Alessia Morris, head of the sponsorship and social services improvement team. I welcome you all. I invite the cabinet secretary to make a brief statement before we move to questions.

The Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy (Nicola Sturgeon): Thanks very much, convener. I will be as brief as possible. I am grateful for the opportunity to give evidence to the committee. I stressed in my statement to the Parliament on 15 September, and I have stressed since then, the importance that I attach to the inquiry. I give an early assurance that your analysis of the issues and any recommendations that you might come up with will form a key part of the commitment that we have given to the on-going review of the arrangements for the regulation of care. The inquiry is both helpful and timely. It gives us the opportunity to consider the complexities involved in ensuring that we have a high degree of confidence in the quality of the care that is provided to our older and most vulnerable citizens.

I said in my statement—and I repeat it today—that I believe that, in general, care services in Scotland are of a good quality and respond well to the needs of older people and those who care for them. I also believe that the regulation and inspection system is fundamentally robust. Nevertheless, I recognise that we must always keep it under review and I am acutely aware of the fact that a number of recent events—the failures of care at the Elsie Inglis nursing home, the Mental Welfare Commission for Scotland's report on Mrs V and the collapse of Southern Cross Healthcare—will have dented public confidence in the services that we provide to older people.

In response, I have taken some initial steps and have, as I said, given a commitment to keep under review the regulations on regulation and inspection. I will reiterate the steps that I have taken so far. All care homes and personal care and support services will be inspected at least once a year rather than once every two years, as was originally envisaged when the care inspectorate came into being. Over and above those mandatory inspections, there will continue to be additional risk-based inspections. I have also indicated that the new inspection regime will be placed on a statutory basis and that regulations will place in law the requirement that, in the future, all inspections of care homes will be unannounced. I am sure that we will discuss funding and resources. I gave a commitment to the Parliament—which I repeat today—that we will ensure that the appropriate resources are in place to support the additional activity that we are asking the care inspectorate to undertake.

Also in my statement to the Parliament, I said that the formal title of SCSWIS would no longer be used on an informal, day-to-day basis and that the organisation would instead be called the care inspectorate. That does not change fundamentally the role and responsibilities of the organisation; it responds to the public's desire for a better understanding of the organisation's role and how they interact with it.

Last, but not least, I have agreed with the chair of the care inspectorate that I will support him and his team in raising the profile of the complaints process. I believe that the complaints process and its good operation are fundamental to the good operation of the risk-based system that we have in place.

I will conclude by mentioning the longer-term issues. I am sure that everybody agrees that the experience of Southern Cross raises a set of wider, more fundamental and undoubtedly more difficult issues. Although the circumstances of the collapse of Southern Cross were particular, it necessitates consideration of what more we can do to minimise the risk of care homes or other care services failing because of private or, indeed, voluntary providers' financial difficulties.

Our approach to that work must reflect a number of important issues, not least the diversity of the market, which includes some very small local services, as well as large national and UK-wide services that might involve private equity or be subject to financial regulation as a consequence of listing on the stock exchange. Before we decide which further steps are necessary, we need a clearer understanding of the existing regulatory framework under which companies require to operate. We recognise the need for that framework to be effective.

11:45

As well as identifying actions that might assist, we must be realistic about the ability of greater regulatory powers for the care inspectorate, for example, to solve the problem in and of themselves, particularly with the bigger providers. It is important to point out that central regulatory intervention would not necessarily have prevented the Southern Cross problem from arising. We must be careful that whatever we do does not have counterproductive effects and make it more likely that providers will be driven out of business.

One of the key points—which I heard Jacquie Roberts of the care inspectorate make earlier—is that the experience of Southern Cross underlined the fundamental importance of contingency planning, which is what gives me and the local authorities the confidence to say, in a Southern Cross-type situation, that quality and continuity of care will be protected. Ensuring that we have strong and robust contingency planning arrangements in place is fundamental.

I will stop there, convener, because I am sure that you are on the verge of telling me to do so. I know that the committee will want to explore a range of issues, some of which I have touched on. I will be happy to answer any of your questions as fully as I can. In addition, the Government will be willing to provide any further detailed information that might assist you with the inquiry.

The Convener: Thank you very much for your opening remarks. Bob Doris has the first question.

Bob Doris: Thank you for your statement, cabinet secretary. I am sure that some of my colleagues will touch on the financial implications of the Southern Cross situation, but my question is about the re-establishment of annual, unannounced inspections, which I think we all welcome, as it will help to address public concerns and to re-establish public confidence in the system.

Counterintuitively or ironically, we were all supportive of the new regime's risk-based approach to assessment. That raises the question, where were the gaps in on-going risk-based assessments? If we could get that right in a structured fashion, we could have fewer inspections. We just figure that perhaps we do not have the balance right when it comes to residents of care homes, their families and allied health professionals, such as pharmacists. We found out today that the care inspectorate does not routinely question even the community pharmacist that supplies a care home. What gaps in the information gathering for risk-based assessments must be plugged?

Nicola Sturgeon: I support the notion of risk-based assessment and inspection, which the

Parliament supported when we passed the Public Service Reform (Scotland) Act 2010 and that was a key recommendation in the Crerar report. It is not right that we apply the same level of scrutiny and inspection to every care provider, regardless of their track record or of current information about how they are performing. We should have a system that allows disproportionate resource—if that is the correct term—to be applied to those providers that we believe are not performing as well as they should be, or in relation to which problems are known to exist or come to light.

The statement that I made to the Parliament two weeks ago should not be taken to signal a move away from that risk-based approach, but it recognised that the move from the old regime—if I can call it that—to the new regime and the reduction in the statutory minimum inspection frequency that it involved was too far, too fast. I remind members that the old regime involved a minimum of not one, but two inspections per year. That changed to a minimum of one inspection every two years. On reflection, having considered some of the issues that we have seen, I realise that the move from the old regime to the new one that was proposed took things too far. The move back to a minimum of one inspection a year is a mid-point between those two positions. We stress that that is a minimum—the care inspectorate will have the ability to inspect services more frequently, based on its assessment of risk.

On your question about how risk is assessed, it is essential that the care inspectorate comes up with an approach—it is currently in the process of working through that—for how it assesses risk on an on-going basis.

I heard some of the previous evidence session and it may be that the care inspectorate, following your line of questioning this morning, will want to reflect on whether, for example, pharmacists should routinely be consulted as part of the risk assessment process. One message that I want to give to GPs, pharmacists and anyone who goes into a care home in a professional capacity is that if they have any concerns they should raise them, so that the care inspectorate has that awareness and knowledge, which feeds directly into the risk assessment.

Likewise, the complaints process is fundamental. That is why I am so keen, as is the care inspectorate, to raise the profile of the complaints process. I heard some interaction in the previous evidence session about the number of people who had clicked on the complaints pages on the care inspectorate's website. I would like to see that number go even higher, because we must ensure that people are aware of that mechanism so that they know that, if they have concerns, they should raise them and that then forms part of the care inspectorate's on-going risk assessment.

Bob Doris: Thank you. I agree with you on the responsibility of allied health professionals and others. The general point is that sometimes they see only one part of the jigsaw, which may not be overly alarming to them but, when we put together different pieces of the jigsaw from different groups, the care inspectorate can get a broader picture and make a risk-based assessment of how it takes the matter forward.

I will move on to another aspect of the evidence that we have tested. Towards the end of the previous evidence session, the care inspectorate said that it supported the inspection of the care pathway. What thought has the Government given to resourcing pilots or otherwise developing an approach such that the care inspectorate, when it goes into care homes for the elderly, takes a batch of residents and backtracks to find out what their care experience has been through all the different health or social agencies that have interacted with them? Does the Scottish Government support that direction of travel?

Nicola Sturgeon: Yes, it does. An example of such an approach would be the new dementia standards that we recently published. Those look at the care pathway and also at care provided to an individual, regardless of where they get that care, so they are not specific to a particular care setting. That is a direction of travel looking at overall care pathways that the health service and social care services generally are more geared towards. We must ensure that our regulatory and inspection system also looks at the totality of a service user's care pathway.

Jim Eadie: My question is about funding—you might have heard the exchange that we had with the care inspectorate. Your announcement on 15 September that there will be an increase in the minimum frequency of inspections in care homes has clearly been welcomed across the committee. As the financial settlement will clearly be tight, can the public have confidence that there are sufficient resources within the system to allow the care inspectorate to undertake the tasks that the Government has asked it to deliver?

Nicola Sturgeon: The short answer to that is yes.

I have a responsibility, working with the care inspectorate, to ensure that it can, within the resources that we are making available to it, carry out the requirements that are being asked of it. As the care inspectorate said this morning, it has internally been planning for a reduced budget and, therefore, the budget that was set out in the spending review, which showed a cash increase in

the grant-in-aid budget, gives it the stability to do what is being asked of it.

I do not want to give the impression that I have been sitting in front of the television all morning—I did not see all the exchanges—

The Convener: We are pleased to see that you have been paying attention.

Nicola Sturgeon: I always pay attention. I heard some of the discussion about budgets and the issue of a cash-terms increase versus a real-terms reduction.

We all look at the real-terms implications of budgets, but it is not always the case that the gross domestic product deflator reflects the actual inflationary pressures that bear down on an organisation. We have this discussion regularly. The GDP deflator often underestimates the inflationary pressures on the health service and I suspect that it might well overestimate the pressures on organisations such as the care inspectorate. The biggest chunk of the care inspectorate's budget is spent on staffing and rents, which are not increasing. There are pay freezes and rent levels are not increasing in the current financial climate. I am therefore not sure that the real-terms issue throws as much light on the matter as people assume. The budget that has been set for grant in aid is increasing in cash terms and I believe it enables the care inspectorate to carry out the functions that it has been given, including the increased frequency of inspection.

Jim Eadie: The committee has discussed the possibility of extending the scope of the care inspectorate's powers. Depending on what the committee recommends, there might be a call for the inspectorate to have greater enforcement powers in relation to commissioning and procurement and we might see the inspectorate develop its role further in engaging with the public and service users. You said that you wish to support the care inspectorate in the work that it undertakes on public complaints. If it believes at any time that it does not have enough resources to undertake its existing responsibilities and any additional ones it takes on, what opportunity will there be for it to have a further discussion with you about that?

Nicola Sturgeon: To some extent that is a hypothetical question, although I understand why you asked it. We will always have a close discussion with the care inspectorate about what it has been asked to do and the resources that are brought to bear to allow it to do that. It is worth making the point that the budget that has been set for the care inspectorate over the next three years is a better budget settlement than that received by many other parts of the public sector. As with all other parts of the public sector, we expect the care inspectorate to do its job as efficiently as possible. I heard the care inspectorate talk about trying to realise the greatest possible efficiency from its premises and its asset base. We expect it to be as efficient as possible in order to ensure that it can carry out its functions.

If at any time we considered, in response either to recommendations from the Health and Sport Committee or to anything else, that we should substantially change the job that we ask the care inspectorate to do, we would need to consider what the appropriate budget was to allow it to do that, but that takes me into the realm of the hypothetical.

The Convener: Is it hypothetical to talk about the increase in fees, which would be a source of income, that is being consulted on? I think my colleague Jim Eadie made the point. When we consider the job that the care inspectorate is requested to do, we would like to get a focus on research and development, but we would also like it to have a financial arm that can look at financial services. We want a full-blown phone service and website for complaints, which will increase people's expectations. Inspectorate staff will have to answer calls and investigate. As Jim Eadie pointed out, we are talking not only about the current role but about widening the role and importance of the inspectorate. How do we fund that? Will it be with increased fees?

Nicola Sturgeon: I will try to break that question down a wee bit. I want to answer it as fully as possible, but it takes me into the realms of speculation.

I do not know what the committee will recommend as a result of its inquiry. I am absolutely sure that the committee will make sensible recommendations that seek to allow us to continue to have a proportionate risk-based inspection system, but I recognise that it might want to recommend changes to aspects of how the care inspectorate does its work. I, as the cabinet secretary, and the Government will need to consider the recommendations and assess whether we believe that they should be followed or not. If they lead us to a change in the way in which the inspectorate does its work, we will need to discuss with the inspectorate whether that can be done within its existing and projected budget or whether changes require to be made. That is the process that we will go through. I cannot tell you what the outcome of the process will be, short of knowing where we will get to.

12:00

I accept absolutely that it is not hypothetical that we will consult on both the structure and the level

of fees, but the outcome of the consultation is still hypothetical. The care home sector is the only part of the care sector in general that currently works on the basis of full cost recovery. In setting fee levels, there are always different factors that have to be balanced. One factor is that fees provide a source of income to the care inspectorate, but a counterbalancing factor is that we must ensure that we do not set fee levels too high and thereby create financial pressure on care providers that may cause instability in the sector or any particular part of it. We need to take care over the issue, which is why consultation is the right way forward.

The Convener: So the announcements in your statement have all been funded, including in relation to complaints and frequency of inspections.

Nicola Sturgeon: I believe that what I am asking the care inspectorate to do now, including the changes that I announced in my statement on 15 September, can be delivered within the current budget and the projected budget for the next three years that was set out in the spending review.

The Convener: Are you confident that there will be no impact on the other services that the care inspectorate provides? It will not scale down other services to provide the new focus: there will not be any impact on the regulation of children's services or social work or on its acting as a catalyst for change and innovation and its supporting improvement. That is quite a list of functions.

Nicola Sturgeon: Interestingly—I appreciate that this point might have been slightly lost in my statement, given that it was about older people's services—the move to the minimum of having annual inspections applies not just to older people's services but to other services, too.

The care inspectorate has to perform all its functions efficiently, and I am sure that, like every other part of the public sector, it can achieve greater efficiencies in how it does its work. It is now funded at a level, with a projection that gives it stability, to allow it to do what I as cabinet secretary am asking it to do. I cannot give definitive answers at the moment on the changes that might be made to it in future as a result of the committee's report or other factors, because I do not know what they might be.

The Convener: We will need to refer to the *Official Report* as I do not want to put words in Jacquie Roberts's mouth, but it seemed to me that part of the concern in the discussions with the Government on broadening the approach beyond elderly care services to include children's residential care services was about the introduction of some ring fencing. We will see what the *Official Report* says, but that was a part of the negotiation, and it came from a concern that other services had to be protected.

Nicola Sturgeon: Do you mean before we made the change?

The Convener: Yes.

Nicola Sturgeon: There must have been a point when I moved away from the television this morning, as I did not hear that part of the discussion, but I am happy to look at the *Official Report* and provide a further response.

The Convener: The broadening of the cover stemmed from a concern that other services may be impacted as a result of a focus that is too narrowly on elderly care services. However, we will see what is in the *Official Report*—I might have been hearing what I wanted to hear.

Nicola Sturgeon: The only point that I would make is that, in increasing the minimum frequency of inspection, we did not apply it just to care homes but to children's residential services and care-at-home services. If I follow what you are saying, I hope that, if there was a concern, not restricting the approach removes it.

The Convener: There may be impacts beyond that, but that is something that we need to take up with the care inspectorate.

Gil Paterson has a supplementary question on fees.

Gil Paterson: Cabinet secretary, do you think that it is possible and practical to have a universal fee for private companies that may have additional costs in certain parts of Scotland? For instance, I have premises in Aberdeen, and I know that the costs of premises and labour in Aberdeen are way over the costs for my other depots. Is it practical and possible to have a universal fee, or could there be a mechanisms to subsidise the costs in, for example, Aberdeen?

Nicola Sturgeon: The current fee structure across the different aspects of care provision is already not uniform, which means that we do not have a completely standard approach to begin with. I am sure that, when we consult on the fee structure and levels, care providers will highlight the kind of issues that you have raised, and we will listen to and reflect on what is said.

Mary Scanlon: Given that our analysis and recommendations will form a key part of your deliberations, I am sure that you have been reading the evidence that has been given to the committee and will have noticed my particular concern about the time taken to train and register support workers. Jacquie Roberts disagreed with the figures that I quoted, but I am simply going by the SPICe briefing, which says, for example, that care-at-home workers do not need to be

registered until 2020, while those working in care homes have until 2015.

I do not know what the committee will recommend on this issue but, given the Scottish Social Services Council's comments on the enormous benefits of training—it not only improves people's learning and understanding and gives them greater skills but gives them confidence to go into care homes—what do you think of the length of time for registration and the current lack of support and training? Of the 140,000 staff who still have to be registered, almost 50 per cent are, according to SPICe, in training. It appears that 70,000 staff who are going into people's homes have no training. Where do you stand on the issue?

Nicola Sturgeon: Before I answer your question, I should confirm that the figures you highlighted earlier are correct. Having listened to Jacquie Roberts's evidence, I think that she might not have been sure whether you were referring to care home and care-at-home staff or just care home staff alone. Care home staff have to complete their registration by 2015 but you are right to say that staff in care-at-home services have until 2020.

I am not making a definite commitment to change this but I have heard the concerns that have been raised not only by you but by others and am certainly prepared to go away, discuss the issue with the Scottish Social Services Council and the care inspectorate and assess whether we can do anything more. Nevertheless, we must acknowledge that all this is taking so long because we are the only part of the UK that has decided to regulate the whole social care workforce in this way. Other parts of the UK have limited the approach to social work but in this exercise we are going significantly and considerably further. We are right to do so, but that means that we will be dealing with a workforce of 200,000 people. Furthermore, as the register is qualifications based, those who wish to get on to it will have to get a qualification. I am sure that members appreciate that that kind of rigorous and robust approach takes time.

As for the order in which sections of the workforce are registered, I am not suggesting that my response will fully satisfy your concerns but I hope that you realise that it is intended to address them in some way. Managers and workers with supervisory responsibilities are first in the queue for registration. The registration of care home managers, for example, was completed in November 2009 and the registration of care home workers with supervisory responsibilities will be completed by next March. As a result, fully registered people will supervise the more junior—if that is the correct terminology—members of staff who are not yet on the register. A lot of thought and planning are going into this. However, although we are right to be taking a comprehensive approach, the undertaking is much bigger here than it has been in other parts of the UK, which is why we have put in place particular time limits.

To finish where I started, of course I am happy to consider whether changes can be made to the process that might allay some of your concerns.

Mary Scanlon: I am grateful for that commitment.

My other question relates to an issue in the Healthcare Improvement Scotland submission about unmet healthcare needs. Generally speaking, people in care homes cannot pick up the phone and make an appointment with the doctor or get to the doctor. We seem to be fairly efficient and effective in relation to personal care needs, but we are not nearly as robust at picking up on healthcare needs and there does not seem to be a system in place that would achieve that. We heard from pharmacists that no one ever asks their opinion and that GPs do not carry out an annual check. Some GPs might visit people more often, but it is a very ad hoc approach. There is a decent emphasis on social care, but healthcare needs seem to be overlooked.

Nicola Sturgeon: As I imagine the care inspectorate would say, that is an area in which we must ensure that the different parts of the system work in an integrated fashion and that the organisations that have responsibility for the social care and the health needs of an older person in a care home talk to one another in the way that we would expect.

A health board has a clear clinical governance responsibility to ensure that an individual's health needs are met. Healthcare Improvement Scotland has responsibility for the inspection of healthcare services, and the care inspectorate has its responsibility. We must ensure that the different elements of the system are properly integrated to assure ourselves that we do not have the situation that Mary Scanlon identifies in which somebody might be getting good social care in a care home, but they do not get basic medical care.

I might have picked this up wrongly, but I think that the care inspectorate said that it would reflect on Bob Doris's point about more routinely asking pharmacists for their opinion. I will wait to see what the inspectorate says in its response.

I would be troubled if any health professional who went into a care home and who had concerns about the healthcare that an individual was receiving did not raise those concerns. If we have a job to do to raise awareness of how such concerns should be raised, we need to do that. I

would not like us to have a system in which pharmacists did not raise concerns proactively because they were waiting for the care inspectorate to ask them as part of a routine risk assessment or evaluation process. We must encourage health professionals and members of the public to get into the mindset that they can and should raise concerns, if they have any, about the care that someone in a care home is receiving.

Mary Scanlon: We have 70,000 staff who are not in training. Adult care home support workers will have to be registered by 2015. If people do not receive training, it is difficult for them to pick up on someone's healthcare needs. That issue was raised by one of the doctors who came to the committee. With care-at-home services, people see only the support worker who goes into their home. If more emphasis was put on training, support workers could pick up issues. A few examples were given of that, such as urinary infections. If people will not be trained until 2020, there will be a gap in the system.

Nicola Sturgeon: I do not want to repeat my earlier answer about the timescale, because that stands on the record. I simply repeat that I know that there is an apparent contradiction. The process is taking so long because of the emphasis that we are putting on qualifications and training before somebody can be registered to work in a care home. All managers are already registered.

It is worth mentioning the dementia skills work. When I launched the dementia standards, I also launched a skills framework for all staff who work with people who have or might have dementia. That is an important part of ensuring that the workforce is properly trained to identify and address the needs of that particularly vulnerable group.

Mary Scanlon: I met staff from Highland Home Carers, who all trained in the dementia standards at the University of Stirling, but that does not count towards the SVQ2 that is required for registration.

12:15

The Convener: There may be a general question to kill this. We have heard evidence that there is a bit of a gap and that the focus is more on residential care and hospitals, although a great number of people receive care at home. Is the cabinet secretary confident that the system ensures the quality of care at home? I do not want to pre-empt anything, but does she think that we can address in the forthcoming regulations the various issues that are giving us concern?

Nicola Sturgeon: Some issues are common to both settings and some are different; some issues are undoubtedly tougher nuts to crack in relation to care being provided in somebody's own home, often behind closed doors. Under the forthcoming regulations, the minimum yearly inspection will apply to care at home as well as to care homes. The announced versus unannounced aspect is more challenging with care-at-home services because, by necessity, inspections must be announced in order to ensure that the inspectors can get access when the service provider is there. A system of purely unannounced inspections probably would not work for care at home.

Beyond that, there are issues that we need to keep under review around the inspection and regulation of care homes. If that is true of care homes, it is even more true of care at home. Over the next few years, as a result of self-directed support and the general trend towards people staying in their own homes longer, more services will be provided to people in their own homes, and we need to continue to think through the implications of that. I heard the earlier discussion about the regulation of personal assistants and family members providing care at home. Those are difficult issues that do not lend themselves to easy answers. We must ensure that we think through the implications of a shift in the balance of care away from institutional settings towards people's own homes.

The Convener: Are you confident that that work is being done? We have heard that people are staying in their own homes for longer and that their problems can be more complex—that there is a greater need for nursing care and so on.

Nicola Sturgeon: We are thinking through all those things and will continue to do so. I am sure that the committee will make its views known in its report on the inquiry. The situation is evolving and changing. We would be complacent if we were ever to think that we have got that nut cracked; we always need to consider how we can better protect people who are receiving care in the home setting, which presents a very different challenge from the provision of care in an institutional setting.

Dr Simpson: Some of the issues that I wanted to cover have been covered.

We heard from the care inspectorate that it is satisfied that publishing the results of the inspection of commissioning is adequate and will achieve the necessary change. Will you comment on that? With SWIA, we have been through the reverse tendering problem, which you solved. However, there is a problem with retendering and the degree to which service users are involved. We know that some services are experiencing significant cuts in the retendering process. Do you feel that the transfer of this area to the care inspectorate will produce adequate results, or does the care inspectorate need some enforcement powers so that we are not faced with

another scandal like the reverse tendering scandal?

My second question is about the other side of things. The Mental Welfare Commission told us that some hospitals would not pass muster if they received a social care inspection. In other words, if the care inspectorate went into hospitals to inspect social care, some hospitals would fail. In terms of an integrated approach, how will that solve the delayed discharge problem, given the much more integrated step up, step down approach that we are taking to care? Does the care inspectorate have a role in that to add to its existing role?

Nicola Sturgeon: There may come a time when we would want to integrate further the care inspectorate with Healthcare Improvement Scotland, but Parliament in the previous session decided to set up the two organisations, so that is the system that we have, although we expect—and will increasingly expect—there to be information sharing and close working between the two organisations.

I have been quite open, and I will be open again today, about concerns that I have about the standard of care—not always the standard of clinical care but the dignity of older people in that regard, particularly in general hospitals. The dementia standards and their applicability in hospital settings as well as care home settings are an important part of raising the standards in hospitals. I have asked the chief nursing officer to oversee the implementation of the dementia standards in hospitals and I have asked HIS to carry out a programme of inspections of hospitals against the care for older people in hospitals standards, because although there is a lot of focus on care homes, we have to ensure that there is the same focus on the standard of care in hospitals.

I am not sure that I will ever sit here and say that there are no improvements that we can make and no lessons that we need to learn. When you are dealing with the care of vulnerable older people, my view is that you should always be open-minded as to how you can do it better. In no walk of life can you eliminate risk, but our obligation should be to try to reduce risk as much as we can.

On commissioning, the care inspectorate scrutinises local authorities and publishes inspection reports with recommendations, which I think provides important transparency. Audit Scotland also has a role to play by auditing the commissioning functions of local authorities. The Public Services Reform (Scotland) Act 2010 specified that local authorities have to take account of care inspectorate reports on particular services in their commissioning and procurement decisions.

One aspect that we should be prepared to think about is whether, although we have processes in place, the teeth in the processes are sharp enough. I am talking not just about enforcement in relation to providers but, in this case, enforcement in relation to local authorities that might be ignoring—I am not saying that any of them do—a care inspectorate report that gives a particular service a poor grading. There might be questions around enforcement in that regard, because the care inspectorate has no specific enforcement powers in the realm of commissioning and procurement.

Dr Simpson: That is very helpful. Thank you.

The Convener: We heard earlier that some work is being carried out on taking a more academic approach to staffing levels and skills mix—nursing and so on—in the various settings, which I would have thought would impact on the procurement and commissioning of services.

Nicola Sturgeon: As I understand it, the care inspectorate is looking at some statistical modelling around that. It is probably best to get the inspectorate to set out the scope of that work.

The Convener: It is important.

Nicola Sturgeon: Absolutely.

The Convener: In our evidence sessions, we have heard continually about staff numbers and skills mix—dealing with people with more complex needs with reduced nursing staff numbers and so on.

Nicola Sturgeon: I think that there is a role for the care inspectorate there.

The committee is probably already aware of this, but Audit Scotland is carrying out a review of local authorities' commissioning practice. That report is due out next January. As we do with all Audit Scotland reports, we will pay that one close attention.

The Convener: I think Edinburgh was talking about a national skills development plan. I will leave that with the care regulator.

Richard Lyle: I want to talk about funding and staffing levels. When you made the announcement—quite rightly; everyone welcomed it—to increase the minimum frequency of inspections in care homes, you also said that funding to the inspectorate would enable it to

"maintain its current overall staffing capacity".—[*Official Report*, 15 September 2011; c 1819.]

Quite rightly, you ensured that the inspectorate was given a 2.4 per cent increase in cash terms. In earlier evidence, the care inspectorate said that, before the predecessor bodies merged, they had 312 staff, which subsequently went down to 284

staff, including managers. By my reckoning, that means that the care inspectorate is minus 28 staff, but it said that 40 people have taken early retirement. When pressed on whether it will take on more staff, given that it will receive extra funding, get money from property sales and make cash savings, the care inspectorate said that it will be able to take on seven or eight extra staff. Does that cause you concern?

Nicola Sturgeon: I did not hear that part of the evidence, so I would like to look at that in detail. Obviously, the care inspectorate is responsible for the detail of its budget and staffing, including its mix of staffing.

Part of the reduction in the number of inspectors from the three predecessor organisations to the current care inspectorate will be down to the fact that three organisations went into one and that, until my parliamentary statement, the organisation was preparing to reduce the minimum frequency of inspection to once every two years. I suspect that, had we not changed that, the number of inspectors would have continued to go down a bit. Because we are upping the minimum frequency of inspections and changing the budget projection—although it is for the care inspectorate to decide the final size and mix of its workforce—the number of staff will remain steady to allow it to carry out the additional inspections. The care inspectorate will also look at how it realises other efficiencies from elsewhere in its business in order to ensure that its front-line resources can meet the requirements that have been placed on it.

The Convener: Is the care inspectorate discussing the implementation of the increased frequency of inspection with the Scottish Government?

Nicola Sturgeon: Yes.

The Convener: When do you hope that it will be implemented?

Nicola Sturgeon: Before coming to that, I should say that, under the 2010 act, ministers must agree an inspection plan. We agreed an inspection plan in March, but the changes will require a changed plan, which will come to ministers for approval. We have not yet got to that stage of approval.

There are almost two answers to your question about the commencement of the increased frequency. I said in my parliamentary statement that the increased frequency will be on a statutory basis, and we will therefore shortly introduce regulations that will have a commencement date of 1 April next year. However, that does not mean that such inspections cannot start earlier in practice. We are discussing with the care inspectorate how the extra inspection activity can commence in practical terms.

The Convener: Thanks for that timescale. If you were optimistic, you would expect the inspections to begin before the statutory commencement date.

Nicola Sturgeon: I am always optimistic, so I would hope so. I am happy to keep the committee updated on that point.

The Convener: Will the frequency of inspection cover out-of-hours and weekend inspection? Will there be a minimum number or percentage of such inspections?

Nicola Sturgeon: That is for the care inspectorate. However, all the inspections will be unannounced. The care inspectorate already carries out inspections as it sees fit at weekends, out of hours or whenever it thinks it appropriate. However, pursuing that issue gets us into the level of trying to micromanage how the care inspectorate does its work. The care inspectorate needs to make judgments about how it carries out inspections and at what time of day, based on its risk assessment.

The Convener: We have had quite a lot of evidence in which people have referred to out-of-hours inspection and said that, to get the real picture, inspection should be in the evening or at weekends. I presume, but I do not know, that inspection costs more at weekends or in the evening, so would budgetary constraints impact on that?

Nicola Sturgeon: Without getting into the level of detail that probably neither of us can give, I am not sure that what you suggest is necessarily the case. People are employed to do a particular job, so no doubt it would be part of their job description to do inspections at different times. We do not have a system that just does in-hours inspections, nor should we.

12:30

Gil Paterson: In your opening remarks, you said that financial viability is an issue not just for the big guys in the care sector, such as Southern Cross, but for providers throughout the sector, however big or small they are—you did not use those words, but I think that that is what you meant. What is the Scottish Government's view on current powers in relation to financial scrutiny? Do you envisage changes and, if so, will you rely on co-operation from Westminster to enable changes to be made?

Nicola Sturgeon: As I said, we need to consider the issue. Partly because of its complexity, I am not yet at a stage at which I can give definitive answers to your questions. The sheer diversity of the market makes the issue incredibly complicated. With Southern Cross, we are talking about a complex UK company, with

complicated models of finance, which involve loan financing and equity financing. We need to understand the broader regulatory system that governs companies that provide care services. I have written to Andrew Lansley about that.

We need to consider whether there is more that we can and should do. The care inspectorate looks at the financial viability of care providers at the point of registration. My initial view is that we should not assume that the care inspectorate in and of itself can resolve the issue, because the complexities are probably beyond that.

Beyond considering whether we need more regulatory and enforcement powers, we need, first, to ensure that robust contingency plans are in place to deal with a care provider that is in financial trouble, whether or not it is possible through the regulation system to identify problems and stop them happening. That is a key lesson of the Southern Cross experience.

Secondly, there is also perhaps more that we should do through the commissioning process to consider the financial viability and stability of care providers. Richard Simpson talked about that. Thirdly, in the longer term, there is the question whether there is a need to consider the shape of the sector and the balance between private, public and voluntary providers. That is something that we have discussed.

Your question raises a big, big issue and it is important that we do not rush to judgment but look at all the aspects and consider what changes might be required.

Gil Paterson: Are you considering how you might drill down into a company's finances on an on-going basis? Can you regulate private companies in such a fashion?

Nicola Sturgeon: In relation to companies such as Southern Cross, we really need input from the Westminster Government. Southern Cross was under regulation as a result of being listed on the stock exchange.

In essence, what I am saying is that—much as I would like this to be otherwise—it is probably unreasonable to think that the care inspectorate, through its regulation and inspection functions, could delve into and get to the kind of issues that were at the root of Southern Cross's problems. What the care inspectorate should be doing is picking up any impact that a company's financial problems are having on quality; I am not sure that it is reasonable to expect the inspectorate to get to such financial issues. It might be a different story for a small provider that had simple funding streams but, in the case of Southern Cross, it is not immediately obvious to me how the care inspectorate could have provided our best or only system of assurance.

Jim Eadie: Notwithstanding the complexity around issues to do with financial scrutiny and regulation, you said in your statement to the Parliament that you had

"tasked officials to work with the care inspectorate, COSLA and other interested parties to bring forward recommendations on how we can provide—and be assured of—greater financial robustness in the sector."—[*Official Report*, 15 September 2011; c 1821.]

The committee would be interested to know what stage the work is at and when we might have sight of the proposals.

Nicola Sturgeon: I hope that this does not sound like I am passing the buck. I am not doing so at all when I say that work is at a fairly early stage and I would be interested to hear what the committee has to say as a result of the evidence that it has taken in its inquiry before we conclude the work and make proposals. Outside that work, there is a need to ensure that we are in tune with and hooked into any discussions that the Westminster Government is having about bigger questions on financial regulations. I cannot give you a definitive timescale, but I am happy to keep the committee apprised of the work.

Jim Eadie: You said that you had written to Mr Lansley. Is it envisaged that there will be discussions between officials and between ministers on the issue?

Nicola Sturgeon: I am happy to make the correspondence available to the committee. Mr Lansley has replied to my correspondence, so it would probably be useful for the committee to have that.

The Convener: There is some correspondence from COSLA on the issue as well, so that would be useful.

Bob Doris: I appreciate that this line of questioning might go beyond the scope of the care inspectorate, as it is about contingencies and the financial viability of various companies. As regards Southern Cross, I imagine—and I invite you to clarify this—that you want it to be a case of business as usual for those in residential nursing homes so that their care journey and experience are not affected. When companies go belly up—for want of a better expression—it is necessary to look at the fixed capital of the care home, the lease that the care home is on, who owns that lease, the fixed capital of the equipment in the care home and the contractual obligations on the staff. When home owners could not pay their mortgages, we looked at protected trust deeds as a way of preventing homes from being repossessed by people who sought to recover debts. Is the purpose of the discussions that you are having with Andrew Lansley and the UK Government to look at which aspects of UK

legislation present barriers to continuity of care? Is that the avenue that you are going down? If so, I am sure that we would be interested in that.

Nicola Sturgeon: The discussions with Andrew Lansley are not at that detailed stage. I will not try to deal with those issues now, because they are big questions, but I would be happy to give some considered thought to the committee in writing on the specific points that you have raised.

I have mentioned contingency planning a couple of times. Let us put to one side, for the time being, the question whether it is possible for us to make changes to the regulatory system that can prevent a care home provider from going bust, as Southern Cross did, as there are some real complexities there. We need to ensure that we are prepared for that eventuality. That is what I mean when I talk about contingency planning. Contingency planning is necessary so that I, as cabinet secretary, COSLA, and the local authorities can give, as we have done in the case of Southern Cross, an assurance to residents in care homes and their families that there will be continuity of care and that the quality of care will be maintained. We should focus on ensuring that that aspect of contingency planning is as robust as it can be.

Bob Doris: In the case of Southern Cross, were attempts made to liquidate assets to recover debt? Was the contingency planning done through the good will of those who sought to recover debts and break leases? Am I right in thinking that you have no additional statutory powers to provide continuity of service? Is that when we refer back to the UK Government?

Nicola Sturgeon: I will let Geoff Huggins say a word on that, as he was involved in this.

Geoff Huggins (Scottish Government): The Southern Cross position is quite complex because, in the vast majority of cases, Southern Cross did not own the property where the service was being delivered. The property was owned by the landlord and Southern Cross was the operator so, in practical terms, there were no assets—or rather, there are no assets, because Southern Cross continues to be a going concern that is still regulated under the listing arrangements of the stock market. The transfer of a set of assets is not part of the Southern Cross story.

The parallel issue is raised that, when operators and landlords are separate, landlords are not regulated in the system because, in effect, they provide premises; they do not provide a care service. That reinforces the need to focus on contingency planning rather than the care service regulatory system as a key element of our approach.

We anticipate that the discussions that we will have with colleagues south of the border will include the degree to which information that may be available to the financial sector regulatory bodies might also be available in other settings to ensure that we can address issues such as continuity of care. Some of the issues might be to do with information sharing rather than different regulatory mechanisms.

The Convener: As there are no more questions for the cabinet secretary, we thank her and her team for their attendance. I am sure that their evidence will be helpful to our final report.

12:39

Meeting continued in private until 13:01.

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