

COMMUNITY CARE PROVIDERS SCOTLAND

CARE COMMISSION PUBLIC CONSULTATION

REGULATING FOR IMPROVEMENT AND ASSESSING THE QUALITY OF CARE SERVICES

Response from CCPS

Community Care Providers Scotland (CCPS) is the association for social care service providers in the voluntary sector. Its membership comprises over fifty of Scotland's most substantial providers of services, supporting more than 50,000 people and their families. Services provided include community care, services for children and families, and housing support.

The vast majority of CCPS members provide services regulated by the Care Commission, in many cases with several services across Scotland. A consultation event for members, facilitated by CCPS and including staff from the Care Commission, was held on 16 June 2005. The CCPS response to the consultation paper is based on views expressed at that event.

As a representative association, CCPS is not in a position to comment on individual experiences of inspection or registration; comments below are general and reflect the commonly held views of members. For this reason, the questionnaire format is not entirely appropriate and we hope that a more general paper will be acceptable to the Care Commission.

SECTION ONE: REVIEW OF REGISTRATION AND INSPECTION

Registration

There is a feeling among members that it would be beneficial to streamline the registration process. This could be facilitated by:

- Rolling out the link officer system used for registration of housing support services to other types of service
- Implementing a system of storing/sharing information about providers
- Ensuring that the registration process is consistent across the country
- Developing a system of registration for integrated services.

Housing support providers welcomed the idea of a link officer for national organisations providing several services. Having one named contact for the organisation simplifies the process, and avoids providers having to duplicate information. It would be beneficial to roll this out to all types of service.

In addition, it would be helpful to have a mechanism whereby organisations are not asked to provide the same core information each time they register a service. This could be as simple as the Care Commission link officer for that organisation holding the information on file, and passing it to colleagues as necessary. Alternatively, a 'passport' system could be implemented, whereby providers could undergo one rigorous check of central systems, and then be allowed to bypass this section of the registration process for individual services, thus avoiding duplication and speeding up the process.

There is recognition that, in some cases, Care Commission officers do take previous registrations into account, but that this is very much dependent on the individual involved. The introduction of a link officer for national organisations would help to combat this inconsistency.

Taking this proposal further, a number of providers would be keen to see exploration of a different kind of registration process, whereby the provider – not the service – is registered. This is something that CCPS floated during the development of the original ‘Aiming for Excellence’ proposals, but to our knowledge it has never been debated properly. Using this model, a rigorous initial assessment process would be completed to enable the provider to enter the market for care, and once this was done, further registration of individual services would not be necessary. (This may also help to address the issue of services which do not appear to “fit” any particular registration category, but should perhaps still be regulated – for example a Healthy Living Centre, which is not a day centre, not a housing support service, not a pre-school service, not a primary health care service but in effect provides some elements of all these as well as focusing on social inclusion, employment and so forth).

Finally, many providers offer integrated services which bring together different ‘categories’ of service as defined in the legislation, for example a care home that has a day service attached. Separate registration processes – and in particular separate registration fee payments – are in some cases causing these providers to question the viability of the service. In these cases, the answer to the question “does the process of registration get in the way of providing flexible, innovative and available services” would be a fairly strong “yes.”

Inspection

Problems with consistency were also noted in respect of the inspection process. In addition, members highlighted the following issues:

- Problems with content of inspection reports
- Lack of focus on users’ experiences of services
- Issues relating to the new legislation on the frequency of inspection.

Inconsistency in recommendations made in inspection reports, both across the country and between Care Commission officers in the same area, make it very difficult for providers to implement changes and create new policies/procedures. CCPS appreciates the work of the National Consistency Forum, of which CCPS is a member, but notes concern that members are still raising this as a significant problem.

In addition, it was felt that recommendations made were often fairly general (one member referred to them as ‘sanitised’) or referred to suggestions for improvement made by the organisation itself, or to work already carried out. This was felt to be unhelpful to organisations striving to improve services.

Members are also concerned that the inspection process tends to concentrate on policies, procedures and compliance with regulations, rather than the experiences of people who use the services. In particular, finding out what very vulnerable users think of the service was highlighted as a key challenge for the Care Commission.

Another challenge for the Care Commission is to work together with other regulators in an attempt to lessen the burden of inspection on providers. In particular, there is a pressing need for the Commission to work more closely with local authorities, who frequently set their own standards, monitor performance and in some cases even carry out their own inspections, duplicating the remit and procedures of the Care Commission. The Care Commission’s intention to regulate more proportionately – perhaps reducing the frequency of inspections for some services – may not in fact reduce the burden of regulation, as local authorities may be likely to step in to fill the ‘vacuum’ left by the Care Commission.

SECTION TWO: MEASURING THE QUALITY OF CARE

The proposals in this section are of clear and immediate interest to service providers. CCPS has consistently recognised the difficulties faced by inspectors in assessing performance against the care standards, particularly where those standards relate to the quality of the service as it is experienced by the person using it, rather than as observed by the Care Commission Officer inspecting it.

However whilst we appreciate the difficulties, we are not entirely sure that the proposals will solve them, at least not without throwing up further problems. Our key issues with the proposals are these:

- there is an underlying assumption that the existing system of regulations, care standards and inspections is not sufficient to enable the Care Commission to come to any view about the quality of a service, and that a new system must be established to do this; we would want to question this assumption
- we would suggest that any difficulties with the application of the care standards might best be addressed by reviewing those standards – and the regulations as well – rather than by introducing new measures. Having both the standards and separate quality indicators does not seem either efficient or effective
- we would have serious doubts about the likelihood of consistent application of the range of new measures by which services would be assessed, given providers' experience of the considerable inconsistencies in the present much narrower range
- we would foresee considerable difficulty in avoiding a “star rating” or “league table” approach, even if this is not the intention, which would raise even more significant problems in relation to consistency
- we would have some specific concerns about the inclusion of ‘comments and complaints’ in the assessment system. The Care Commission will surely be very well aware that high quality services welcome and facilitate complaints, whereas poor quality services may not.

CCPS is, however, very supportive of the proposal to link Care Commission activity in relation to quality assessment to providers' own quality assurance systems. Good sense and present knowledge about quality all point towards supporting and empowering providers to take on quality. It must happen close to users and be embedded in practice. Providers' systems can then produce evidence of what they do, in ways that should satisfy regulators (and indeed purchasers). The Care Commission is not designed to do this for providers, even if it were desirable. There is a significant risk that this will lead to a major increase in regulatory activity with few, if any, of the suggested benefits. The costs will fall to providers and, assuming the continuing existence of both good and poor quality services, be unevenly shared.

SECTION THREE: THE PROCESS OF SELF-ASSESSMENT

Quality themes and statements

Our comments on Section Two are equally relevant here.

Our understanding of the specific proposal is that through self-assessment, providers will in effect be self-inspecting against the (more or less) full set of care standards, using the quality statements as a guide in doing so, and that they will be required to do this largely because the Care Commission itself is only able, within current resources, to inspect against a small selection of those standards.

If this is the case, then we feel bound to ask firstly how the document can possibly assert that this will not add to the regulatory burden; and secondly, how the Care Commission intends to process and ‘validate’ all these self-assessments?

We would argue that the Care Commission ought to be validating providers’ own quality assurance systems, which can generate the evidence sought by regulators (and others), rather than attempting to validate the evidence itself. There needs to be much greater clarity about how self-assessment will be tied in with those systems.

Finally, we have some concerns that once the Care Commission has validated a provider’s own gradings, they will then become “official”, despite the intention not to introduce a league-table or star-rating approach.

Performance indicators

Again, our earlier comments apply here.

We would also want to express particular concern about the indicator relating to staff turnover. Care service providers experience considerable difficulties in relation to recruitment and retention of staff, and most providers attribute this to labour market competition, especially with local authorities.

Local authorities’ pay and conditions packages for the care staff they employ directly are almost invariably better than the packages that those same authorities are prepared to fund in the voluntary sector. This is highly likely to be reflected in the turnover rates for each sector.

It would be completely unacceptable for voluntary sector services to be assessed by the Care Commission – or indeed anyone else – as less satisfactory, or of poorer quality, on account of higher turnover rates, without a very clear and explicit explanation of the factors contributing to this and indeed a commitment to resolving it.

CCPS has worked for a number of years to draw attention to the need to hold purchasers, as well as providers, responsible for the delivery of the care standards. These proposals makes this need all the more urgent.

*CCPS
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