

**JRF scoping paper:  
Rights, risks and responsibilities**

# A 'four nations' perspective on rights, responsibilities, risk and regulation in adult social care

**David Wiseman**

**September 2011**

This paper:

- reviews the prevailing approaches and attitudes to risk-taking across the four nations of the UK;
- considers current and likely future regulatory responses regarding this, drawing out similarities and differences and implications for these; and
- highlights potential areas for shared learning.

**The Joseph Rowntree Foundation (JRF) commissioned this paper primarily to inform our own thinking, as we scope a potential new programme on Rights, responsibilities, risk and regulation. How do these four themes connect in the lives of adults who use care and support? How do rights and responsibilities feature when it comes to weighing up risk in the lives of people involved in caring relationships? What needs to change, for example in the protective shell of regulation, to enable people to have good lives?**

ISBN 978 1 85935 874 0  
© David Wiseman 2011



**JOSEPH ROWNTREE  
FOUNDATION**

**[www.jrf.org.uk](http://www.jrf.org.uk)**

The Joseph Rowntree Foundation (JRF) commissioned this paper primarily to inform our own thinking, as we scope a potential new programme on Rights, responsibilities, risk and regulation. How do these four themes connect in the lives of adults who use care and support? How do rights and responsibilities feature when it comes to weighing up risk in the lives of people involved in caring relationships? What needs to change, for example in the protective shell of regulation, to enable people to have good lives?

The JRF has supported this project to inform its own thinking and programme development. The facts presented and views expressed in this paper are, however, those of the authors and not necessarily those of JRF.

Joseph Rowntree Foundation  
The Homestead  
40 Water End  
York YO30 6WP  
[www.jrf.org.uk](http://www.jrf.org.uk)

This report, or any other JRF publication, can be downloaded free from the JRF website ([www.jrf.org.uk/publications/](http://www.jrf.org.uk/publications/)).

© David Wiseman 2011

First published 2011 by the Joseph Rowntree Foundation

All rights reserved. Reproduction of this report by photocopying or electronic means for non-commercial purposes is permitted. Otherwise, no part of this report may be reproduced, adapted, stored in a retrieval system or transmitted by any means, electronic, mechanical, photocopying, or otherwise without the prior written permission of the Joseph Rowntree Foundation.

ISBN 978 1 85935 8 740 (pdf)

Contact:  
Ilona Haslewood  
[Ilona.haslewood@jrf.org.uk](mailto:Ilona.haslewood@jrf.org.uk)

# Contents

	<b>Page</b>
Introduction	4
Summary	4
The shifting policy, regulatory and fiscal context	5
Funding social care	11
Current and likely future regulatory responses	15
References	21
About the author	23

## Introduction

The subject of rights, responsibilities, risk and regulation in adult social care needs to be considered in the context of what people want. Most people will want a decent quality of life where they are able to fulfil their potential and live with dignity and respect. Those that require support and/or care shouldn't be seen as any different in that they are people first and someone needing support and/or care second. Therefore this should be seen as a basic human right and consequently I have considered the degree of focus on human rights in social care practice and in regulation.

## Summary

It has been suggested by the UK and all but one of the devolved governments that personalisation holds the prospect of significant change in the way social care services are organised for all age groups. One aspect of this potential change is that there will be increased choice and control of individual care arrangements.

However, if personalisation is going to be about giving people more choice and control over their lives it needs to go further than simply giving people who are eligible for local authority funding personal budgets. It also needs to be about people starting to take charge of not just what they get and who they get it from, but the design, delivery and evaluation of those services; it also needs to be about people having greater individual control on the identification and management of risk.

One of the challenges facing national and local government across the four nations will be whether the promise of transformation associated with the 'personalisation' agenda can be delivered.

There is a need for the current debate on the future funding of social care to be considered in the context of wider considerations of public sector expenditure priorities. The big questions of whether we should prioritise social care expenditure as against defence (or perhaps better described these days as attack or war) expenditure are not, apparently, on the table. Are we being prevented from raising these bigger questions by the fact that the propaganda pigeonholes the debate in a limited social policy context rather than a wider one that raises questions such as what society do we actually want?

Have we got sufficient information about the degree of defensiveness/risk aversion in care practices in the devolved nations and do we really understand the different views of stakeholders, particularly those of people who use care services and their informal carers? If not how can we claim that services are person centred if we don't really understand people's perspectives on risks, rights and responsibilities?

National and local government talk a good game about the need to empower individuals and communities. However, if they really believe in the need for empowered individuals and communities in order to deliver the vision of social care for the future, national and local government need to make sure that appropriate and

adequate support is provided to ensure that individuals and communities have the skills, capacity and recognition required to engage in such discussions.

As budgets are cut for regulators alongside the continuing push for more risk-based, proportionate regulation, how will they ensure that they are able to continue to provide protection and assurance for people who use adult care services, and other key stakeholders?

It would be interesting to ascertain whether there are any benefits arising from the different approaches of care regulators across the UK and, if there are, is it possible to build on these in the light of devolution.

What changes will regulators have to make in order to respond effectively to the changes brought on by the 'personalisation' agenda and people having greater individual control of the identification and management of risk?

This thinkpiece raises more questions than it provides answers. I believe this is a reflection of where we currently are with our thinking across the UK. However, I hope that it provokes some further thinking about how we are going to move forward in transforming adult care provision and balancing rights, responsibilities, risks and regulation in ways which ensure people receive good quality support and care and enable them rather than prevent them from fulfilling their ambitions.

## **The shifting policy, regulatory and fiscal context**

### **Social care policy**

In January 2010, the Joseph Rowntree Foundation (JRF) published a report *The Impact of Devolution: Long-term Care Provision in the UK* (Bell, 2010). This report looked at why and how long-term care policies had diverged in England, Scotland, Wales and Northern Ireland.

It found:

- population ageing was common to all parts of the UK
- levels of disability were somewhat higher in Wales and Northern Ireland than in Scotland and England
- there was a dual system of support for those with long-term conditions. One system being run largely by local authorities and health authorities and funded by the devolved administrations, the other operating through the Department of Work and Pensions. It also found that there was little interaction between these
- in relation to the demand for long-term care, differences within UK countries were much greater than differences between them
- levels of support for long-term care differed partly because of differences in funding. Also that those devolved nations more generously treated by the Barnett Formula could afford to provide better services
- in reality, the devolved authorities couldn't follow radically different long-term care policies as they were constrained by the UK structure of taxes and benefits, where power was reserved to Westminster

- so far, UK nations had not been good at learning lessons from each other's experiences of long-term care policies
- Scotland, Wales and Northern Ireland were at a disadvantage compared with England because they did not have the resources to conduct large-scale evaluations of policy effectiveness
- much of the legislation that influenced long-term care provision had been passed before devolution and that changing this legislation to permit greater policy differentiation was not high on the legislative agenda.

While I accept most of the above conclusions, my experience in recent years in Scotland has been that the Scottish Government has devoted a significant amount of its time to the development of social care policy. I wonder whether the fact that the first two sessions of the Scottish Parliament were headed by parties also having a majority in the UK Parliament had anything to do with the reluctance to pursue a different agenda. It will be interesting to see whether the fact that the Scottish Parliament is now led by the Scottish Nationalist Party, at odds with the UK Coalition Government, will make any difference.

In recent years, social care policy across the UK has been aimed at developing a person-centred approach for the arrangement of individual care services under the banner of 'personalisation'. This was specifically referred to by the previous UK government when it published *Our health, Our Care, Our Say* (Department of Health, 2006) and followed up in *Putting People First – A Shared Vision and Commitment to the Transformation of Adult Social Care* (HM Government, 2007).

In November 2010, the UK Coalition Government launched *A Vision for Adult Social Care: Capable Communities and Active Citizens* (Department of Health, 2010) for England. It sets out how the Government wishes to see services delivered for people – 'a new direction for adult social care, putting personalised services and outcomes centre stage'.

The UK Coalition Government stated that this vision was built on seven principles:

- prevention
- personalisation
- partnership
- plurality
- protection
- productivity
- people.

The **protection** principle is of particular interest to the subject matter of this paper as it is described as meaning having sensible safeguards against the risk of abuse or neglect but that such risk is no longer an excuse to limit people's freedom.

In 2010, the Scottish Government and the Convention of Scottish Local Authorities launched *Self-directed Support: A National Strategy for Scotland*, a ten-year strategy for self-directed support in Scotland which aims to set out and drive a cultural shift around the delivery of support that views people as equal citizens with rights and responsibilities. Self-directed support is defined as the support individuals and families have after making an informed choice on how their individual budget is used

to meet the outcomes they have agreed. The mechanisms for getting support can be through a direct payment or through the person deciding how their individual budget is allocated by the local authority to arrange the support by a provider.

'Cultural shift' is perhaps the key phrase in this policy statement. It will be interesting to see whether over the next few years a cultural shift is actually delivered.

The self-directed support strategy also allows individuals to leave the decision on how their support is provided to the local authority. This allows some people to make an informed choice not to take control of all of their arrangements.

This strategy was developed with people who already direct their own support as well as those who design and deliver support. The strategy sets out a clear message about individuals and families having real choice and control, and the key challenges that need to be addressed to deliver that. Specific mention is made to embedding co-production in the approach to delivering self-directed support locally and nationally. The strategy defines co-production in this context as support that is designed and delivered in equal partnership between people and professionals.

The strategy demonstrates the human rights principles of:

- equality and non-discrimination – all individuals are equal as human beings and by virtue of the inherent dignity of each human person
- participation and inclusion – all people have the right to participate in and access information relating to the decision-making processes that affect their lives and well-being.

It does this through:

- inclusion – everyone, no matter what their level of impairment, is capable of exercising some choice and control in their living, with or without that choice and control being supported by others
- dignity – everyone is treated with dignity at work, at home and in the community
- equality – everyone is an equal citizen of the state and has the right to live life as fully as they can, to be free from discrimination, and to be safeguarded and protected.

The Scottish Government plans to consult formally on a draft Self-Directed Support (Scotland) Bill later in 2011.

In **Scotland**, the devolved government launched *Better Health, Better Care: A Discussion Document* (Scottish Executive, 2007a) in August 2007 and followed this up with the *Better Health, Better Care: Action Plan* (Scottish Executive, 2007b). While this concentrated on the NHS in Scotland it also linked to the devolved government's vision for social care services. However, in the main the debate has been dominated by the discussion about the future for older people's services. One of the devolved government's policy discussions and programmes has been *Reshaping Care for Older People*. It launched a national debate between March and September 2010, carrying out a public consultation exercise throughout Scotland, engaging with communities through eleven national and three local events, about how it could change the way it delivered care. These events were attended by 1,100 people.

The analysis of the discussions has been published by the Scottish Government and the following is an attempt to pull out the key points that are relevant to the subject of this paper.

The consultation identified several things wrong with the current system, for example its tendency to promote dependency through lack of incentives to invest in re-ablement and build up resilience. The inadequacy of out-of-hour care services often leading to unplanned hospital admission, often as a result of risk averse decisions by health professionals, also came to light. However, free personal care, which is offered in Scotland alone among the UK nations, was felt to be of real benefit to those receiving care. However I am not sure whether people actually understand what free personal care actually means and whether in reality there is a significant difference financially for individuals in the position in Scotland compared with the rest of the UK as regards so-called free personal care.

Regarding the question of how future care and support should look, in a nutshell people wanted more choice and better, more realistic options for older people. This includes better information about choices and options and more involvement in decision-making; less bureaucracy and professional preciousness; better integration across health and social care; more preventative health and care services; as well as simple things such as consistency of visiting home carers in order to allow the building up of trust and rapport with the people they care for.

A further question was about who should be responsible for paying for care. Information on this is included later in the report, under *Funding Social Care*.

In February, the Scottish National Party (SNP) Government revealed its proposals to integrate health and social care for adults. It has stated that it will establish a lead commissioning implementation group, backed by £2 million for investment over the next financial year, to support partnerships around the country to continue to take the integration agenda forward.

In **Northern Ireland**, the Department of Health, Social Services and Public Safety (DHSSPSNI) published a regional strategy *A Healthier Future* (DHSSPSNI, 2004). It placed a special emphasis on promoting equality of access for all groups. In the section headed *Involving People – Building Caring Communities* is the statement that ‘People will be able to take control of their own care and will take an active role in promoting their own health and well-being and that of their communities’. There are also references to ‘personalisation’ within a number of other documents published by the DHSSPSNI although I have not been able to find a policy document specifically devoted to this subject.

The DHSSPSNI has recently published *Reshaping the System: Implications for Northern Ireland’s Health and Social Care Services of the 2010 Spending Review* (DHSSPSNI, 2011). This document sets out a vision for a reformed social care and health service for Northern Ireland. It talks about needing high-quality and productive services, high-quality services being services that are:

- effective and safe with easily accessible care for people from all sections of society who need it
- patient- or user-centred and provide a good user experience

and productive services being services that make efficient use of all resources and that these are allocated efficiently and effectively.

The document also refers to the opportunity of generating revenue by developing co-payment with services users. I find this terminology interesting – is it charges by another name? Or is the use of co-payment seen as sitting alongside co-production and linking to rights and responsibilities?

In **Wales**, the Welsh Assembly published *Fulfilled Lives, Supportive Communities – A Strategy for Social Services in Wales Over the Next Decade* (Welsh Assembly Government, 2007). This referred to social services and social care in Wales playing a vital part in the lives of many citizens in Wales by promoting social inclusion and independence, advocating on people's behalf, asserting their rights and supporting them to achieve their potential and to be active citizens. The document went on to state that whatever their difficulty or impairment, people should be supported to have control over the life they wished to live. It stated that its vision was firmly rooted in both the social model of disability, and in a rights-based approach derived from UN conventions and principles. It stated that the social model promotes rights, equality and choice for all disabled people.

In November 2009, an independent commission on social services in Wales was established. The Commission was charged with considering the provision of social services and social care over the next decade. In November 2010 the Commission's report was published (*Independent Commission on Social Services in Wales, 2010*). The Commission endorsed the vision and principles set out in the Welsh Assembly's strategy for social services *Fulfilled Lives, Supportive Communities* (Welsh Assembly Government, 2007), referred to above.

Following the Commission a new policy document *Sustainable Social Services for Wales: A Framework for Action* (Welsh Assembly Government, 2011) was published. It states that service users and carers should have a much stronger voice and greater control over their services. It also says that the days in which public services could act separately are past and that where appropriate it is expected that public services should work together to deliver integrated services. The report states that the Welsh Assembly will capitalise on the benefits of the unique Welsh approach of integrated family-based services and that it will make accountability for delivery simpler by making it clearer and seeing the quality and safety of services as being held firmly by providers and commissioners of services. It suggests that to support these priorities, it will refocus the way in which improvement is driven, and that citizens must have the assurance that comes from inspection and regulation and from knowing that robust action will be taken where needed. It also suggests that the changes will reduce the overall burden of regulation and inspection. It states that social services and social care must act in ways that strengthen the voice of service users, allows them to have the maximum control over their lives, builds on their strengths and enables them to make a full contribution to the community and draw on it to support them.

Much of the contents of the Welsh policy documents could be seen as being similar in concept to that of the 'personalisation' approach and they do talk about such concepts as self-directed support and individual budgets. However, in *Sustainable Social Services for Wales: A Framework for Action* (Welsh Assembly Government, 2011) it is stated "We believe that the label "personalisation" has become too closely

associated with a market-led model of consumer choice, but we are taken by the Commission's approach to stronger citizen control. We will therefore expect our recently published guidance on commissioning to drive services built upon this approach'. As I understand it, the Welsh Assembly wants to have a planned/commissioned provision of social care rather than one that is market driven.

It has been suggested by the UK and all but one of the devolved governments that personalisation holds the prospect of significant change in the way social care services are organised for all age groups, one aspect of this potential change being that there will be increased choice and control of individual care arrangements.

However, if personalisation is going to be about giving people more choice and control over their lives it needs to go further than simply giving people who are eligible for local authority funding personal budgets. The term co-production is an increasingly used term which emphasises that people who use services, and their informal carers, don't just have needs but also have skills and expertise that can contribute to the transformation of services. There may be a number of meanings for this term but what I mean by co-production is an approach that is about working together for a strong community and more effective services. Co-production is therefore a method of working together to achieve an agreed outcome: an approach that values everyone involved as equal, where the trading of each other's skills, experience and knowledge is respected and employed to the full and where the understanding and wishes of the end user are the main drivers. Social work authorities, commissioners, service providers and scrutiny bodies must open their doors to the talents, creativity, life experiences and expectations of those who will ultimately gain from good quality adult care services.

People of all ages and abilities need to have the same freedom, choice, dignity and control as other citizens at home, at work, and in the community. Co-production needs to mean that rights to practical assistance and support to participate in society and live an ordinary life are available to those who need it. This concept is therefore about human and civil rights, with independent living being a right under the United Nations Convention of Rights for People with Disabilities.

One of the challenges facing national and local government across the four nations will be whether the promise of transformation associated with the 'personalisation' agenda can be delivered.

- Can and will people's expectations be met?
- Is 'personalisation', or its equivalent in Wales, driving a radical change to the adult social care system and if so does this differ in the four nations? Or will service users only shape the care they receive at the margins and continue to find that their needs will still be assessed by the agency they will use to provide those services and that what they can get is still service-led rather than needs-led?
- Do we know what works best in making such a radical change?
- Are people really becoming in charge of not just what they get from what is currently available but of the design, delivery and monitoring of adult care services?

- What, if any, effect is the drive towards greater individual control having on choice and the identification and management of risk?
- What can be done to better understand risk as perceived from the service user and informal carer's perspective?
- Are the implications for workforce development being addressed?
- Is there sufficient leadership capability and capacity?
- Is there sufficient political support for these changes?
- What changes need to be taken on board by the regulatory bodies across the four nations if we are going to see more and more 'personalised' services?

## Funding social care

It appears that the increasing cost and future unsustainability, as well as the widely perceived unfairness of the current system, sets the tone for and is closely inter-linked with, discussions of other current issues in social care.

The UK Coalition Government set up the Commission on Funding of Care and Support in July 2010, chaired by Andrew Dilnot with Lord Norman Warner and Dame Jo Williams as fellow commissioners. While the Commission is hosted by the Department of Health, it is independent of both the department and government. Its report *Fairer Care Funding* (Commission on Funding of Care and Support, 2011) makes recommendations on how to achieve an affordable and sustainable funding system for care and support in England.

While the Commission was only charged with looking at funding in England it has recognised that it needed to look at what was happening elsewhere in the UK and that any recommendations it made might have implications for the devolved governments. It has therefore held listening sessions across the four nations.

In March 2010, JRF published *Funding Social Care: What Service Users Say* (Beresford, 2010). This states that 'Service users have not been adequately involved in discussions about the future funding of social care, yet they are the people most affected by these decisions'. It reported on the views of a diverse range of social care service users, brought together to explore proposals for funding social care. The report drew on an England-wide consultation with 18 service users and major national and regional service user organisations were also represented.

Some of the key points are:

- Service users felt that the public did not understand what social care is or who pays for it and that this made it more difficult to have a meaningful public debate about social care.
- The above, linked to social care's low political profile and the policy panic about the increasing elderly population, means that service users are seen as a burden and ignores the contribution they could and do make.

- Almost all service users consulted thought that general taxation was the best way to fund social care.
- Service users rejected any withdrawal of existing universal benefits to fund means and needs tested social care.
- More open public debate was needed to work out what was wanted and how it should be funded.

It is a pity that this piece of work only drew on a small sample of service users and only from within England. Bearing in mind that some policy and funding differences do apply in some of the devolved nations, it would be useful if a similar piece of work was carried out across the four nations and with a larger and more representative sample group.

However, some insight is provided by looking at the response to the question ‘Who should be responsible for paying for care?’ which was looked at during the Scottish Government’s consultation on their Better Health, Better Care policy, referred to earlier.

In response to this question, most audiences found it difficult to reach any real consensus, but there was often an acknowledgment that the current system was flawed because:

- it was unfair to those who had saved and acted responsibly throughout their lives
- it is confusing and complex and very different depending on whether or not you needed to go into a residential care setting
- the burden on younger generations was too great, especially if more was to be provided free of charge such as in the NHS.

Many people over 70-years-old remembered entering into the ‘contract’ with the state after the creation of the welfare state in 1940s, and some expressed anger because they perceived they’d paid taxes and their national insurance all their lives and the state owed them their care in return.

What changes to funding did people want to see?

- Some felt that all public funding was taxpayer’s money, and splitting budgets with separate ringfencing for health and social care should not continue, because it is costly and not working well for individuals.
- Many also felt that taxes, or national insurance contributions, should be increased and then ringfenced to cover social care;
- The state should provide a basic level of care for everyone, and above this basic package, people should be able to top up care by choosing to pay for it.
- When pressed, most audiences expressed a preference for a continued dual contribution from the state with individuals contributing to their own care where they could afford to do so.

One of the concerns I and a number of people share about the current debate on the future funding of social care is that those orchestrating the debate appear not to want

this to be considered in the context of wider considerations of public sector expenditure priorities. The big questions about what type of society we want and whether we should prioritise social care expenditure, as against military spending, are not apparently on the table.

## **Attitudes to risk**

Respecting people's basic human rights to dignity, freedom and respect should underpin quality social care. People may need support in managing their care and making decisions but they have the right to make choices about their lives and to take risks.

Achieving zero risk is neither a realistic nor a desirable target, as indicated in *Risk, Responsibility and Regulation – Whose Risk is it Anyway?* (Better Regulation Commission, 2006).

Risk is a central defining feature and area of concern in adult social care provision, but are the attitudes of different stakeholders (service users, their families, carers, care providers and the wider community) to risk known and understood? With the policy push towards a 'personalisation' approach that advocates greater service user choice and control this becomes an even more important question.

*Risk and Adult Social Care: What does UK Research Evidence Tell Us?* (Glendinning and Mitchell, 2007), reported the results of a UK-based scoping review and demonstrated how different groups of adult social care service users and service providers view and seek to rationalise the everyday risks they face very differently.

It indicated that:

- certain views and concerns existed before personal budgets and self-directed support were introduced
- risk in adult social care is a topic that has not been subject to intensive empirical research in the UK
- the view of people who use services is largely absent in the literature
- there were few empirical research studies and evaluations of risk management systems and interventions.

Risk assessment is often described as the determination of the possibility of accident or danger in relation to a given situation or any existing recognised threat. However, risk assessments should not be focused simply on keeping people who use care services safe at all costs. They should be person-centred and promote independence, choice and autonomy. Adopting a more positive, person-centred approach to risk encourages services and service providers to look for new ways to support and empower the people they work with. This can also involve people who use care services and their families in decisions made about risk-taking.

*Enabling Risk, Ensuring Safety: Self-directed Support and Personal Budgets* (Carr, 2010) looked at some of the research findings and emerging principles from UK and international studies and emerging practice concerning risk enablement in the self-directed support and personal budget process while also recognising the wider context of adult safeguarding in social care. The paper states that 'the promotion of

choice and control, particularly through the use of personal budgets and direct payments, implies the need for change in the way risk is understood, managed and negotiated with the person using the service. It also implies the need for organisational transformation to respond to new person-centred ways of working in all aspects of adult social care, including safeguarding’.

One of the significant measures for frontline practitioners and adult care service organisations is that ‘positive risk-taking’ or ‘risk enablement’ is central to the philosophy behind self-directed support and personal budgets, but social care practitioners can be concerned about how to both empower the individual and fulfil their duty of care. However, with different perspectives existing in Wales and Northern Ireland it may be that these concepts have limited currency in those parts of the UK.

The Scottish Executive commissioned an international literature review on effective approaches to risk assessment (Barry, 2007). Some of the main findings from that review were:

- the relationship between worker and client is paramount to effective working in risk assessment and management and yet is being eroded by the language and politics of risk
- most of social work’s current accountability systems are reactive, adversarial and stifle professional autonomy
- there is an over preoccupation with thresholds and short-term crisis intervention, resulting in risk-averse management, minimal scope for learning from mistakes and a lack of user involvement in decision making
- social workers’ views of the language of risk are largely absent from the literature and yet they actively engage with risk on a daily basis
- differing organisational cultures, differing definitions of risk and a hierarchy of professional expertise may deter the development of a common understanding and language of risk
- risk has to be seen as a positive as well as a potential harmful issue, that allows workers some discretion to support some risk-taking among client groups but also ensures that all efforts are made to reduce the likelihood of harmful results
- organisations involved in risk assessment and management need to adopt a more participative, holistic and pro-active approach which allows dialogue between workers, users and managers and organisational flexibility and performance incentives.

Despite this useful piece of work, I am not sure whether we have sufficient information about the degree of defensiveness/risk aversion in care practices in the devolved nations and perhaps this is an area that would benefit from more research.

The views of people who use care services are still largely absent but their role in taking and managing risks on an everyday basis must not be overlooked, nor should their potential to play a more significant role in the process. One of the other challenges will be that the views of informal carers (family, friends and so on) regarding risk may also conflict with those of the person using the care service and this will have to be managed.

I believe this is another area where little has been done to try and capture and understand the different views of stakeholders, particular those of people who use care services and their informal carers. How can we claim that services are person-centred if we don't really understand people's perspectives on risks, rights and responsibilities?

In the main it appears that social policy across the UK has been developed in a similar fashion. There are differences but in the main these are at the margins.

In Wales there is a stronger emphasis on family-based solutions leading to less distinction between adults and children. Therefore strengthening families is seen as important rather than just developing services for individuals. The role of communities is also seen as important.

There are structural differences with Northern Ireland having a more integrated health and social care system and with proposals for a national care service being considered in Scotland.

However, whatever the terminology used the main approach being promoted across the UK is one of empowerment of people who use care services, giving more choice and control to them.

With the policy push towards a personalisation approach that advocates greater choice and control for individuals using care services, how we as a society perceive and manage risk becomes an even more important question.

Perhaps the most significant political challenge is that of taking forward the personalisation agenda within the context of significant cuts in public funding. There are already some signs that local authorities are starting to raise the barriers and indicating that only the highest needs will be supported. Personalisation may founder on a perception by people who use care services, and their informal carers, that rather than this approach being one that provides greater choice, freedom and control it becomes a method of shifting responsibility from the state to the individual, while at the same time not providing adequate resources to make this meaningful and provide people with a decent quality of life.

## **Current and likely future regulatory responses**

Scrutiny (including regulation) helps to ensure that people receive the highest quality of care and provides assurance and protection for people who use those services, their families and carers and the wider public.

In England the social care regulator is the Care Quality Commission (CQC) and in Wales it is the Care and Social Services Inspectorate Wales (CSSIW). In Northern Ireland it is the Regulation and Quality Improvement Authority (RQIA) and in Scotland it is the Social Care and Social Work Improvement Scotland (SCSWIS).

## Scotland

SCSWIS is the new unified independent scrutiny and improvement body for care, social work and children's services in Scotland and was established under the Public Services Reform (Scotland) Act 2010. It brings together the scrutiny work previously undertaken by the Care Commission, HMIE child protection team and the Social Work Inspection Agency. The Public Services Reform (Scotland) Act 2010, and its associated regulations, forms the basis for regulating adult social care services in Scotland.

In Scotland care commission officers (inspectors) had to be registered with the Scottish Social Services Council (SSSC), the workforce regulator (a requirement that does not exist in the rest of the UK). Registration is qualification based and care commission officers have to not only have a relevant professional qualification but also had to gain, within three years of initial registration, the Regulation of Care Award (Scotland). (This qualification was jointly developed by the Care Commission and the SSSC. It is currently provided by Anglia Ruskin University and is delivered using a mix of online and open learning texts over the course of a year. Face-to-face learning sets take place in four locations in Scotland facilitated by Scotland-based Anglia Ruskin tutors. Students are assessed in a number of different ways including practice observation and written work on inspection techniques and concepts such as quality improvement). As a result of the above requirement, there is an expectation, by the Scottish Government and service providers, that the quality of regulation has been improved, with inspectors having a better understanding and performing more effectively.

Decisions as to the future of the award in light of the creation of SCSWIS are still to be made.

It would be interesting to ascertain whether there are any benefits in Scotland, compared to the rest of the UK, that have arisen from the fact that care commission officers (inspectors) have to be registered with the workforce regulator and have to obtain a regulatory award as well as hold a relevant professional qualification.

In Scotland, the National Care Standards (developed from the point of view of people who use the services and describing what each individual person can expect from the service provider) focus on the quality of life that the person using the service actually experiences. They are taken into account by the regulator when assessing care services, and are based on a set of principles:

- dignity
- privacy
- choice
- safety
- realising potential
- equality and diversity.

Many of these relate to basic human rights.

Each of the National Care Standards (NCS) includes a section on Feeling Safe and Secure. I have taken as an example the NCS for Care Homes for Older People,

which states that 'You take responsibility for your own actions, secure in the knowledge that the home has proper systems in place to protect your interests'. This is expanded to include the following statements:

1. A sensible balance is offered to you in everyday events and activities, between the reasonable risks you want to take and the safety of the staff and other residents. This results from the home's individual risk assessment approach.
2. You are fully involved in your own risk assessment, as are any other people you may want to be involved, such as a family member or independent representative. You receive a copy of your risk assessment report.
3. You can discuss risks with staff.

The National Care Standards also include a section on Exercising Your Rights, which states that 'You keep your rights as an individual'. This is expanded to include the following statements which I believe are relevant to the subject of this paper:

1. You are helped to understand your rights and responsibilities in relation to equal opportunities.
2. You are supported in keeping your civil rights (for example, in voting at elections).

The Scottish Human Rights Commission (SHRC) has launched *Care about Rights?* jointly developed with the Care Commission and Scottish Care (Scottish Human Rights Commission, 2011). The main focus of this project is the development of training and awareness-raising resources relating to the care and support of older people. The main aim is to empower people to understand their human rights, and increase the ability and accountability of those who have the duties to respect, protect and fulfill rights.

The training materials are a useful resource for older people, carers, care workers, managers, regulators/scrutiny organisations, policy makers and commissioners of care.

Care about Rights explains the benefits of applying human rights principles to everyday situations. The training is designed to increase awareness and knowledge of human rights issues, and give practical advice about how to apply human rights principles in the delivery of care.

The interactive resources help to increase understanding and awareness about:

- what human rights are and how they are applicable in care settings
- the relationship between human rights and other legislation and standards
- how human rights can help to balance risks and rights in decision making
- how human rights can support the delivery of person centred care
- how human rights can help resolve conflict and improve communication with people using services, their families and others.

The resources are intended to allow everybody who is involved in care home and care at home/housing support services for older people to better understand human

rights and how a human rights-based approach to care and support can benefit people who use care services, their informal carers, care staff and the people around them.

The materials on the Scottish Human Rights Commission's website are about empowering people to understand their rights and increasing the accountability and ability of those who have duties to respect, protect and fulfill human rights.

## **England**

The Health and Social Care Act 2008, and its associated regulation, forms the basis for regulation of adult social care services in England.

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. It licenses (registers) and monitors (through inspection and enforcement) providers of care services. Unlike the regulators in Scotland and Wales it does not investigate individual complaints against registered care services.

The CQC has published guidance, *Essential Standards of Quality and Safety* (Care Quality Commission, 2010a), for service providers. They refer to providers having to consider equality, diversity and human rights in every aspect of their work. The CQC has an equality and human rights scheme (Care Quality Commission, 2010b) which it states promotes a culture of care, putting individuals at the heart of health and social care services. It states that it believes human rights should be at the centre of everything it does and that emphasising people's rights and entitlements, as opposed to their needs and requirements, the scheme will guide its work as a regulator. The scheme states that through the registration system, it has a real opportunity to focus on outcomes for people rather than processes and inputs, and believes quality care will maintain and protect people's rights and promote equality.

The CQC and the Equality and Human Rights Commission (EHRC) are producing some joint guidance for CQC inspectors on equality and human rights. However there appears to be some conflicting information regarding the progress of this work. The EHRC website states that a public consultation was held on draft guidance and this consultation closed on 12 November 2010. Their website also states that officials of the EHRC and CQC are now analysing the responses to the consultation and will be producing a summary report of responses and recommendations for amendments to the guidance. It goes on to say that this report and the guidance will be published online at the end of January 2011. The CQC website states that guidance will be available in the summer of 2011. At the time of writing no further information was forthcoming.

## **Wales**

The Care and Social Services Inspectorate Wales (CSSIW) is the regulator of adult care services in Wales. It also has responsibility for regulating children's services. As in Scotland CSSIW has a responsibility for investigating complaints against registered care services.

The Care Standards Act 2000, The Children Act 1989 and The Adoption and Children Act 2002 give powers to register and inspect establishments and agencies in Wales that provide social care.

CSSIW carries out its functions on behalf of Welsh ministers, and although it is part of a department within the Welsh Assembly Government it states that there are a number of safeguards in place to ensure its independence.

The national minimum standards used by the CSSIW when determining whether care services are providing adequate care, meeting the needs of the persons receiving the care service and otherwise being carried on in accordance with regulatory requirements, do not appear to make a specific reference to equality and human rights. However, a number of the standards can be seen as relevant and there are specific references to legal and civic rights being respected.

For example, under the section on Quality of Life in the National Minimum Standards for Care Homes, Section 8 refers to autonomy and choice and Section 11 refers to rights. The outcome stated for Section 8 is that 'service users are helped to exercise choice and control over their lives'. The outcome stated for section 11 is that 'service users' legal and civic rights are respected and protected'.

The purpose of the Equality and Human Rights Commission in Wales, which is part of the UK body, is to ensure that UK policy-making reflects the needs of Wales and to deliver a programme of work in Wales. As I understand it, they have not carried out any specific work in respect of social care except for a report on life in Wales for people with mental health conditions (Equality and Human Rights Commission, 2010).

## **Northern Ireland**

The Regulation, Quality and Improvement Authority (RQIA) is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services. This includes the regulation of children's homes. Unlike in Scotland and Wales, the RQIA does not have responsibility for investigating individual complaints against regulated care services.

The RQIA was established under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

The RQIA committed to a human rights-based approach to its work in 2009. The RQIA board agreed a strategy that was based on the core human rights principles of:

- fairness
- respect
- equality
- dignity
- autonomy.

The strategy put human rights and human rights principles at the heart of the RQIA's policy and planning. It also empowered staff and people using services with knowledge, skills and the organisational leadership and commitment to achieve human rights-based approaches. It enabled meaningful involvement and participation of all key people and non-discrimination and attention to vulnerable groups.

In 2009, the Equality and Human Rights Commission published a policy paper *From Safety Net to Springboard* (Equality and Human Rights Commission, 2009). In this document the Commission stated that it was its view that care and support should act as a springboard by promoting people's abilities and by seeking to benefit society as a whole. It was based on users' views of what they needed. It stated that fundamental to the Commission's vision was the belief that all groups should be able to access support of their choice, to enhance and maximise their life chances and quality of life across the life course.

The outcome of the Commission's fieldwork and research to try and track how far personalisation reaches diverse groups within the community suggests that there will need to be improved effort and action to make personalisation successful. Despite the fact that diverse groups are the ones that could arguably benefit the most from this approach, there will need to be more done to enable individuals within these groups to become competent consumers.

Across the UK, The Equality and Human Rights Commission has been undertaking an inquiry into disability-related harassment and how well this is currently being addressed by public authorities. They have been examining how people with disabilities, their family, friends and carers who have experienced harassment have been supported, or not, by public authorities.

As part of this inquiry it has sought evidence from each of the social care regulators in the UK and it will be interesting to see what each has said and whether there are any different perspectives across the four nations.

As regulatory budgets are cut alongside the continuing push for more risk-based, proportionate regulation, regulators may find that less frequent inspections for what are currently assessed as the good performers could mean they are faced with other challenges such as:

- ensuring that they continue to provide protection and assurance for people who use adult care services, and other key stakeholders
- ensuring that they are able to provide information on the quality of adult care services
- ensuring that they are able to be responsive to changes in the operating environment and to knowledge and intelligence gained
- ensuring that they have relevant and adequate information available which will enable them to identify any possible changes in their assessment of risk applying to individual services
- continuing to develop new integrated approaches to scrutiny and improvement
- as more reliance is placed on self-evaluation, ensuring that there is an adequate but proportional process for validating this.

## Regulatory divergence between the four nations

It is interesting to note the differences between social care regulatory bodies within the UK and it might be worthwhile examining what, if any, difference this makes to outcomes within the four nations. For example:

- Are there any benefits in Scotland and Wales that have arisen through the fact that the same regulator is responsible for both adult care and children's services?
- Are there any benefits in Scotland and Wales that have arisen from the fact that their regulators are also responsible for investigating complaints against registered care services?
- Are there any benefits in England and Northern Ireland that have arisen from the fact that the same regulator/scrutiny body is responsible for both health and social care services?
- What has been the effect of having a separate Scottish Human Rights Commission as well as the Equalities and Human Rights Commission operating in Scotland?
- Are there any benefits in Scotland that have arisen from the fact that care commission officers (inspectors) had to be registered with the workforce regulator and had to obtain a regulatory award as well as hold a relevant professional qualification?
- How have these differences, if at all, enhanced and enabled users' rights to make their own decisions (or be involved in decision-making), including about the risks they wish to take or not take?
- What changes will regulators have to make in order to respond effectively to the changes brought on by the personalisation agenda?
- Which, if any, of the existing models will work best?
- Which of the existing models is the most flexible to rise to the challenge?

## References

Bell, D. (2010) *The Impact of Devolution: Long-term Care Provision in the UK*. York: JRF.

Beresford, P. (2010) *Funding Social Care: What Service Users Say*. York: JRF.

Better Regulation Commission (2006) *Risk, Responsibility and Regulation - Whose Risk is it Anyway?* London: Better Regulation Commission.

Care Quality Commission. (2010a) *Essential Standards of Quality and Safety*. Newcastle upon Tyne: Care Quality Commission.

Care Quality Commission (2010b) *Equality and Human Rights Scheme 2010–2013*. Newcastle upon Tyne: Care Quality Commission.

Carr, S. (2010) *Enabling Risk, Ensuring Safety: Self-directed Support and Personal Budgets*. London: SCIE.

Commission on Funding of Care and Support (2011) *Fairer Care Funding*. London: Commission on Funding of Care and Support.

Department of Health (2010). *A Vision for Adult Social Care: Capable Communities and Active Citizens*. London: Department of Health.

Department of Health (2007). *Putting People First: A Shared Vision and Commitment to the Transformation of Adult Social Care*. London: HM Government.

Department of Health (2006) *Our Health, Our Care, Our Say*. London: TSO.

DHSSPSNI (2011) *Reshaping the System: Implications for Northern Ireland's Health and Social Care Services of the 2010 Spending Review*. Belfast: DHSSPSNI.

DHSSPSNI (2004) *A Healthier Future*. Belfast: DHSSPSNI.

Barry, M. (2007) *Effective Approaches to Risk Assessment in Social Work: An International Literature Review*. Edinburgh: Scottish Executive.

Equality and Human Rights Commission. (2009). *From Safety Net to Springboard*. Equality and Human Rights Commission.

Equality and Human Rights Commission (2010) *Not Just Another Statistic: Life in Wales for People with Mental Health Conditions*. Cardiff: Equality and Human Rights Commission.

Glendinning and Mitchell (2007) *Risk and Adult Social Care: What Does UK Research Evidence Tell Us?* York: York University Social Policy Research Unit.

Independent Commission on Social Services in Wales (2010) *From Vision to Action: The Report of the Independent Commission on Social Services in Wales, 2010*. Available at: <http://www.wlga.gov.uk/english/library/independent-commission-on-social-services-in-wales-from-vision-to-action> (accessed 15 June 2011).

Scottish Executive. (2007a) *Better Health, Better Care: A Discussion Document*. Edinburgh: Scottish Executive.

Scottish Executive (2007b) *Better Health, Better Care: Action Plan*. Edinburgh: Scottish Executive.

Scottish Human Rights Commission (2011) *Care about Rights?* [online]. Available at: [www.scottishhumanrights.com/ourresources/training](http://www.scottishhumanrights.com/ourresources/training) (accessed 15 June 2011).

Welsh Assembly Government (2011) *Sustainable Social Services for Wales: A Framework for Action*. Cardiff: Welsh Assembly Government.

Welsh Assembly Government (2007) *Fulfilled Lives, Supportive Communities*.  
Cardiff: Welsh Assembly Government.

## **About the author**

David Wiseman started his social care career as a care officer in a home for older people before going on to work for Strathclyde Region in a variety of positions including community worker, welfare rights and community development officer and assistant district manager. He then joined South Lanarkshire Council as Head of Strategic Services in the social work department, where he also had responsibility for the registration and inspection unit. Following a period of secondment to the Convention of Scottish Local Authorities (COSLA), as an adviser on the Regulation of Care (Scotland) Bill, he returned to South Lanarkshire as Head of Older People's Services before joining the Care Commission (the Scottish regulator of children, adult care and independent healthcare services) as Director of Operations in February 2002. He then became the Director of Strategic Development and Deputy Chief Executive of the Care Commission in 2005, taking early retirement in 2011.

He is a member of the UK-wide Residential Forum, whose purpose is to promote the achievement of high standards of care for children and adults in care homes and schools, and to contribute to improving the quality of service to the public. He is also a board member of the Scottish based Institute for Research in Social Services (IRISS) and of Social Care and Social Work Improvement Scotland.