Scottish Care
Voice of the independent care sector

THE INGREDIENTS FOR GROWTH

CARE PROVIDERS EXPERIENCE OF REGULATION AND OVERSIGHT

NOVEMBER 2021

CONTENTS

INTRODUCTION

Care providers across Scotland have told us that they have mixed experience of regulation and oversight and feel that there is confusion between the two. This report aims to capture the range of experience and the impact that is having upon the sector, as well as to explore potential improvement for the future.

Imagery can help us to understand purpose, value and context; just as new shoots require certain ingredients to grow, improvement in care and support can only happen when the conditions are right. As described in the report 'What if and Why not', which was written before oversight arrangements existed, a symbiotic relationship is a necessary underpinning for regulation. Scottish Care recommends that the metaphor of a symbiotic relationship be extended to incorporate collaboration stemming from this report regarding both regulation and oversight, and is seen as an opportunity to create a flourishing social care garden.

For context, the roles of public bodies who have regulatory responsibilities are enshrined in law. The Public Services Reform (Scotland) Act 2010 outlines the actors in social care regulation - the Care Inspectorate for providers of care, and Healthcare Improvement Scotland (HIS) in supporting healthcare priorities. [1] The social work and social care workforce are regulated by the Scottish Social Services Council as directed by the Regulation of Care (Scotland) Act 2001. [2]

In May 2020, the Cabinet Secretary instructed Scottish Government to introduce oversight arrangements to care homes which sit beyond the regulatory function. [3] They outline a role for the NHS Director of Public Health, Executive Nurse lead, Medical Director, Chief Social Work Officer, and the Health and Social Care Partnership (HSCP) Chief Officer in providing operational leadership.

These arrangements sit external to direct care provision.

Whilst it is always possible to come back to statute or decree for definition or purpose, providers have told us that this bears little resemblance to how that experience might feel like on the ground.

In May 2021, Scottish Care wrote and presented a briefing raising anecdotal concerns about oversight arrangements alongside examples of good practice to policy makers, including Nurse Directors responsible for oversight, regulators, and members of the Pandemic Response Adult Social Care Group (see Appendix A). However, at a members forum held in October 2021, it was clear that issues had not been resolved and for many, had grown worse. At that forum it was agreed that more robust evidence was required to support action and a survey and focus group were planned to inform a report.

Concerns about inconsistency in regulation have been raised by providers via the joint working group of Scottish Care and the Care Inspectorate where thematic concerns can be raised and addressed collaboratively. As with oversight, this work is an opportunity to supply more robust evidence to that group to support action.

A scrutiny and improvement model of regulation and oversight provides opportunities for improvement based on a set of priorities. It enables collaboration and innovation. The findings of the questionnaire resonate with a more compliance-based approach with little opportunity for collaboration and prioritisation for improvement and very little scope for challenge. A scrutiny-based model is most effective where an improvement approach is taken. [4] Systems theory proves that collaboration and partnership working are key to improvement, and it is with this ethos that Scottish Care has undertaken our research. As we move into an era where pandemic response becomes part of everyday life, it is critical that we have the right conditions in place to ensure that those who access care and support across Scotland have access to a system of high quality and an ethos of continual improvement, driven by all actors in the system.

This report acts as a formal invitation to partners across the sector to work together, harnessing the might of combined knowledge and expertise towards high quality delivery which upholds the rights-based approach set out in the Health and Social Care Standards. [5]

We welcome offers by both the Chief Nursing Officers Directorate and the Care Inspectorate to progress in this vein, with work beginning around the time of publication.

METHODOLOGY

Scottish Care issued surveys to all Care Home and Care at Home/Housing Support (CAH) members between 22 October – 31 October 2021 on their regulation and oversight experience with the purpose of providing quantitative and qualitative evidence of their experiences.

In sharing the findings from the surveys, we hope to highlight both positive and negative experiences, where inconsistencies and challenges lie for providers, as well as areas for improvement. Worryingly, many comments raised concern that neither the regulatory body nor the oversight teams understand the complexity of the context within which care providers currently operate.

BACKGROUND

CARE HOMES

152 individuals responded to the survey. The biggest response representation was from registered Care Homes with Nursing (72.9%), vs. Care Homes without Nursing (28.5%). Most respondents indicated their service has 26-100 beds, which is supportive of the size of most independent care providers in Scotland being small and medium-sized enterprises (SME). The location of respondents was also representative of Scottish Care's membership, with responses from every local authority area excluding Comhairle nan Eilean Siar. Most respondents (73.3%) only operate one service.

CARE AT HOME / HOUSING SUPPORT

51 individuals responded to the survey. The biggest response was from Care at Home Services (64.7%), followed by Care at Home with Housing Support combined (27.5%), Housing Support Service (25.5%) and Day Care Services for Adults (2%). In terms of the number of hours of care provided, the largest response was 'Up to 3000 hours' (28%). Fewer local authority areas were represented than care homes, though responses are representative of care at home services and membership across Scotland. Most respondents (68.6%) only operate one service.

The findings are summarised below, separated by survey.

CARE HOMES

EXPERIENCE OF REGULATION

We asked several questions on the overall experience of regulation, perceptions of the Care Inspectorate and areas for improvement and comment.

Overall experience with regulation mostly ranged from 'adequate' (17.5%) to 'good' (35.7%) to 'very good' (22.2%). When asked about whether the Care Inspectorate understands the sector they regulate, the responses were almost evenly split: 53.5% Yes, 46.5% No. This raises questions surrounding expertise of the sector. We received a significant number of comments on several issues and categorised these thematically – most notably on a lack of real understanding from the Care Inspectorate and inspectors themselves regarding what care homes have been through and how hard staff continue to work; inconsistencies with regulation; unrealistic expectations imposed on care homes; care homes generally (as they have been compared to and treated as clinical settings); and on the impact of their decisions or regulatory burden placed on financial or operational aspects of service provision. Providers commented:

"One of the reasons that staff are leaving the care sector is the pressure … put on to services even more so in the middle of a pandemic when staff are simply trying to do their best for their residents including keeping them safe from Covid-19."

"Advocate for the sector rather than claim neutrality."

When asked about how regulation can be improved, most indicated that they wanted a greater understanding of the wider influences impacting the sector. This refers to pandemic response and context, workforce pressures, commissioning and procurement etc. Additional areas of improvement include consistency in approach (frequency of inspection, complaints processes, requirements and recommendations made by Care Inspectorate and assurance teams etc.), followed by greater support for the sector, standardised approaches to inspection, greater communication, and transparency. Without standardised approaches we will not have consistency.

Other comments on aspects of regulation elaborated on some of the themes mentioned: many feel there is a lack of support and general consideration - standards are expected without consideration of funding, resourcing and practicalities of implementation or assessment impact. Further, inspector personalities are varied and give differing pieces of advice. One respondent remarked that:

"Care Inspectorate are out of their depth - which when we pay for them to regulate us, is disheartening, especially as we feel that they understand the person-centred model of social care. Clinical teams have shown no interest nor understanding in this. The Care Inspectorate understand that wrapping someone in cotton wool during their twilight years is a very long way from care."

Approaches to inspection are increasingly clinical since the pandemic, but more so since the introduction of oversight arrangements as they do not take the social care context/homely setting into consideration; gradings are inconsistent as inspectors issuing grades will leave it to providers to make the relevant changes, but a change in inspector may lead to a change in grade if they do not agree with their predecessor. This means there is no fair way to demonstrate improvement and this disincentivises providers from making changes.

Overall, while there are positive experiences with inspection, this is entirely dependent on the relationship with individual inspectors. The lack of objectivity and failure to take pandemic adjustments into consideration has been sorely felt by the sector; staff feel demoralised, the inspections do not recognise the work and changes that have happened over the past 20 months and heightened scrutiny increases challenges for staff and residents alike. For many, it has felt like regulators have been overtaken by improvement and oversight bodies trying to justify their role. This detracts from prioritising the needs and wellbeing of those in receipt of care and support.

EXPERIENCE OF INSPECTIONS

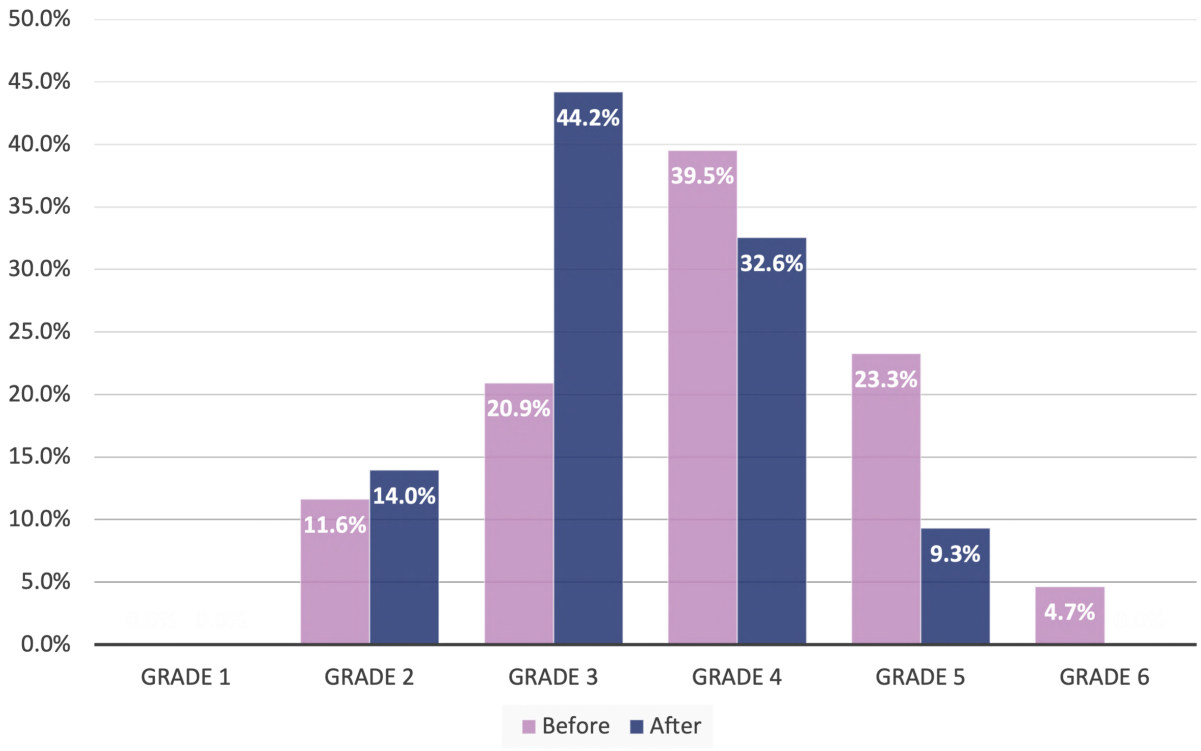
When asked about inspection, 74% of respondents report they now have a different inspector to before the pandemic. Comments stated mixed experience with this – some inspectors are supportive while others are not. The more meaningful relationships tend to be with those who have had the same inspector, indicating that continuity of a relationship is linked to better relationships. However, many report inconsistencies in their inspectors – some have had changes without ever meeting an inspector or are assigned a new one without being informed. Inspecting teams are also short staffed.

Half of respondents (49.2%) say they have *not* had at least one inspection from the Care Inspectorate since March 2020. Whilst we recognise this would have been appropriate as early pandemic response to reduce footfall in care homes, it is concerning that while almost ¾ of care homes have a different inspector now, only about half have had an inspection. New inspectors will not be able to develop greater understandings of the care homes if they have not visited.

For the half that have had more than one inspection, since March 2020 the number of inspections has ranged from 2-8. Care homes may have multiple inspectors for one visit.

When asked about whether grades have changed over this time (for those that *were* inspected), 46.7% reported downgrading. 23.3% stated their grades had increased, and 30% had stayed the same. This is evidenced by changing in grades from 5 and 4s to 4s and 3s.

Grading changes (2019 - Present)



Inspection plays a role in improvement. Whilst it was helpful to reduce footfall in the early days, the absence of inspection reduced the opportunity to address areas for improvement in a timely manner. We recommend more work to be done in supporting self-evaluation and a focus for the Care Inspectorate's role in improvement support.

We asked whether homes could challenge inspections: 68% said Yes, though there are consequences in doing so – respondents said there is often little room for discussion, there is fear of further downgrading, and it is simply not worth the effort to challenge if minds are already made up.

Generally, the timescale to implement improvement requirements is sufficient: 72.3% said they have enough time.

LARGE SCALE INVESTIGATIONS

Lastly under inspection, we asked about large-scale investigations (LSIs) and whether homes had experienced one. Twelve respondents stated they had, with only half upheld. The remaining 50% are either still ongoing or staff are dealing with the repercussions. The overall sentiment is unfairness and a conscious bias - that care homes are bad and need to prove their innocence.

Providers told us that with the introduction of oversight arrangements, many more people had become involved with LSIs. When asked how many people attended the LSI review, responses ranged from 2 to 20, though most reported higher numbers. The fundamental purpose of the review is to quickly establish if there is an issue and what immediate action should be taken. Too many people involved creates a disproportionate power imbalance and a process with the feel of a legal trial - an experience not conducive to improvement. Providers also told us that the timeframes for improvement have been unreasonable for homes with such requests as 'by the end of the day' and 'within three days' for improvements such as repairing chipped paint or replacing carpet, and at a time when there is a national shortage of service workers.

EXPERIENCE OF OVERSIGHT

The Executive Nurse Directors (ENDs) were given oversight for Care Homes in May 2020 and assurance teams were developed to support the ENDs with this additional responsibility. [6] The oversight arrangements were brought in for care homes, but in some areas, these have been extended to homecare. Whilst the letter from the Cabinet Secretary outlined oversight arrangements, some areas adopted the term assurance instead. We will refer to the assurance and oversight simply as 'oversight' and any quotes that use assurance can be interchanged with 'oversight.'

Providers told us in our Forum that they experienced confusion between oversight and inspection. We asked how well individuals understood the Care Inspectorate's role as it related to oversight: the average answer was 4.9/10, meaning just less than half understood how regulation and oversight differ and interact. This also highlights a lack of clarity and understanding of the purpose of oversight arrangements. Providers also told us that the relationship between inspectors and oversight teams varied across Scotland with some working collaboratively with the Care Inspectorate and others operating in isolation.

The majority of homes (77.4%) have had at least one visit from the oversight team. Overall comments were highly negative and cited a lack of understanding from the teams to grasp care home operations; respondents noted a lack of experience and lack of respect for frontline staff experience:

"One example of the way the home was treated was the use of <the word> "soiled" to describe a mark on a bed leg when it was clearly evident to anyone that it was simply a 'scratch/scuff' mark from a piece of equipment such as a hoist. This was a deliberate misrepresentation which they refused to change in their report! They were, for whatever reason, out to get that home! It was quite frankly a horrible experience."

It is also challenging to reconcile conflicting information; while oversight teams are generally more supportive than regulatory teams, providers are unsure as to whom they are meant to listen to for improvement:

"If the oversight team says something is fine, but the Care Inspectorate says it isn't, what should be done?"

Most (64.4%) oversight visits have been announced to providers in advance, yet over a third have had unannounced visits. During conference calls, providers were told unannounced visits were because *'otherwise homes would prepare for the inspection and not give a true reflection of how they are operating.'* This is a complete misunderstanding of what the oversight visit is – it is not to regulate or inspect and demonstrates how the oversight teams view care homes before they even set foot inside. **76% feel that the oversight visits are like inspections**. When asked to describe the nature of the visits: 35% said the visits are 'supportive', 23.3% selected 'collaborative' and 23.3% said 'critical'. 16.5% selected 'Other,' which listed an array of comments:

"Far too many scrutiny bodies now and each one acting like inspectors (CI <Care Inspectorate>, care home support team, Public Health inspections, residential review team). The support team offer many services however this is more than often not delivered…often they will walk around in pairs and their comments and criticisms can be overheard."

"I had two oversight visits which were thorough and reassuring only for the CI <Care Inspectorate> to come in and grade us '2' on the same thing. One of them is wrong."

As previously iterated, inconsistency cannot lead to improvement. The sector knows itself best and visits need to be collaborative to lead to better outcomes. It is in areas where the oversight teams engaged with the sector at a strategic level that a more positive oversight experience was reported, as outlined in the briefing (Appendix A).

Respondents were asked about the difference between oversight visits and inspections. We felt it was necessary to hold space for providers to elaborate on their experiences and qualify these into themes. The most recurring comments were around oversight being 'supportive' and 'understanding.' This may be attributable to visits being more collaborative with a feeling of working together for the benefits of the residents; there is more

communication and support in place with these types of visits which enable services to work towards best outcomes. This has continued to improve since the visits began in 2020, but this observation cannot be made in isolation of the context, and we know that significant sums of money have been made available to create the oversight function and delivery. If the funding had been directed to the Care Inspectorate, it is feasible that it would have given them capacity to function more effectively, given their expertise in social care and support.

Other comments state there is little difference, that oversight feels like inspections and is quite critical, with an emphasis on clinical and acute medical model approaches applied to the visit. This indicates a lack of knowledge of care home environments. Oversight visits must take homely settings into consideration and [NHS] teams conducting visits do not have the experience do not do this. Overall, the inspection process is more structured and is underpinned by clear quality measures followed up by detailed feedback. The skills and knowledge of qualified nurses and staff must be respected by oversight teams so they are not undermined. One comment related a terrible experience:

"Inspection visits are generally supportive and stem from a place of mutual knowledge about the home…The oversight visit seems determined to find fault, not look for positives and highlighted an acute lack of knowledge about what constitutes good care for the elderly and was very much based on a hospital model. The oversight personnel demonstrated a lack of knowledge or understanding of the needs of residents with dementia or the frail elderly and what was important to them and what was considered best practice in dementia care. Oversight visit did not seem focussed on the residents or their well-being beyond infection control and very specific items of paperwork."

The comment elaborated on how this seriously impacts staff and morale, not solely by the interactions but how information from inspection and oversight is presented.

Providers also made comment that if the money used in oversight had been given to them to deliver direct care and support, there would be marked immediate improvement for residents and staff.

NATURE OF OVERSIGHT VISITS

We wanted to know whether oversight improved outcomes for residents, whether homes had changed aspects of providing care and support in homes and if they felt oversight visits were grounded in person centred, rights-based and outcome focused approaches to care. 43.6% stated they had changed aspects. **Where oversight was applicable, it appeared to *not* have improved outcomes: 57.3% it has not helped, 26.4% said it has and 16.4% said 'not applicable.'**

The areas where there has been improvement are centred around infection prevention and control (IPC) management and awareness and staff focus on this. Comments such as ***"...the guidance from Oversight has been of a confirmative nature. This has been helpful and means that we can seek advice & guidance from the oversight team without fear of reprisal or judgement."***

Conversely, other comments indicate outcomes have worsened for both residents and staff:

"If anything, the battering staff morale took after assurance visit reduced outcomes for residents as the staff struggled to feel their value in the workplace."

"Complete lack of understanding of a care home ethos; care home experience is less relaxed; carers have less time with residents."

Others said that oversight has not impacted outcomes:

"Oversight visits are not interested in outcomes - too clinical."

"CH <Care Homes> listen to feedback from oversight visits but made our own decisions with regards to improving outcomes for the residents."

Just over half (56.4%) said oversight visits were not person-centred. Comments stated visits tended to be clinically focused and misguided. One said that during a visit, oversight ***"suggested that our support plans should be more person focused by summarising people's medical history and using this to develop their personal outcomes!"***

Other comments highlighted the overbearing and critical nature of visits, with a stringent focus on IPC rather than recognising residents' rights. Respondents said:

"It felt like big brother was watching us," and ***"they are based on looking for ways to blame care homes for deaths and outbreaks by sending in what they consider to be superior staff from the NHS."***

STAFF IMPACT

The nature of these visits has varying impact staff on staff. 28.6% of staff have been positively impacted, 35.7% have been negatively impacted and 26.8% have not been impacted. The remaining percentage did not deem the question applicable.

We asked whether staff retention, wellbeing, morale, none of the above or anything else had been impacted by the visits. **Oversight has mostly impacted morale (63.4%),** with less impact in other areas.

For a handful, oversight feels more supportive than inspections and boosts staff morale. However, this does not appear to be the case for the majority. Many feel this is like an additional inspection and low morale has contributed to staff leaving the sector and made recruitment/retention increasingly difficult. Also, complaints about lack of knowledge from oversight teams focusing on the wrong issues:

"Oversight has decimated the self-belief of our staff - 'we can't do anything right.' We have lost many good staff as a direct result of this process and we cannot recruit due to the rural nature of the home, as well as the fact that no-one wants to work in care when they hear around the village what we have been treated like. They are destroying our sector!"

"Critical, authoritarian and very poorly informed."

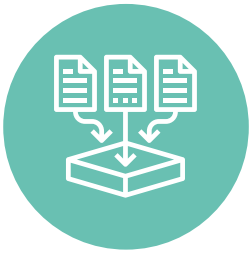
EXPERIENCE OF OTHER AGENCY INVOLVEMENT

We asked whether other agencies have been into homes to carry out (what might feel like) oversight and inspection. 72% said no, though we did ask respondents to list organisations if this was applicable. These included the following:

HSCP, Local Authority (community care and response team), [NHS] Health Protection, Social Work, environmental health, NHS Infection Control, Citation health and safety inspection, Fire Inspection, Healthcare Improvement Scotland (HIS), Hospital Infection Control, care home support teams, Public Health Scotland, deputy nurse manager, Covid support teams, mental health teams, independent advocacy, practice development nurse, continuing care review team Social Workers.

Comments said that the number of these visits tended to range from 2-5, with the mode being 2.

EXPERIENCE OF REPORTING AND DATA COLLECTION



Data reporting can be useful from a quality improvement perspective, however "Scotland is currently data rich but intelligence poor." [7] Care providers have told us that they must submit data to a wide range of bodies for a purpose which is unclear and in a way which creates duplication in the system. For example, care homes are asked to report information to council commissioning teams, HSCPs, the Care Inspectorate, the Turas safety huddle tool, among others. Scottish Care previously worked with social care and data experts to explore this further, highlighting that there is much potential for data in social care and support if approached using the co-produced principles for data in social care as outlined in the report 'Seeing the Diamond in Social Care Data'. By adopting these principles, we can build trust, improve strategy and policy, and ultimately, quality of care and support.

71.6% of respondents said there is duplication in the data providers are required to report. Information duplication mostly occurs in the following areas:

- Across TURAS and Care Inspectorate regarding staffing levels, reporting of positive COVID tests, vacancies.
- Different test types are submitted to different agencies [lateral flow (LFT) vs. PCR]
  - Ex: If positive or suspected case of Covid, then information is sent to the Care Inspectorate with e-forms, Public Health team via email, HSCP via email, Care Home Liaison Nurse via telephone call, and Turas online.
- Duplicate information on vaccines (which is already held by NHS).
- Duplication with Public Health information.

Only half (51.4%) of respondents report they know the reasons for data collection. This is concerning. Several commented that the reasons for collection were explained when Turas was first introduced - through webinars to collate information for the government and to give homes a platform to raise concerns and to keep an eye on trends in different areas. Those unsure said that the reasons why it has been asked for, how it is being used, how it will be presented or what the expected or actual outcome is has simply not been explained. It is unclear why there is a need for so many diverse sources of information.

When asked if they understand the impact of their submissions, 69.8% said they did *not*. The reasons that respondents cited for the impact of this included:

- Awareness that information is required for the bigger picture
- COVID-related (outbreaks, staffing, support, and access to personal protective equipment (PPE)/staff)
- For government statistics and oversight

We also asked how data reporting can be improved. An overwhelming number of respondents commented to suggest one single reporting tool that can be used by agencies wherein data is shared, integrated and accessible to all. However, from our detailed research in the area, we would take this a stage further, to ask for the adoption of systems which interact with the existing reporting tools that people, and providers already use to capture data, and which would give ownership of data to the citizen in a method which is not dissimilar in conception to a simplified Blockchain technology, and which already exists in the marketplace. This emphasises the real need for a joined-up approach to improving outcomes and reducing burden and waste for the sector. Other suggestions included:

- Reduce reporting frequency (whether once a week, twice a week or only when there are changes)
- Reduce amount of information being asked
- Evidence how information is used
- Easy access and user-friendly guidance
- Consult with care sector regarding data, not just NHS
- Employ government statisticians to gather information rather than giving managers additional data responsibilities OR compensate managers for this work

RELATIONSHIPS

Since the introduction of assurance in May 2020, the relationship across agencies (Care Inspectorate, Social Work, Local Authority, HSCP) is mostly unchanged, according to respondents: 45.8% stated 'no change,' 26.2% stated relationships have improved and 28% said that they have worsened. General feedback on agency relationships is that there is an expectation mismatch, wherein there is inconsistency in what is being asked of providers. There are also feelings of power imbalance as providers describe agencies trying to defend themselves and their roles, rather than focus on how well residents are cared for and supported. This is detrimental to creating an effective system with true partnership working.

There are mixed areas of improvement – some feel relationships have improved in terms of intent, with individuals connecting and supporting each other more and with some bodies. However, a chasm remains between Government and authorities:

"We feel we have improved relationships with the HSCP at a strategic level through Chief Officer and the creation of a Strategic Advisory Group for Providers that feeds into the IJB Subgroup - Strategic Planning Group, however relationships with the HSCP - mainly NHS at a local level have not been good given their approach to assurance. We have also struggled in relationships with the Local Authority in their processing of sustainability and inconsistency of interpretation across different local authorities."

Generally, respondents agreed that the Care Inspectorate is most effective at providing assurance and scrutiny, followed by family members, assurance teams, other organisations and HIS.

Lastly, we asked respondents whether there was any other point they would like to raise. These comments were also grouped thematically, with the most common responses being on staffing – recruitment and retention. There are factors outwith the control of the sector such as Brexit, COVID, perception, competition from other industries offering higher wages for jobs which do not require professional registration, and negative press coverage. These influence the ability to attract people to the sector as well as retain staff. One manager commented experiencing the greatest staff turnover in their 19 years in the role. Another said:

"Staffing is a huge issue. As a manager I have had to adapt my role to being more supportive and hands on with staff and residents. This has impacted on my ability to do my role. Working to the addendum and ARHAI <Antimicrobial Resistance and Healthcare Associated Infection Scotland> is a challenge. Audits, risk assessments, testing, managing visiting safely...extra hours of paperwork with no extra time to complete it. Something has to give, and it is usually the manager's workload that is affected most. Recruitment is a nightmare, supervisions - not done, staff training not done - current immediate training relevant to Covid is undertaken but no additional training. Staff working all sorts of hours to cover the home and are tired and demoralised."

Following staffing, respondents commented on the impact of regulation and oversight on the workforce - on morale, mental wellbeing, feeling burnt-out because of never-ending scrutiny, seeing the impact of resident's lives changing, feeling constantly undervalued and constant dealing with restrictions. This all affects standards. Some poignant remarks included:

"Morale in the sector is like nothing I have ever seen. We have lost so many good people who have gone onto other sectors where there is far less stress and far more support and pay. New people to social care coming on board are running out of experienced people to train them. I personally would not take another role in social care should I leave, which I am on the brink of doing. I'm not sure how much more stress I can take. In care homes we are constantly put down, undervalued, seem to be getting treated as an example by the government for things that even they have admitted were done incorrectly at the start of the pandemic. There is so much bloat above us that no one seems to know what the other person is doing, and it has to stop."

"I believe the additional pressures on Health and Social care have to be carefully considered...staff are exhausted across several sectors and work to a very high standard despite their own feelings of exhaustion. Care homes are often scrutinised for staffing but given the current climate I think this has to be taken into consideration by inspectors."

Other comments touched upon finance and lack of investment, leading to financial instability, issues with payment of covid related sustainability support to providers; increasing costs; reiterations of previous points on the lack of understanding from regulators on how care homes work; lack of parity with the NHS; role of the media on staff recruitment and retention, and morale.

CARE AT HOME & HOUSING SUPPORT

EXPERIENCE OF REGULATION

All the questions asked to care home providers were also asked to the care at home and housing support sector – on their experience of regulation, perceptions of the Care Inspectorate and areas for improvement and comment.

CAH respondents had a wider range of experience with regulation. The options available were unsatisfactory, weak, adequate, good, very good and excellent. Overall experiences ranged from 'weak' (18.2%) to 'adequate' (25%) to 'good' (11.4%) to 'very good' (36.4%). While mixed, overall appearance here seems to slightly more positive than for the care home sector. The Care Inspectorate grading system was evenly selected as 'adequate' and 'good,' (27.9% each) and the complaints system ranged from 'adequate' (27.3%) to 'good' (20.5%) to 'very good' (25%) as the most selected answers.

When asked about whether the Care Inspectorate understands the sector they regulate, 65.1% said no. There is less understanding here than in the care home sector which raises greater about who is regulating and the knowledge that they have. Comments from respondents highlighted the lack of understanding from inspectors and regulators, an inconsistency in inspection and unrealistic expectations imposed on providers.

When asked about improvement in regulation experience, respondents were asked to select which elements they felt would help. **81.8% selected 'greater understanding of the sector - pandemic response and context, workforce pressures, commissioning and procurement etc.'** This was followed by 'greater support for the sector' (59.1%), 'consistency in approach' (54.6%), 'standardised approach to inspection' (47.7%), 'greater transparency' (38.6%) and 'level of communication' (29.6%). There were a handful of comments centred around consistency and objectivity, similar to care home responses:

"Inspecting your services depends on the allocated inspector on that day as you can present the same platforms, paperwork, evidence to one inspector and be graded weak and give all the same information to another and be graded good/very good. I have experienced this across Scotland with many different inspectors."

"Inspection appears to be based on who is carrying out the inspection and can be very biased."

Other aspects of regulation that respondents highlighted echoed these findings. Respondents commented on the Care Inspectorate having misguided expectations – such as what a service is able to provide in 15 mins not matching regulator or indeed purchaser expectations. Greater recognition for the sector as it currently stands is needed:

"Before it can be properly regulated it needs to be staffed properly with better paid staff."

"Local authorities pay their care workers £14 - £15 per hour. We have to provide a full service based on a contract for £17.50 per hour. We have to train, provide free uniforms, PPE, holiday pay, CPD, National Insurance, tax, pension, and many other things for £2.50 more. The inspectors then come in and assess the quality and hammer everyone. How can they talk about quality when they know this practice happens across the sector? Hypocrisy at the highest level. They should tackle the real issues in care rather than hammer companies who are trying to provide a good service."

COVID has had a significant impact on services over the past 20 months and there is effective communication in place, but consistency in regulation must be improved.

EXPERIENCE OF INSPECTIONS

61.9% of respondents now have a different inspector than prior to the pandemic. Services have been assigned several inspectors over the course of the pandemic – such inconsistency leading to a lack of understanding. One said:

"I have had 3 different inspectors since start of pandemic. Early on I received regular calls to see how things are going. I have had nothing from them for over a year even though we have had a few positive cases. They say they are there for support but clearly not!"

When asked about inspections, 81% said they have not had one since before the pandemic – this means they are approaching a 2-year period with no inspection. For the 8 services that had an inspection, 1 had a grade improvement, 4 did not have a change in grade and 3 had grade decreases.

"We had a change of inspector, and the second inspector came 3 months after the old inspector had been to inspect and changed the grades even though the evidence hadn't changed from the previous inspection."

This is concerning for several reasons – whilst self-improvement plays a vital role in

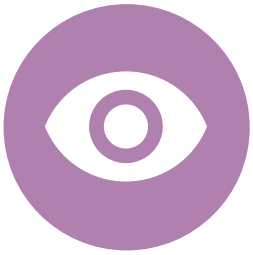
quality assurance, providers see inspection as a helpful tool to further that experience. The Care Inspectorate's role in knowledge mobilisation often occurs through regulation and there is a risk that a lack of connection creates a disconnect causing some providers to 'fall behind' and end up downgraded. In addition, organisations who changed ownership could not get access to the National Care and Support Framework held by Scotland Excel without a grade which risked continuity of care. Fundamentally, however, a lack of regulation raises adult support and protection risks.

Respondents were asked whether they felt able to challenge inspection decisions: 63.6% said Yes. Comments left by those who said yes reported that inspectors are open for discussion in most cases, but this may not influence the final outcome. Those who said no were more negative, with the general sentiment being that when you challenge there is little dialogue with the inspector, and it is unheard of that grades change: ***"It is a waste of time and counterproductive."***

Where improvement requirements have been made, the timescale to implement these is sufficient, according to 78.8% of respondents.

On the subject of large-scale investigations, only one respondent reported having one which was upheld and generally had over 7 people attending the review.

EXPERIENCE OF ASSURANCE AND OVERSIGHT



Understanding of the Care Inspectorate's role as it relates to oversight is worse than for care homes; the average answer was 3.7/10, meaning that around 37% understood it. This might be because the oversight arrangements were initiated as intended for care homes.

The overwhelming majority (92.9%) of respondents said that oversight arrangements have *not* been extended to care at home in their local area. Many are unsure, and just 5.8% (or 2 of 34) have had an oversight visit. Of these two, one has had many visits with no understanding of the purpose of it. This same provider has had unannounced visits, which they say were critical of their service. While both report the visits feel like inspections, the other provider's experience has been more supportive.

It would not be appropriate to say that oversight has improved outcomes when it is not applicable to the majority of care at home providers, nor to say that they are grounded in person centred, rights-based and outcome focused approaches to care.

Similarly, as only two respondents have experience of an oversight visit, we cannot speak to the impact of oversight on staff.

EXPERIENCE OF OTHER AGENCY INVOLVEMENT

When asked if any other agencies been visited to carry out (what might feel like) oversight and inspection, only one respondent said yes – the local HSCP.

EXPERIENCE OF REPORTING AND DATA COLLECTION

On the topic of data duplication, 63% said there was *not* duplication in reporting. This is a contrast to care home providers. For those that said that there is duplication in local authority, they cited Public Health, Care Inspectorate reporting and with Scotland Excel on the topics of staff absences, infection control and Covid updates.

Similar to care home responses, reporting can be improved by adopting the principles outlined in the report 'Seeing the Diamond in Social Care Data.'

When asking if the reasons for collecting data have been explained by those asking for it, responses were split – 44% said Yes and 56% No, with the majority (80.8%) *not* knowing the impact of their submissions.

RELATIONSHIPS

Since oversight was introduced in May 2020, the relationship across agencies (Care Inspectorate, Social Work, Local Authority) is felt to be unchanged by respondents: 73.1% reported no change, 19.2% said improved relationships and 7.7% said relationships have worsened. This could be considered better than the relationships between agencies and care home providers, however CAH has not had as much regulation and oversight since the pandemic began, therefore they have had less interaction with agencies.

Generally, respondents agreed that the Care Inspectorate is most effective at providing assurance and scrutiny, followed by family members, assurance teams, HIS and other organisations.

Lastly, we asked whether respondents would like to comment on anything else. There were several comments on the role of the Care Inspectorate and the lack of recognition from them of the challenges on services and comments on the known issues of recruitment and staffing:

"[We] cannot compete with NHS and Local Authority terms, conditions, rates of pay. More staff would mean organisations could take on more commissioned care packages. CAH will have to close if staffing levels aren't addressed – CAH is forgotten."

Another comment was on staff recognition:

"Staff need to be recognised as a professional work force with decent pay for the level of responsibility and visits they do…recognition from Scottish Government is needed, that this is the only pathway forward to stabilise the sector."

Carers need to be respected and truly valued; they have huge responsibility and accountability, and it is time that they are compensated as such.

CONCLUSION

The report covers several themes, but key ones running throughout are the need for clarity in the role and function of all parts of the system, and greater partnership working and consistency which includes recognition of sector expertise.

Going forward, a review of the purpose and function of regulation and oversight arrangements should be undertaken which recognises existing legislation and purpose, as well as the conditions required to enact that effectively.

It should also be recognised that oversight arrangements were introduced at a point of crisis in pandemic response. Now 20 months on, it is time to review whether they are meeting their purpose, and if that original purpose still exists.

This report recommends that a fully resourced and co-produced solution incorporating expertise across the sector should be explored and implemented should that group agree they are still required.

Whilst some of the changes and concerns experienced by care providers were in direct response to the Covid-19 pandemic, on greater interrogation, they would appear to highlight long-term systemic challenges across health and social care. Specifically, on value, as defined by the long-term under-recognition and under-resourcing of social care when compared to the health-led parts of the system. In light of this, the group should explore how the system, through greater collaboration, valuing of expertise and understanding, can make more effective and efficient use of what already exists without adding additional bureaucracy or resource implications. Sadly, where the experience of providers has been poor, this has impacted staffing and quality of care in the worst cases. It may be that additional work will need to be undertaken, not only to improve systems, but to repair any damage from negative impact. As these factors concern people, these should be priority areas of focus going forward.

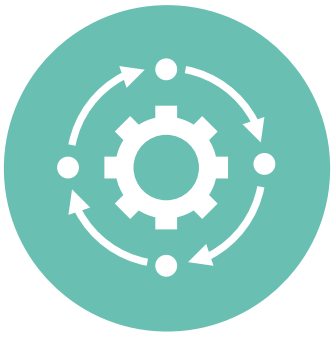
It is also possible to pull from the research where there can be improvement. This thinking aligns with the briefing paper which Scottish Care produced in May 2021 (Appendix A). These examples of good practice should act as leading lights for future regulation and improvement systems and interventions.

Whilst this report describes some difficult experiences, there is ahead of us a real opportunity to combine our expertise, maximising the potential of design and delivery to create the context for the flourishing social care garden as outlined in the introduction. And no matter what that may look like, it must have people at its heart.

ABOUT SCOTTISH CARE

Scottish Care is a membership organisation and the representative body for independent social care services in Scotland. We represent over 400 organisations, which totals almost 1000 individual services, delivering residential care, nursing care, day care, care at home and housing support services. Our membership covers both private and voluntary sector provider organisations.

For more information on Scottish Care's work: www.scottishcare.org
For media enquiries including interviews, please contact comms@scottishcare.org



APPENDIX A

Briefing on Care Home Experience of Assurance Visits

The Care Home Assurance visits are evolving into a second phase. Feedback from our members suggest this has yet again resulted in a varied picture across Scotland. In many areas, there are positives to report, but there are also many inconsistencies and questions raised.

A year into pandemic response, there is opportunity to learn from experience, enabling more cohesive and proactive improvement support.

This paper was collated with the purpose of a quick turnaround and whilst it contains some examples, we recommend that a more detailed compilation of 'good practice' is co-produced to be shared across HSCPs.

Purpose and Governance

This is the fundamental theme. There must be a purpose to the visit, and that desired outcome must be clearly defined and agreed by all involved, including contributors, with risk and mitigating factors and a pathway to response. This was not always clear in all cases, with confusion when conflicting reports are received from different professionals e.g., Care Inspector, Public Health and Social Work Perspectives often differ/ highlight different aspects.

The governance surrounding this is at risk of becoming confused as we move out of the second wave of the pandemic and care homes become more self-reliant and have been equipped through accessible PPE; testing capacity, enhanced infection prevention control (IPC) measures and greater access to Community Health Teams. The risk of workforce depletion has lessened, and care homes are themselves remobilising their strengths, skills and specialisms in meeting the clinical and social needs of residents.

The balance needs to consider the need for assurance and how it is provided longer term, not forgetting that no industry was prepared for Covid-19 and care homes were able to respond and demonstrated their resilience overall. The clinical leadership within care homes with nursing would benefit from being integrated to the HSCP governance arrangements, with care homes without nursing being valued for the non-clinical skill sets they provide in partnership with community colleagues.

There is opportunity for the visits to act as an alert/early warning system and highlight where a provider may require additional support. However, for this to be enacted upon, there needs to be understanding of what support might be available/possible to deliver. In some areas, there is limited resource on the ground, in others, there has been significant investment, but not always where needed, including the recruitment of nursing staff at a much higher rate than what the national care home contract would allow. In worst case scenarios, the uncertainty around purpose and governance has ended with initiating, rather than preventing Large Scale Investigation.

Positive Example:

Clear governance procedures should include and be available to the sector to ensure consistency and purpose. The support network to care homes should be developed with the sector to ensure that it can best serve its needs effectively and efficiently.

In some areas, the additional resources created within HSCP Teams mean that they now have greater depth to respond proactively and where necessary, reactively where they previously did not.

Process

Again, a varied picture; in some area's visits are announced, others unannounced. The people involved in the visits vary also, and critically, the role of the regulator in the process is often unclear or unrecognised. Frequency should also be scoped, for instance in Aberdeen visits will be every 3 months. Some areas have also shared a template with providers to support them in meeting targets – others have refused which raises the rather critical question *how can care homes improve if they do not know what they are being asked to do?.*

In one area the Care Inspectorate findings are read prior to the assurance visit which avoids the need for duplication and seems to promote a more focussed visit.

Positive Example:

Sharing universal templates and checklists e.g., for checking mattresses/ other furnishings.
Pre planning the visit in conjunction with the Care Home in some areas this made the visits feel they were about support and not scrutiny. For example, in one area the Care Inspectorate findings are read prior to the assurance visit which avoids the need for duplication and seems to promote a more focussed visit.

Method

There is no standardised training or methodology for those carrying out visits. For example, we know of one area that says they are taking an Appreciative Inquiry approach but that some of those conducting the visits do not know what that is or means. This highlights a scenario of scrutiny and support by those who are not qualified to undertake the role and the risks associated with such an approach. In some areas it feels simply like a 'tick box' process, raising questions around purpose and longer-term impact. A national defined methodology should be applied and those carrying out the visits should have been trained in undertaking the task.

Positive Example:

In one area, the IPC nurses use Key question 7 as a guide which has made the process more appropriate and easier to respond to.

Relationships

In some areas, the expertise has been a mutual exchange of support and knowledge to provide assurance with the use of an external resource to validate provider perspectives of compliance. Whilst those areas report that relationships have at times been strained, overall, the relationships are strengthened, and appreciation of roles and responsibilities is on a more mature footing. This is not the case everywhere.

In addition, a hierarchy has developed whereby care home nurses are no longer considered capable by some of their NHS peers. For instance, nursing roles are being re-allocated to community nurses. This de-values and de-skills those who are working in care homes and puts additional pressure on a limited resource as well as increasing footfall amid a pandemic.

Relationships have been established over many years between provider and regulator which has led to an environment of trust and mutual respect. In places, these relationships have been lost which ties in to the less than positive experience of the assurance visits by some providers. For example, in some areas there remains confusion around the relationship between and the role of the regulator and group visits.

In addition, due to the limited nature of resource, there have arisen challenges where there is a clash of personality – there is no alternative route for support or arbitration.

Positive Example:

Create the conditions for an environment of mutual support and improvement.

Estates/Soft Furnishings

Much of the concern here lies in the medicalisation of the sector. There are mixed reports around recommendations in relation to estates for example – around the use of soft furnishings. This leads to additional questions around finance. In one instance, a provider had recently replaced their alarm system but have since been told that they cannot have cloth pull-cords which will require significant new investment. There is also mixed guidance about the type of cleaning products to use with some Health Boards making recommendations which differ from national guidance, and the damaging effect of chlorinated cleaning products.

In addition, there needs to be greater thought around personal items and items which promote wellbeing such as animatronic pets. Cleaning regimes must be suited to the environment. In one home a person's effects were described as 'trinkets to be removed' rather than recognised as valid memories, comfort, homeliness and personalisation.

Positive Example:

Clear guidance interpreted and understood locally, designed specifically for the environment rather than transplanted from a hospital setting.

Expertise/Learning

This section reiterates an imbalanced approach whereby health professionals are meeting to discuss the learning and support which care homes require without care home representation or expertise. Scottish Care has been lobbying for some years on the need for more CHEFs and the positive support that they give. Instead, we find ourselves in a reactive scenario where learning needs are being assumed by those too far from the frontline or with an overly clinical approach. In addition, learning is a mutual process and can be applied both ways with clinical staff learning more about the care setting as someone's home.

Positive Example:

In one area, those carrying out the assurance visits had a development session with a Scottish Care Independent Sector Lead to fully understand the care home context. Providers can also feedback any comments via the Independent Sector Lead and this will be raised at a multi-disciplinary Care Home meeting ensuring that they have a route to conciliation.

In another area, initial results raised that knowledge on safe IPC Measures, training etc was very mixed. As a result, an IPC Group was formed and included Care Home Managers, the IPC Team and Independent Sector Leads. This led to a coherent approach to training. As a result, there has been significant improvement between the first and second round of assurance visits.

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