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23 February 2018

Dear Rami

Consultation on a draft quality framework for care homes for older people

The Royal College of Nursing (RCN) is the UK's largest professional association and union for nurses with more than 435,000 members, of which over 40,000 are in Scotland. Nurses and health care support workers make up the majority of those working in health and care services and their contribution is vital to delivery of the Scottish Government's health and care policy objectives. The RCN welcomes the opportunity to respond to the Care Inspectorate's consultation on a draft quality framework for care homes for older people. We are responding in the form of a letter, as the questions on the survey were more suited for respondents based in care homes.

Our main comments are:

- We support that the Care Inspectorate is aiming to develop a proportionate scrutiny model with a focus on people's outcomes and continuous improvement. However, we ask for greater clarity on how it will be implemented and on the Care Inspectorate's own role in supporting improvement
- There should be a greater coherence between the Care Inspectorate's quality framework and the quality framework used by Healthcare Improvement Scotland, to ensure that people receive the same standard of care irrespective of setting
- The quality framework does not reference clinical care needs or clinical safety. This is a major omission. It needs to include the importance of clinical decision-making in identifying clinical care needs. This then needs to be reflected in the staffing levels and skills mix required, including the key role of registered nurses as clinical decision makers who are responsible for the delegation of care, to ensure that high quality care is delivered according to clinical need

Clarity around the Care Inspectorate's new approach to scrutiny and improvement

We support the new approach to the Care Inspectorate's scrutiny model where there is an emphasis on the experience and outcomes of people, a proportionate response and a focus on continuous improvement and quality. The greater emphasis on self-evaluation that the quality framework promotes is a positive step in promoting a constant audit loop and cycle for improvement. This will support improvement plans being 'live' and not just one off occurrences following inspection.

A key issue in the new approach is how the Care Inspectorate will judge that they have seen evidence that the Quality Indicators have been achieved as part of the inspection process. For example, will this be through observations of care and interactions on the day of an inspection visit? Or will it be through examination of material such as care plans? Overall the quality indicator examples which demonstrate 'Very good' are very aspirational. There is likely to be a degree of subjectivity in the approach and care homes are likely to require a considerable amount of training as to the types of written evidence providers will need to produce.

It is also important to consider the contextual factors which influence the capacity for an organisation to improve, such as the importance of adequate funding for staff. As the Care Inspectorate is well aware, care homes are facing many challenges that impact their capacity for improvement, including the high vacancy rate for registered nurses.

The improvement support that the Care Inspectorate can provide will be vital to ensuring the success of this new model. Staff need to feel that this is being 'done with' not 'done to' them. The Care Inspectorate calls itself the *"*national scrutiny and *improvement* body*"* and says the changes it is introducing have a focus on "*supporting improvement in quality".* However the Care Inspectorate's role around improvement and the improvement support it provides is not clear. Will the Care Inspectorate be enhancing its own improvement role and supporting providers to build improvement capacity and improvement methodology? Does the Care Inspectorate have the internal capacity, skills and resources needed to implement this and to respond to changes in the way care homes are being used for people with increasingly complex clinical care needs?

Coherence between approaches across different scrutiny bodies

The health and social care landscape, and the role of scrutiny and improvement within it, are changing rapidly. Along with the introduction of the new Health and Social Care Standards, both the Care Inspectorate and Healthcare Improvement Scotland are launching new quality frameworks and changes to the way they carry out scrutiny and improvement activities. We support that different scrutiny bodies are becoming more 'joined up'. However, given the backdrop of health and social care integration and the national policy aim of ensuring that people receive the same standards of high quality care, no matter where the setting, we had expected greater coherence between the Care Inspectorate's new quality framework and that of Healthcare Improvement Scotland's.

While both have adapted the EFQM model and largely incorporated the new Health and Social Care Standards, there are a number of areas included in Healthcare Improvement Scotland's quality framework that the Care Inspectorate either has not included or not to the same level of focus. 'Safe delivery of care', 'clinical excellence', 'continuity of care' and 'workforce planning' feature strongly in HIS's framework but not in the Care Inspectorate's. We have expanded on this in the section below, but in

essence the Care Inspectorate's quality framework does not reflect the clinical care needs of people in care homes. This means, for example, that people coming out of hospital into a care home will not be supported to receive the same standard of clinical care. In addition, the Care Inspectorate's quality framework does not include the same level of focus that Healthcare Improvement Scotland's does on improvement and evidence-based learning, risk management and audit, and communication and multidisciplinary working.

Greater emphasis on clinical care needs and clinical safety

A key issue is that the quality framework does not include any references to clinical care needs. This is a major omission. This is especially important given the increasing proportion of people in care homes with complex clinical care needs and the increase in use of care homes to provide services such as intermediate care. These people require highly skilled clinical care delivered by registered nurses, support workers and other registered professionals. The quality framework needs to emphasise the importance of clinical decision-making to identify the clinical care needs of older people in care homes. There is currently no reference to the ways in which acuity and complexity of clinical needs should be assessed or measured, nor about the tools needed to support clinical decisions.

This emphasis on clinical need then has to be reflected in the staffing levels and skills mix required, including the key role of registered nurses, to ensure that high quality care is delivered according to clinical need. Registered nurses are the ones that are accountable for the delegation of clinical care to other members of the team and this therefore impacts on staffing and skills / competence required. Currently the references to staffing levels and skill mix throughout the quality framework are too 'light touch' and there is no reference to the need for nursing care. As it stands, the quality framework does not give the necessary assurance that high quality clinical care will be delivered to people by the right person, with the rights skills at the right time. Given the emerging focus on the Care Inspectorate's potential role around staffing for safe and effective care in the upcoming Scottish Government legislation, it seems even more important that these issues are addressed.

Related to this, references to clinical safety need to be more clearly embedded into the quality framework. The RCN raised the issue of clinical safety during the consultation and subsequent conversations around the development of the new Health and Social Care Standards. As a consequence, safety was better incorporated into the standards. This needs to be reflected in this quality framework.

In addition, end of life care is only briefly referenced in the quality framework. Given the huge importance that end of life care has on how people will experience the new Health and Social Care Standards, this needs to be strengthened.

Increased focus on support for staff

While it is right that the quality framework focuses on the outcomes of residents and the quality of care they experience, the references to support for staff also need to be strengthened. For example staff, as well as residents, should be treated with compassion, dignity and respect, and have a focus on their health and wellbeing. While there is a reference to a 'safe-to-challenge' culture, there also need to be procedures for staff to raise concerns and whistleblowing policies in place and for staff to be aware of these, to feel confident in using them and for concerns to be acted on.

Specific suggestions about individual quality indicators

- Page 7 *"How good is the care and support and what difference is it making?"* There is no reference to clinical need or safety anywhere under this heading or within the sub categories on this page.

- Quality Indicator 1.1 (page 9): *"People experience wellbeing as a result of their care and support"* What is meant by wellbeing should be more clearly defined. We need to understand this from an integrated perspective, as it has been an issue in other policy areas that people from health have a different understanding of wellbeing to those from social care.

- Quality Indicator 1.2 (page 10): *"people...feel safe and are protected but have the opportunity to take informed risks"* This should emphasise that people both feel safe and *are* safe, but have the opportunity to take informed, positive risks.

- Quality Indicator 1.3 (page 11): *"people…receive the right healthcare at the right time"* This should be expanded to include "*from the right person".*

  "based on good practice and evidence-based guidance" The common terminology is *"best practice"* as opposed to *"good practice".*

  "Residents benefit from regular assessments by a qualified person who involves other professionals as required, including prevention and early detection interventions. Residents are fully involved in making decisions about their care and support through anticipatory care plans and joint management of long term conditions and end of life care."
  The term "*qualified person"* is not suitable. Many people have qualifications, this does not denote competence or that they have the requisite skills. The use of the term *"professionals"* in this section and other sections in the quality framework should read *"registered professionals".* This section also needs to take account of people's ongoing or daily clinical care needs.

- Quality Indicator 1.4 (page 12): "*People are getting the right service commissioned from their needs"*
  This section should make reference to identifying clinical care needs and the need for nursing care.

- Quality Indicator 2.2 (page 15): "*Quality assurance and improvement is led well"* This should reference robust systems of care and clinical governance, and clear lines of professional accountability.

- Quality Indicator 2.2 (page 17): *"Leaders are skilled at identifying the appropriate type and level of resources needed to deliver high quality care and support, intervening at the earliest opportunity to ensure residents experience high quality care and support"* This should be "identifying *and delivering"* resources needed. It should also reference the need for succession planning within care teams and that leaders should be active in identifying and providing development opportunities for staff.

- Quality Indicator 3.1 (page 19) *"Staff have been well recruited"* The wording is too insubstantial to be used as an overarching quality indicator, it should be more specific.

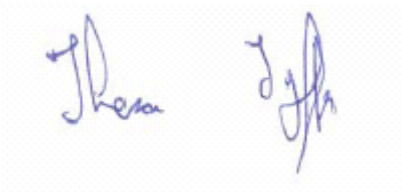
  "safer recruitment principles". It is not clear whether this is referring to specific principles already developed.

- Quality Indicator 3.2 (page 20) *"Staff have the right competence and development to support people"* This should include a reference to staff having access to and protected time for training and continuous professional development.

- Quality Indicator 3.3 (page 21) *"Staffing levels are right and staff work well together"* This should be expanded to include how to assess the acuity and complexity of clinical needs and how this is reflected in the staffing levels and skill mix required to deliver high quality clinical care. It should also mention workforce planning tools.

We support the ongoing work the Care Inspectorate is leading to improve its approach to scrutiny and improvement. For further information or to discuss any of the points raised please contact Helen Malo or Lisa Mackenzie, Policy Officers (job share) on sharedpolicy@rcn.org.uk.

Yours sincerely,



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