

**Health and Sport Committee
3rd Report, 2011 (Session 4)**

**Report on Inquiry into the
Regulation of Care for Older
People**

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The Scottish Parliament
Pàrlamaid na h-Alba

Health and Sport Committee

3rd Report, 2011 (Session 4)

Report on Inquiry into the Regulation of Care for Older People

Published by the Scottish Parliament on 29 November 2011



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CONTENTS

Remit and membership

Report	1
Introduction	1
Motivations for the inquiry	2
Inquiry remit	2
Summary of conclusions and recommendations	3
List of report conclusions and recommendations	5
Structure of report	12
Background	12
Regulatory system	12
Crerar Review	13
Recent changes	14
The inspection process	16
Risk-based approach to inspections	16
Complaints	18
Frequency and type of inspections	22
Thematic inspections	24
Engagement of healthcare professions	26
Inspectors and inspection gradings	28
Involving service users, friends and relatives	29
Lay inspectors	31
Publication and dissemination of inspection reports	32
Registration of care services	33
Enforcement powers	34

Regulation of the workforce	37
Support and investment in the workforce	41
Integration of regulation of health and social care	47
Background	47
Joint working and integration of inspectorates	47
Data collection	50
Assessment of healthcare needs	51
Healthcare regulation in the community	53
National Care Standards	54
Commissioning and procurement	56
Monitoring financial viability	58
Resourcing the Care Inspectorate	63
Overall conclusions	66
Annexe A: Extract from Minutes of the Health and Sport Committee	69
Annexe B: Oral evidence and associated written evidence	73
Annexe C: List of other written evidence	75
Annexe D: Notes from consultations with stakeholders	77



The Scottish Parliament
Pàrlamaid na h-Alba

Health and Sport Committee

Remit and membership

Remit:

To consider and report on health policy, the NHS in Scotland, anti poverty measures, equalities, sport and other matters falling within the responsibility of the Cabinet Secretary for Health, Wellbeing and Cities Strategy apart from those covered by the remit of the Economy, Energy and Tourism Committee.

Membership:

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The Scottish Parliament
Pàrlamaid na h-Alba

Health and Sport Committee

3rd Report, 2011 (Session 4)

Report on Inquiry into the Regulation of Care for Older People

The Committee reports to the Parliament as follows—

INTRODUCTION

1. One test of a society's morality is how it treats its older people. As Scotland's population continues to age, with a 50% increase in people aged over 60 projected by 2033,¹ ensuring that older people receive good quality and appropriate care is ever-more important.
2. Scotland's demographic change will bring with it an increase in demand for care services for older people. Life expectancy has been increasing in Scotland over recent decades, figures for 1980 give life expectancy of 69 and 75 years for men and women; for 2008 the figures stood at 75.3 and 80 years respectively.²
3. Healthy life expectancy, however, has not increased at the same rate as life expectancy. The gap between life expectancy and healthy life expectancy has, for men, actually been widening.³ Men and women can currently expect to spend around seven years and nine years, respectively, in poor health.⁴
4. The type of care required for older people is changing due to the nature of people living longer with long term and life-limiting conditions including dementia. Scotland's National Dementia Strategy indicated that there were approximately 71,000 people with dementia in Scotland, its prevalence increasing with age; around 1.5% of the 65-69 age group being affected, increasing to around one in

¹ Scottish Government. (2010) *Demographic change in Scotland: Scottish Government Social Research*. Available at: <http://www.scotland.gov.uk/Publications/2010/11/24111237/13> [Accessed 17 November 2011].

² Scottish Government. (2010) *Demographic change in Scotland: Scottish Government Social Research*.

³ Scottish Government. (2010) *Demographic change in Scotland: Scottish Government Social Research*.

⁴ Scottish Government. (2010) *Demographic change in Scotland: Scottish Government Social Research*.

three for those over 90.⁵ It is estimated that the number of people with dementia in Scotland will double over the next 25 years.⁶

5. Care services will also need to adapt to accommodate the move towards increasing provision of care in a person's home rather than in a care home setting.

6. In order to rise to the challenges posed by changes in the demand, type and setting for care, the regulatory system which underpins the care sector must be fit for purpose to ensure that it can deliver the appropriate scrutiny and improvement in care for older people.

7. The regulatory system was established ten years ago, with recent changes to its structure implemented by the Public Services Reform (Scotland) Act 2010 ("the 2010 Act") including the establishment of a new body, Social Care and Social Work Improvement Scotland ("SCSWIS").⁷

Motivations for the inquiry

8. Although SCSWIS had only become operational from 1 April 2011, the Health and Sport Committee agreed that it was timely to conduct an inquiry into the regulation of care for older people.

9. The Committee considered the options of detailed consideration of the issues or a one off evidence session. The Committee decided to hold a substantive inquiry as it wished to examine a series of recent high profile events in the care sector. This included the launch of a police investigation following the death of a resident at the Elsie Inglis Nursing Home in Edinburgh in May 2011 and the announcement in July 2011 that Southern Cross Healthcare Group would cease to operate as a care home operator, affecting more than 90 care homes in Scotland. Conducting an inquiry also provided an opportunity for the Committee to conduct some post-legislative scrutiny in this area.

Inquiry remit

10. The Committee's short and focused inquiry sought to investigate whether there were any particular weak points in the regulatory regime and whether safeguards were robust enough. Consideration of the issues focused on four key questions:

- Can we be confident that the regulatory system is picking up on care services where the quality of care is poor?
- Are there any particular weaknesses in the current system?
- Does the system adequately take into account the views of service users?

⁵ Scottish Government. (2010) *Scotland's National Dementia Strategy*. Available at: <http://www.scotland.gov.uk/Publications/2010/09/10151751/17> [Accessed 17 November 2011]

⁶ Alzheimer Scotland. Written submission.

⁷ Additional background information is provided later in the report.

- Does the registration and regulatory system provide an appropriate basis for the regulation, inspection and enforcement of integrated social and NHS care in the community?

11. Further information on the Committee's call for written views on the inquiry and its programme of oral evidence is available on the Parliament's website.⁸

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

Introduction

12. The purpose of the inquiry was to investigate whether there were any particular weak points in the regulatory regime and whether safeguards were sufficiently robust. In the wake of high profile events in the care sector such as the collapse of Southern Cross Healthcare Group and closure of the Elsie Inglis Nursing Home following the death of a resident, the Committee considered that it was timely to consider the regulatory system for social care in Scotland and conduct some post-legislative scrutiny in this area.

13. The Committee's inquiry has already prompted, the Scottish Government to take action to address weaknesses which were brought into focus by the Elsie Inglis case. In particular, the Committee welcomes the announcement from the Cabinet Secretary that care services for older people will receive at least one unannounced inspection each year. The Committee hopes that this increase in inspection frequency can be implemented before the expected statutory commencement date of 1 April 2012.

14. Following detailed consideration of a significant volume of written and oral evidence, the Committee has reached the conclusion that the current regulatory system is sufficiently rigorous to identify care services for older people which are failing to deliver high quality care. However, that does not mean that there are no weaknesses or areas for improvement evident within the current system.

15. The Committee has identified several areas where the regulator, the Care Inspectorate, must take action. These include:

- Guidance for care staff in relation to "whistleblowing"
- Enhanced engagement of healthcare professionals in the inspection process
- Improved accessibility and better dissemination of inspection reports
- Action to improve the consistency of inspection gradings
- Research into the appropriate staffing mix for care homes and other services for older people

16. The Committee has also identified several areas where the Scottish Government, must take action. These include:

⁸ Available at:

<http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/30530.aspx>
[Accessed 17 November 2011]

- Consideration of the establishment of a single point of entry for complaints about integrated services
- Discussion with the General Medical Council and the Nursing and Midwifery Council ways of ensuring healthcare professionals responsibilities in relation to having a duty of care to report all concerns, including those that apply to social care, emphasised during healthcare professionals' training
- Consideration of legislative changes to grant the Care Inspectorate powers to refuse further registration of care services from a provider who has other poorly performing services
- Consideration as to whether changes should be made to the current enforcement system available to the Care Inspectorate and the appeals process
- Consideration given to accelerating the current timetable for registration of care workers
- Addressing concerns in forthcoming primary legislation regarding the regulatory framework for the move to self-directed support
- A review of the National Care Standards to embed equality and human rights for service users
- Exploring the merit in extending the Care Inspectorate's powers in relation to commissioning and procurement

Involvement of service users

17. More needs to be done to encourage the involvement of service users in the inspection regime. In order to support the Care Inspectorate's risk based approach to inspections, the Committee believes that service user engagement should be encouraged and enhanced including the use of independent advocacy where appropriate.

Complaints procedures

18. When something goes wrong and the care of an older person falls below acceptable standards, there needs to be an effective complaints procedure in order to offer redress and bring about improvements as swiftly as possible. Ideally, complaints should be raised with and resolved by the service provider without the need for recourse to the Care Inspectorate. The Committee considers that more could be done by service providers to bring this about, but the Care Inspectorate also has a role to play by offering support and guidance on good practice.

Regulating integrated health and social care

19. As moves towards greater integration between health and social care services gather pace over the next few years, there will be an increasing need to closely integrate the regulatory regimes which have oversight of these services. The Committee was, therefore, pleased that the Care Inspectorate and Healthcare Improvement Scotland both expressed a willingness to work more closely together moving forward. The Committee considers that early action should include the

introduction of joint inspections of care pathways, including clinical care in the community and the inspection of social care for older people in NHS acute services. The Committee believes that this would be facilitated by a review of the National Care Standards. In relation to complaints, the Committee has recommended that the Scottish Government should consider the establishment of a single point of entry, with a view to greater integration in the future.

List of report conclusions and recommendations

20. A full list of the conclusions and recommendations from the report are reproduced below. However, in order to understand fully the nature of the key conclusions and recommendations it is important to consider them in the context of the full report. Paragraph references have been included in this section to allow easy cross-referencing.

Risk-based approach to inspections

21. The self-assessment system is a key component of the Regulatory Support Assessment (RSA) tool used by the Care Inspectorate. The Committee recognises the importance of ensuring that the model of proportionate and risk-based assessment is robust. The Committee therefore recommends that independent research and evaluation of the RSA tool, including the self-assessment system, should be conducted. [paragraph 88]

22. The Committee believes that corroboration of the content of self-assessments should be sought from service users. The Committee therefore recommends that the Care Inspectorate should ensure that all self-assessment information is sent to health professionals, service users, friends and relatives to invite comment. [paragraph 89]

Complaints

23. The Committee considers that comments and complaints from service users, their relatives and carers can help to drive improvements in a care service. The Committee believes that all service providers should actively encourage feedback in order to support a culture of improvement and development within their organisations. The Committee considers that this would be assisted if service providers routinely published information about their own feedback and complaints systems. In order to promote accessibility, such information should be made available in alternative formats, such as large print and audio, on request. [paragraph 96]

24. The Committee was concerned by evidence which suggested that, in some cases, residents of care homes and other service users do not feel confident about making a complaint to a service provider directly. The Committee was also concerned that the National Care Standard for Care Homes for Older People does not include any guidance on the feedback and complaints system which should be implemented by service providers. The Committee recommends that the Care Inspectorate should review in early course the guidance currently available to all care service providers and bring forward additional guidance as necessary. [paragraph 97]

25. The Committee considers that the complaints process is a positive and important element of the risk-based approach to inspections used by the Care Inspectorate, as it can alert the Care Inspectorate to potential problems with a care service to which it can then respond. It is vital, therefore, that service users, carers and staff who witness poor care, but are unable or unwilling to raise concerns with a service provider directly, are aware of the Care Inspectorate's complaints procedure. [paragraph 106]

26. The Committee acknowledges the Care Inspectorate's intention to address this issue and welcomes the commitment made by the Cabinet Secretary to support the Care Inspectorate in raising the profile of the complaints process. The Committee looks forward to receiving additional information about this new approach in due course. [paragraph 107]

27. However, the Committee also believes that improved public awareness of the complaints procedure needs to be coupled with enhanced confidence in its effectiveness. Complaints must be considered, investigated and resolved as quickly as possible for the benefit of service users and providers alike. The Committee, therefore, recommends that the Care Inspectorate should review the manner in which it handles complaints in order to reduce the time taken to reach a determination, and to introduce an appeals process. [paragraph 108]

28. In relation to whistleblowing, the Committee recommends that the Care Inspectorate publish guidance for care staff who wish to raise concerns about a care service on a confidential basis. [paragraph 109]

29. The Committee notes the comments made by the Scottish Public Services Ombudsman that improvements could be made to dealing with complaints about integrated services. The Committee recommends that the Scottish Government should consider the establishment of a single point of entry for complaints about integrated services, with a view to greater integration in the future. [paragraph 112]

Frequency and type of inspections

30. The Committee notes the changes introduced by the Public Services Reform (Scotland) Act 2010 removed the statutory minimum frequency for inspections by the Care Inspectorate. Recent events in the care sector have highlighted a potential weakness in the new approach, which had not yet been implemented, and the Committee therefore welcomes the Cabinet Secretary's announcement of an increase in the frequency of inspections for care homes and personal care and support services. The Committee is pleased that the Cabinet Secretary has recognised that the previously planned rate of inspections was not sufficiently frequent to provide reassurance that standards of service were being maintained and improved. The Committee believes that the increase in frequency will enhance the Care Inspectorate's ability to identify services that may have experienced a sudden and dramatic decline in the standards of care they provide.[paragraph 124]

31. The Committee is keen for the increase in inspection frequency to commence before the expected statutory commencement date of 1 April 2012. The Committee considers that, until the increased frequency is implemented, a potential weakness in the regulatory system remains. Care services experiencing a dramatic decline in their care provision could still go unidentified for an extended

period. The Committee therefore urges the Care Inspectorate to implement this new regime as soon as reasonably practicable. [paragraph 125]

Thematic inspections

32. The Committee notes that the system of inspections, established under the Care Commission and continued following the establishment of SCSWIS, grades services according to themes and statements linked to the National Care Standards. The Committee further notes the commitment made by the Care Inspectorate that, alongside a revised minimum frequency of inspections, it will conduct inspections against a minimum of two quality themes, increasing to four for any poorer-performing service. [paragraph 136]

33. The Committee supports the use of a risk based approach to determine the appropriate frequency and intensity of inspections for a particular care service. The Committee recognises that, following a thorough risk based assessment, it may be considered necessary for an inspection to consider more than two quality themes. [paragraph 137]

Engagement of healthcare professions

34. The Committee notes that healthcare professionals have a duty of care to report all concerns, not just those related to health care, but those that apply to social care as well. The Committee therefore welcomes the call from the Cabinet Secretary for healthcare professionals to raise any concerns they may have with the Care Inspectorate. The Committee believes that the Cabinet Secretary should discuss with the General Medical Council and the Nursing and Midwifery Council ways of ensuring that these responsibilities are emphasised during healthcare professionals' training. [paragraph 143]

35. The Committee believes that healthcare professionals who are directly involved in the provision of care for residents of care homes have a unique insight into the quality of care being delivered. The Committee was, therefore, concerned by the evidence it received which indicated that healthcare professionals are not routinely invited to contribute to the inspection process. The Committee considers that information obtained from these professionals could significantly enhance the Care Inspectorate's risk assessment process. The Committee welcomes the Care Inspectorate's development of a questionnaire for all health and social care professionals involved in care services and seeks further information from the Care Inspectorate regarding the timetable for implementation of this system. [paragraph 144]

Inspectors and grading of inspections

36. The Committee welcomes the Care Inspectorate's programme of training for its inspectors and its development of forums for feedback with providers on the grading process. The Committee encourages the Care Inspectorate to continue to engage with service providers in order to improve the consistency of inspection gradings. [paragraph 152]

Involving service users, friends and relatives

37. The Committee believes that engaging service users, carers and relatives in the inspection regime is vital. Their engagement helps to ensure that the Care Inspectorate is focusing not just on the inputs into the care service but its

outcomes for the service users. The Committee welcomes the steps taken by the Care Inspectorate to engage them in the inspection process. [paragraph 164]

38. The Committee recommends that the Care Inspectorate consider whether there are other areas of the risk assessment process where service user engagement could be encouraged and enhanced particularly the use of independent advocacy. [paragraph 165]

Lay inspectors

39. The Committee believes, on balance, that lay inspectors can add value to inspections. The Committee welcomes the Care Inspectorate's use of lay inspectors as part of the inspection process. [paragraph 171]

Publication and dissemination of inspection reports

40. The Committee believes that the Care Inspectorate needs to improve its present system for alerting service users (both existing and potential), relatives and others to the quality of a particular service through the publication of inspection reports. The Committee calls upon the Care Inspectorate to take active steps to reduce the time taken between inspection and publication of an inspection report. The Committee also believes that the Care Inspectorate should take steps to improve the accessibility of a report's content, including providing a summary of the report's recommendations at the beginning and to do more to disseminate report findings to interested parties via its website and other means. [paragraph 177]

Registration

41. The Committee supports the call from the Care Inspectorate for it to be granted powers to refuse further registration of care services from a provider which has other poorly performing services. The Committee recommends that the Scottish Government explore how the Care Inspectorate's suggested legislative changes in this area could be taken forward. [paragraph 182]

Enforcement powers

42. The Committee notes the comments made by organisations including COSLA and the City of Edinburgh Council that the current enforcement system available to the Care Inspectorate may not be responsive enough to bring about changes quickly. [paragraph 195]

43. The Committee is keen to ensure that the enforcement system does not rely too heavily on pre-emptive action being taken by local authorities having to decide to remove clients from a care home or change care at home service providers. The Committee therefore invites the Scottish Government to consider whether changes should be made to the current enforcement and appeals process. [paragraph 196]

Regulation of the workforce

44. The Committee recognises that Scotland is the only part of the UK that has decided to regulate the whole of the social care workforce. The Committee believes that the registration of the entire workforce is vital to ensure that the highest standards of care are delivered by staff. The Committee welcomes the commitment given by the Cabinet Secretary that she will discuss the timetabling of

the registration of the workforce with the Scottish Social Services Council (SSSC) and the Care Inspectorate. Whilst the Committee recognises that additional resources will be required, it recommends that the Scottish Government should consider accelerating the current timetable for registration of care workers. [paragraph 215]

Support and investment in workforce

45. The Committee considers that for many years the social care workforce has been undervalued – as reflected in wage levels, terms and conditions and limited investment in training and development. Looking to the future, the Committee believes that in order to ensure that care services are of the highest quality, the sector must be seen as an attractive occupation for people with a range of skills. Current fiscal austerity measures should not be seen as an excuse to drive down wage levels. The Committee considers that employers in the social care sector should aim to pay all staff at least the “Living Wage”. [paragraph 232]

46. The requirement in Scotland for all social care staff to complete appropriate vocational training prior to registration with the SSSC should act as a catalyst for increasing staff confidence and morale, leading to improved standards of care. The Committee encourages employers to consider the funding available from ILA Scotland as one way of supporting training for staff. [paragraph 233]

47. The Committee was concerned by evidence it received that, against a backdrop of increasing numbers of older people with complex care needs such as dementia, the proportion of qualified nursing staff employed in certain care settings had declined. The Committee, therefore, welcomes the fact that the Care Inspectorate has commissioned research into the appropriate staffing mix for care homes and other services for older people. It looks forward to receiving a copy of this research in due course. [paragraph 234]

Care at home

48. The Committee notes the comments made in evidence regarding concerns about the regulatory framework for the move to self-directed support. The Committee believes that these concerns will need to be addressed by the Scottish Government in the forthcoming self-directed support Bill. [paragraph 251]

Integration of regulation of health and social care - inspectorates

49. The Committee believes that assessment of care pathways may represent a useful tool which can enhance the existing approach to regulation of care services. The Committee welcomes the Care Inspectorate's move to closer engagement with local authorities and Healthcare Improvement Scotland (HIS) as the regulatory system increasingly needs to take account of the continuum of care experienced by older people. [paragraph 270]

Integration of regulation of health and social care - data collection

50. The Committee believes that if emergency admissions to hospitals from care homes are high, the Care Inspectorate should not be reliant solely on notifications from staff to identify this potential problem. The Committee recommends that the Care Inspectorate explores with HIS the possibility of systemically gathering and analysing the SPARRA data. The Committee also invites the Care Inspectorate to consider whether emergency admissions to hospital from a care setting should

result in a mandatory report to the Care Inspectorate in order to inform the risk assessment process. [paragraph 273]

Integration of regulation of health and social care - assessment of healthcare needs

51. The Committee was concerned by the evidence it received regarding the widespread prescription of psychoactive medications to residents of care homes. In order to address its concerns, the Committee supports the call from the Mental Welfare Commission for Scotland for greater clinical pharmacy involvement in care homes, improved training for staff and better adherence to good prescribing practice. The Committee, therefore, recommends that the Care Inspectorate should engage with the Mental Welfare Commission for Scotland and other interested parties in order to produce guidance and information to service providers on the use of psychoactive medications. This issue should be considered as part of a review of National Care Standards. [paragraph 285]

52. The Committee recommends that the Scottish Government should consider allowing care home residents to register with the chronic medication service. [paragraph 286]

Integration of regulation of health and social care - healthcare regulation in the community

53. The Committee calls upon the Care Inspectorate, HIS and other interested parties to work together in order to ensure that there is proper clinical and social care input into care home, community and acute hospital inspections. The Committee believes this may be facilitated by a review of the National Care Standards. [paragraph 292]

National Care Standards

54. It is ten years since the National Care Standards were originally drafted. In this time the delivery of care for older people has changed and there has been a move towards greater integration of health and social care. The Committee believes that these changes need to be reflected in the National Care Standards to ensure that they remain a current, relevant and credible basis for the regulation of care. The Committee also believes that there is scope for integration with other care standards, particularly the national standards for dementia care. The National Care Standards should provide a key mechanism for ensuring that equality and human rights issues are embedded in the framework for the delivery of care services for older people. [paragraph 301]

55. The Committee, therefore, recommends that the Scottish Government should conduct a review of the National Care Standards. The Committee also believes that it is vital that HIS and the Care Inspectorate work together on the revision of the Standards so that they reflect the direction of travel towards the further integration of health and social care. [paragraph 302]

Commissioning and procurement

56. The Committee believes that good commissioning and procurement practices are important determinants of quality care. The Committee therefore welcomes the approach recently adopted by the City of Edinburgh Council to use the findings of Care Inspectorate reports to directly inform the commissioning of new services.

The Committee considers that this will have a positive impact on care quality. The Committee recommends that the Care Inspectorate should encourage all local authorities to adopt a similar approach in order to improve outcomes. [paragraph 316]

57. The Committee notes the comments made by the Cabinet Secretary that there may be questions about the Care Inspectorate not having enforcement powers in relation to commissioning and procurement. The Care Inspectorate currently has “far fewer teeth” to challenge commissioning practice compared with its powers of intervention in service delivery. The Committee believes that extending the Care Inspectorate’s powers will further strengthen the regulatory system. The Committee, therefore, recommends that the Scottish Government should explore further the merit in extending the Care Inspectorate’s powers. [paragraph 317]

Monitoring financial viability

58. The Committee is keen to ensure that the sudden collapse of a care service provider like Southern Cross does not happen again. The Committee notes the comments made by the Cabinet Secretary that the Care Inspectorate may not be the appropriate body to be given responsibility for monitoring the financial viability of care services. The Committee recognises that the current focus of the Care Inspectorate is on care provision not financial scrutiny. [paragraph 337]

59. The Committee, however, believes that there is scope for the Care Inspectorate to build into its risk assessment process a greater degree of ongoing financial scrutiny. The Committee recommends that the Care Inspectorate should require registered service providers to submit copies of their annual accounts. This is information currently gathered from providers as part of the registration process and is, therefore, data the Inspectorate is already experienced in analysing. [paragraph 338]

60. The Committee welcomes the Cabinet Secretary’s announcement that she will work with the Care Inspectorate, COSLA and other interested parties to bring forward recommendations on how financial robustness in the sector can be assured. The Committee also welcomes the liaison between the Scottish Government and UK Government on the issue and recommends that both Governments maintain regular contact so that interactions between reserved and devolved responsibilities within these areas are considered fully. [paragraph 339]

61. The Committee welcomes the steps taken by the Scottish Government, COSLA and the Care Inspectorate to put in place contingency arrangements following the collapse of Southern Cross. The Committee considers that these organisations should continue this joint working in order to ensure that a plan is in place should another care provider fall into financial difficulty in future. [paragraph 343]

Resourcing the Care Inspectorate

62. The Committee considers it essential that the Care Inspectorate has sufficient resources in order to carry out its regulatory role effectively. The Committee notes that the voluntary redundancy scheme, introduced as part of the merger process which established SCSWIS, was predicated on a planned

reduction in frequency of inspections. As a consequence, the Care Inspectorate now has insufficient numbers of inspectors to allow it to fulfil the increased frequency of inspections required from 2012 onwards. The Committee welcomes the assurance given by the Care Inspectorate that it will be able to find £400,000 of efficiencies which can be reinvested to supplement the current complement of inspection staff in order to meet the increased demands required of it. [paragraph 358]

63. The Committee has recommended in this report that the Care Inspectorate should address a number of important issues through a combination of reviews, revised procedures, enhanced joint working and research. The Committee acknowledges the additional demands that this will place on the Care Inspectorate and calls upon the Scottish Government to ensure that it has the necessary support to fulfil these requirements. [paragraph 359]

64. The Committee notes that the Scottish Government is planning to carry out a review of the Care Inspectorate's fee regime. Care Inspectorate witnesses suggested that there was scope to increase fees charged to service providers for registration and annual continuation if such a policy decision was taken. The Committee invites the Scottish Government to clarify, in its response to this report, its intentions regarding fees charged by the Care Inspectorate. [paragraph 360]

STRUCTURE OF REPORT

65. The remainder of the report is structured around the following themes:

- The inspection process
- Regulation of the workforce
- Integration of regulation of health and social care
- National Care Standards
- Commissioning and procurement
- Monitoring financial viability
- Resourcing the Care Inspectorate

BACKGROUND

Regulatory system

66. The regulatory system for care services in Scotland was established by the Regulation of Care (Scotland) Act 2001 ("the 2001 Act"). The Act's main provisions included the creation of the Scottish Commission for the Regulation of Care ("Care Commission") to oversee the regulation of registered care services and a requirement for Ministers to develop care standards, against which the Commission would inspect services. One of the key aims of the 2001 Act was to

ensure care services were of a consistently good standard across the country. The Care Commission was to achieve this through four broad functions:

- Regulation
- Inspection
- Complaints
- Enforcement

67. The 2001 Act also established the Scottish Social Services Council (SSSC). Its responsibilities included registering people who work in social services and regulating their education and training. This included all social workers and social care workers.⁹

68. The Social Work Inspection Agency (“SWIA”) was a Government executive agency established in 2005 to inspect local authority social work functions and advise Ministers about these services.¹⁰

Crerar Review

69. The Care Commission was part of a much wider review of public services, following the publication in 2007 of *The Crerar Review: the report of the independent review of regulation, audit, inspection and complaints handling of public services in Scotland*.¹¹

70. Professor Lorne Crerar (“Crerar”) considered the then scrutiny system of public services to be over-complex, which resulted in increased costs. He recommended a system of regulation where the service provider was ultimately responsible for their performance, with external scrutiny being part of a much wider performance management and reporting framework, which included self-assessment. Ultimately, Crerar envisaged a single national scrutiny body for all public services. However, he proposed, as a first step, a simplification of current scrutiny bodies.¹²

71. The Scottish Government's response to the Crerar Review was taken forward in the Public Services Reform (Scotland) Act 2010 (“the 2010 Act”). It implemented some changes to the structure of the regulatory system. The Act

⁹ Scottish Parliament Information Centre (2011) Regulating Care for Older People. SPICe Briefing 11/60. Available at:

<http://www.scottish.parliament.uk/SPICeResources/Research%20briefings%20and%20fact%20sheets/SB11-60.pdf> [Accessed 17 November 2011].

¹⁰ Scottish Parliament Information Centre (2011) Public Services Reform (Scotland) Bill: Social Services SPICe Briefing 09/54. Available at:

<http://www.scottish.parliament.uk/SPICeResources/Research%20briefings%20and%20fact%20sheets/SB09-54.pdf> [Accessed 17 November 2011]

¹¹ Scottish Government (2007). *The Crerar Review: the report of the independent review of regulation, audit, inspection and complaints handling of public services in Scotland*. Available at: <http://www.scotland.gov.uk/Resource/Doc/82980/0053065.pdf> [Accessed 17 November 2011]

¹² Scottish Parliament Information Centre (2011) Regulating Care for Older People. SPICe Briefing 11/60.

amalgamated the Care Commission's functions with those of SWIA and Her Majesty's Inspectorate for Education's responsibilities for child protection, to form a new body, Social Care and Social Work Improvement Scotland ("SCSWIS"). SCSWIS was formally established on 1 April 2011 as a Non-Departmental Public Body. The four broad functions of the Care Commission remained under SCSWIS. The structure and functions of the SSSC did not change.¹³

72. The 2010 Act also established Healthcare Improvement Scotland ("HIS"). HIS took on the functions of NHS Quality Improvement Scotland (which produced advice, standards and guidance for the NHS in Scotland and could inspect against these) together with the regulatory functions of the Care Commission over the independent healthcare sector.

73. The Act also provided for a duty of cooperation between health and social care regulatory bodies.

Recent changes

74. In response to the Committee's inquiry the Cabinet Secretary for Health, Wellbeing and Cities Strategy announced changes to the regulatory system on 15 September 2011 in a statement to the Parliament. In this, she announced a revised statutory inspection regime for all care homes and personal care and support services to be inspected at least once every year rather than once every two years and a change in the day-to-day name for SCSWIS to the Care Inspectorate.¹⁴

75. Table 1 below outlines the changes in the frequency of inspections from 2001– 2011.

¹³ Scottish Parliament Information Centre (2011) Regulating Care for Older People. SPICe Briefing 11/60.

¹⁴ Scottish Parliament. Official Report, 15 September 2011, Cols 1818-1821.

Table 1 Frequency of Inspection

Inspection regime as stipulated by the Regulation of Care (Scotland) Act 2001 [as passed]	New regime following the Public Services Reform (Scotland) Act 2010	Regime proposed by the Cabinet Secretary in the Ministerial Statement
<p>The statutory minimum frequency for inspections was originally stipulated under the Regulation of Care (Scotland) Act 2001.</p> <p>Services providing 24 hour care (including care homes):</p> <ul style="list-style-type: none"> • 2 inspections per year, one of which should be unannounced <p>All other services:</p> <ul style="list-style-type: none"> • 1 inspection per year (announced or unannounced) <p>This was a statutory minimum and did not prevent the Care Commission from inspecting more frequently if necessary.</p>	<p>The Public Services Reform (Scotland) Act 2010 removed the statutory minimum frequency for inspections, although the new inspection plan does require Ministerial approval under the 2010 Act. The revised regime is risk-based and differs depending on the service. The following shows inspection frequency for the services most relevant to older people.</p> <p>Care Homes for Older People:</p> <ul style="list-style-type: none"> • If grades 4+ and assessed risk is low – 1 unannounced inspection in 24 months • If grades are <4 and/or assessed risk is high – 2 unannounced/short notice inspections in each 12 months <p>Support services - Care at home:</p> <ul style="list-style-type: none"> • If grades 4+ and assessed risk is low – 1 unannounced inspection in each 24 months • If grades are <4 and/or assessed risk is high 1 inspection in each 12 months <p>In addition to the inspections scheduled, the Care Inspectorate can undertake more frequent risk-based inspections on the basis of intelligence triggers from other regulators, local authorities, the Police, notifications from providers as well as complaints. The Care Inspectorate also undertakes random sample checks of services.</p>	<p>The Cabinet Secretary has said she will bring forward regulations to implement the new inspection regime outlined in her statement.</p> <p>All Care Homes:</p> <ul style="list-style-type: none"> • 1 unannounced inspection at least once a year <p>Personal Care and Support Services (care at home):</p> <ul style="list-style-type: none"> • 1 unannounced inspection at least once a year <p>In addition to the statutory inspection schedule for certain services, the Care Inspectorate will continue to undertake risk-based inspections and random checks.</p>

Source: Scottish Parliament Information Centre

THE INSPECTION PROCESS

Risk-based approach to inspections

76. The Committee's inquiry explored whether the Care Inspectorate's regulatory system, designed to be "risk-based, targeted and proportionate",¹⁵ was ensuring that instances of poor care quality were being identified.

77. The proportionate and risk-based approach adopted by the Care Inspectorate fits with some of the principles developed by Crerar. As part of its approach the Care Inspectorate uses a Regulatory Support Assessment ("RSA") tool. This takes into account a number of factors, including information from the provider through annual return, self-evaluation and notifications. Complaint activity, variation and change to management are also included. Finally any information which is received from other agencies, such as social work and health, are also taken into account.¹⁶

78. The Care Inspectorate uses the RSA tool to help decide how often to inspect care services, how much time to spend on each inspection and what the focus of the inspection should be.¹⁷ The tool is currently being reviewed by the Inspectorate.¹⁸

79. In evidence to the Committee, Dr Lyons of the Mental Welfare Commission ("MWC") for Scotland stated that the issue was not whether the model of proportionate and risk-based assessment was appropriate but the value and appropriateness of the information gathered as part of this approach.¹⁹

Self-assessment

80. One key element of the RSA is self-assessment. The Care Commission introduced a system of self-assessment in 2008, which has continued under the Care Inspectorate.²⁰ Under this system each service is required to grade itself against a series of quality statements under each quality theme. The service is required to provide evidence for its statements.²¹

81. Some merits of the self-assessment process were outlined to the Committee. Some witnesses pointed to the fact that primary responsibility for the quality of care rested with the service provider and the self-assessment process recognised this. Lord Sutherland considered that there were values and benefits to self-assessment—

¹⁵ SCSWIS. Written submission, 24 August 2011.

¹⁶ Care Inspectorate. Written submission, 29 September 2011.

¹⁷ SCSWIS. Written submission, 24 August 2011.

¹⁸ Care Inspectorate. Pilot of revised Risk Assessment Document. Available at:

http://www.scswis.com/index.php?option=com_content&task=view&id=7923&Itemid=729

[Accessed 17 November 2011]

¹⁹ Scottish Parliament Health and Sport Committee. *Official Report, 13 September 2011*, Col 141.

²⁰ Scottish Parliament Information Centre (2011) Regulating Care for Older People. SPICe Briefing 11/60.

²¹ Scottish Parliament Information Centre (2011) Regulating Care for Older People. SPICe Briefing 11/60.

“it is the path to self-knowledge and, as someone who was trained in philosophy, I think that self-knowledge is the beginning of wisdom.”²²

82. He explained that if the process was conducted properly the individual would understand things about their own service which would be much more deeply embedded in their response than if someone else told them.²³

83. However, some concerns were raised that the Care Inspectorate’s reliance on self-assessment was a weakness in its risk-based system.

84. Fife Elderly Forum stated that the system rewarded service providers that were good at managing paperwork, which did not always translate to an ability to deliver a high quality care service.²⁴

85. The Committee also received evidence that self-assessments were subjective, honesty-dependent and did not require collaboration. Peter Ritchie of UNISON told the Committee—

“The major concern about the approach ... is that it can become a paper-based exercise. Its big weakness is that it sometimes relies on other people’s opinion. For the front-line inspector, nothing beats feet on the ground and being in a home.”²⁵

86. HIS suggested that it might be useful to consider verification of self-assessment returns by service users/public partners or patient interest groups.²⁶

87. COSLA argued that an absence of self-assessment issues did not mean an absence of poor care and that self-assessment and investigation of complaints should “sit within the context of an effective programme of announced and unannounced inspection”.²⁷

Committee conclusion

88. The self-assessment system is a key component of the Regulatory Support Assessment (RSA) tool used by the Care Inspectorate. The Committee recognises the importance of ensuring that the model of proportionate and risk-based assessment is robust. The Committee therefore recommends that independent research and evaluation of the RSA tool, including the self-assessment system, should be conducted.

89. The Committee believes that corroboration of the content of self-assessments should be sought from service users. The Committee therefore recommends that the Care Inspectorate should ensure that all self-assessment information is sent to health professionals, service users, friends and relatives to invite comment.

²² Scottish Parliament Health and Sport Committee. *Official Report*, 6 September 2011, Col 71.

²³ Scottish Parliament Health and Sport Committee. *Official Report*, 6 September 2011, Col 71.

²⁴ Fife Elderly Forum. Written submission.

²⁵ Scottish Parliament Health and Sport Committee. *Official Report*, 13 September 2011, Col 142.

²⁶ Healthcare Improvement Scotland. Written submission, 23 August 2011.

²⁷ COSLA. Written submission.

Complaints

Approach to complaint handling

90. Another component of the RSA is complaint activity. Under the 2010 Act the Care Inspectorate is required to establish a complaints procedure for service users, their carers or others wishing to make a complaint about the provision of a care service or the Care Inspectorate. The Care Inspectorate has a national inquiries line and a national complaints team that can take anonymous complaints.²⁸ It uses anonymous complaints to obtain early warning of potential or actual problems in care services.²⁹

91. During the course of the inquiry the Committee received evidence questioning the reliance on service user and employee complaints to highlight failings within the care system. COSLA stated that absence of complaints could not deliver an assurance that quality care was being delivered.³⁰ The Committee also heard that there were barriers to individuals complaining. Henry Simmons of Alzheimer Scotland told the Committee that people were “frequently pretty terrified of complaining”³¹.

92. The Committee also received evidence that many service users still do not want to complain for fear of repercussions, or because they do not want to upset the relationship they have with carers. A focus group conducted by Alzheimer Scotland (which provided views of carers and people with dementia) felt that this was a particular problem for a person with dementia, as they may not be listened to if they were to talk about mistreatment by staff.³²

93. Participants in Alzheimer Scotland’s focus group highlighted that the Care Inspectorate’s complaints process was felt to be overly complex and stressful. Having been through the process on one occasion, a family member felt reluctant to do so a second time.³³

94. Henry Simmons of Alzheimer Scotland suggested that it was not that complaints were not dealt with; the problem lay with complaints not being made. There was a need for a change in culture in which people felt empowered to complain and recognition to be given to organisations which tried to deal effectively with complaints.³⁴

95. The Scottish Public Services Ombudsman (“SPSO”) questioned whether the level of guidance currently provided to care homes regarding the complaints process was sufficient. The SPSO highlighted that the National Care Standard in

²⁸ Scottish Parliament Health and Sport Committee. *Official Report*, 4 October 2011, Col 318.

²⁹ Scottish Parliament Information Centre (2011) *Regulating Care for Older People*. SPICe Briefing 11/60.

³⁰ COSLA. Written submission.

³¹ Scottish Parliament Health and Sport Committee. *Official Report*, 6 September 2011, Col 83.

³² Alzheimer Scotland focus group report.

³³ Alzheimer Scotland focus group report.

³⁴ Scottish Parliament Health and Sport Committee. *Official Report*, 6 September 2011, Col 83.

relation to Care Homes for Older People did not provide detailed guidance on the complaints processes that should be operated by care homes.³⁵

Committee conclusion

96. **The Committee considers that comments and complaints from service users, their relatives and carers can help to drive improvements in a care service. The Committee believes that all service providers should actively encourage feedback in order to support a culture of improvement and development within their organisations. The Committee considers that this would be assisted if service providers routinely published information about their own feedback and complaints systems. In order to promote accessibility, such information should be made available in alternative formats, such as large print and audio, on request.**

97. **The Committee was concerned by evidence which suggested that, in some cases, residents of care homes and other service users do not feel confident about making a complaint to a service provider directly. The Committee was also concerned that the National Care Standard for Care Homes for Older People does not include any guidance on the feedback and complaints system which should be implemented by service providers. The Committee recommends that the Care Inspectorate should review in early course the guidance currently available to all care service providers and bring forward additional guidance as necessary.**

Whistleblowing

98. Some witnesses felt that the system could be bolstered by greater support for “whistleblowers” as care staff often did not feel confident in being able to complain about poor care they had witnessed. Ruth Stark of the Scottish Association of Social Workers (“SASW”) told the Committee that the current complaints system did not work as it did not hear complaints in a positive way or protect the individuals who complain.³⁶ The Royal College of Nursing (“RCN”) called for the Care Inspectorate to provide explicit advice about whistleblowing to staff within services it regulates and a “clear confidential avenue for staff to raise concerns”.³⁷

Investigation of complaints

99. BUPA was critical of the time taken by the Care Inspectorate to investigate complaints—

“Within the complaints area: a complaint may be made, but is either not investigated or the outcome is not feedback for a number of months. As an example a complaint made in October 2010 did not lead to any feedback to us until April 2011. The feedback led to the home being regarded as weak, based on an issue which took place in June 2010, some nine months earlier.

We have also found that it takes too long to have inspection grades published for public viewing. It can take six months between visit and

³⁵ Scottish Public Service Ombudsman. Written submission.

³⁶ Scottish Parliament Health and Sport Committee. *Official Report*, 13 September 2011, Col 157-158.

³⁷ Royal College of Nursing. Written submission.

publication on the web site. Thus the information available to stakeholders is often misleading.”³⁸

Right of appeal

100. The City of Edinburgh Council, in its written submission, raised concern that there was no right of appeal for service providers regarding complaints—

“These are published, irrespective of their validity. The fairness and objectivity of the complaints process is regularly questioned by providers. Complaints may remain on the regulator’s website for years, even though these may have been addressed immediately.”³⁹

101. The call for an appeals mechanism was supported by the findings from a Scottish Care survey of its members. Comments from Scottish Care members included—

“The lack of opportunity to appeal to the regulator is extremely frustrating and leads to a strong feeling that it is often a very one sided process.”

“Disgruntled staff ha[ve] an open door to fictitious complaints.”⁴⁰

Care Inspectorate response

102. In oral evidence to the Committee Jacquie Roberts Chief Executive of the Care Inspectorate, told the Committee that—

“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.”⁴¹

103. The Care Inspectorate placed emphasis on not only care service staff but other visiting professions having a responsibility to report poor practice to its national complaints team.⁴²

104. Jacquie Roberts also explained that the Care Inspectorate was aware of the issue of older people and their relatives fearing repercussions if they complained. She highlighted that the new everyday name for the organisation provided an opportunity to raise the profile of what people had a right to expect from a care service and how to make complaints.⁴³

Scottish Government

105. In evidence to the Committee the Cabinet Secretary stated that she had agreed with the Chair of the Care Inspectorate to support it in raising the profile of the complaints process. She stated that “the complaints process and its good

³⁸ BUPA. Written submission.

³⁹ City of Edinburgh Council. Written submission.

⁴⁰ Scottish Care. Written Submission.

⁴¹ Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011, Col 317.*

⁴² Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011, Col 317.*

⁴³ Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011, Col 318-319.*

operation are fundamental to the good operation of the risk-based system that we have in place".⁴⁴

Committee conclusion

106. **The Committee considers that the complaints process is a positive and important element of the risk-based approach to inspections used by the Care Inspectorate, as it can alert the Care Inspectorate to potential problems with a care service to which it can then respond. It is vital, therefore, that service users, carers and staff who witness poor care, but are unable or unwilling to raise concerns with a service provider directly, are aware of the Care Inspectorate's complaints procedure.**

107. **The Committee acknowledges the Care Inspectorate's intention to address this issue and welcomes the commitment made by the Cabinet Secretary to support the Care Inspectorate in raising the profile of the complaints process. The Committee looks forward to receiving additional information about this new approach in due course.**

108. **However, the Committee also believes that improved public awareness of the complaints procedure needs to be coupled with enhanced confidence in its effectiveness. Complaints must be considered, investigated and resolved as quickly as possible for the benefit of service users and providers alike. The Committee, therefore, recommends that the Care Inspectorate should review the manner in which it handles complaints in order to reduce the time taken to reach a determination, and to introduce an appeals process.**

109. **In relation to whistleblowing, the Committee recommends that the Care Inspectorate publish guidance for care staff who wish to raise concerns about a care service on a confidential basis.**

Complaint handling across health and social care

110. The SPSO considered that there was a need to amend statutory schemes guiding social care, social work and NHS complaints. The SPSO suggested this could include provisions for a single procedure to be used, rather than a member of the public having to make three separate complaints—

“the system for complaining about care for older people would benefit from standardisation, simplification and better arrangements for dealing with complaints about integrated services.”⁴⁵

111. HIS felt that there had been significant improvements in complaints and feedback through national initiatives like the Better Together Programme and those planned in relation to the Patient Rights (Scotland) Act 2011. This Act requires that Health Boards encourage patients to provide feedback, comments,

⁴⁴ Scottish Parliament Health and Sport Committee. *Official Report*, 4 October 2011, Col 347.

⁴⁵ Scottish Public Service Ombudsman. Written submission.

and raise concerns or complaints on health care.⁴⁶ HIS, however, felt there was more to be done—

“One possibility could be to consider the introduction of a national portal for logging concerns/complaints about health and social care services.”⁴⁷

Committee conclusion

112. The Committee notes the comments made by the Scottish Public Services Ombudsman that improvements could be made to dealing with complaints about integrated services. The Committee recommends that the Scottish Government should consider the establishment of a single point of entry for complaints about integrated services, with a view to greater integration in the future.

Frequency and type of inspections

113. The Committee's consideration of the Care Inspectorate's RSA tool highlighted that there were some potential limitations in the system's ability to provide an early warning of poorly performing care services. This, therefore, raised the issue of how much reliance should be placed on the risk-assessment approach as a way of determining the frequency and level of inspection of a service.

114. Under the terms of the 2010 Act the statutory minimum frequency for inspections by the Care Inspectorate was removed and the frequency of planned inspections was changed as a consequence (as detailed in Table 1). The aim of this was to allow the Care Inspectorate the flexibility to concentrate on those services requiring most input, using a risk assessment system.⁴⁸

115. The Committee received several written submissions which criticised the proposed reduction in the frequency of inspections. When the Committee began its inquiry in June 2011 all care homes were scheduled to have a minimum of one unannounced inspection every two years. If a service's assessed risk was high or its quality grade was low this increased to two unannounced or short notice inspections every year.⁴⁹

116. The Committee received evidence which stated that a two year gap between inspections was far too long, even for well performing services. Fife Elderly Forum stated—

“It is alarming to note that there will be an extended period between inspections for those deemed to be at “lower risk”. The performance of a service can be affected by numerous factors and a service which has been achieving good quality grades may not continue to do so.”⁵⁰

⁴⁶ Patient Rights (Scotland) Act 2011 (asp 5) Available at: <http://www.legislation.gov.uk/asp/2011/5/contents/enacted> [Accessed 17 November 2011]

⁴⁷ Healthcare Improvement Scotland. Written submission, 23 August 2011.

⁴⁸ Scottish Parliament Information Centre (2011) Regulating Care for Older People. SPICe Briefing 11/60.

⁴⁹ Scottish Parliament Information Centre (2011) Regulating Care for Older People. SPICe Briefing 11/60.

⁵⁰ Fife Elderly Forum. Written submission.

117. UNISON and the City of Edinburgh Council shared the view that a service providing good quality care could decline rapidly, particularly where there had been a change or absence of an external or unit manager.⁵¹

118. David Manion from Age Scotland pointed to the example of Elsie Inglis Nursing Home, which had seen a very dramatic drop in the standard of care over a short period.⁵² Age Scotland's written submission highlighted that the nursing home had received a good rating from the Care Inspectorate in October 2010 and, had complaints not been received about the home, it might not have been inspected again until October 2012.⁵³

119. The Committee also received several submissions calling for all inspections to be unannounced. Glasgow City Council stated that in the past there had been too many announced inspections which gave care homes "time to tidy up and present a front".⁵⁴ Age Scotland argued—

"All inspections should now be unannounced to ensure a more accurate assessment of the home. Only with unannounced inspections can the regulator ensure they are getting an accurate report of the quality of care and the standard of day-to-day care being delivered to service users."⁵⁵

Scottish Government announcement on frequency of inspections

120. On 15 September 2011, the Cabinet Secretary for Health, Wellbeing and Cities Strategy announced statutory changes to the frequency of inspections. All care homes and personal care and support services would now be subject to unannounced inspections at least once every year, rather than once every two years. There would also continue to be additional risk-based inspections.⁵⁶

121. The Cabinet Secretary's announcement identified the need to increase the number of inspections due to—

"the risk that services that have previously been regarded as being of good quality might deteriorate quickly and dramatically in quality between inspections."⁵⁷

Care Inspectorate response

122. Jacquie Roberts of the Care Inspectorate told the Committee that in response to the change, it wanted to adjust to base its activity on knowledge, information and risk—

"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

⁵¹ UNISON. Written submission. City of Edinburgh Council. Written submission.

⁵² Scottish Parliament Health and Sport Committee. *Official Report*, 6 September 2011, Col 82.

⁵³ Age Scotland. Written submission.

⁵⁴ Glasgow City Council. Written submission.

⁵⁵ Age Scotland. Written submission.

⁵⁶ Scottish Parliament Health and Sport Committee. *Official Report*, 15 September 2011, Col 1818-1821

⁵⁷ Scottish Parliament Health and Sport Committee. *Official Report*, 15 September 2011, Col 1819.

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.”⁵⁸

123. The expected statutory commencement date for the changes to the inspection regime is 1 April 2012. In evidence to the Committee the Cabinet Secretary expressed her hope that the increased frequency of inspections may begin before next April and stated that she would be happy to keep the Committee informed of progress.⁵⁹

Committee conclusion

124. The Committee notes the changes introduced by the 2010 Act removed the statutory minimum frequency for inspections by the Care Inspectorate. Recent events in the care sector have highlighted a potential weakness in the new approach, which had not yet been implemented, and the Committee therefore welcomes the Cabinet Secretary's announcement of an increase in the frequency of inspections for care homes and personal care and support services. The Committee is pleased that the Cabinet Secretary has recognised that the previously planned rate of inspections was not sufficiently frequent to provide reassurance that standards of service were being maintained and improved. The Committee believes that the increase in frequency will enhance the Care Inspectorate's ability to identify services that may have experienced a sudden and dramatic decline in the standards of care they provide.

125. The Committee is keen for the increase in inspection frequency to commence before the expected statutory commencement date of 1 April 2012. The Committee considers that, until the increased frequency is implemented, a potential weakness in the regulatory system remains. Care services experiencing a dramatic decline in their care provision could still go unidentified for an extended period. The Committee therefore urges the Care Inspectorate to implement this new regime as soon as reasonably practicable.

Thematic inspections

126. The Committee explored the grading themes used in the inspection process. There are four grade themes:

- Quality of care and support
- Quality of environment
- Quality of staffing
- Quality of management and leadership

⁵⁸ Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011*, Col 340.

⁵⁹ Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011*, Col 361-362.

127. Within each theme are a number of statements, which are related to the National Care Standards. Inspectors assess performance against a selection of these quality statements within a selection of the quality themes.⁶⁰

128. The level of risk of the service and previous gradings determine how many quality themes and statements will be reviewed during the inspection of a particular service.⁶¹ Not every inspection covers all four grading themes. Services with high risk assessment or poor grades can expect to receive more inspections and be inspected according to all themes and at least two statements from each theme.⁶²

129. The Committee received evidence of concerns about the Care Inspectorate's use of grade themes and statements in its approach to inspections. West Lothian Community Health and Care Partnership ("CHCP") felt that, as a themed inspection visit only focused on particular areas, there was potential to miss areas of poor performance and possible concern if they were not an inclusive part of the theme under scrutiny.⁶³

130. Monica Boyle of City of Edinburgh Council raised concerns that inspecting against specific themes and statements could result in inconsistencies in the assessment of care services—

"There are questions about the way in which SCSWIS inspects services. It might inspect only particular statements in one theme—for example, there may be six statements in one theme, but it inspects only two of them in any inspection. Therefore, we might find that, because it has inspected two particular statements, it gives a grading of 4 on one inspection and then, as it looks at other statements or themes in the next inspection, there is a variation in the grading."⁶⁴

131. Age Scotland was highly critical of the approach to inspections—

"The current fragmented approach to inspections can lead to care homes of questionable quality being under-assessed and potentially over-rated."⁶⁵

132. Age Scotland called for the practice to end immediately and for each of the four quality themes to be robustly assessed as part of a coherent "whole-care service" review whenever an inspection was conducted.⁶⁶

133. Peter Ritchie of UNISON argued, however, that the inspection process against themes and statements had a degree of flexibility—

⁶⁰ Scottish Parliament Information Centre (2011) Regulating Care for Older People. SPICe Briefing 11/60.

⁶¹ Scottish Parliament Information Centre (2011) Regulating Care for Older People. SPICe Briefing 11/60.

⁶² Scottish Parliament Information Centre (2011) Regulating Care for Older People. SPICe Briefing 11/60.

⁶³ West Lothian CHCP. Written submission.

⁶⁴ Scottish Parliament Health and Sport Committee. *Official Report*, 27 September 2011, Col 186

⁶⁵ Age Scotland. Written submission.

⁶⁶ Age Scotland. Written submission.

“It is not mandatory to look at any particular area, but inspectors take a sample of care plans and if a need is picked up that is not being met they are obliged to go in and explore that further. What starts out as one quality theme or statement can quickly expand into much wider areas. We trust that someone would pick up such issues and carry them through properly.”⁶⁷

134. Jacquie Roberts of the Care Inspectorate told the Committee—

“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.”⁶⁸

135. In oral evidence, Jacquie Roberts also explained to the Committee that, allied to the frequency of inspection, the Care Inspectorate varied the intensity of inspections, spending more time inspecting certain services.⁶⁹

Committee conclusion

136. The Committee notes that the system of inspections, established under the Care Commission and continued following the establishment of SCSWIS, grades services according to themes and statements linked to the National Care Standards. The Committee further notes the commitment made by the Care Inspectorate that, alongside a revised minimum frequency of inspections, it will conduct inspections against a minimum of two quality themes, increasing to four for any poorer-performing service.

137. The Committee supports the use of a risk based approach to determine the appropriate frequency and intensity of inspections for a particular care service. The Committee recognises that, following a thorough risk based assessment, it may be considered necessary for an inspection to consider more than two quality themes.

Engagement of healthcare professions

138. The Committee heard concerns that there was a lack of engagement of general practitioners, pharmacists, physiotherapists and other allied health professionals in the Care Inspectorate’s inspection process, even though they were directly involved in the provision of care for people in care homes. Martin Green of Community Pharmacy Scotland was particularly critical of the Care Inspectorate’s approach—

“The regulator does not engage with us at all. We are not asked to comment on the services that we are involved with in the care home and we receive no direct feedback on the input that we have into any given care home. If we hear anything, we hear it at second hand, through the care service, and there

⁶⁷ Scottish Parliament Health and Sport Committee. *Official Report, 13 September 2011*, Col 148-149.

⁶⁸ Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011*, Col 342

⁶⁹ Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011*, Col 338

can be a dramatic change between what is said at the time and what is reported back through a third party.”⁷⁰

139. Dr Gillies of the Royal College of General Practitioners (“RCGP”) painted a similar picture in relation to engagement between GPs and the Care Inspectorate. Reflecting on his own personal experience, he told the Committee—

“As far as I know, I do not think that the Care Commission has ever asked me for an opinion on either of the two homes in my area that our practice serves. Because we have close relationships with the homes, we hear the outcomes of the commission’s visits and inspections—we hear that from the homes, not the commission.”⁷¹

140. In a supplementary written submission, the Care Inspectorate responded to earlier evidence regarding the engagement of healthcare professionals in commenting on services—

“Pharmacists and doctors have played a crucial role in alerting the regulator to concerns about the standard of health care, and in particular medicines management, in care homes. These have tended to come from pharmacists or doctors working in the NHS managed service with a role in care homes, or from pharmacists attached to GP practices.....

We believe our methodology engages the views of such professionals and we are developing a questionnaire for such use. We are also discussing engagement with various interested parties.”⁷²

141. When asked if the Care Inspectorate routinely asked health professionals about issues prior to an inspection, Jacquie Roberts responded—

“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.”⁷³

142. The Cabinet Secretary told the Committee—

“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

⁷⁰ Scottish Parliament Health and Sport Committee .*Official Report*, 13 September 2011, Col 143.

⁷¹ Scottish Parliament Health and Sport Committee .*Official Report*, 13 September 2011, Col 144.

⁷² Care Inspectorate. Written submission, 24 August 2011.

⁷³ Scottish Parliament Health and Sport Committee .*Official Report*, 4 October 2011, Col 321.

care inspectorate has that awareness and knowledge, which feeds directly into the risk assessment.”⁷⁴

Committee conclusion

143. The Committee notes that healthcare professionals have a duty of care to report all concerns, not just those related to health care, but those that apply to social care as well. The Committee therefore welcomes the call from the Cabinet Secretary for healthcare professionals to raise any concerns they may have with the Care Inspectorate. The Committee believes that the Cabinet Secretary should discuss with the General Medical Council and the Nursing and Midwifery Council ways of ensuring that these responsibilities are emphasised during healthcare professionals’ training.

144. The Committee believes that healthcare professionals who are directly involved in the provision of care for residents of care homes have a unique insight into the quality of care being delivered. The Committee was, therefore, concerned by the evidence it received which indicated that healthcare professionals are not routinely invited to contribute to the inspection process. The Committee considers that information obtained from these professionals could significantly enhance the Care Inspectorate’s risk assessment process. The Committee welcomes the Care Inspectorate’s development of a questionnaire for all health and social care professionals involved in care services and seeks further information from the Care Inspectorate regarding the timetable for implementation of this system.

Inspectors and inspection gradings

145. Each care service that is inspected is graded. Grades are awarded according to a six point scale, where one is unsatisfactory, three is adequate and six is excellent. Services receiving a one or two grade for any theme are required to make improvements (either through recommendations or requirements) with enforcement procedures being used if they do not comply.⁷⁵

146. Some concerns were raised regarding the consistency of the grades awarded by inspectors. Randal Mair of Scottish Care suggested that there were inconsistencies in the grading process.⁷⁶ Providers who believed they were delivering the same standard of service in homes in different parts of the country reported that they had received different grades.⁷⁷

147. BUPA claimed that inspectors got a reputation and services knew which inspectors would issue notices and which ones would not.⁷⁸

⁷⁴ Scottish Parliament Health and Sport Committee .*Official Report*, 4 October 2011, Col 349.

⁷⁵ Scottish Parliament Information Centre (2011) Regulating Care for Older People. SPICe Briefing 11/60.

⁷⁶ Scottish Parliament Health and Sport Committee .*Official Report*, 13 September 2011, Col 139.

⁷⁷ Scottish Parliament Health and Sport Committee .*Official Report*, 13 September 2011, Col 139-140.

⁷⁸ BUPA. Written submission.

148. Monica Boyle of City of Edinburgh Council also felt that there could be improvements in the grading system. She pointed to examples of services which had received a grade 5 but which were given recommendations and requirements from the Inspectorate, whilst other services graded lower at 4 had no recommendations or requirements imposed.⁷⁹

149. In relation to the consistency of grading, the Care Inspectorate explained that they had an internal quality assurance process to look at consistency of grading and were developing forums for feedback and debate with providers.⁸⁰

150. Some witnesses suggested that one solution would be to require all inspectors to have a practice background relevant to the type of service being inspected. Randal Mair of Scottish Care felt that it would enable the inspectors to better engage with the issues as they knew and understood them.⁸¹ He felt that if inspectors with limited practice experience and trained only in regulation were used there would be a danger it would become “a tick-box exercise rather than an interactive process of engaging with the people on the front line”.⁸²

151. The Care Inspectorate also told the committee that all inspectors were required to complete the Regulation of Care Award. The award is an academic programme involving theory and practice assessments which lead to a Graduate Certificate (equivalent level to an ordinary degree).⁸³ All current staff were expected to complete the award in the next year to 18 months. In addition, inspecting staff were allocated an average of almost nine days of training a year and specialist staff attend specific training courses and programmes.⁸⁴

Committee conclusion

152. The Committee welcomes the Care Inspectorate's programme of training for its inspectors and its development of forums for feedback with providers on the grading process. The Committee encourages the Care Inspectorate to continue to engage with service providers in order to improve the consistency of inspection gradings.

Involving service users, friends and relatives

153. As part of the self-assessment and inspection process, service providers are judged on the extent to which they involve service users and their carers in the provision of care. In addition, inspectors are supposed to discuss with service users what they think of the service being provided to them.

154. The 2010 Act introduced a duty of user focus to ensure that services users are appropriately involved in the work of the Care Inspectorate and other scrutiny bodies.

⁷⁹ Scottish Parliament Health and Sport Committee .Official Report, 27 September 2011, Col 185-186.

⁸⁰ Care Inspectorate. Written submission 29 September 2011.

⁸¹ Scottish Parliament Health and Sport Committee. *Official Report*, 13 September 2011, Col 129.

⁸² Scottish Parliament Health and Sport Committee. *Official Report*, 13 September 2011, Col 129.

⁸³ Care Inspectorate. Written submission 29 September 2011.

⁸⁴ Scottish Parliament Health and Sport Committee .*Official Report*, 4 October 2011, Col 331.

155. Several written submissions commented favourably about the efforts of the Care Inspectorate to engage with service users and seek their views—

- The MWC: “We know that SCSWIS makes determined efforts to obtain the views of users and carers.”⁸⁵
- BUPA: “We believe that during an inspection the regulator is very good at capturing the views of the residents.”⁸⁶

156. Others pointed to the fact that the importance of service user involvement and consultation is built into the inspection system, as services that can evidence user involvement may receive higher grades.

157. However, some concerns were raised that there was a need for more direct engagement with service users carers and their families. David Manion of Age Scotland told the Committee—

“We do not give enough space and time to relatives in the process. They are often the people who are closest to a service user, who for a variety of reasons may be unable to advocate adequately for themselves.”⁸⁷

158. Ruth Stark of SASW expressed the view that “the skills of the inspector are important in listening to how relatives or direct service users convey their concerns”.⁸⁸

159. A frequently expressed concern was the difficulties associated with engaging with people who have dementia or communication problems. While it was recognised that this is much more challenging, Lord Sutherland expressed the view that these users are the most vulnerable and therefore extra effort should be made to garner their views.⁸⁹

160. In line with this, several respondents to the call for written views wished to see more innovative practice for gathering user views. It was felt that questionnaires were not always the best approach as they can be lengthy and difficult to understand. Alternatives mentioned included:

- Greater use and availability of advocacy
- Focus groups
- Inspectors spending more time with service users
- The use of specific tools, which are designed to help people with dementia or communication difficulties communicate their views and needs

⁸⁵ Mental Welfare Commission. Written submission.

⁸⁶ BUPA. Written submission.

⁸⁷ Scottish Parliament Health and Sport Committee. *Official Report*, 6 September 2011, Col 81.

⁸⁸ Scottish Parliament Health and Sport Committee. *Official Report*, 13 September 2011, Col 143.

⁸⁹ Scottish Parliament Health and Sport Committee. *Official Report*, 6 September 2011, Col 73-74.

161. The Scottish Independent Advocacy Alliance stated in its written submission that independent advocacy can help to tackle the barriers older people face in making their views known. Independent advocates can support service users during inspections and empower individuals to raise issues.⁹⁰

Care Inspectorate response

162. Jacquie Roberts of the Care Inspectorate told the Committee that when grading a service, inspectors considered whether there was a good engagement and involvement system for service users and carers—

“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.”⁹¹

163. She explained that there had been discussions about how the Care Inspectorate could build in even more user focus into inspections.⁹²

Committee conclusion

164. The Committee believes that engaging service users, carers and relatives in the inspection regime is vital. Their engagement helps to ensure that the Care Inspectorate is focusing not just on the inputs into the care service but its outcomes for the service users. The Committee welcomes the steps taken by the Care Inspectorate to engage them in the inspection process.

165. The Committee recommends that the Care Inspectorate consider whether there are other areas of the risk assessment process where service user engagement could be encouraged and enhanced particularly the use of independent advocacy.

Lay inspectors

166. Scottish Care’s survey of its members highlighted a near even split between those members who believed participation of lay inspectors enhanced care and those who did not. The majority of members who had experienced a lay assessor at inspection did not comment positively on their role. Comments made by members included—

“My experience is that they often do not have the skills or understanding regarding the service.”

“This is not for amateurs”

“Lay assessors are beneficial in the inspection process but they do not enhance the care provided in any way”⁹³

⁹⁰ Scottish Independent Advocacy Alliance. Written submission.

⁹¹ Scottish Parliament Health and Sport Committee. *Official Report*, 4 October 2011, Col 341.

⁹² Scottish Parliament Health and Sport Committee. *Official Report*, 4 October 2011, Col 341.

⁹³ Scottish Care. Written submission.

167. In contrast Dr Lyons of the MWC emphasised the merits of lay inspectors. He felt they were able to pick up on things that professionals missed. He told the Committee that it could be an eye-opener to visit a service with a lay person, service user or carer as it was possible to get inured to things that were bad practice.⁹⁴

168. The Committee also received evidence from its sessions with carers arranged by Carers Scotland about the value of using lay inspectors.

169. Anne Conlin of Carers Scotland highlighted that they had worked in partnership with the former SWIA to employ, recruit and train carer inspectors for social care inspections across the 32 local authorities. She told the Committee that this had resulted in recommendations tailored to carers. Carers Scotland was currently in dialogue with the Care Inspectorate to ensure this model of good practice continued.⁹⁵

170. In oral evidence, Jacquie Roberts highlighted the Care Inspectorate's continuing use of lay inspectors with there being over 200 lay inspections since the start of April 2011.⁹⁶

Committee conclusion

171. The Committee believes on balance that lay inspectors can add value to inspections. The Committee welcomes the Care Inspectorate's use of lay inspectors as part of the inspection process.

Publication and dissemination of inspection reports

172. A number of issues relating to the publication and dissemination of inspection report findings were raised with the Committee.

173. Monica Boyle of the City of Edinburgh Council told the Committee that they were "sometimes concerned about the speed at which an inspection report comes out following an inspection".⁹⁷ BUPA and COSLA both shared the concern that there could be long delays between inspections providing verbal feedback and the publication of reports.⁹⁸

174. The City of Edinburgh Council criticised inspection reports for being "cumbersome and therefore making inefficient reading".⁹⁹ It called for changes to the content of reports, stating that "the first 7 pages are general and should not need to appear in every report". It also recommended that there should be a list of requirements at the end of the report for ease of reference, together with timescales for their implementation. COSLA felt that information contained in reports could be presented to make it more accessible to the public.¹⁰⁰

⁹⁴ Scottish Parliament Health and Sport Committee. *Official Report, 13 September 2011*, Col 158.

⁹⁵ Scottish Parliament Health and Sport Committee. *Official Report, 6 September 2011*, Col 84.

⁹⁶ Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011*, Col 341.

⁹⁷ Scottish Parliament Health and Sport Committee. *Official Report, 27 September 2011*, Col 190.

⁹⁸ BUPA. Written submission. COSLA. Written submission.

⁹⁹ City of Edinburgh Council. Written submission.

¹⁰⁰ COSLA. Written submission.

175. North Lanarkshire Older Adults Partnership Board highlighted the importance of inspection reports as the basis from which people made decisions on their future care provision.¹⁰¹

176. The Committee's informal meeting with service users arranged by Age Scotland highlighted that there was a general lack of awareness of the Care Inspectorate and its reports.

Committee conclusion

177. The Committee believes that the Care Inspectorate needs to improve its present system for alerting service users (both existing and potential), relatives and others to the quality of a particular service through the publication of inspection reports. The Committee calls upon the Care Inspectorate to take active steps to reduce the time taken between inspection and publication of an inspection report. The Committee also believes that the Care Inspectorate should take steps to improve the accessibility of a report's content, including providing a summary of the report's recommendations at the beginning and to do more to disseminate report findings to interested parties via its website and other means.

Registration of care services

178. All care services are required to be registered with the Care Inspectorate in order to be able to operate. As part of the application process the Care Inspectorate can check a number of factors, including that the applicant is a fit and proper person and that the premises in which the proposed care service will be provided are fit for purpose. Fees are payable on application, and if successful, the provider pays an annual license continuation fee.¹⁰²

179. The Care Inspectorate was asked in oral evidence whether it would be possible to block an applicant's registration if they had other poor performing homes. Jacquie Roberts of the Care Inspectorate told the Committee—

“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.”¹⁰³

180. In supplementary written evidence the Care Inspectorate stated that existing legislation did not explicitly provide that poorly performing providers of care services may be refused further registrations. The Care Inspectorate explained what this meant in practice—

“If the Care Inspectorate was not satisfied, based on the applicant provider's performance while providing another registered care service that the requirements of regulations would be complied with, that **may** be a basis for refusal of registration. It is anticipated, however, based on the experience of the Care Commission, that lengthy argument and frequent appeal against

¹⁰¹ North Lanarkshire Older Adults Partnership Board. Written submission.

¹⁰² Scottish Parliament Information Centre (2011) Regulating Care for Older People. SPICe Briefing 11/60.

¹⁰³ Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011*, Col 327.

refusal of registration could result, based on the assertion that whatever the deficiencies in the existing registered care service, the question for the Care Inspectorate is whether adequate measures are in place in relation to the proposed new registration, to ensure that they would not be repeated.”¹⁰⁴

181. The Care Inspectorate made two proposals to overcome this problem—

“Specific provision could be made in legislation to the effect that in considering whether a proposed care service will comply with the regulations / other relevant enactments, the Care Inspectorate shall have regard to the extent to which other care services provided by the applicant (or, in the case of a company, an associated company) are compliant with obligations placed on them by regulations / other enactments in the jurisdiction in which they operate, as demonstrated by the grades (or equivalent) they have achieved and by any enforcement action taken against them by the Care Inspectorate or other regulators of care quality. This is entirely consistent with the Care Inspectorate’s intelligence-led approach to regulation.”

The Care Inspectorate also proposes that to ensure that new companies cannot be incorporated with the purpose of defeating such a provision, that “associated company” should be broadly defined to include wholly-owned subsidiaries, “parent” companies, companies which have the same “parent” company, and companies which have one or more directors in common.”¹⁰⁵

Committee conclusion

182. The Committee supports the call from the Care Inspectorate for it to be granted powers to refuse further registration of care services from a provider which has other poorly performing services. The Committee recommends that the Scottish Government explore how the Care Inspectorate’s suggested legislative changes in this area could be taken forward.

Enforcement powers

Background

183. The Care Inspectorate has powers to enforce requirements when a care service does not meet the national standards expected of it. It has a graduated approach to enforcement, where the first step is usually to enter into discussions with the service provider. However, that does not mean that legal sanctions will not be taken if it is deemed necessary for the good of service users.¹⁰⁶

184. Where necessary, the Care Inspectorate will make recommendations or requirements for improvement. In areas where there is serious cause for concern, the Care Inspectorate has the power to place improvement notices with the provider, including time limits for compliance. Ultimately, the Care Inspectorate has the power to cancel the registration of a service if the improvement notices are

¹⁰⁴ Care Inspectorate. Written submission, 21 October, 2011.

¹⁰⁵ Care Inspectorate. Written submission, 21 October, 2011.

¹⁰⁶ Scottish Parliament Information Centre (2011) Regulating Care for Older People. SPICe Briefing 11/60.

not adhered to. Cancellation of the registration means that the provider can no longer provide that service and is effectively prevented from operating.¹⁰⁷

185. Local authorities often procure care services as well as providing services themselves. Therefore, they often consider that they have a responsibility to ensure that those services they are funding are providing a safe and quality level of service. They have a number of powers available to take action against a provider if concerns are raised about its standards of care. Local authorities, through contracts with service providers, can, ultimately, withdraw funding from the service if they are not providing good quality care under the terms of the contract. However, they also have duties and powers to protect adults at risk, through the Adult Support and Protection (Scotland) Act 2007.¹⁰⁸

Speed of enforcement

186. Age Scotland raised concerns that the Care Inspectorate's improvement notices did not bring about changes quickly enough as it often provided "a generous window of opportunity for corrective action to be taken".¹⁰⁹ Dumfries and Galloway Partnership felt that the move to enforcement could be "slow and cumbersome".¹¹⁰

187. The City of Edinburgh Council also suggested that the Care Inspectorate's graduated approach to enforcement could result in local authorities having to take pre-emptive action. Monica Boyle of the City of Edinburgh Council told the Committee—

"Often SCSWIS falls short of recommending that we do not admit people to those care homes [graded 1 or 2]. Therefore, the local authority often has to decide not to put new clients into a home that has been graded 1 or 2."¹¹¹

188. COSLA suggested that improvements to the system were required—

"A more robust approach to follow up on improvement and enforcement notices and their associated timescales would be welcomed. For example, the National Care Home Contract allows for the withdrawal of a quality award if a care home achieves a low grading (1 or 2 on the SCSWIS QAF system in the theme of quality if care and support). This contractual mechanism is designed to act as an improvement incentive and the role of SCSWIS is vital in being able to validate that improvement timeously."¹¹²

¹⁰⁷ Scottish Parliament Information Centre (2011) Regulating Care for Older People. SPICe Briefing 11/60.

¹⁰⁸ Scottish Parliament Information Centre (2011) Regulating Care for Older People. SPICe Briefing 11/60.

¹⁰⁹ Age Scotland. Written submission.

¹¹⁰ Dumfries and Galloway Partnership. Written submission.

¹¹¹ Scottish Parliament Health and Sport Committee. *Official Report, 27 September 2011*, Col 190.

¹¹² COSLA. Written submission.

189. Councillor Yates of COSLA, however, suggested that it was better to put in an improvement plan to try to bring a care home to an acceptable standard than to displace elderly people by closing the home.¹¹³

190. Monica Boyle also felt that changes were needed as the current legal framework was not responsive enough—

“If SCSWIS has concerns about an organisation and has to go to court to get agreement on the closure of a service, that can take a long time. We recommend that the Committee consider the time that it takes under the legislation to make decisions through the courts about poorly performing homes.”¹¹⁴

191. The Care Inspectorate, in written evidence, also supported the call for changes to the enforcement process. The Care Inspectorate highlighted that, under the 2010 Act, the new conditions of registration and decisions to cancel registration could be appealed to the sheriff, or in the case of an emergency cancellation to the sheriff principal. The Care Inspectorate raised concerns that the 2010 Act did not specify on what grounds an appeal may be made to the sheriff against a decision of the Care Inspectorate, nor what criteria the sheriff should apply in considering such an appeal.¹¹⁵ The Care Inspectorate also told the Committee—

“These appeals can be lengthy and, apart from appeals against orders made under s65 of the Act and emergency conditions, the decision to cancel registrations suspended until such an appeal is determined.”¹¹⁶

192. The Care Inspectorate recommended that the 2010 Act be amended—

“To make clear on what grounds the decisions of SCSWIS in relation to enforcement actions may be appealed, and that there be clarity as to the test or tests to be applied by the court in determining such appeals as well as tighter time limits because of the potential risks to people using care services. This would avoid any potential delays in acting quickly and effectively in protecting vulnerable people.”¹¹⁷

193. In supplementary written evidence the Care Inspectorate also raised concerns regarding the procedure for the application to court for an “Emergency Cancellation of Registration” —

“Where the statutory test (“serious risk to life, health or wellbeing”) is satisfied, the sheriff has discretion as to whether to cancel registration. The Act does not specify what matters are to be taken into account in exercising that discretion. The fact that a provider’s livelihood may be adversely affected

¹¹³ Scottish Parliament Health and Sport Committee. *Official Report, 27 September 2011*, Col 190-191.

¹¹⁴ Scottish Parliament Health and Sport Committee. *Official Report, 27 September 2011*, Col 190.

¹¹⁵ Care Inspectorate. Written submission, 21 October, 2011.

¹¹⁶ SCSWIS. Written submission., 24 August 2011.

¹¹⁷ SCSWIS. Written submission. 24 August 2011.

may be argued in support of maintaining registration where “serious risk” has been established, but may perpetuate serious risk to vulnerable people.”¹¹⁸

194. The Care Inspectorate suggested that its enforcement powers would be improved if the matters to be taken into account by the sheriff in considering the statutory test and in exercising his or her discretion in the event that the test is met, were prescribed by statute—

“As a minimum, we would recommend that in considering an application for an interim order in terms of s65(3), that the sheriff should be specifically directed to take account of the professional opinion expressed in any affidavit sworn by an appropriately qualified member of the Care Inspectorate’s staff and lodged in support of the application – so that there could be rapid but informed response by the court to an emergency, in a manner similar to that for Child Protection Orders under the Children (Scotland) Act 1995.”¹¹⁹

Committee conclusion

195. The Committee notes the comments made by organisations including COSLA and the City of Edinburgh Council that the current enforcement system available to the Care Inspectorate may not be responsive enough to bring about changes quickly.

196. The Committee is keen to ensure that the enforcement system does not rely too heavily on pre-emptive action being taken by local authorities having to decide to remove clients from a care home or change care at home service providers. The Committee therefore invites the Scottish Government to consider whether changes should be made to the current enforcement and appeals process.

REGULATION OF THE WORKFORCE

197. The SSSC is responsible for registering people who work in social services and regulating their education and training. This includes all social workers and social care workers, who are not already in a regulated profession such as nursing.

198. In 2003, it was estimated that there were 138,000 social services staff in Scotland. The figure is now estimated to be 198,000.¹²⁰

199. The primary purpose of registration is to ensure that such staff have the skills and knowledge necessary to carry out their roles, improve standards of delivery of services and protect service users. One of the criteria for registration is that staff hold, or attain, the required qualifications for the role they undertake. If an applicant does not currently hold all the required qualifications they can still be granted registration, subject to the condition that they achieve the required qualifications within a specified period (normally the first three year period of registration). Upon applying for registration, the SSSC will also require full

¹¹⁸ Care Inspectorate. Written submission, 21 October, 2011.

¹¹⁹ Care Inspectorate. Written submission, 21 October, 2011.

¹²⁰ Scottish Parliament Information Centre (2011) Regulating Care for Older People. SPICe Briefing 11/60.

disclosure of any criminal offences and also any action taken by the SSSC (in the case of those re-registering).¹²¹

200. Given the number of staff involved, and to allow employers time to plan for registration, registration of key groups is taking place in a staged approach.

201. In relation to those working within care homes for adults, whilst managers should be registered within six months of taking up employment, other workers are to submit applications to the SSSC by the end of September in the following years: Supervisors – by 2011; Practitioners – by 2012; Support Workers – by 2014.

202. As regards those working in care at home services, there are no timescales set as yet for supervisors or support workers to submit applications. However registration of supervisors should commence in 2014, with completion of registration taking place in 2017. In addition, the registration of support workers should commence in 2017, with completion of registration by 2020. Managers of these services should be registered within six months of commencing employment.¹²²

203. Geraldine Doherty of SSSC told the Committee that the SSSC wanted to see people trained and qualified, as training was improving the quality of care delivered and giving care workers the confidence to look after elderly people—

“The SSSC is completely committed to having a registered, regulated and well-trained workforce. That is what secures safe practice and safe care. Inspection looks in on care, but what will really make a difference is a confident, well-trained workforce.”¹²³

204. She explained that for workers in care homes for older people they had required managers to register first, then supervisors, practitioners and workers. Due to the resources required for training a phased approach had been adopted—

“We start with managers because we think that they are responsible for the ethos and culture of the unit and because it is important that organisations have the infrastructure to offer SVQs—managers and supervisors can be workplace assessors and internal verifiers. The managers have to be registered by next March, supervisors by 2013, and then practitioners and support workers.”¹²⁴

205. Geraldine Doherty told the Committee that of the 90,000 people within the scope of registration, just under 50,000 people were registered. Of the 60,000 care at home and housing support workers, only the managers were required to be registered at present. The decision had been made in 2010 to register the other workers—

¹²¹ Scottish Parliament Information Centre (2011) *Regulating Care for Older People*. SPICe Briefing 11/60.

¹²² Scottish Parliament Information Centre (2011) *Regulating Care for Older People*. SPICe Briefing 11/60.

¹²³ Scottish Parliament Health and Sport Committee. *Official Report, 27 September 2011*, Col 176.

¹²⁴ Scottish Parliament Health and Sport Committee. *Official Report, 27 September 2011*, Col 174.

“The timing of that was influenced by the timing of the registration of care home workers, because they require to be registered by 2015. They are a large group of staff—around 26,000—so to allow employers to plan out the resources needed to qualify all those workers, we looked at phasing that before we started registering the care at home workers. The issue is that it does take time.”¹²⁵

206. Geraldine Doherty was asked about the scope for bringing forward the registration of the workforce. In response she explained that there were two elements that would need to be considered: the resourcing of the registration; and employers being able to resource people to achieve qualifications within shorter timescales.¹²⁶

207. Geraldine Doherty explained that the SSSC was keen to ensure that training reflected the shift in the care pattern and that currently there were care workers outwith the scope of registration including: social work assistants, adult placement officers and workers in day care for adults.¹²⁷

208. Other witnesses, including Ron Culley of COSLA, pointed to the need for greater investment if the deadline for registration was to be brought forward.

209. Ruth Stark pointed out that if registration was to be extended to everyone who provided home care, additional costs would be involved. She described it as a “political thistle that the committee will have to wrestle with”.¹²⁸

210. Several witnesses including Lord Sutherland and David Manion expressed surprise at the length of time allowed for some members of the workforce between being able to work in the sector and having to register with the SSSC.¹²⁹ RCN, in its written submission, stated that until the registration of the workforce was complete—

“This could represent a weakness in the regulatory system as it means that the scrutiny of the staff delivering services is only as good as the checks and processes put in place by employers.”¹³⁰

211. Ellen Hudson of RCN also told the Committee that it wanted regulation of the workforce to be expanded so that care workers who are delegated their duties by a nurse should also be regulated by the Nursing and Midwifery Council.¹³¹

212. Jacquie Roberts of the Care Inspectorate told the Committee—

¹²⁵ Scottish Parliament Health and Sport Committee. *Official Report, 27 September 2011*, Col 175.

¹²⁶ Scottish Parliament Health and Sport Committee. *Official Report, 27 September 2011*, Col 176.

¹²⁷ Scottish Parliament Health and Sport Committee. *Official Report, 27 September 2011*, Col 176-177.

¹²⁸ Scottish Parliament Health and Sport Committee. *Official Report, 13 September 2011*, Col 159.

¹²⁹ Scottish Parliament Health and Sport Committee. *Official Report, 6 September 2011*, Col 67, Col 92,

¹³⁰ RCN. Written submission.

¹³¹ Scottish Parliament Health and Sport Committee. *Official Report, 13 September 2011*, Col 148.

“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.”¹³²

213. She told the Committee that the SSSC had managed the compulsory registration calendar within its resources and that it was the right decision to start with the managers—

“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.”¹³³

Scottish Government response

214. Responding to the evidence received on the timetabling of the registration of the workforce the Cabinet Secretary told the Committee that she was happy to consider whether changes could be made to the process and would discuss the issue with the SSSC and the Care Inspectorate, she added—

“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.”¹³⁴

Committee conclusion

215. The Committee recognises that Scotland is the only part of the UK that has decided to regulate the whole of the social care workforce. The Committee believes that the registration of the entire workforce is vital to ensure that the highest standards of care are delivered by staff. The Committee welcomes the commitment given by the Cabinet Secretary that she will discuss the timetabling of the registration of the workforce with the SSSC and the Care Inspectorate. Whilst the Committee recognises that additional resources will be required, it recommends that the Scottish Government should consider accelerating the current timetable for registration of care workers.

¹³² Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011*, Col 325.

¹³³ Scottish Parliament Health and Sport Committee. *Official Report, 27 September 2011*, Col 324.

¹³⁴ Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011*, Col 355.

Support and investment in the workforce

216. From the outset of the inquiry, staffing was highlighted as an important driver for the delivery of quality care. Scottish Care submitted that “quality of care depends on the quality of the investment in the workforce”.¹³⁵

Staff terms and conditions and training

217. Particular issues were raised about recruitment and retention of staff in social care services. The Committee received evidence that attention needed to be paid to the training and development of staff, as well as their terms and conditions. Lord Sutherland raised concerns that he had heard of instances in Edinburgh where care home staff had left their jobs during the summer to take on casual jobs in the Edinburgh Festival as they were better paid. He pointed to this as telling us “something about the value that we attached to the rewards that we give to people who work in care homes”.¹³⁶

218. The Committee received evidence that, in tight financial times, providers looked to cut staff pay and opportunities for training, which had implications for care delivery. Annie Gunner Logan of CCPS highlighted findings from research CCPS had conducted with the University of Strathclyde that suggested a clear link between the quality of care provision across the different care settings and the ability of a provider to maintain a healthy training budget.¹³⁷

219. The Committee also received specific examples of evidence of gaps in people’s training. Dr Denise Coia of HIS told the Committee that some admissions to hospital from care homes could be prevented by appropriate staff training. She provided the example that a common reason for the admission of older people to acute hospitals was delirium due to dehydration and not receiving proper nutrition and fluids, because they had a urinary tract infection or because their catheters were blocked. Dr Coia told the Committee that these admissions could be prevented by giving people the skills to recognise the common clinical symptoms when they occur.¹³⁸

220. The Committee received evidence regarding the training that was available and in development for the care workforce. The SSSC’s written submission stated that the qualifications set for registration required workers to demonstrate they were competent in practice and that they had underpinning knowledge and an appropriate value base for their work.¹³⁹

221. Henry Simmons of Alzheimer Scotland drew attention to the work he was doing with the SSSC and NHS Education for Scotland as chair of the programme board for “Promoting Excellence: A framework for all health and social services staff working with people with dementia, their families and carers”. The Board had been working on proposals for psychological intervention and other forms of

¹³⁵ Scottish Care. Written submission.

¹³⁶ Scottish Parliament Health and Sport Committee. *Official Report*, 6 September 2011, Col 67.

¹³⁷ Scottish Parliament Health and Sport Committee. *Official Report*, 13 September 2011, Col 133-134.

¹³⁸ Scottish Parliament Health and Sport Committee. *Official Report*, 27 September 2011, Col 199.

¹³⁹ Scottish Social Services Council. Written submission.

training for all staff, to help tackle the issue of how to deal with someone who presents challenging behaviour.¹⁴⁰

ILA Scotland support

222. The Committee also learned that care service workers (with income of £22,000 a year or less) may be able to apply for funding towards Scottish Vocational Qualification (“SVQ”) level 2 courses available in health and social care. The Scottish Government funded scheme “ILA Scotland 200” provides up to £200 a year (non-repayable) towards the cost of learning (either full-time or part-time) a variety of different subjects or courses. The scheme is for individuals over the age of 16 with an individual (not household) income of £22,000 a year or less, or who are on benefits.

223. There are at least 72 SVQ level 2 courses available in health and social care across Scotland, registered with ILA Scotland. These courses are provided by a range of training providers, including colleges and private training companies and some cover only aspects of the full SVQ level 2 qualification. Courses range from approximately £250 to a maximum of £1500 (inclusive of VAT), dependent on course.

Skills mix and staffing levels

224. Another issue raised was the skills mix of staff and staffing levels. In its written submission, the RCN stated that “poor standards of care are often accompanied by an underlying failure to ensure safe staffing levels and the right level of skills and knowledge”.¹⁴¹

225. Ranald Mair of Scottish Care told the Committee that turnover in the sector was too high—

“We have to get the skills mix right, which requires investment in training. We must also make it an attractive and rewarding occupational sector for people to come into. If we do not, we will, in the not-too-distant future, hit a crisis of not having enough people with the right skills mix, as well as the right values and attitudes, to deliver the care that we are going to need.”¹⁴²

226. An RCN employment survey in 2009 showed that there had been a change in skills mix in care homes. Registered Nurses made up 25% of staff in 2009 compared with 34% in 2007. This corresponded with an increase in the number of patients per Registered Nurse on duty (from 15.5 on average to 18.3).¹⁴³

227. These findings were supported by anecdotal evidence from Dr John Gillies that there had been a reduction in the number of qualified staff in care homes compared with 10 or 15 years ago. He told the Committee that in one home in his practice area—

¹⁴⁰ Scottish Parliament Health and Sport Committee. *Official Report, 6 September 2011*, Col 89.

¹⁴¹ Royal College of Nursing. Written submission.

¹⁴² Scottish Parliament Health and Sport Committee. *Official Report, 13 September 2011*, Col 134.

¹⁴³ Royal College of Nursing. Written submission.

“We no longer have, on a regular basis, a registered mental nurse with expertise in the management of people with mental health and dementia problems, despite the fact that the needs have increased considerably.”¹⁴⁴

228. Dr Gillies suggested that difficulties in recruiting mental health nurses may be due to wage rates, terms and conditions and training. He also felt that having the right organisational structure within a home to support the staff was critical.¹⁴⁵

229. David Manion of Age Scotland highlighted that the rise in the complexity of needs of people being cared for meant that in some areas there would be a need for more highly qualified nursing staff and people with a better understanding of drug regimes. He suggested that the skills mix in a number of care homes had not kept pace.¹⁴⁶ He discussed the need for a minimum percentage of qualified staff in all care homes, with the number of qualified staff being determined by a needs assessment of the individual care setting.¹⁴⁷

230. The RCN highlighted that there was no nationally agreed standard for staffing ratios. It called for work to develop tools in this area to continue and a national approach to be agreed.¹⁴⁸

231. Jacquie Roberts told the Committee that when conducting inspections, the Care Inspectorate looked at the number of staff on duty and the needs of the people receiving the service. Referring to a piece of research which the Care Inspectorate expected to complete in early 2012, she explained—

“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.”¹⁴⁹

Committee conclusion

232. The Committee considers that for many years the social care workforce has been undervalued – as reflected in wage levels, terms and conditions and limited investment in training and development. Looking to the future, the Committee believes that in order to ensure that care services are of the highest quality, the sector must be seen as an attractive occupation for people with a range of skills. Current fiscal austerity measures should not be seen as an excuse to drive down wage levels. The Committee considers that employers in the social care sector should aim to pay all staff at least the “Living Wage”.

¹⁴⁴ Scottish Parliament Health and Sport Committee. *Official Report, 13 September 2011*, Col 144.

¹⁴⁵ Scottish Parliament Health and Sport Committee. *Official Report, 13 September 2011*, Col 145.

¹⁴⁶ Scottish Parliament Health and Sport Committee. *Official Report, 6 September 2011*, Col 91-92.

¹⁴⁷ Scottish Parliament Health and Sport Committee. *Official Report, 6 September 2011*, Col 95.

¹⁴⁸ Royal College of Nursing. Written submission.

¹⁴⁹ Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011*, Cols 328-329.

233. **The requirement in Scotland for all social care staff to complete appropriate vocational training prior to registration with the SSSC should act as a catalyst for increasing staff confidence and morale, leading to improved standards of care. The Committee encourages employers to consider the funding available from ILA Scotland as one way of supporting training for staff.**

234. **The Committee was concerned by evidence it received that, against a backdrop of increasing numbers of older people with complex care needs such as dementia, the proportion of qualified nursing staff employed in certain care settings had declined. The Committee, therefore, welcomes the fact that the Care Inspectorate has commissioned research into the appropriate staffing mix for care homes and other services for older people. It looks forward to receiving a copy of this research in due course.**

Care at home

235. Particular issues were raised about the delivery of care at home services. Lord Sutherland told the Committee—

“Among those who are most at risk are those who live alone at home and who have a stranger, as they might see it, coming in once a day or three times a week.”¹⁵⁰

236. Noni Cobban of UK Homecare Association told the Committee that in a care at home setting “service users’ experience relates directly to the quality of the worker with whom they are in contact day to day”.¹⁵¹

237. She went on to tell the Committee that “the care-at-home world is still very much a cottage industry that uses under qualified and underdeveloped workers”.¹⁵²

238. Noni Cobban felt that there had been limited investment in developing the home-care workforce for providers in Scotland, as opposed to England, where Skills for Care had invested considerably in helping providers to upskill the workforce. Noni Cobban believed investment was required and the relationship between the SSSC and Care Inspectorate was critical—

“On shifting the balance of care, the perception is still that home care is cheaper than care in a home—but in some cases it is not. Some care can be very effective, but in other cases, if care is to be really meaningful to the service user, it is not a money-saving exercise. The system as a whole, which includes the workforce, still needs to be taken into our regulatory function.”¹⁵³

239. Lord Sutherland felt it was particularly important to ensure carers in these settings were getting support in professional development or in dealing with

¹⁵⁰ Scottish Parliament Health and Sport Committee. *Official Report*, 6 September 2011, Col 76.

¹⁵¹ Scottish Parliament Health and Sport Committee. *Official Report*, 13 September 2011, Col 132.

¹⁵² Scottish Parliament Health and Sport Committee. *Official Report*, 13 September 2011, Col 132.

¹⁵³ Scottish Parliament Health and Sport Committee. *Official Report*, 13 September 2011, Col 132.

particular problems. He highlighted that this could particularly be the case in caring for someone with dementia—

“It is a particular skill and unless that skill is imparted when necessary and the right carer drafted in when a change has taken place in the old person’s responses, the care will be more at risk, not necessarily for malign reasons but for want of the expertise. It does not come naturally.”¹⁵⁴

240. Anne Conlin of Carers Scotland raised concerns that sometimes it wasn’t training that was required but that people delivering care at home were sometimes not given the time or resources to provide the care they would like. She highlighted the concerns of a carer that care at home was not a caring workforce—

“it is a time-based workforce. It is a workforce that has to work to rule and deliver the good within a set period of time, so what happens is that caring goes out the window. A person’s slot may be from 10 to 11 or from 2 to 3, but that is not when the caring is required or needed, so as a result the caring can break down. It does not seem to be a caring workforce; it is just a workforce.”¹⁵⁵

241. Noni Cobban pointed to good work that had been done by the Care Inspectorate’s predecessor in regulating care at home services—

“The Care Commission invested a great deal in understanding how care at home works and evolved means by which it could sample not only service users, which it does through questionnaires as well as individual visits, but also the lone workers who go out and work on their own and are not, at the moment, qualified to do that work- they are not a mature workforce.”¹⁵⁶

242. Henry Simmons also sought to reassure the Committee that many local authorities, who commission the majority of care at home services, had monitoring and standards teams in operation which expected reports on staff turnover and complaints and would set standards and criteria for training. He did, however, raise the concern that the way a service was commissioned could result in people not being highly skilled or trained to deal with the care of a person with dementia—

“If local authorities do not set the bar higher than simply providing a generic service for older people, which is about very basic care, people may end up receiving a 15-minute slot for a visit.”¹⁵⁷

Self-directed support

243. It is not only that increasing numbers of older people are being cared for at home but the delivery of that care which is changing, with a shift to self-directed support and personalised services. In 2010 the Scottish Government published a

¹⁵⁴ Scottish Parliament Health and Sport Committee. *Official Report*, 6 September 2011, Col 76.

¹⁵⁵ Scottish Parliament Health and Sport Committee. *Official Report*, 6 September 2011, Col 93.

¹⁵⁶ Scottish Parliament Health and Sport Committee. *Official Report*, 13 September 2011, Col 127.

¹⁵⁷ Scottish Parliament Health and Sport Committee. *Official Report*, 6 September 2011, Col 92.

ten year strategy to grow self-directed support. The Strategy will be underpinned by a Bill due to be introduced in the next parliamentary year.¹⁵⁸

244. The Committee received evidence that these changes presented challenges to ensuring proper scrutiny of services and protection of care at home users.

245. Geraldine Doherty of the SSSC highlighted that under the Regulation of Care (Scotland) Act 2001 the SSSC did not regulate personal assistants in a one-to-one arrangement, but regulated for care at home.¹⁵⁹

246. Geraldine Doherty explained that this arrangement had been questioned due to concerns that someone who is looking for care might not be in the best position to decide whether it would be safe for a particular person to care for them. She highlighted that there was, therefore, a differentiation between care at home and housing support arrangements and personal direct arrangements.¹⁶⁰

247. Lord Sutherland emphasised that those receiving self-directed support would need close monitoring—

“There are charlatans out there who will devise ways of extracting money from vulnerable old people. I do not dissent from any move towards self-directed support, because some people would make a pretty good fist of providing for themselves but, if someone does so, they will need fairly regular visits from an independent professional to see what is happening. That would be one way of beginning to deal with the situation.”¹⁶¹

248. COSLA also supported the move towards more personalisation through self-directed support, where people can manage and take responsibility for their own care and choose what type of care they receive and how often they receive it. Ron Culley did, however, feel that there was potential for some to seeing self-directed support as being over regulated—

“Clearly, there must be an overall regulatory environment, but we do not want to create an arrangement in which individual choice and autonomy are stifled because of regulatory constraints, which can often be to the detriment of individual outcomes.”¹⁶²

Care Inspectorate response

249. Jacque Roberts told the Committee—

“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.

¹⁵⁸ Scottish Government *Self-Directed Support web page*. Available at:

<http://scotland.gov.uk/Topics/Health/care/sdsbill> [Accessed 17 November 2010]

¹⁵⁹ Scottish Parliament Health and Sport Committee. *Official Report, 27 September 2011*, Col 195.

¹⁶⁰ Scottish Parliament Health and Sport Committee. *Official Report, 27 September 2011*, Col 195.

¹⁶¹ Scottish Parliament Health and Sport Committee. *Official Report, 6 September 2011*, Col 76-77.

¹⁶² Scottish Parliament Health and Sport Committee. *Official Report, 27 September 2011*, Col 195.

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.”¹⁶³

250. Jacquie Roberts added that her personal view was that there was scope for all those delivering care to be registered including those in the home.¹⁶⁴

Committee conclusion

251. The Committee notes the comments made in evidence regarding concerns about the regulatory framework for the move to self-directed support. The Committee believes that these concerns will need to be addressed by the Scottish Government in the forthcoming self-directed support Bill.

INTEGRATION OF REGULATION OF HEALTH AND SOCIAL CARE

Background

252. Further integration of health and social care is a policy direction being pursued by the Scottish Government. Lord Sutherland told the Committee, “the integration of health and social care service is, in the medium and long terms, one of the essentials for ensuring quality and sustainability of care”.¹⁶⁵

253. The former Health and Sport Committee considered the issue of integrating services during its consideration of the Public Services Reform (Scotland) Bill. In its Stage 1 report to the Finance Committee on the Bill the Committee concluded that, on balance, it favoured taking the step of creating a single scrutiny body rather than two bodies, HIS and SCSWIS, in keeping with the recommendations of the Crerar review. Ultimately SCSWIS and HIS were established as separate regulatory bodies.

Joint working and integration of inspectorates

254. A recurring theme during the course of the Committee's inquiry was consideration of whether the regulation of health and social care was sufficiently integrated to ensure the adequate inspection and regulation of integrated services.

255. The Committee received evidence that the boundaries between care services and health services were becoming increasingly blurred. Dr Frances Elliot of HIS told the Committee that “older people have much more complex needs that cross the areas of health and social care, and they are more vulnerable in all primary care and hospital settings”.¹⁶⁶ Ranald Mair of Scottish Care told the Committee—

“I think SCSWIS and HIS will have to get their act together to establish whether people are receiving a health service or a social care service. Some

¹⁶³ Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011*, Col 330.

¹⁶⁴ Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011*, Col330.

¹⁶⁵ Scottish Parliament Health and Sport Committee. *Official Report, 6 September 2011*, Col 65.

¹⁶⁶ Scottish Parliament Health and Sport Committee. *Official Report, 27 September 2011*, Col 196.

of the boundaries that were clear in the past will be less clear in the future, so we may need to take a fresh look at how the regulator interacts with the changing pattern of service delivery.”¹⁶⁷

Care pathways

256. One specific area where the integration of the regulatory system was raised was the assessment of an individual’s care pathway. This type of assessment analyses an individual’s care experience through the different health and social care agencies they have come into contact with.

257. The Committee received evidence that this approach to assessment was to be encouraged as the current focus of assessment was on processes rather than service users’ experiences. Ron Culley of COSLA told the Committee that the current system of regulation was centred on general service provision and should move to a system more focused on individual outcomes.¹⁶⁸

258. Geraldine Doherty of SSSC told the Committee that “it would be an advantage if the new organisation [Care Inspectorate] could examine the whole journey to ensure that people get the right care in the right place”.¹⁶⁹

259. Ron Culley saw the challenge in analysing care pathways being how the two main regulators, the Care Inspectorate and HIS, worked together to deliver this assessment.¹⁷⁰

260. Dr Elliot of HIS recognised the need for the Inspectorates to work together in analysing care pathways—

“The individual and his or her carers expect to have his or her needs met, whatever those needs and whatever the setting might be. As a regulatory body, we will need to do much closer regulation with the care inspectorate to determine whether the quality of health and social care in the community as well as in hospitals is adequate.”¹⁷¹

261. Dr Elliot told the Committee that her organisation’s predecessor, NHS Quality Improvement Scotland, had worked together with SWIA and the Care Commission 18 months – two years ago on piloting multi-agency inspection of older people’s care in Forth Valley and Tayside.¹⁷² HIS added in supplementary written evidence—

“We believe this is a good model to consider for the comprehensive review of care for older people. The methodology would require revision and updating if it was to be used more comprehensively but is a good starting point.”¹⁷³

¹⁶⁷ Scottish Parliament Health and Sport Committee. *Official Report, 13 September 2011*, Col 130-131.

¹⁶⁸ Scottish Parliament Health and Sport Committee. *Official Report, 27 September 2011*, Col 187.

¹⁶⁹ Scottish Parliament Health and Sport Committee. *Official Report, 27 September 2011*, Col 180.

¹⁷⁰ Scottish Parliament Health and Sport Committee. *Official Report, 27 September 2011*, Col 181.

¹⁷¹ Scottish Parliament Health and Sport Committee. *Official Report, 27 September 2011*, Col 196-197.

¹⁷² Scottish Parliament Health and Sport Committee. *Official Report, 27 September 2011*, Col 197.

¹⁷³ Healthcare Improvement Scotland. Written submission, 29 September 2011.

262. Dr Coia told the Committee that HIS wanted the two new organisations to have the ability to carry out joint inspections. There was an overarching scrutiny group in the Scottish Government that HIS attended along with the Care Inspectorate—

“We have pushed strongly for joint inspections of care pathways so that we do not just focus on acute hospitals-as HIS does at present- and on care homes. Rather we should look at the whole pathway and start to see that it is about the person rather than where the person happens to be.”¹⁷⁴

263. Dr Elliot told the Committee that considering care pathways as an approach had been well received by the Scottish Government. She told the Committee that HIS was working with the Care Inspectorate and the MWC to look at the dementia standards and considering how, collectively, they could inspect services against these standards both in the community and in care institutions.¹⁷⁵

264. Dr Coia highlighted that the issue regarding integration initially lay with bringing together common methodologies—

“At the moment, the care inspectorate is resourced for inspecting care homes and we are resourced for inspecting acute hospitals. We do not have a common resource to allow us to do joint inspections across the pathway.”¹⁷⁶

265. Monica Boyle of the City of Edinburgh Council also provided evidence of the Care Inspectorate having closer engagement with local authorities on the assessment of older people's care. She highlighted a four-month pilot which the City of Edinburgh Council was about to undertake with the Care Inspectorate which would consider how the Care Inspectorate inspections of care homes fit with the Council's work to review care packages. She added—

“That pilot will bring together the timing of when we review people's care packages and when SCSWIS inspects a care home, and bring together the information. Once we have finished the pilot, we might be able to recommend how improvements could be made in the inspection systems.”¹⁷⁷

Care Inspectorate response

266. The Care Inspectorate also told the Committee that it supported the inspection of the care pathway. Jacquie Roberts told the Committee that work on care pathways would be in development over the next year and that various opportunities were now available for closer working with local authorities and HIS.¹⁷⁸

267. Since the Care Inspectorate encompassed the functions of SWIA, it could undertake performance inspections of local authorities looking at the quality of assessment, review and commissioning. The Care Inspectorate also stated that

¹⁷⁴ Scottish Parliament Health and Sport Committee. *Official Report, 27 September 2011*, Col 201.

¹⁷⁵ Scottish Parliament Health and Sport Committee. *Official Report, 27 September 2011*, Col 201.

¹⁷⁶ Scottish Parliament Health and Sport Committee. *Official Report, 27 September 2011*, Col 198.

¹⁷⁷ Scottish Parliament Health and Sport Committee. *Official Report, 27 September 2011*, Col 188.

¹⁷⁸ Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011*, Col 340.

this allowed a more joined up approach as it could follow the care journey of individuals from assessment, review and commissioning to service delivery.¹⁷⁹

268. In addition, the Care Inspectorate now had scope for linking in with the inspection of acute services for older people in the NHS and examining discharge and care management arrangements in local authorities.¹⁸⁰

Scottish Government

269. The Cabinet Secretary stated that analysis of care pathways was a direction of travel that the health service and social care services were generally more geared towards. The Cabinet Secretary pointed to the new dementia standards as an example of care pathways being considered regardless of the care setting in which they were delivered.¹⁸¹

Committee conclusion

270. The Committee believes that assessment of care pathways may represent a useful tool which can enhance the existing approach to regulation of care services. The Committee welcomes the Care Inspectorate's move to closer engagement with local authorities and HIS as the regulatory system increasingly needs to take account of the continuum of care experienced by older people.

Data collection

271. Another aspect of integration with acute services for older people explored with the Care Inspectorate was whether it used the Scottish Patients at Risk of Readmission and Admission Data ("SPARRA") as part of its risk assessment process. SPARRA data could be used to determine whether the percentage of terminal and emergency admissions to hospital from a care home was high. This could be an indicator that the quality of care in a home is poor.

272. The Care Inspectorate explained that it did not analyse the SPARRA information systematically at present. It did, however, act upon notifications from district nurses, from admissions to hospital departments and general practitioners alerting them to concerns about the quality of care in a home. The Care Inspectorate's duty of cooperation with HIS also provided them with an opportunity for working alongside HIS on the data.¹⁸²

Committee conclusion

273. The Committee believes that if emergency admissions to hospitals from care homes are high, the Care Inspectorate should not be reliant solely on notifications from staff to identify this potential problem. The Committee recommends that the Care Inspectorate explores with HIS the possibility of systemically gathering and analysing the SPARRA data. The Committee also invites the Care Inspectorate to consider whether emergency admissions to hospital from a care setting should result in a mandatory report to the Care Inspectorate in order to inform the risk assessment process.

¹⁷⁹ Care Inspectorate. Written submission, 29 September 2011.

¹⁸⁰ Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011*, Col 340.

¹⁸¹ Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011*, Col 350.

¹⁸² Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011*, Col 316.

Assessment of healthcare needs

274. The Committee received evidence, in relation to the integration of health and social care, that there may be gaps in the current assessment of health provision in care settings. The Committee received some evidence that the assessment of healthcare needed to be strengthened.

275. Ellen Hudson of RCN believed there was a risk that unmet healthcare needs may not be identified by the Care Inspectorate through its inspection regime, because health had a low prominence within the quality themes and statements. She pointed to there being only one quality statement within a theme focused on “health and wellbeing” and it not being mandatory for the inspector to inspect the service against this statement.¹⁸³

Medicines management

276. Within the context of the regulation of healthcare in care settings a specific concern was raised regarding medicines management. The MWC and Care Commission Report “Remember I’m Still Me”¹⁸⁴ had found that most people with dementia had a good health assessment on or before admission to a care home, however, very few had a planned (even annual) health check from their GP.

277. The report also found that there was very little evidence that medication was regularly reviewed. It noted that 75% of people in care homes were taking one or more psychoactive medications.

278. Henry Simmons of Alzheimer Scotland told the Committee that the report had helped them understand that many actors were involved in the inappropriate prescribing of a psychoactive drug to a person with dementia.¹⁸⁵

279. The Committee heard some debate between witnesses about what these figures for psychoactive medication meant. Martin Green told the Committee that—

“Statistics can be a little dangerous at times. The startling figure that 75 per cent of people were taking psychoactive medicines knocks people off their chairs, but the term is broad. Many medicines that are considered psychoactive are not necessarily used to deal with aggressive or challenging behaviour. Psychoactive medicine is rarely the first solution to tackling a patient’s aggressive and challenging behaviour, although it will be prescribed for the patient.”¹⁸⁶

280. In response, Dr Lyons explained—

¹⁸³ Scottish Parliament Health and Sport Committee. *Official Report*, 13 September 2011, Col 147.

¹⁸⁴ Care Commission and Mental Welfare Commission . (2009) “Remember I’m still me” *Joint report on the quality of care for people with dementia living in care homes*. Available at: http://www.mwscot.org.uk/web/FILES/Publications/CC_MWC_joint_report.pdf [Accessed 17 November 2011]

¹⁸⁵ Scottish Parliament Health and Sport Committee. *Official Report*, 6 September 2011, Col 88.

¹⁸⁶ Scottish Parliament Health and Sport Committee. *Official Report*, 13 September 2011, Col 154.

“We saw that much medication was being used not for improving mood, which antidepressants can help with and might be underused in care homes, but for sedation and behaviour control.”¹⁸⁷

281. Dr Gillies reinforced Dr Lyons opinion—

“There is a risk of drugs being used not because they are really needed but because it is a quick fix in a complex situation. The answer is to ensure that our workforce has the skills and training to meet the complex physical and mental health needs of such residents.”¹⁸⁸

282. Dr Lyons saw a solution to these concerns being more clinical pharmacy involvement in nursing homes, training and better adherence to good prescribing guidance.¹⁸⁹

283. Martin Green pointed to the chronic medication service to support patients in the community being developed through the national community pharmacy contract. He highlighted that patients in care homes are excluded from the service, “which greatly disappoints us, because including them would facilitate a platform from which such input could begin”.¹⁹⁰

284. Jacquie Roberts told the Committee—

“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.”¹⁹¹

Committee conclusion

285. The Committee was concerned by the evidence it received regarding the widespread prescription of psychoactive medications to residents of care homes. In order to address its concerns, the Committee supports the call from the Mental Welfare Commission for Scotland for greater clinical pharmacy involvement in care homes, improved training for staff and better adherence to good prescribing practice. The Committee, therefore, recommends that the Care Inspectorate should engage with the Mental Welfare Commission for Scotland and other interested parties in order to produce guidance and information to service providers on the use of psychoactive medications. This issue should be considered as part of a review of National Care Standards.

¹⁸⁷ Scottish Parliament Health and Sport Committee. *Official Report, 13 September 2011*, Col 154-155.

¹⁸⁸ Scottish Parliament Health and Sport Committee. *Official Report, 13 September 2011*, Col 152-153.

¹⁸⁹ Scottish Parliament Health and Sport Committee. *Official Report, 13 September 2011*, Col 152.

¹⁹⁰ Scottish Parliament Health and Sport Committee. *Official Report, 13 September 2011*, Col 154.

¹⁹¹ Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011*, Col 318.

286. The Committee recommends that the Scottish Government should consider allowing care home residents to register with the chronic medication service.

Healthcare regulation in the community

287. NHS QIS, the predecessor of HIS, had no locus to assess healthcare delivered in a person's home. Dr Elliot of HIS told the Committee that this had been the role of the Care Commission and the Care Inspectorate.

288. Dr Coia of HIS explained to the Committee that HIS and the Care Inspectorate shared a common vision about inspection and regulation in the community—

“We are both concerned that at the moment there is a gap in the community with regard to healthcare regulation. Given that, as earlier witnesses have suggested, many care at home and care home issues are actually physical clinical matters, we must ensure that there is proper clinical input into care home and community inspections.”¹⁹²

289. Dr Lyons felt that a potential weakness in the system was that the split in the regulation of health and social care could cause a “disparity in what is assessed by whom”. He added—

“SCSWIS would have closed yesterday long-stay hospital wards for people with dementia that we visit if they were in the regulated care sector, as they do not come anywhere near any standards for individual privacy and dignity. Let us be clear. There are huge disparities across the care sector, and one of the big regulation tasks for SCSWIS, HIS and us is to try to bring those areas together and get greater uniformity. That is what dementia care standards were about.”¹⁹³

290. In oral evidence Dr Elliot told the Committee—

“We have completely separate systems. It is Healthcare Improvement Scotland's responsibility to look at healthcare needs. Our responsibility is to identify the appropriate evidence to develop standards and quality measures for healthcare. The Care Inspectorate looks after the social care and care elements. It may not be easy, but it would be possible to ask us to consider jointly how we might bring those things together. With the Government drive on the integration of health and social care, it is a necessary and fundamental step for the future.”¹⁹⁴

291. Jacquie Roberts also spoke about the scope of the Care Inspectorate working with HIS—

“Now that our senior inspectors are also responsible for assessing local authorities' performance and can link with Healthcare Improvement

¹⁹² Scottish Parliament Health and Sport Committee. *Official Report, 27 September 2011*, Col 197.

¹⁹³ Scottish Parliament Health and Sport Committee. *Official Report, 13 September 2011*, Col 149.

¹⁹⁴ Scottish Parliament Health and Sport Committee. *Official Report, 27 September 2011*, Col 200.

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."¹⁹⁵

Committee conclusion

292. The Committee calls upon the Care Inspectorate, Healthcare Improvement Scotland and other interested parties to work together in order to ensure that there is proper clinical and social care input into care home, community and acute hospital inspections. The Committee believes this may be facilitated by a review of the National Care Standards.

NATIONAL CARE STANDARDS

293. All care services are inspected taking into account the National Care Standards. The National Care Standards were originally produced in 2000 and 2001. Set out in regulations are 23 sets of National Care Standards, ten of which are specifically for adult services. Each set of standards is written from the point of view of the service user, and details what they can expect from the service.¹⁹⁶

294. A number of organisations called for the National Care Standards to be reviewed by the Scottish Government to reflect developments in the delivery of care for older people since the standards were produced ten years ago. Peter Ritchie of UNISON told the Committee that the National Care Standards were "getting a bit long in the tooth and creaky at the edges".¹⁹⁷

295. Dr Lyons of the MWC felt that the National Care Standards needed to be updated and made more specific in terms of expectations as "some of the content can be a bit loose and woolly".¹⁹⁸ He pointed to the "Standards of Care for Dementia in Scotland", published in June 2011, which aim to help people with dementia, their families and carers understand and assert their rights, as a good example to draw upon for revising the National Care Standards.¹⁹⁹

296. The Committee also received evidence from the Equality and Human Rights Commission regarding the importance of ensuring equality and human rights concerns are embedded in the design and delivery of services with a failure to do so having "a direct impact on the quality and appropriateness of these services".²⁰⁰

297. The Committee also received calls for greater incorporation of health care needs into the National Care Standards from organisations including RCN and HIS. Dr Elliot of HIS told the Committee that appropriate clinical elements should be considered for incorporation into the National Care Standards. Quality

¹⁹⁵ Scottish Parliament Health and Sport Committee. *Official Report*, 4 October 2011, Col 340.

¹⁹⁶ Scottish Parliament Information Centre (2011) *Regulating Care for Older People*. SPICe Briefing 11/60.

¹⁹⁷ Scottish Parliament Health and Sport Committee. *Official Report*, 13 September 2011, Col 151.

¹⁹⁸ Scottish Parliament Health and Sport Committee. *Official Report*, 13 September 2011, Col 147.

¹⁹⁹ Scottish Parliament Health and Sport Committee. *Official Report*, 13 September 2011, Col 146-147.

²⁰⁰ Equality and Human Rights Commission. Written submission.

indicators could be devised from many existing clinical standards and linked to updated National Care Standards. Dr Elliot believed this would provide genuinely integrated health and social care and a much better basis for joint inspection work across the regulatory bodies.²⁰¹

298. Dr Elliot stated that it was perfectly feasible for HIS to start to identify what might feed into the National Care Standards as part of its work programme for 2012-13.²⁰²

Care Inspectorate response

299. The Care Inspectorate also called for a review of National Care Standards as “the standards should remain current, relevant and credible in the rapidly changing environment”.²⁰³ In oral evidence, Jacquie Roberts told the Committee that the National Care Standards needed “to become more integrated with other quality indicators and standards that have been developed since, especially the national standards for dementia care”.²⁰⁴

300. Jacquie Roberts also supported the call for greater integration of standards across different care settings—

“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.”²⁰⁵

Committee conclusion

301. It is ten years since the National Care Standards were originally drafted. In this time the delivery of care for older people has changed and there has been a move towards greater integration of health and social care. The Committee believes that these changes need to be reflected in the National Care Standards to ensure that they remain a current, relevant and credible basis for the regulation of care. The Committee also believes that there is scope for integration with other care standards, particularly the national standards for dementia care. The National Care Standards should provide a key mechanism for ensuring that equality and human rights issues are embedded in the framework for the delivery of care services for older people.

302. The Committee, therefore, recommends that the Scottish Government should conduct a review of the National Care Standards. The Committee also believes that it is vital that HIS and the Care Inspectorate work together on the revision of the Standards so that they reflect the direction of travel towards the further integration of health and social care.

²⁰¹ Scottish Parliament Health and Sport Committee. *Official Report*, 27 September 2011, Col 197-198.

²⁰² Scottish Parliament Health and Sport Committee. *Official Report*, 27 September 2011, Col 199.

²⁰³ SCSWIS. Written submission, 24 August 2011.

²⁰⁴ Scottish Parliament Health and Sport Committee. *Official Report*, 4 October 2011, Col 322.

²⁰⁵ Scottish Parliament Health and Sport Committee. *Official Report*, 4 October 2011, Col 322.

COMMISSIONING AND PROCUREMENT

303. Prior to the 2010 Act there was no statutory requirement for a local authority to take into account the then Care Commission's inspection reports, gradings or notices when commissioning or re-commissioning services.²⁰⁶

304. Under the 2010 Act, local authorities must now take account of reports, information and notices produced by the Care Inspectorate in relation to care services when they are providing care services or procuring them from external organisations.²⁰⁷ The Care Inspectorate also has the power to look at the commissioning and procurement practices of local authorities but, like its predecessor, it has no enforcement powers in this regard.

305. The Committee received evidence which suggested that the scrutiny of local authority commissioning and procurement practices was a potential weakness in the regulatory system. A written submission received from Rhona Murray (a relative of a care home resident) summed up concerns expressed about this matter—

“SCSWIS's remit is narrow and is a significant limitation for the regulator. Challenging funding, commissioning and also procurement which are all interwoven with service quality is vital if there are to be genuine improvements in the service delivery for older people. There is accountability for the quality of the service that should not always be the sole responsibility of the provider if the specification of the service and price essentially determines the quality.”²⁰⁸

306. Henry Simmons of Alzheimer Scotland told the Committee that it would be a “worthless exercise” to assess a service “strangled by a low-level funding agreement” when the Care Inspectorate did not have the power to challenge the way in which the service had been commissioned and procured in the first instance.²⁰⁹

307. Henry Simmons also felt that if regulation and inspection were to deliver improvements in services there was a need “to be more creative in giving powers to SCSWIS to influence the shape and design of the commissioning”.²¹⁰

308. Ranald Mair of Scottish Care also felt that the different aspects of the regulatory system were related. He argued that “we cannot regulate care delivery separately from commissioning and funding”.²¹¹

²⁰⁶ Scottish Parliament Information Centre (2011) Regulating Care for Older People. SPICe Briefing 11/60.

²⁰⁷ Scottish Parliament Information Centre (2011) Regulating Care for Older People. SPICe Briefing 11/60.

²⁰⁸ Rhona Murray. Written submission.

²⁰⁹ Scottish Parliament Health and Sport Committee. *Official Report*, 6 September 2011, Col 98-99.

²¹⁰ Scottish Parliament Health and Sport Committee. *Official Report*, 6 September 2011, Col 82.

²¹¹ Scottish Parliament Health and Sport Committee. *Official Report*, 13 September 2011, Col 120.

309. In its written submission, CCPS set out issues with the commissioning and procurement of services and the role it saw for the Care Inspectorate in addressing them—

“The regulator must in our view challenge those authorities whose commissioning, procurement and funding arrangements are inadequate either to stimulate a local market of good quality providers or to enable those providers to attract and retain a sufficiently skilled and qualified workforce, which is arguably the most crucial enabling factor for good quality care. We are extremely concerned that some authorities are now capping the price they are prepared to pay for care at a level which is in our view entirely inadequate in these respects, and we believe that the regulator has a major role to play in challenging such practice.”

310. CCPS expressed concerns that the Care Inspectorate had “far fewer teeth” in respect of challenging commissioning practice compared with its powers of intervention in service delivery.²¹² CCPS highlighted that the Care Inspectorate had no power to investigate complaints about any of the relevant processes of an authority (assessment, care management, commissioning) that impact on quality of care; or any power to issue improvement notices or take enforcement measures where it identified poor practice.²¹³

311. Both the CCPS and the Care Inspectorate pointed to the City of Edinburgh Council being an example of good practice in the approach taken to the commissioning of services. The Care Inspectorate had worked with the City of Edinburgh Council to develop a new approach to commissioning, planning and delivering care and support services. The Council’s “Commissioning Strategy for Care and Support Services” contained a set of nine principles, to be adopted by each department when commissioning social care and support services.²¹⁴

312. The strategy included a commitment to commissioning new services which achieved at least a grade 4 in “quality of care and support” at Care Inspectorate inspection.²¹⁵

313. Monica Boyle of the City of Edinburgh Council told the Committee in oral evidence that all existing services would also be expected to work towards achieving this standard.²¹⁶

314. The CCPS and the Care Inspectorate called for other local authorities to be encouraged to adopt the City of Edinburgh Council’s approach to commissioning.²¹⁷

²¹² CCPS. Written submission.

²¹³ CCPS. Written submission.

²¹⁴ SCSWIS. Written submission, 23 August 2011, Scottish Parliament Health and Sport Committee. *Official Report*, 13 September 2011, Col 138-139.

²¹⁵ SCSWIS. Written submission, 23 August 2011.

²¹⁶ Scottish Parliament Health and Sport Committee. *Official Report*, 27 September 2011, Col 179.

²¹⁷ Scottish Parliament Health and Sport Committee. *Official Report*, 13 September 2011, Col 139. SCSWIS written submission, 23 August 2011.

Scottish Government response

315. The Cabinet Secretary told the Committee that in relation to the Care Inspectorate having enforcement powers for commissioning and procurement—

“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.”²¹⁸

Committee conclusion

316. The Committee believes that good commissioning and procurement practices are important determinants of quality care. The Committee therefore welcomes the approach recently adopted by the City of Edinburgh Council to use the findings of Care Inspectorate reports to directly inform the commissioning of new services. The Committee considers that this will have a positive impact on care quality. The Committee recommends that the Care Inspectorate should encourage all local authorities to adopt a similar approach in order to improve outcomes.

317. The Committee notes the comments made by the Cabinet Secretary that there may be questions about the Care Inspectorate not having enforcement powers in relation to commissioning and procurement. The Care Inspectorate currently has “far fewer teeth” to challenge commissioning practice compared with its powers of intervention in service delivery. The Committee believes that extending the Care Inspectorate’s powers will further strengthen the regulatory system. The Committee, therefore, recommends that the Scottish Government should explore further the merit in extending the Care Inspectorate’s powers.

MONITORING FINANCIAL VIABILITY

318. The Committee’s inquiry was conducted against the backdrop of the financial collapse of Southern Cross. This heightened interest in exploring whether there should be greater powers to probe into the financial matters and business practices of service providers to ensure that care services did not fail due to a provider’s financial difficulties.

319. Currently, the Care Inspectorate looks at the financial viability of care providers at the point of registration.²¹⁹ Gordon Weir of the Care Inspectorate explained—

“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

²¹⁸ Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011*, Col 360.

²¹⁹ Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011*, Col 331-332.

much adopt the care regulation methodology and do not carry out financial regulation beyond initial registration.”²²⁰

320. Lord Sutherland's Royal Commission on Long Term Care, which reported in 1999, recommended a National Care Commission with responsibilities for monitoring the market for long term care.²²¹ In oral evidence to the Committee, Lord Sutherland reflected on the Commission's recommendations and suggested that an examination of the financial sustainability of a provider's long-term plans could be part of the inspection process. In his view the Care Inspectorate could use accountants, possibly drawing on expertise from Audit Scotland, to examine business plans and report on the long-term financial sustainability of the big service operators in particular.²²²

321. In its written submission, the Chartered Institute of Public Finance and Accountancy (CIPFA) explained that there was financial assessment during the contract commissioning process by the local authority. This would involve the evaluation of financial health and, typically, would include a review of the financial statements. As part of procurement, supply chain management would generally result in on-going assessment.²²³

322. The CIPFA submission highlighted that there was no on-going prescribed financial assessment by the Care Inspectorate or local authorities—

“We have identified that a gap exists because the financial tests are at registration and then at the point of commissioning only, without any on-going test of financial viability.

Importantly, the professional skills required to assess and regulate the provision of care are different to the professional skills required to conduct initial and on-going financial viability assessments. We consider however that the regulatory process would be strengthened by introduction of prescribed financial assessments.”²²⁴

323. The Committee received evidence from other witnesses which suggested that giving the regulator increased powers to look at the financial viability of companies could strengthen the system and limit disruptions to care provision.

324. The City of Edinburgh Council called for closer monitoring of the financial viability of services to be developed, particularly when a care home is taken over.²²⁵ Annie Gunner Logan of CCPS suggested that there may be a role for CIPFA in monitoring finances.

²²⁰ Scottish Parliament Health and Sport Committee. *Official Report*, 4 October 2011, Col 331-332.

²²¹ Royal Commission on Long Term Care (1999) With respect to old age: long term care - rights and responsibilities Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008520 [Accessed 10 November 2011]

²²² Scottish Parliament Health and Sport Committee. *Official Report*, 6 September 2011, Col 68-69.

²²³ CIPFA. Written submission.

²²⁴ CIPFA. Written submission.

²²⁵ City of Edinburgh Council. Written submission.

325. However, Henry Simmons of Alzheimer Scotland sounded a note of caution regarding monitoring financial viability as not all systems operated using the same financial model as Southern Cross—

“Many voluntary organisations can be quite small-scale operations that do not have a big reserve or a lot of capital. They could probably not develop an exit strategy in the event that things went wrong with their occupancy levels, but they provide an extremely high level of care. We must allow a reasonable level of proportionality when it comes to business viability.”²²⁶

326. The Committee was told by COSLA that monitoring the financial viability of care providers was complex. COSLA had written to Vince Cable MP, Secretary of State for Business, Innovation and Skills raising concerns about the coordination of the regulation of care and the regulation of private capital and finance. Ron Culley of COSLA believed that the issue was “more in the domain of the UK Government and its management of the City of London than a devolved matter of the regulation of care”.²²⁷

327. The Committee sought an assurance that a similar situation to the case of Southern Cross would not occur again. COSLA told the Committee—

“The answer is that there is no guarantee. Until such time as the Westminster Government puts some regulation in place, we cannot guarantee that we will not end up in the same situation in future.”²²⁸

328. In the Cabinet Secretary's statement to the Parliament on 15 September she announced that she had tasked officials to work with the Care Inspectorate, COSLA and other interested parties to bring forward recommendations on how it could provide and be assured of greater financial robustness in the sector.²²⁹ The Care Inspectorate highlighted that the Care Quality Commission in England had sought help from an organisation called Monitor, set up to conduct financial regulation of NHS Trusts.²³⁰

329. In oral evidence to the Committee, the Care Inspectorate was asked for its view on increasing its financial monitoring role. Gordon Weir explained that currently “complicated financial models” and use of published accounts meant that the Care Inspectorate became aware of any financial issues with care services through a care overview rather than a financial reporting process.²³¹

330. Jacquie Roberts told the Committee—

“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

²²⁶ Scottish Parliament Health and Sport Committee. *Official Report*, 6 September 2011, Col 100.

²²⁷ Scottish Parliament Health and Sport Committee. *Official Report*, 27 September 2011, Col 182, 183.

²²⁸ Scottish Parliament Health and Sport Committee. *Official Report*, 27 September 2011, Col 185.

²²⁹ Scottish Parliament. *Official Report*, 15 September 2011, Col 1818-1821.

²³⁰ Scottish Parliament Health and Sport Committee. *Official Report*, 4 October 2011, Col 333.

²³¹ Scottish Parliament Health and Sport Committee. *Official Report*, 4 October 2011, Col 332.

be right for the care regulator to do it or whether other systems of financial regulation should be put in place.”²³²

331. Gordon Weir went on to tell the Committee—

“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.”²³³

332. Jacquie Roberts explained that whilst it would be possible for the Care Inspectorate to put in place an annual financial check this could result in the closure of services if they were found not to be financially viable. Thus precipitating the situation which conducting the financial check was intended to avoid.²³⁴

Scottish Government response

333. The Cabinet Secretary also emphasised the financial complexities of the care service market and suggested that it might not be the Care Inspectorate which was best placed to consider these issues—

“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.”²³⁵

334. Following the Cabinet Secretary’s oral evidence session she provided supplementary written evidence which included correspondence between the Scottish Government and the UK Government on the financial regulation of care providers. In the Cabinet Secretary for Health’s letter of September 2011 to Andrew Lansley MP, Secretary of State for Health, she stated—

335. “Our approach to this work must reflect the diversity of the market, with both very small local services as well as some very large service providers operating across the UK who are backed by bank loans, private equity and in a few cases subject to financial regulation as a consequence of Stock Exchange listing requirements. This interaction of reserved and devolved responsibilities means that the action that your Government takes will have an important role to play in the security of supply of services to vulnerable people in Scotland.”²³⁶ The Secretary of State for Health’s response to the Cabinet Secretary’s letter stated—

²³² Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011*, Col 332.

²³³ Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011*, Col 333.

²³⁴ Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011*, Col 332.

²³⁵ Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011*, Col 363.

²³⁶ Scottish Government Written submission. Cabinet Secretary for Health, Wellbeing and Cities Strategy letter.

“Your concerns regarding appropriate measures to ensure financial stability given the complexities of the market are well justified, and this is something we have been investigating suitable policy responses to for some time. In particular, you will have seen that our Vision for Adult Social Care, published last November, said we would consider a proposed role for Monitor in overseeing the market for social care in the future. I am sure you are also aware that when we introduced the Health and Social Care Bill in January, it included provisions to allow us to extend to social care – if we decide it is needed – the financial regulatory regime we’re putting in place in the NHS.”²³⁷

336. The UK Department for Health has now issued a discussion document on “Oversight of the Social Care Market”, which sets out a series of questions about whether existing mechanisms can effectively ensure service continuity within social care, or whether new measures are necessary.²³⁸

Committee conclusion

337. The Committee is keen to ensure that the sudden collapse of a care service provider like Southern Cross does not happen again. The Committee notes the comments made by the Cabinet Secretary that the Care Inspectorate may not be the appropriate body to be given responsibility for monitoring the financial viability of care services. The Committee recognises that the current focus of the Care Inspectorate is on care provision not financial scrutiny.

338. The Committee, however, believes that there is scope for the Care Inspectorate to build into its risk assessment process a greater degree of ongoing financial scrutiny. The Committee recommends that the Care Inspectorate should require registered service providers to submit copies of their annual accounts. This is information currently gathered from providers as part of the registration process and is, therefore, data the Inspectorate is already experienced in analysing.

339. The Committee welcomes the Cabinet Secretary's announcement that she will work with the Care Inspectorate, COSLA and other interested parties to bring forward recommendations on how financial robustness in the sector can be assured. The Committee also welcomes the liaison between the Scottish Government and UK Government on the issue and recommends that both Governments maintain regular contact so that interactions between reserved and devolved responsibilities within these areas are considered fully.

²³⁷ Scottish Government Written submission. Secretary of State for Health letter.

²³⁸ Department of Health (2011) Oversight of the Social Care Market - Discussion Paper. Available at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_130438 [Accessed 10 November 2011]

Contingency planning

340. COSLA explained that it was easier for councils to be better prepared to react to financial collapse of a care service provider than to prevent financial collapse from occurring.²³⁹

341. Jacquie Roberts also emphasised the importance of ensuring care services had contingency arrangements to ensure continuity of service when services fell into financial difficulty.²⁴⁰

342. The Cabinet Secretary, like COSLA and the Care Inspectorate, emphasised the importance of having good contingency plans—

“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.”²⁴¹

Committee conclusion

343. The Committee welcomes the steps taken by the Scottish Government, COSLA and the Care Inspectorate to put in place contingency arrangements following the collapse of Southern Cross. The Committee considers that these organisations should continue this joint working in order to ensure that a plan is in place should another care provider fall into financial difficulty in future.

RESOURCING THE CARE INSPECTORATE

344. As part of its inquiry, the Committee explored the future funding settlement for the Care Inspectorate and whether this provided sufficient resources for it to carry out its current responsibilities and any additional role if its powers were to be extended in future.

345. Several witnesses including COSLA and the City of Edinburgh Council, raised concerns about whether the Care Inspectorate was adequately resourced to carry out its current role.

346. Prior to the Cabinet Secretary's announcement on 15 September 2011, the Care Inspectorate had anticipated that its funding would be reduced by 25% over four years. In her announcement the Cabinet Secretary stated that the Care Inspectorate budget would enable the organisation to deliver the more frequent inspections she had announced and “maintain its current overall staffing capacity”.²⁴²

347. This announcement was followed by the publication of the Scottish Spending Review 2011 and Draft Budget 2012-13 which proposes that the Care

²³⁹ Scottish Parliament Health and Sport Committee. *Official Report*, 27 September 2011, Col 184.

²⁴⁰ Scottish Parliament Health and Sport Committee. *Official Report*, 4 October 2011, Col 333.

²⁴¹ Scottish Parliament Health and Sport Committee. *Official Report*, 4 October 2011, Col 363.

²⁴² Scottish Parliament. *Official Report*, 15 September 2011, Col 1818-1821.

Inspectorate grant-in-aid will rise from £21.4m in 2011-12 to £21.6m in 2012-13, £21.8m in 2013-14 and £21.9m in 2014-15.²⁴³

348. Tables published by the Scottish Parliament Information Centre Financial Scrutiny Unit show that this represents a 2.4% increase in cash terms over the course of the Spending Review but a real terms decrease of 5.3%. The remainder of the Care Inspectorate's funding (£12.3m in 2010/11) comes from registration fees.²⁴⁴

349. Gordon Weir of the Care Inspectorate explained—

“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. [...] 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.”²⁴⁵

350. Jacquie Roberts was asked about the impact of the Scottish Government's funding announcement for the Care Inspectorate. She told the Committee—

“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.”²⁴⁶

351. She told the Committee that the extra funding took into account the extra costs of having to increase the frequency of inspections and that increasing inspecting resources could include using associate and specialist advisers and assessors as well as recruiting staff.²⁴⁷

352. Jacquie Roberts also explained that her understanding was that the Scottish Government would be undertaking a review of the Care Inspectorate's fee regime. Gordon Weir provided some further information on the fee scheme—

“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

²⁴³ Scottish Government (2011) *Scottish Spending Review 2011 and Draft Budget 2012-13*. Available at: <http://www.scotland.gov.uk/Resource/Doc/358356/0121130.pdf> [Accessed 17 November 2011]

²⁴⁴ Financial Scrutiny Unit: Key Budget 2012-13 and spending review 2011 documents: <http://www.scottish.parliament.uk/parliamentarybusiness/16305.aspx> [Accessed 17 November 2011]

²⁴⁵ Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011*, Col 336.

²⁴⁶ Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011*, Col 334.

²⁴⁷ Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011*, Col 334-335.

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.”²⁴⁸

353. The Committee was also told that as part of the merger of the three pre-existing organisations to form the Care Inspectorate it had run a voluntary redundancy scheme costing £2.4 million. ²⁴⁹ Gordon Weir explained—

“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.”²⁵⁰

354. Mr Weir also told that Committee that, in addition, there were 21 senior inspectors.²⁵¹

355. Following the Cabinet Secretary's announcement, the Care Inspectorate estimated that it would need increased human resources to cope with the increase in frequency and intensity of inspections. Gordon Weir estimated that an additional £400,000 would be required from next year. This would be funded through other efficiencies that the Care Inspectorate had made or was planning to make.²⁵²

356. In response to questions about the Care Inspectorate's budget the Cabinet Secretary told the Committee—

“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.”²⁵³

357. She added—

“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.

[...] 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

²⁴⁸ Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011*, Col 335.

²⁴⁹ Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011*, Col 339.

²⁵⁰ Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011*, Col 336.

²⁵¹ Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011*, Col 336.

²⁵² Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011*, Col 339.

²⁵³ Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011*, Col 350-351.

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.”²⁵⁴

Committee conclusion

358. The Committee considers it essential that the Care Inspectorate has sufficient resources in order to carry out its regulatory role effectively. The Committee notes that the voluntary redundancy scheme, introduced as part of the merger process which established SCSWIS, was predicated on a planned reduction in frequency of inspections. As a consequence, the Care Inspectorate now has insufficient numbers of inspectors to allow it to fulfil the increased frequency of inspections required from 2012 onwards. The Committee welcomes the assurance given by the Care Inspectorate that it will be able to find £400,000 of efficiencies which can be reinvested to supplement the current complement of inspection staff in order to meet the increased demands required of it.

359. The Committee has recommended in this report that the Care Inspectorate should address a number of important issues through a combination of reviews, revised procedures, enhanced joint working and research. The Committee acknowledges the additional demands that this will place on the Care Inspectorate and calls upon the Scottish Government to ensure that it has the necessary support to fulfil these requirements.

360. The Committee notes that the Scottish Government is planning to carry out a review of the Care Inspectorate’s fee regime. Care Inspectorate witnesses suggested that there was scope to increase fees charged to service providers for registration and annual continuation if such a policy decision was taken. The Committee invites the Scottish Government to clarify, in its response to this report, its intentions regarding fees charged by the Care Inspectorate.

OVERALL CONCLUSIONS

361. The purpose of the inquiry was to investigate whether there were any particular weak points in the regulatory regime and whether safeguards were sufficiently robust. In the wake of high profile events in the care sector such as the collapse of Southern Cross Healthcare Group and closure of the Elsie Inglis Nursing Home following the death of a resident, the Committee considered that it was timely to consider the regulatory system for social care in Scotland and conduct some post-legislative scrutiny in this area.

362. The Committee’s inquiry has already prompted, the Scottish Government to take action to address weaknesses which were brought into focus by the Elsie Inglis case. In particular, the Committee welcomes the announcement from the Cabinet Secretary that care services for older people will receive at least one unannounced inspection each year. The Committee hopes that this increase in inspection frequency can be

²⁵⁴ Scottish Parliament Health and Sport Committee. *Official Report, 4 October 2011*, Col 351.

implemented before the expected statutory commencement date of 1 April 2012.

363. At the outset of this inquiry, the Committee posed four specific questions—

- Can we be confident that the regulatory system is picking up on care services where the quality of care is poor?**
- Are there any particular weaknesses in the current system?**
- Does the system adequately take into account the views of service users?**
- Does the registration and regulatory system provide an appropriate basis for the regulation, inspection and enforcement of integrated social and NHS care in the community?**

364. Following detailed consideration of a significant volume of written and oral evidence, the Committee has reached the conclusion that the current regulatory system is sufficiently rigorous to identify care services for older people which are failing to deliver high quality care. However, that does not mean that there are no weaknesses or areas for improvement evident within the current system.

365. The Committee has identified several areas where the regulator, the Care Inspectorate, must take action. These include:

- Guidance for care staff in relation to “whistleblowing”**
- Enhanced engagement of healthcare professionals in the inspection process**
- Improved accessibility and better dissemination of inspection reports**
- Action to improve the consistency of inspection gradings**
- Research into the appropriate staffing mix for care homes and other services for older people**

366. The Committee has also identified several areas where the Scottish Government, must take action. These include:

- Consideration of the establishment of a single point of entry for complaints about integrated services**
- Discussion with the General Medical Council and the Nursing and Midwifery Council ways of ensuring healthcare professionals responsibilities in relation to having a duty of care to report all concerns, including those that apply to social care, emphasised during healthcare professionals’ training**

- **Consideration of legislative changes to grant the Care Inspectorate powers to refuse further registration of care services from a provider who has other poorly performing services**
- **Consideration as to whether changes should be made to the current enforcement system available to the Care Inspectorate and the appeals process**
- **Consideration given to accelerating the current timetable for registration of care workers**
- **Addressing concerns in forthcoming primary legislation regarding the regulatory framework for the move to self-directed support**
- **A review of the National Care Standards to embed equality and human rights for service users**
- **Exploring the merit in extending the Care Inspectorate's powers in relation to commissioning and procurement**

Involvement of service users

367. More needs to be done to encourage the involvement of service users in the inspection regime. In order to support the Care Inspectorate's risk based approach to inspections, the Committee believes that service user engagement should be encouraged and enhanced including the use of independent advocacy where appropriate.

Complaints procedures

368. When something goes wrong and the care of an older person falls below acceptable standards, there needs to be an effective complaints procedure in order to offer redress and bring about improvements as swiftly as possible. Ideally, complaints should be raised with and resolved by the service provider without the need for recourse to the Care Inspectorate. The Committee considers that more could be done by service providers to bring this about, but the Care Inspectorate also has a role to play by offering support and guidance on good practice.

Regulating integrated health and social care

369. As moves towards greater integration between health and social care services gather pace over the next few years, there will be an increasing need to closely integrate the regulatory regimes which have oversight of these services. The Committee was, therefore, pleased that the Care Inspectorate and Healthcare Improvement Scotland both expressed a willingness to work more closely together moving forward. The Committee considers that early action should include the introduction of joint inspections of care pathways, including clinical care in the community and the inspection of social care for older people in NHS acute services. The Committee believes that this would be facilitated by a review of the National Care Standards. In relation to complaints, the Committee has recommended that the Scottish Government should consider the establishment of a single point of entry, with a view to greater integration in the future.

ANNEXE A: EXTRACT FROM MINUTES OF THE HEALTH AND SPORT COMMITTEE

3rd Meeting, 2011 (Session 4)

Tuesday 28 June 2011

Work programme (in private): The Committee considered its work programme and agreed to undertake an inquiry on the regulation of care. The Committee agreed to seek permission to appoint a budget adviser and to delegate to the Convener and Deputy Convener approval of the programme for the Committee's business planning day at the end of summer recess.

4th Meeting, 2011 (Session 4)

Tuesday 6 September 2011

Regulation of care for older people: The Committee took evidence from—

Lord Sutherland;

Henry Simmons, Chief Executive, Alzheimer Scotland;

Anne Conlin, Development and Training Manager, Carers Scotland;

David Manion, Chief Executive, Age Scotland.

Regulation of care for older people (in private): The Committee considered its approach to the inquiry and agreed to hold informal meetings with service users and their carers, facilitated by Alzheimer Scotland, Carers Scotland and Age Scotland.

5th Meeting, 2011 (Session 4)

Tuesday 13 September 2011

Regulation of care for older people: The Committee took evidence from—

Ranald Mair, Chief Executive, Scottish Care;

Annie Gunner Logan, Director, Coalition of care and support providers;

Dorry McLauchlin, Chief Executive, Viewpoint Housing Association;

Noni Cobban, Vice-President, UK Home Care Association;

Ellen Hudson, Associate Director, Royal College of Nursing Scotland;

Peter Ritchie, Member of the Regulation of Care Branch, UNISON;

Ruth Stark, Social Worker and Manager, Scottish Association of Social Work;

Martin Green, Chairman, Community Pharmacy Scotland;

Mark Smith, Consultant, Chartered Society of Physiotherapists;

Dr John Gillies, Chair, Royal College of General Practitioners Scotland;

Dr Donald Lyons, Chief Executive, Mental Welfare Commission for Scotland.

6th Meeting, 2011 (Session 4)

Tuesday 27 September 2011

Regulation of care for older people: The Committee took evidence from—

Monica Boyle, Head of Older People and Disabilities, City of Edinburgh Council;

Geraldine Doherty, Registrar, Scottish Social Services Council;

Councillor Douglas Yates, Spokesperson for Health & Well-being, and Ron Culley, Team Leader Health & Well-being, COSLA;

Dr Denise Coia, Chairman, and Dr Frances Elliot, Chief Executive, Healthcare Improvement Scotland.

Regulation of care for older people (in private): The Committee reviewed the evidence heard earlier in the meeting.

7th Meeting, 2011 (Session 4)

Tuesday 4 October 2011

Regulation of care for older people: The Committee took evidence from—

Jacque Roberts, Interim Chief Executive, and Gordon Weir, Director of Resources, Care Inspectorate;

Nicola Sturgeon MSP, Cabinet Secretary for Health, Wellbeing and Cities Strategy, and Geoff Huggins, Deputy Director of Health and Social Care Integration, Scottish Government.

Regulation of care for older people (in private): The Committee reviewed the evidence heard earlier in the meeting.

8th Meeting, 2011 (Session 4)

Tuesday 25 October 2011

Regulation of care for older people (in private): The Committee agreed to defer consideration of a draft report to its next meeting.

9th Meeting, 2011 (Session 4)

Tuesday 1 November 2011

Regulation of care for older people (in private): The Committee considered a draft report. Various changes were agreed to, and the Committee agreed to consider a revised draft, in private, at its next meeting.

10th Meeting, 2011 (Session 4)

Tuesday 8 November 2011

Regulation of care for older people (in private): The Committee considered a revised draft report. Various changes were agreed to, and the Committee agreed to continue its consideration, in private, at its next meeting.

11th Meeting, 2011 (Session 4)

Tuesday 8 November 2011

Regulation of care for older people (in private): The Committee considered a revised draft report. Various changes were agreed to, and the Committee agreed to consider a further revised draft, in private, at a future meeting.

12th Meeting, 2011 (Session 4)

Tuesday 15 November 2011

Regulation of care for older people (in private): The Committee agreed to defer consideration of a revised draft report to its next meeting.

13th Meeting, 2011 (Session 4)

Tuesday 15 November 2011

Regulation of care for older people (in private): The Committee considered a revised draft report. Various changes were agreed to, and the Committee agreed to consider a further revised draft, in private, at a future meeting.

15th Meeting, 2011 (Session 4)

Tuesday 22 November 2011

Regulation of care for older people (in private): The Committee considered a revised draft report. Various changes were agreed to, and the report was agreed for publication.

ANNEXE B: ORAL EVIDENCE AND ASSOCIATED WRITTEN EVIDENCE

4th Meeting 2011 (Session 4), 6 September 2011

Written Evidence

[Age Scotland](#)
[Alzheimer Scotland](#)

Oral Evidence

Age Scotland
Alzheimer Scotland
Carers Scotland
Lord Sutherland

5th Meeting 2011 (Session 4), 13 September 2011

Written Evidence

[Scottish Care](#)
[Coalition of Care and Support Providers in Scotland](#)
[Viewpoint Housing Association](#)
[Royal College of Nursing Scotland](#)
[UNISON Scotland](#)
[Scottish Association of Social Work](#)
[Community Pharmacy Scotland](#)
[Mental Welfare Commission for Scotland](#)

Oral Evidence

Scottish Care
Coalition of care and support providers
Viewpoint Housing Association
UK Home Care Association
Royal College of Nursing Scotland
UNISON
Scottish Association of Social Work
Community Pharmacy Scotland
Chartered Society of Physiotherapists
Royal College of General Practitioners Scotland
Mental Welfare Commission for Scotland

6th Meeting 2011 (Session 4), 27 September 2011

Written Evidence

[City of Edinburgh Council](#)
[Scottish Social Services Council](#)
[COSLA](#)

[Healthcare Improvement Scotland](#)

Oral Evidence

City of Edinburgh Council
Scottish Social Services Council
COSLA
Healthcare Improvement Scotland

Supplementary Written Evidence

[COSLA](#)
[Healthcare Improvement Scotland](#)

7th Meeting 2011 (Session 4), 4 October 2011

Written Evidence

[Social Care and Social Work Improvement Scotland \(SCSWIS\)](#)
[Care Inspectorate](#)

Oral Evidence

Care Inspectorate
Scottish Government

Supplementary Written Evidence

[Care Inspectorate](#)
[Scottish Government](#)

ANNEXE C: LIST OF OTHER WRITTEN EVIDENCE

A city for all ages advisory group
Action on Hearing Loss Scotland
Archibald M (indiv.)
Association of Directors of Social Work
Banff Support Workers
Bield, Hanover and Trust Housing Associations
British Red Cross
Bupa
Cairn Housing Association
Chartered Institute of Public Finance and Accountancy
Cockwell J (indiv.)
Consumer Focus Scotland
Dumfries and Galloway Partnership
East Lothian Council
Equality and Human Rights Commission Scotland
Fife Council
Fife Elderly Forum
Glasgow City Council
Highland Home Carers Limited
Jolly R (indiv.)
Learning Disability Alliance Scotland
Lothian NHS Board
Methodist Homes (MHA)
Midlothian Council
Murray R (indiv.)
National Pharmacy Association
Newbery A (indiv.)
NHS Ayrshire & Arran Mental Health Services
NHS Borders
NHS Grampian
NHS Greater Glasgow and Clyde
NHS Highland and the Highland Council
NHS Tayside
North Ayrshire Council
North Lanarkshire Adult Protection Committee
North Lanarkshire Older Peoples Partnership Board
Nursing and Midwifery Council
Parkinson's UK
Parsons R (indiv.)
Perth & Kinross Council Housing & Community Care Service
Renfrewshire Social Work
Royal Blind and Scottish War Blinded
Royal College of Psychiatrists in Scotland
Royal Pharmaceutical Society
Scotland Patients Association
Scottish Ambulance Service
Scottish Council on Deafness

Scottish Federation of Housing Associations
Scottish Human Rights Commission
Scottish Independent Advocacy Alliance – Part 1
Scottish Independent Advocacy Alliance – Part 2
Scottish Public Services Ombudsman
Shetland Islands Council
Social Care Alba Ltd
South Lanarkshire Council
Townsend K (indiv.)
West Lothian CHCP

ANNEXE D: NOTES FROM CONSULTATIONS WITH STAKEHOLDERS

Age Scotland and Caring in Craigmillar

Alzheimer Scotland

Carers Scotland

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Published in Edinburgh by APS Group Scotland

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Printed in Scotland by APS Group Scotland

ISBN 978-1-4061-7921-7
