The Scottish Government
Riaghaltas na h-Alba

National Care Standards Review: Consultation Analysis

Health and Social Care

social research

NATIONAL CARE STANDARDS REVIEW: CONSULTATION ANALYSIS

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Scottish Government Social Research
2015

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1 EXECUTIVE SUMMARY

1.1 National Care Standards were established in 2002 to help people to understand what to expect from care standards and services to understand the standards they should deliver. The Scottish Government wishes the standards to be updated and improved to meet current expectations and models of service.

1.2 Scoping work with a range of stakeholders informed the development of a consultation paper, published by the Scottish Government on 25 June 2014 in a variety of formats including easy-read, large print and on-line. 475 responses to the consultation were received, from a wide range of stakeholders, organisations that represent the views of people who use services, providers of services, and professional bodies.

1.3 A summary of views contained in the consultation responses follows.

Foundations of the new National Care Standards

1.4 92% of those who addressed the issue agreed with the Scottish Government's proposal that the new standards should take a human rights-based approach in which people using services are at the centre of how they are planned and delivered. Many felt that human rights are relevant to all and the proposal would ensure people are placed at the heart of services, and treated equally.

1.5 Key advantages to grounding the new standards in human rights were identified as the alignment of this approach with modern UK approaches and European Union legislation; clarification for service providers and users alike of what can be expected in terms of service; and empowering users to be more fully involved in decisions affecting them.

1.6 The main concern expressed was that service providers may not be able to meet service users' raised expectations of service, due to constraints beyond their control, such as limited budgets.

1.7 Other concerns included doubt over the degree to which achieving a human rights-based approach would be measurable; concerns that the human rights framework may be too inflexible to accommodate the broad range of care and health services; that it may result in overly bureaucratic and zealous emphasis out of proportion to the size and nature of the organisation; and the need to balance the human rights of users, providers and carers.

1.8 A common view was that in order to ensure the success of the proposed human rights-based approach, there would need to be clarity on precisely what this means within the context of the new standards, including examples of how human rights would be manifested.

New structure for the National Care Standards

Development of overarching quality standards

1.9 It is proposed that under the new structure for National Care Standards, overarching quality standards should be developed, based on human rights law and standards. These would describe the elements of a quality care experience rather than the requirements that are specific to a particular service type.

1.10 89% of those who addressed the issue expressed support for developing the overarching quality standards. This proposal was viewed as promoting greater consistency between agencies in the way services are delivered; being helpful in that people could expect the same level of care no matter who they are; and beneficial in promoting greater integration of care across health and social care services. The most commonly raised concern was that it may be challenging to produce overarching, relevant standards across both areas of service without the medical model dominating.

1.11 Many respondents called for the overarching standards to dovetail with those to which professionals already work, including those associated with Getting It Right For Every Child (GIRFEC), the Healthcare Quality Strategy, National Health and Wellbeing outcomes and Standards of Care for Dementia.

1.12 92% of those who commented agreed that overarching quality standards should set out essential requirements based on human rights. A common theme was that service providers should have training to help them to understand how human rights-based quality standards should manifest in their daily working practices. Another prevailing theme was that achievement of the overarching standards should be readily measurable, with regulators requiring guidance on how to assess this in their inspection regime.

Streamlining the National Care Standards and developing general standards

1.13 82% of those who addressed the issue agreed with the Scottish Government proposal that the current National Care Standards should be streamlined and a set of general standards developed that would sit below the overarching standards and apply to all services. The prevailing view was that streamlining the standards would help to create a simplified structure of standards, which will be easier for service user and service deliverer to understand and access.

1.14 The joined-up potential of the proposal was viewed as particularly beneficial in circumstances such as: users transferring from one service to another; first-time users unfamiliar with the system; a person using more than one type of service or a person delivering care across more than one type of service.

1.15 A common concern was that streamlining may result in standards that are so vague and general as to be meaningless and unaccountable.

Setting out essential requirements and aspirational elements of the National Care Standards

1.16 It was proposed that the National Care Standards should set out both essential requirements and aspriational elements. 75% of respondents who commented on this agreed with the proposal. The most common view in support of the proposal was that it would help to drive improvement and increase overall quality of care.

1.17 A common concern was that introducing both essential and aspirational elements to this tier of standards could be overly complex and may detract from the key message and expectation that general standards should reflect high quality in themselves. Another prevailing concern was that designating aspects of service “aspirational” may give out the message that these are optional extras, which may result in providers de-prioritising them.

Proposal to develop a suite of specific standards for aspects of care, circumstances or need

1.18 Of the respondents who addressed this proposal 79% were in agreement. In particular, respondents welcomed the tailoring of standards to particular circumstances, which they felt would be meaningful and helpful to user and provider alike. Some felt that specific standards would be more measurable than general standards. Another benefit identified was that basing these around aspects of care, circumstance or need would encourage cross-cutting support and liaison between providers and help to minimise gaps in provision.

1.19 A common concern, however, was that this approach could result in a myriad of standards to cover the diverse range of care, circumstances and need existing, thereby negating the overall aim of streamlining the current standards. It was also considered by many that such specific standards may not align with a human rights-based approach in which the focus is on the whole person and their overall needs.

Views on how the National Care Standards should be written

1.20 There was general agreement that the National Care Standards should be written in a manner which strikes a balance between the need to use language that is simple and easy to understand, whilst also requiring to express standards in a way that makes it clear when a service provider has breached a standard.

1.21 A common view was that the standards should be written in unambiguous, lay terminology, in plain English and avoiding jargon. Easy-read and large print versions were also called for along with production in a range of other accessible formats such as Braille, audio and different languages.

1.22 Repeated calls were made for the standards to be developed in conjunction with service users, carers and providers in order to increase their accessibility.

Proposal for an overall statement of standards

1.23 The main consultation document proposed a clear overall statement of standards which includes both appropriately worded explanations of the rights of people using the services and the responsibilities of service providers to deliver high quality care. There was much support for the proposal with this perceived to be a clear and user-friendly way of presenting rights and responsibilities for both users and providers of services. The visual appearance of the proposal, which included two columns side-by-side written from the perspectives of the service user and service provider respectively, was singled out for praise by a few respondents who considered this created the impression of partnership working. A few others, however, perceived this as potentially combative in appearance.

1.24 A minority of respondents criticised the text used in the proposal, deeming this to be vague, jargonistic and overly complex.

1.25 Calls were made for the proposal to be supplemented with specific examples and case studies, perhaps in an additional third column. Others requested the addition of links to related policy documents and standards.

Accountability and enforcement

Inspection of regulated services

1.26 88% of those who addressed the issue agreed that the Care Inspectorate (CI) and Healthcare Improvement Scotland (HIS) should hold services they regulate to account for meeting the proposed overarching standards, the general standards and the suite of specific standards.

1.27 It was commonly felt that without this arrangement the standards would be rendered ineffective, with patchy take up. The proposal was viewed as contributing to a transparent and independent scrutiny process which would promote consistent standards of care.

1.28 A dominant theme was that incorporating these standards within these regulatory regimes will help to make expectations of service provision clear for both service providers and users. Calls were made for greater consistency in approaches to inspection and clarity on the criteria against which providers will be held to account.

1.29 Many respondents emphasised that the new scrutiny processes should operate within an overarching supportive framework in which services are helped to work towards the standards, whether by additional funding, staff training or advice. Some called for the involvement of service users, carers and staff in the scrutiny process, to enhance its value.

1.30 Concerns were raised that the proposal could lead to confusion and duplication with inspections of all three sets of standards imposed over and above existing regulatory regimes and inspections. Some cautioned that the inspection regime should avoid being relegated to a paper-based tick-box exercise.

Inspection of non-regulated services

1.31 A recurring comment was that the implementation of self-directed support made it much more likely that non-regulated services may be procured by users, thus increasing the current challenge around ensuring compliance with standards.

1.32 A common view amongst individual respondents was that all providers of health and social care services should be required to become regulated. Others, however, acknowledged that the potential disproportionate cost and bureaucracy this may incur for some small providers and recommended compromises, such as voluntary registration with quality schemes which could be publicised and assessed by service users.

1.33 Another commonly held view was that the inspectorate bodies should have their remits extended to encompass monitoring of compliance amongst non-regulated service providers, even if this is done on an “informal” basis. Others recommended that commissioners of services such as local health and social care partnerships be responsible for monitoring adherence to standards amongst the services they procure, with compliance specified in the service contracts.

1.34 A prevailing theme was that awareness-raising of the standards amongst service providers and service users could go some way to ensuring shared, high expectations of service provision with failure to achieve these more readily identified by all. Calls were made for discreet complaints procedures in which users and whistle-blowers can air their grievances in confidence.

Views on the proposal that the CI and HIS develop the suite of specific standards in consultation with others

1.35 Amongst those who addressed this issue 85% agreed with it. These inspectorates were considered to be well placed to lead the development of the specific standards, being in the position to engage with stakeholders and using their experience and expertise.

1.36 It was felt that standards developed in this way would have credibility, be meaningful, realistic and achievable and cover all of the relevant aspects of care.

1.37 Many respondents advocated a co-productive process with collaborators working alongside each other, engaging specialists where necessary, in order to develop the standards.

1.38 A minority of respondents expressed concern, however, over scrutiny bodies being involved in developing the standards which they will subsequently be scrutinising, suggesting that this proposal lacked independence and rigour.

Assessing impact

1.39 Views were sought on potential impacts of the proposals, particularly with reference to the “protected” characteristics. It was generally agreed that there may be short-term challenges as providers and users become acquainted with the standards and make necessary adjustments to procedures, but over the longer term, most respondents viewed the proposals as having positive impacts.

1.40 The aspect of the proposals most frequently identified as positive for those with protected characteristics was the grounding of the new standards in human rights. This was seen as ensuring the individual user is at the centre of service provision, having control over their care and being listened to. Another benefit identified by many was that those with protected characteristics would receive higher standards of care, with users more likely to be protected from harm and services tailored more to their individual needs.

1.41 The most prominent concern was that service users with cognitive impairment and/or communication challenges, may find the changes to the standards confusing. Some respondents expressed concern that people with complex needs may fall between the different categories of service provision.

1.42 Implementation costs of the proposals were envisaged, largely connected with training of staff, public and provider awareness-raising, and re-working regulatory and guidance materials. Some envisaged the inspectorates having to expand to accommodate broader responsibilities, particularly if required to inspect non-regulated services.

1.43 Some respondents predicted savings would result largely from streamlined standards reducing bureaucracy and a reduction in the need for staff training over time, as procedures simplify. A recurring view was that higher standards of preventative work would lead to a reduction in remedial action required in the longer term.

Additional comments

1.44 Many respondents made additional comments over and above those documented in response to the specific questions raised in the consultation.

1.45 There was much support for the proposal for further consultation on the new standards before they are finalised. However, many respondents emphasised that this should be inclusive, in order to get views from a wide variety of perspectives.

1.46 A recurring view was that the new standards would require to be widely publicised using a variety of media. Some felt that proposed implementation date of April 2015 was ambitious.

1.47 Other significant additional comments related largely to: implementing the standards in phased approach; welcoming the outcome-focus of the standards as making them more meaningful; suggesting the word “care” is removed from their title; urging greater acknowledgement of the influence of resourcing in achieving the standards; and establishing clear timings for reviewing the standards.

2 INTRODUCTION

2.1 National Care Standards were established in 2002 to help people to understand what to expect from care services and to help services understand the standards they should deliver. There are currently 23 sets of standards which cover a wide range of care services from childminders and nurseries to care homes and independent hospitals.

2.2 Significant changes have occurred since 2002 in terms of demographics (for example, an ageing population); greater focus on community and home settings for care rather than institutional models of care provision; integration of health and social care; greater emphasis on user-empowerment and choice of care (e.g. through self-directed support); and priority afforded to human rights-based approaches to planning services and delivering care.

2.3 The Scottish Government wishes the 2002 National Care Standards to be updated and improved to meet current expectations and models of service. Central to its proposals are that people working in health and care services should have a common understanding of what quality means and they should work to common core values, through the introduction of quality standards for health and care services.

2.4 Scoping work with a range of stakeholders informed the development of a consultation paper which the Scottish Government published on 25 June 2014 in a variety of formats including easy-read, large print and on-line. The main consultation paper posed 14 questions, eight of which included a closed aspect in addition to inviting qualitative commentary. Views were invited by 17 September 2014 on proposals to update the care standards. The views expressed in the responses will inform further discussions with stakeholders and the introduction of new standards in April 2015.

2.5 This report presents the analysis of views contained in the responses to the consultation. These responses have been made publicly available on the Scottish Government website unless the respondent has specifically requested otherwise. Consultation responses

2.6 The Scottish Government received 475 responses to the consultation. Table 2.1 overleaf shows the distribution of responses by category of respondent. A full list of the organisations who responded is in Annex 1. In addition, Scottish Independent Advocacy Alliance, Age Scotland and Social Care Alliance Scotland hosted 10 events in partnership with the Scottish Government to capture the views of people who use services.

2.7 Just over half (52%) of all respondents were individuals, including members of the public, service users, and those with experience of working in the care services profession. The largest organisation sector to respond was voluntary organisations and groups which accounted for just under one-quarter (22%) of all respondents

Table 2.1: Distribution of responses by category of respondent

Category	**No.**	**%**
Individuals	248	52
Voluntary organisations and groups	106	22
Private sector	26	5
Professional representative bodies	22	5
Local authority bodies	18	4
Day care of children services	16	3
National Health Service	10	2
Community Health and Care Partnerships	8	2
Housing Associations	6	1
Regulatory/Inspectorate/Scrutiny	5	1
Educational establishments	3	1
Academic bodies	2	..
Other	5	1
Total	**475**	**100**

NB Percentages do not total 100% exactly due to rounding.

2.8 Most respondents submitted their response on-line, some using Citizen Space submission which was available until the deadline for responding, others emailing their completed response form. 18 respondents used the easy read version of the response form. Many responses comprised summaries from user-group discussions which resulted in a higher proportion of “mixed view” responses to the closed aspects of questions than would be usual. Although 475 responses were received, the views of many more respondents are reflected in these, on account of the significant number of group and workshop discussions which fed into individual responses. The views contained in all submissions were amalgamated into one electronic spreadsheet to aid analysis

Report of findings

2.9 The findings are presented in the following 6 chapters. **Chapter 3** summarises views on whether the new National Care Standards should be grounded in human rights. In **Chapter 4** views on a proposed new, hierarchical structure for the National Care Standards are analysed. **Chapter 5** presents views on how standards should be written. Views on accountability and enforcement of the standards are presented in **Chapter 6**. Respondents’ views on the potential impacts of the proposals, either positive or negative, are documented in **Chapter 7.** Other significant comments over and above those raised specifically on the questions posed in the consultation are summarised in **Chapter 8.**

Respondent categories have been abbreviated in the report as follows:

Voluntary organisations and groups	Vol
Private sector	Priv
Professional representative bodies	Rep
Local authority bodies	LA
Day care of children services	DC
National Health Service	NHS
Housing Associations	HA
Community Health and Care Partnerships	CHCP
Regulatory/Inspectorate/Scrutiny	Reg
Educational establishments	Educ
Academic bodies	Acad
Other organisations	Oth
Individuals	Ind

3 THE FOUNDATIONS OF NEW NATIONAL CARE STANDARDS

Background

3.1 The Scottish Government believes that new National Care Standards should take a human rights-based approach. By this they mean putting people who use services at the centre of how they are planned and delivered. They also mean increasing understanding and respect for human rights in those services.

3.2 The Scottish Government thinks that standards should make it easier for public services to work together, and that they must therefore work in very different settings. They wish to develop standards which people using and working in these services will understand easily.

3.3 It is proposed that the new standards should set out both the essential requirements of a service and the elements to which services should aspire to help them to improve.

Question 1: Do you think that the new National Care Standards should be grounded in human rights?

3.4 434 respondents (91% of all those who responded to the consultation) addressed the closed aspect of this question, indicating yes, no or don’t know. Of these, 401 respondents (92%) agreed that the new National Care Standards should be grounded in human rights. Amongst the remaining 33 respondents, 27 (21 of whom were individual respondents) did not know whether they agreed or disagreed with the proposal, and six (five individuals and one professional representative body) disagreed.

3.5 Recurring views were that human rights are relevant to all and the proposal would ensure people are placed at the heart of services, enabling everyone to be treated equally.

3.6 Many respondents from a variety of sectors proposed rights which they felt were particularly relevant in the context of care and health services including: dignity; respect; privacy; choice; participation; wellbeing; availability of services; equality of access to services; being treated in a polite manner; and access to independent advocacy. One respondent (Vol) commented that rights should go beyond basic, minimum levels, to those which make life worth living such as scope for socialising, mental stimulation and participation in physical activities.

Perceived benefits of the proposal

3.7 Some respondents outlined what they perceived to be the more specific benefits of grounding the new National Care Standards in human rights. The three most commonly cited were:

- Will align the standards with modern UK approaches and European Union legislation.
- Will clarify for service providers and service users alike, what can be expected in terms of service. One respondent remarked:
- “It also makes clear to providers of care services the expectations of individuals and society toward those who come under their care and the

responsibilities and obligations that they must meet as care providers" (NHS Education for Scotland).

- Will empower users to be more fully involved in decisions affecting them.

3.8 Other key advantages to the proposal were identified less frequently:

- Services will need to fit around patients, rather than the other way around.
- Will result in greater transparency of care and more accountability in provision and delivery of services.
- Promotes greater consistency of delivery of care and health services.
- Easy to understand for user and deliverer alike.
- Will make staff more aware of their responsibilities.
- Can be used as the basis of decision-making in care and health provision.
- Will make the National Care Standards more meaningful and accessible for service users.
- Will contribute to reducing/avoiding discriminatory practices.

Concerns over the proposal

3.9 Both opponents and supporters of the proposal raised concerns over aspects of the proposal. Most commonly raised were concerns that the proposal would **increase service user expectations** which service providers may not be able to meet, due to **constraints outwith their control**. Limited budgets and large caseloads were raised in this respect as variables which could impact on the ability to deliver services in adherence to human rights principles. Two respondents (Rep, Vol) envisaged a danger in paying only lip service to human rights principles if services are not underpinned with adequate resourcing.

3.10 Many different views emerged in responses about the **degree to which achieving a human rights-based approach can be measured.** There appeared to be a spectrum from those perceiving the approach to be measurable, concrete, able to be enforced and inspected, to those viewing the approach as intangible, more of a reference point, and a philosophy. Some respondents urged that the standards be developed with a focus on outcome, against which performance can be assessed. Others, however, felt that human rights provided a context, which fitted more with process than with absolute standards. A few argued that interpreting human rights within the context of care services depended largely on individual relationships between the deliver and the user, which made it difficult for inspectors to assess.

3.11 A few respondents expressed concern that human rights law and frameworks may be **too rigid** to cover the broad area of care and health services, with one respondent (Vol) commenting that although the proposal was desirable, it should not have the unintentional consequence of restricting the frame of reference used to develop the standards.

3.12 Another less prominent theme to emerge from responses was that the **rights of service providers should also be part of the framework** of the new standards, as should **associated responsibilities** of users and providers. One respondent (Vol) suggested that this would help to prevent future abuses of the term human rights.

3.13 Another minor theme was that **common sense** should prevail in the application of a human rights-based approach in order to maintain proportionality and balance. A few individual respondents urged that the approach should not become overly bureaucratic with over-zealous emphasis on human rights leading to lack of judgement (which some considered had occurred in relation to health and safety legislation). One respondent (Vol) remarked that some people's rights are already impeded for various reasons, such as being on a court order, and that a sensible and balanced approach should be taken when applying human rights-based standards to their care.

3.14 A few respondents highlighted their view that clarity would be required on **how to handle conflicting needs and rights**. Examples were provided of user and carer rights, parent and child rights, the rights of the many and the rights of the few, all presenting possible conflicts. One respondent commented:

> "....there must be a balance of rights in care – there are competing rights – carers, clients, communities, organisations etc., all have rights. Others may have an interest in the care of a person and this should also be taken into consideration" (LifeCare (Edinburgh) Limited).

3.15 One respondent (Vol) commented that the consultation had not provided an alternative approach to that of human-rights, and questioned whether there was another option for consideration.

Views on the added benefits of the proposal

3.16 A recurring view was that the current care standards already take account of human rights, with human rights legislation already covering care services' professional practice. A few respondents, however, emphasised their view of the importance of making links to human rights explicit to reflect the vulnerability of service users.

3.17 One respondent (Vol) suggested that the proposal served to move services from their current stance of focusing on not breaching an individual's rights, to one of pro-active consideration of their rights with these at the centre of decision-making.

3.18 Many respondents identified the opportunity which the proposal brought to developing the approach in line with other approaches. Most commonly cited was aligning with the United Nations Convention on the Rights of the Child (UNCRC) and with the GIRFEC approaches. Other approaches mentioned in this regard included: self-directed support; new national health and wellbeing outcomes; dementia standards; National Action Plan for Human Rights in Scotland; the SHANARRI wellbeing indicators; and the Mental Health Act.

Raising awareness

3.19 A common view was that in order for the new approach to be successful, there would need to be clarity on precisely what human rights mean in this context, and how they would be manifested in the standards. Respondents from across a range of sectors argued for a clear and common understanding of these issues which could be promoted to service users and providers alike in education and other formal and informal contexts. One respondent remarked:

> "Being explicit about human rights in the standards will help to develop a better culture around human rights by informing both service users and staff about a human rights based approach and how it applies to daily lives" (NHS Health Scotland).

3.20 Several respondents emphasised that particular effort would need to be applied to ensuring people with communication difficulties due to, for example, hearing loss or cognitive impairment, are made aware of the human rights-based underpinning to care services.

3.21 A recurring recommendation was for the standards to be written in a manner which made sense to users and deliverers of care, to move beyond rhetoric and include, for example, illustrations of how human rights principles should be applied in practice. One individual respondent provided their rationale for this:

> "Some people (like me) know they have human rights but don't know how to use them. Or what they mean in reality."

3.22 The notion of a Charter of Service User Rights was promulgated as a way of enabling the standards to become less abstract and more meaningful for users.

Summary of main findings

- There was much support for the proposal that new standards adopt a human rights-based approach. This was seen as in alignment with modern UK approaches and European Union legislation and would enable users to be more involved in decisions affecting them.
- A key concern was that service providers may not be able to meet service users' raised expectations of service due to constraints beyond their control.
- Clarity on how the human rights-based approach would be manifested in the context of the new standards was requested.

4 A NEW STRUCTURE FOR THE NATIONAL CARE STANDARDS

Background

4.1 The Scottish Government proposes a new structure for the National Care Standards which makes it easier for those receiving care to understand what to expect, and helps service providers deliver high quality care more easily. Under this model, overarching quality standards, based on human rights law and standards, would set out the essential requirements that should be core to any service such as dignity, equality, fairness, respect, the best interest of the child and children's evolving capacities. They would describe elements of a quality care experience rather than requirements that are specific to a particular service type.

4.2 A general set of standards would sit below the overarching quality standards and cover areas relevant to all health and care services, for example, participation, quality assurance and improvement, personalisation and health and wellbeing. These general standards would set out both the essential requirements which anyone using a service can expect and the aspirational elements which promote improvement.

4.3 A suite of specific standards would sit underneath the general standards and would apply to particular groups of people or particular types of service.

4.4 It is proposed that there would be clear links between the three tiers to show how the overarching quality standards guide the way services are delivered. The Scottish Government's aim is to simplify, align and reduce overlap whilst ensuring the standards drive improvement.

Question 2a): Do you agree that overarching quality standards should be developed for all health and social care in Scotland (Yes/No/DK)

4.5 439 respondents (92% of all respondents) provided a response to this question. Of these, 390 (89%) agreed that overarching quality standards should be developed for all health and social care in Scotland. 23 respondents (5%) disagreed, 2 respondents had mixed views, and 25 respondents (6%) did not know. Significant amongst those opposing the proposal were six day care providers (over one-third of all day care providers) and ten individual respondents. Four private sector bodies, two voluntary sector respondents and one housing association also disagreed with the proposal.

Views in favour of overarching quality standards being developed for all health and social care in Scotland

4.6 In addition to most respondents providing general, broad support for the proposal, three specific reasons to support it dominated responses:

- Overarching quality standards will promote greater consistency between agencies in how they deliver services.
  35 respondents from a wide range of sectors highlighted this specifically. One individual respondent remarked:
  "It means that everyone who knows me should want the same thing for me".
- Everyone can expect the same level of care no matter who they are.

33 respondents, largely voluntary organisations and individuals provided this argument, commenting that users will know what to expect irrespective of the service they are accessing or their specific needs.

- Will result in greater integration of care.

4.7 33 respondents across seven different sectors commented that the proposal was sensible in view of the current overlaps in health and social care services, with both having to work together in many cases, for example, where people have complex needs. Some individual respondents suggested that it would be artificial to maintain a separation of health and social care. One respondent (Vol) remarked that staff competencies are shared across these different services. Another (Ind) considered that the proposal would lead to more effective use of limited resources.

4.8 Three other key reasons to support the development of overarching quality standards for health and social care were put forward by fewer respondents. 17 respondents envisaged this as helping to promote a shared value base across the different domains. One respondent expressed their view thus:

> "....this is essential in the light of health and social care integration legislation. Overarching quality standards will support the development of shared understanding and cultures across health and social care" (Social Work Scotland).

4.9 14 respondents referred specifically to the Public Bodies (Joint Working) (Scotland) Act 2014 and the agenda to integrate health and social care services, commenting that overarching quality standards are essential in this context.

4.10 14 respondents described how they found the previous 23 standards confusing and welcomed the proposed approach as a means of streamlining and consolidating the standards. One respondent stated:

> "When I first started in my current position and looked for the National Care Standards for a Care at Home service, I found the range of different versions quite bewildering, especially when a lot of the core principles are shared by all care providers.
> Unifying these shared principles into overarching quality standards is a positive step that should make it easier for people seeking care and care providers alike to see the guiding principles for all care" (Assistance in Care Services).

4.11 Two further respondents (LA, Vol) were in agreement that developing overarching standards would help those inspecting services, by producing a more coherent picture nationally and reflecting the increasing integration between regulatory bodies.

4.12 A prevailing view amongst supporters was that any new overarching standards should dovetail with those which professionals already work to including those associated with GIRFEC, the Healthcare Quality Strategy, national health and care wellbeing outcomes and Standards of Care for Dementia.

Concerns over the proposal

4.13 The most commonly raised concern over the proposal (highlighted specifically by 12 respondents) was that what they perceived to be the current imbalance between health and social care with different models and approaches to outcome and risk associated with each, may work against an effective, integrated approach to standards. Several considered that it would be challenging to produce overarching, relevant standards across both areas of service without the medical model dominating. One individual respondent remarked:

> "I am concerned that if there were overarching health and social care standards they would be health focused and therefore based on achieving performance standards and targets, waiting lists etc. Person-centred outcome focused quality standards may be reduced in stature and therefore may not be the main driver of service improvements or focus."

4.14 One individual respondent held an opposing view, however, envisaging that the proposal would contribute to addressing this imbalance:

> "Right now there is a difference in the quality of the care between the social care and the health services, with social care being seen as the poor relation but with the health service causing the most damage. Being judged against the same standards, which the population would be aware of, would give an even playing field and allow the prioritising of funding and support for failing services."

4.15 Another dominant concern over developing overarching quality standards was that these would need to be relatively general and broad brush and that this may result in their being "dumbed down" to a level of generality which loses meaning and effectiveness. One respondent commented:

> "We have concerns that a political initiative about overarching standards may result in a set of standards that are so high level and abstract that they could become impossible to meet because they will have to address so many diverse professional workstreams and care environments" (United Kingdom Homecare Association).

4.16 Four further respondents agreed that overarching standards may not be detailed enough to be enforceable or measureable. They argued that the standards would require to be written in a manner which would ensure genuine regulatory impact.

4.17 Other arguments and cautions against the proposal were expressed each by only a few respondents:

- One size does not fit all and standards should be tailored for each sector (children and adults were identified as different sectors in this respect).
- The previous standards were not overly complicated and the proposal may well confuse rather than simplify.
- Current standards work well and there is no need to change.
- Even with overarching standards, there will be little sign of joined-up thinking between different care services.

- The more tiers of standards which are produced the greater the more likelihood that they will be ignored.

Other comments

4.18 Ten respondents commented on terminology with several recommending that the word “standards” be replaced with words such as “principles”, “duties” or “framework”, to reflect their view that these are not actually standards *per se* but more an ethos and approach.

4.19 Three respondents requested a definition of what is meant by “service”. One (Reg) asked for clarity on the meaning of “social care” which they argued could mean different things across different local authorities.

4.20 One individual respondent perceived the proposal as positive in contributing to common terminologies across health and social care services.

4.21 One respondent (Rep) sought more information on the precise relationship between the proposed three tiers of standards.

Question 2b): Do you agree that overarching quality standards should set out essential requirements based on human rights? (Yes/No/DK)

4.22 434 respondents (91% of all respondents) provided a response to this question. Of these, 398 (92%) agreed that overarching quality standards should set out essential requirements based on human rights. Six respondents (1%) disagreed, 2 respondents had mixed views, and 28 respondents (6%) did not know.

Views in favour of the proposal

4.23 Many respondents referred to arguments in favour of human rights-based standards which they had documented in response to question 1. Amongst those respondents who provided clear reasons in support of the proposal in question 2b), the most common view was that human rights are generally applicable across different services and different sectors of users. Basing the overarching quality standards on human rights was seen as a way of making expectations clear for both service user and provider, and providing re-assurance of this to the user. A few respondents commented that a human rights-based approach is wholly compatible with the current person-centred approach. One respondent (Ind) remarked that as Scotland becomes more diverse in culture, it is important to re-emphasise underlying principles of Scotland’s public services.

4.24 A recurring theme was that overarching standards based on human rights will lay the foundation and baseline against which other standards can be benchmarked.

4.25 Two voluntary organisations agreed that the proposal will be important in leading change. One commented:

> “A focus on human rights at this overarching level could positively impact on the purpose and mission of each discrete and individual organisation and service, whatever the speciality” (Who Cares? Scotland).

4.26 Two respondents (Rep, Vol) argued that the proposal does not go far enough, and standards for each proposed tier (not just the top tier) should be grounded in human rights. They argued that this would help to translate abstract human rights into meaningful ways of working on the ground.

Views on development and implementation of overarching standards based on human rights

4.27 Some respondents expressed views on how best to develop and implement the overarching standards. There was a call for use of consistent terminology between the standards and human rights information in order to avoid confusion. One voluntary organisation recommended that the quality standards be co-produced with service users to ensure these are meaningful and enable users to exercise their rights proactively.

4.28 A common theme, emerging from six different sectors, was that the service delivers should have assistance and training to help them to understand how human rights-based quality standards should be manifest in their daily working practices. One idea was for good practice to be promoted and publicised:

> “We would like examples of good practice ‘sector leaders’ to be highlighted and that this can give inspiration to other less well performing services to aspire to improve” (Healthcare Improvement Scotland’s Public Partners).

4.29 Some respondents felt that the standards would need to be more specific in identifying more precisely the implications of their human rights grounding. For example, supporting those with incapacity to make decisions affecting their care; providing BSL interpreters, access to advocates, transport and other active support for people with disabilities. A few respondents called for the quality standards to be presented to users in a manner which they could readily understand and access.

4.30 Another dominant theme was that of ensuring new standards are measurable and can be used as a yardstick against which to assess level of and improvements in service provision. Various respondents emphasised what they perceived to be the importance of regulators being able to assess service delivery objectively and consistently. It was envisaged that regulators would require guidance on how to use the standards as part of their inspection regime. One individual respondent remarked:

> “....we still have to make meeting those rights affordable and deliverable - and enforceable. Rights alone are pie in the sky if the related regulatory support is inadequately constructed.”

4.31 One respondent (Vol) re-iterated a point previously made that some people subject to criminal justice measures have restricted rights, and that their particular position will need to be considered when developing and implementing the new standards.

4.32 One local authority recommended that the standards should make clear that human rights should be exercised only to the extent that one person’s rights should not impinge on the rights of others.

Concerns about the proposal

4.33 A variety of concerns were raised about the proposal, with each tending to be highlighted by only a few respondents. Some questioned what individual service users would do if they felt that their human rights had been breached, with suggestions that guidance is made available on how to assess this, and steps to take if human rights are not upheld.

4.34 Another concern was that human rights-based standards would replace commonsense with regard to delivering quality services, which might lead to curtailed initiative, individual decision-making, risk-taking and good leadership.

4.35 Other queries and concerns were:

- Why would the standards be based on human rights and not equality rights? Both already feature in legislation governing service provision, yet only human rights feature in the proposals on new care standards (Vol).
- The human rights focus may reflect minimum standards which is at odds with aspirational levels of provision (Rep).
- What are the implications for costs? What will be the situation if there are insufficient resources to implement human rights-based quality standards? (HA).
- Not all services deal with all people, for example, some focus on specific age groups to the exclusion of others. How would this reconcile with standards based on non-discriminatory practice? (Priv).

Views of those opposed to the proposal

4.36 Amongst the very small minority of respondents who disagreed with the proposal the following reasons were provided:

- Not necessary as Scotland is already signed up to the convention of Human Rights.
- There should be responsibilities to accompany the rights.
- The human rights-base makes the standards too vague.
- Contributes to unnecessary bureaucracy.
- Overarching standards should be clinically and operationally justifiable, deliverable and sustainable within the resources available. Human rights should provide only an adjunct rather than a dominant part of this.

Question 2c): Do you agree that the current National Care Standards should be streamlined and a set of general standards developed that would sit below the overarching standards and apply to all services? (Yes/No/DK)

4.37 423 respondents (89% of all respondents) provided a response to this question. Of these, 349 (82%) agreed that the current National Care Standards should be streamlined and a set of general standards developed that would sit below the overarching standards and apply to all services. 28 respondents (7%) disagreed, nine respondents (2%) had mixed views, and 37 respondents (9%) did not know. Amongst the 28 respondents who disagreed, were nine individuals, with the remaining opponents spread across six different sectors.

Views in support of the proposal

4.38 The prevailing view amongst supporters of the proposal was that streamlining the standards would help to create a simplified structure of standards, which will be easier for service user and service deliverer to understand and access. A typical remark was:

> "Alzheimer Scotland supports the proposed structure of the National Care Standards and believes that the tiered approach of standards is a useful way of distinguishing between the different intended outcomes of each, as well as making it clear which standards apply to each service."

4.39 A recurring view was that streamlining would reduce what some perceived to be the current duplication in standards, by amalgamating common themes which cross-cut health and social care services. Some described the proposed structure of standards as logical, providing a natural flow from the overarching vision to more specific issues. One respondent described this progression as a "golden thread" (CHCP).

4.40 The joined-up potential of the proposed structure was viewed as particularly helpful in a range of scenarios:

- where users are transferring from one service to another, for example, a young person transferring between children's and adults' services;
- for first-time service users who are unfamiliar with the system and do not yet know about their rights and entitlements;
- where someone uses more than one type of service or a person delivers care across more than one type of service.

4.41 Despite offering general support to what was proposed, many respondents argued that in addition to common standards, there was a clear need for more specific, tailored standards dedicated to particular sectors. Most commonly identified in this respect were children's services, although others mentioned older people's services and mental health services.

Concerns over the proposal

4.42 The most common concern (amongst supporters and opponents of the proposal alike) was that streamlining may result in standards that are so vague and general as to be rendered meaningless and unaccountable. Concerns were raised that important technical and specific safeguards particular to certain groups could be lost in the rationalisation of standards. The needs and rights of minority ethnic service users was one example provided. Some considered that common areas between services may be fewer than suggested in the consultation.

4.43 Many respondents emphasised that they supported the notion of streamlining, but were concerned that what was suggested may result in a framework of equal complexity to the status quo, thus inadvertently running contrary to the intention of simplifying. A typical remark was:

> "There is a real danger that, in the pursuit of streamlining the system, too many tiers are created which could be confusing for those who use services" (Barnardo's Scotland & Children1ST).

4.44 Some organisations queried whether it was necessary to have three tiers in the new framework, or whether the proposed top two tiers could be amalgamated. If kept separate, some called for greater clarity and distinction between them. One respondent commented:

> "....work would need to be undertaken to ensure that the 'second tier' general standards are sufficiently different from the over-arching standards based on human rights. For example, themes such as participation and personalisation are not wholly different from the type of over-arching standards that are grounded on human rights principles. It may therefore be an unnecessary complication and as such a single structure of national care standards with specific standards sitting below these may be more appropriate" (COSLA).

4.45 A small minority of respondents were more strongly opposed, providing their view that what was proposed appeared to be a replacement of one complex framework with another. Typical remarks included:

> "PAMIS is unsure about the benefits of a three tier approach and we are concerned that it will cause confusion. On a practical level care and health providers are going to look at the set of standards that pertains to the aspect of care that is relevant to what they deliver."

4.46 Other concerns were expressed by only a few respondents:

- The more general the standards the more open to individual interpretation they will be.
- In striving to find commonalities between services the standards should not lose sight of the central focus on the care of the person.
- General standards should not result in losing the flexibility to accommodate the wide range of circumstances across different services.
- The new standards need to align with existing legal requirements and targets or this will result in confusion and duplication.
- The case has not been made strongly enough for revising the current standards and perhaps these should simply be reviewed and streamlined, rather than creating new ones.
- When standards are too generic this can result in producing misplaced expectations on some services.

Requests for more information

4.47 Ten respondents requested more detail and subsequent debate on the content of the proposal before giving judgement on it. In particular, some wished to see the balance of commonality of issues against specifics relating to particular areas and issues.

4.48 Five respondents requested illustrative examples and guidance to illuminate how the standards would apply in a range of circumstances.

Question 2d): Do you agree that the current National Care Standards should set out essential requirements and aspirational elements? (Yes/No/DK)

4.49 419 respondents (88% of all respondents) provided a response to this question (although several others provided related commentary but did not indicate clearly whether they agreed or disagreed with the proposal). Of these, 315 (75%) agreed that the current National Care Standards should set out essential requirements and aspirational elements. 51 respondents (12%) disagreed, 11 respondents (3%) had mixed views, and 42 respondents (10%) did not know. Almost half of those opposing the proposal were individuals; 12

were voluntary organisations and the remaining opponents were spread across five different sectors.

Views in support of the proposal

4.50 The most common view in support of the proposal was that setting out clearly the essential requirements in additional to aspirational elements of standards would help to drive improvement and increase overall quality of care. Those expressing this view explicitly were largely voluntary organisations and individual respondents along with six professional representative bodies and five representatives of the NHS. A recurring view was that detailing essential and aspirational aspects would provide services with helpful signposting for their “journey” to improved standards of care and prevent them stagnating at the lowest acceptable level. Typical comments included:

> “There has to be essential minimum standards and these need to be clear to ensure that they are understood and adhered to. Aspirational standards give people the opportunity to think about how they can improve and do this in a creative way” (Individual respondent).
>
> “The Society welcomes the suggestion of introducing essential elements which should be the hall mark of any care or support service. Introducing aspirational elements if done in a constructive and assets based way could help to raise standards, support continuous improvement and could help to transform organisational cultures” (British Psychological Society).
>
> “This will give a clear indication of the difference between satisfactory and excellent performance. Including both will provide a clear pathway for health and social care services to develop and incorporate the principles of performance and continuous improvement to service delivery” (NHS Health Scotland).

4.51 One respondent (Ind) commented that this approach already works well in the education sector. Others (Vol, LA) predicted that introducing essential and aspirational elements of standards would encourage services to self-evaluate.

4.52 Four respondents recommended that within a framework of both essential and aspirational elements, it will be important to focus on achieving the essential aspects first and foremost. One individual respondent presented their view thus:

> “....what is essential should not be held back by what would be desirable. Once the essential goals are achieved, more efficient focus can be given to the desirable but non essential elements”.

4.53 A further four respondents including three local authorities, argued that essential and aspirational elements should form part of the overarching tier of standards rather than the second tier.

4.54 It was commonly felt across several sectors that in order to be meaningful, the aspirational elements should be realistic and achievable over time, and not just a “wish list”. For some, this meant that additional resources would need to be put in place to support the drive towards attaining the aspirational level of standards. Two respondents (Vol, Ind) suggested that attaching a timeframe to the aspirational elements might focus services on the need to achieve these, and make them more meaningful.

Concerns over the proposal

4.55 Many respondents (both supporters and opponents) raised concerns over aspects of the proposal. The most common concern was that introducing essential and aspirational elements to this tier of standards could be **overly complex and may detract from the key message** and expectation that general standards should reflect high quality in themselves. Some felt that whilst it was helpful to express aspirational levels as something to aim for, this could be done more effectively by separate illustrations of good practice, or recognition of excellence, outwith the care standards framework. Comments included:

> “ENABLE Scotland believes that all of the essential requirements for a good quality health and social care support service should be aspirational for the achievement of the individual’s person centred outcomes.
>
> In our experience, there is an issue already with a lack of consistency of approach to grading, and we would fear that adding another layer of complexity to this would be unwelcome, and more worryingly, create an opportunity for service providers to seek to deliver only the ‘essential’ and not the ‘aspirational’ elements of a good quality service in order to pass the Inspection process (ENABLE Scotland).
>
> “We have some concerns that if we are looking to improve standards of care by aspiring to “best practice” that we do not divorce best practice from what are considered essential requirements. Often the essential elements focus on process and factors that can be counted and may not be linked with achieving good outcomes which best practice aspires to achieve” (North Lanarkshire Council).

4.56 Amongst those recommending simplification and restriction to essential requirements only were several who referred to what they considered to be effective sliding scales and grades used in inspection and regulatory frameworks which they felt recognised and encouraged improvement and best practice, without the need for setting aspirational targets.

4.57 Another common concern was that including both essential and aspirational elements within the general standards could result in an ambiguous inspection regime in which increased emphasis will be placed on individual inspectors’ value judgements. Clarity was called for over the status of aspirational elements and whether these would fall within the scope of inspection. Some respondents argued that they had no place in a compliance framework and would not be enforceable. Comments included:

> “We strongly believe the standards should set out essential requirements as they will be 'policed', and it will cause confusion if 'aspirational elements' cloud what is vital” (Treasure Island Nursery Ltd.).
>
> “If aspirational elements are included in Standards, what would be the mechanism for monitoring these, so that the aspiration showed some measurable progress towards being achieved? In the absence of this,

> having aspirations included in Standards which are then marketed to people using services as something they can use as a yardstick to measure their experience against, becomes confusing" (Befriending Networks).

4.58 One further prevailing concern was over terminology, with a recurring view that to designate elements of service as "aspirational" could give out a message that these were **optional extras**, not part of the general scheme of things, add-ons rather than mainstream priorities. Coupled with what many saw as a lack of regulatory requirement and incentive to achieve these, the aspirational elements were predicted to be de-prioritised by services. One respondent commented:

> "we have concerns surrounding the language used in this section of the consultation. Describing requirements or components as essential and aspirational, implies that there is a minimum standard that services need to achieve and anything over and above is optional. This should not be the case; there should be considerable focus on continuous improvement, and scrutiny programmes to inspect quality standards should reflect this" (Voluntary Health Scotland).

4.59 17 respondents remarked that if aspirational elements are introduced, these will require regular review, updating and stretching as services begin to achieve them. Flexibility was called for so that innovative practices of different providers can be incorporated into the framework, but also so that differences in approach across services can be accommodated.

4.60 A view expressed explicitly by 13 respondents was that only essential elements should be set out in the standards, with individual service providers left to establish their own aspirational targets, individualised and tailored for their particular circumstances.

4.61 12 respondents cautioned that services users may be confused by aspirational elements, with expectations falsely raised that these are statutory requirements to be met by service providers. One respondent remarked:

> "....there would have to be a very clear understanding of how these aspirational elements were communicated to people who use services, as they may lead to unrealistic expectations on service providers which funding and commission arrangements may not allow for" (CrossReach).

4.62 Other substantive concerns expressed by only a few respondents were:

- Difficult for services to evidence that they have achieved aspirational elements.
- Would the aspirational element of service provision be eligible for funding?
- Could create complexities over procurement of services – at what level of expectation would procurement take place and be assessed, essential or aspirational?

Question 2e): Do you agree a suite of specific standards are developed for particular aspects of care, circumstances or need? (Yes/No/DK)

4.63 412 respondents (87% of all respondents) provided a response to this question (although several others provided related commentary but did not indicate clearly whether they agreed or disagreed with the proposal). Of these, 327 (79%) agreed that a suite of specific standards should be developed for particular aspects of care, circumstances or need. 23 respondents (6%) disagreed, five respondents (1%) had mixed views, and 57 respondents (14%) did not know. Those opposing the proposal were largely individual respondents and voluntary organisations and groups.

4.64 Overall the responses to this question revealed some confusion about the topic and the examples provided in the consultation document, which resulted in a plethora of responses from individuals listing aspects of care they appreciated, and other areas they wished to see improved and prioritised (e.g. seeing the same professional consistently over time; being listened to; being given meaningful things to do; prompt access to services when needed).

4.65 Amongst the few substantive reasons for supporting the proposal, the following emerged most frequently:

- Specific standards are more reflective of specific needs and are more tailored to particular circumstances.
- Specific standards are helpful for service provider and user alike. One respondent commented:
- “Clarity and specificity are necessary if the new standards are to be more manageable and accessible for practitioners than has been the case to date” (Educational Institute of Scotland).
- Specific standards help the inspectoral regime by being more measurable and focused than general standards.
- Standards based on aspects of care, circumstance or need encourage cross-cutting support and liaison between providers and serve to limit gaps in provision.

4.66 Other reasons provided by one or a few respondents for supporting the proposal were:

- The specific standards could potentially apply to unregulated providers too.
- A need to ensure safety and wellbeing.
- Able to signpost to relevant legislation and guidance such as the Dementia Standards and GIRFEC.

4.67 The seven examples provided in the consultation document generated much debate. Whilst some respondents welcomed a specific standard relating to children and young people, others called for a separation of infants from children, or young people as a distinct standard. Other recommendations were for standards relating to:

- looked after children
- children in foster or adoptive care
- children in need
- children and young people at points of transition, e.g. between children’s and adults’ services

4.68 Several respondents advocated specific standards for adults; vulnerable adults; or older adults. Two remarked that older people as the largest group of care recipients and should therefore merit a standard dedicated to them.

4.69 Whilst one respondent (Vol) specifically welcomed the proposed standard on nutrition for older people, four others requested that this be broadened to nutrition for all.

4.70 The proposed standard on people in the criminal justice system received very little comment, the few respondents referring to this, in favour.

4.71 Six respondents welcomed the proposed standard on supporting people who use medication, although one dissenting view was that most people who are cared for are on medication and this topic would be better placed within a general standard.

4.72 There was support for including infection control in communal settings within the specific standards, largely from individual respondents. Likewise, a few respondents expressed their support for including people with learning disabilities, although one (Reg) recommended threading this topic through other standards rather than focusing on it in isolation.

4.73 Five respondents referred specifically to the proposed specific standard on palliative care, with all in support.

4.74 Many respondents recommended additional standards which they wished to see included in the final suite (listed below from most to fewest mentioned):

- dementia
- mental health
- general support services such as housing
- sensory impairment/loss
- communication issues
- addiction services
- complex needs
- non-medical interventions (such as psychological therapies)
- minority ethnic communities
- restraint for children/young people in distress
- people in the community
- safety
- control of diabetes
- homelessness
- carers

4.75 A small number of respondents urged that specific standards focus on health and social care settings such as hospital; day services; residential/care homes; and own home.

4.76 Some felt that particular themes should run through whichever standards are finally adopted: adult and child protection; human rights; safety, hygiene and respect.

Concerns about the proposal

4.77 Although there was much support and enthusiasm for the proposal, there were also many concerns raised by supporters and opponents alike. The most commonly raised concern (46 respondents) was that this approach could result in a myriad of standards to cover the diverse range of care, circumstances and need existing, thereby negating the overall aim to streamline the current standards. Comments included:

> “A common sense approach would be needed to make these simple as there may be a tendency to create complex systems which are difficult to implement. It is unclear whether the specific standards will be based around place, client type, circumstances or a combination of all which may not result in the streamlining of the present standards and publications and ultimately non achievement” (Perth and Kinross Council).
>
> “....there is risk of the end product being no less, or even more complex, than existing standards” (Social Work Scotland).

4.78 Another prevailing theme was that specific standards such as these which focus on particular characteristics of a person and specific services, do not align with person-centred or human rights approaches, which focus on the whole person and their overall needs. Many respondents provided examples such as that of a disabled child with learning disabilities and physical impairments, who is in need of a range of support and will not fit neatly into one or two of the specific standard categories.

4.79 A recurring view was that the examples provided are confusing in that they reflect a mix of aspects of care, groups and services, with approaches from the general to the specific. Some respondents called for greater consistency in the nature of the specific standards. One respondent remarked:

> “The topics included for illustration are not like-for-like, some refer to groups of people others to specific issues such as nutrition. We feel that a subject such as nutrition is directly related to the overarching human rights aspiration and should therefore come under a general quality standard. Many of the people with learning disabilities that we support would come under several of the proposed headings. We are concerned that a suite of many different issues will cause confusion; running the risk that groups of people may not be included in important standards” (Real Life Options).

4.80 Whilst five respondents expressed their view that the proposed standards may not be specific enough to be useful, others called for broad, flexibility in the standards so as to avoid prescription which some perceived to be incongruous with self-directed support and personalisation. One respondent remarked:

> “We do not want to create an inflexible regime that risks limiting innovation” (CCPS).

4.81 A small number of respondents highlighted what they saw as the importance of developing the specific standards in collaboration with users, carers, service providers and the third sector.

4.82 16 respondents did not see the need for the third tier of standards, with most considering that only overarching and general standards would be needed within the new framework. Some envisaged the specific standards would be better packaged as guidelines or protocol which could be referred to in the overarching and general standards. Two voluntary sector respondents cautioned that the specifics of the third tier could detract from the important, broad standards presented in the overarching tier.

4.83 Three respondents expressed concern that the more specific the standards, the more likely they will need regular updating.

4.84 Two voluntary sector respondents perceived the word “suite” to be meaningless for most readers, and preferred instead “guidelines” or “indicators”.

Summary of main findings

- There was much support for the proposal for overarching quality standards under the new National Care Standards structure.
- Most respondents wished to see the current National Care Standards streamlined and a set of general standards developed that would sit below the overarching standards and which would apply to all services.
- A common concern, however, was that streamlining may result in standards that are too vague to be of use.
- The majority view was in favour of the National Care Standards setting out both essential requirements and aspirational elements, although some respondents were concerned that this may be too complex.
- Much support was expressed for the development of a suite of specific standards for aspects of care, circumstances or need.

5 VIEWS ON HOW THE NATIONAL CARE STANDARDS SHOULD BE WRITTEN

Background

5.1 The Scottish Government believes that new National Care Standards should have a clear, overall statement of standards which includes both appropriately worded explanations of the rights of people using services and the responsibilities of service providers to deliver high quality care. The consultation document (full version but not the easy-read version) provided an example of how this could be set out with two columns: one headed, "As a person who uses services I have the following rights...", and the other headed, "As a service provider we have the following responsibilities...."

Question 3a) What are your views on how standards should be written?

Question 3b) (full version only) What are your views on the example of how the rights and entitlements of people using services and the responsibilities of service providers could be set out?

5.2 The responses to question 3a) and 3b) from the main version of the consultation paper were analysed together as there was considerable overlap in the content of these, indeed, some respondents simply providing the same comments in response to both. Furthermore, the easy-read version of the consultation paper asked only one generic question: "What are your thoughts about how the standards should be written?", and the responses to this have been amalgamated with the others for the purposes of analysis below.

5.3 426 respondents (90% of all those who responded to the consultation) addressed the broad topic of how the standards should be written. There was variety in how respondents interpreted the various questions posed in the full and easy-read versions of the consultation. A few respondents stated that they were unclear about what was being asked. Many respondents focused entirely on the language and presentational features of the proposed standards. Others referred to the particular example of how overarching standards could be set out (although those responding to the easy-read version did not have sight of this); or provided their views on detailed points of difference between, for example, rights and entitlements. This resulted in a complex array of views with some clear messages, but also some ambiguity over what a few respondents were referring to and where their preferences lay.

Comments regarding clarity of language and accessibility of standards

5.4 There was a general agreement with the statement in the consultation document that the National Care Standards should be written in a manner which strikes a balance between the need to use language that is simple and easy to understand, whilst also needing to express standards in a way that makes it clear when they have been breached by a provider. One respondent concurred:

> "These need to strike a balance between being meaningful for service providers but still understandable to service users and their families" (Renfrewshire Council).

5.5 Over one-third (36%) of those who addressed these questions recommended that the standards be written in unambiguous, lay terminology, in plain English, avoiding jargon. 49 respondents (12% of those who provided a response) specifically advocated publishing the standards in an easy-read version with symbols and pictorial representation to promote understanding. Nine respondents called for a large print version.

5.6 37 respondents urged that the standards should be presented concisely, nine respondents suggesting a bulleted format and three suggesting the use of colour-coding.

5.7 Recurring themes included ensuring that the standards were presented in an accessible manner (22 respondents); and in a range of formats including BSL (21 respondents). Six respondents explicitly requested a Braille version of the standards; 13 recommended publishing the standards in different community languages; a further 13 advocated audio versions of the standards on CDs or DVDs. One voluntary organisation suggested a "talking tablet" could be used to communicate the National Care Standards.

5.8 31 respondents considered that the accessibility of the standards would increase if they were developed in conjunction with service users, carers and providers. One respondent commented:

> "We understand that there is a balance to ensuring the standards are both easy to understand and yet comprehensive and believe that the best way to achieve this balance is to ensure people who use services and their carers are at the heart of developing the Care Standards. They should be involved in large numbers, across a broad spectrum of illnesses (including neurological) and there should be a wide geographical spread" (The Neurological Alliance of Scotland).

5.9 Two voluntary sector respondents, however, argued that an independent person with no affiliation to any particular group or body would be best placed to draft the standards, as this would ensure impartiality.

Comments on dissemination of and access to the standards

5.10 Many respondents recommended that a robust public awareness campaign should accompany the development and publication of the standards and suggested ways to publicise them:

- internet
- hard copy
- on Facebook and other social media
- using Apps
- posters
- leaflets
- on view at GP surgeries
- by post directly to service users
- face-to-face (e.g. in the case of people with learning disabilities).

5.11 Two voluntary organisations suggested that a distinctive logo would also help to make the standards memorable.

5.12 12 organisations from a range of sectors referred explicitly to the Standards of Care for Dementia in Scotland as a useful model of how principles can be written in a way that applies across a wide range of service settings; others (12 respondents including 11 organisations and one individual) felt that GIRFEC principles and indicators could be adapted and written in a way that applies across all age groups. Other respondents identified potentially useful examples of frameworks as the Patient Rights Charter (two voluntary organisations) and Developing a Quality Framework for General Practice in Scotland (Rep).

5.13 Whilst respondents appreciated the need for clarity and simplicity in presentation of the National Care Standards, many acknowledged the need to accommodate supporting detail also. Various suggestions were made for documenting this in appendices, a glossary, or an accompanying document.

Views on the proposal for overall statement of standards

5.14 The main consultation document proposed a clear, overall statement of standards which includes both appropriately worded explanations of the rights of people using services and the responsibilities of service providers to deliver high quality care (see boxed background paragraph at the start of this chapter). The main consultation document asked for views on the example provided.

Views in favour of the example provided

5.15 Amongst those who provided views on how the standards should be written, 135 respondents were explicit in stating that they were in favour of the layout provided in the example. It was perceived to be a clear and user-friendly way of presenting rights and responsibilities for both users and providers of services. Some identified it as transparent, streamlined and helpful in enabling users and providers to know what to expect, contributing to ensuring compliance with the standards. A few respondents remarked that the visual appearance of the two columns, side-by-side, created the impression of partnership working between user and provider. A repeated view was that the layout was in keeping with a rights-based approach, with a few respondents commenting that they particularly supported the use of the first person, “I have the right...” and “We will ensure....” in the example provided. A typical remark was:

> “The example given, using both “I” and “We” as terminology, is, in our view, a good one making it clear who the standards are written for. It indicates to the individual what they can expect and also the provider’s responsibilities” (Social Work Scotland).

5.16 50 respondents (including 23 individual respondents) commented that they preferred more of a focus on the users’ rights, amongst them being some respondents who felt that there was perhaps no need for the second column of service providers’ responsibilities. For example, one individual respondent commented that there would be an implicit expectation that users’ rights will be met, thus no need for articulating providers’ responsibilities. Another individual remarked:

> “A clear statement of rights and entitlements is required by the service user. This way there is no muddying of the waters and it is clear what

> can be expected from service providers. Please do not mix the two, it just creates a watered down set of standards."

5.17 In contrast, one local authority expressed their preference for setting out the standards from the service providers' perspective.

Views against the example provided

5.18 The most common criticism of the example (23 mentions) was over some of the language used, which was described variously as vague, jargonistic and far too complex for some service users. Terms like "take steps to" or "adequate" were perceived to be open to interpretation. A few respondents criticised what they felt were long-winded sentences used in the example.

5.19 Another common criticism (14 mentions) was that the example does not recognise that service users also have responsibilities and service providers also have rights.

5.20 A few respondents felt that the columnar presentation created an artificial, combative, "them and us" impression which they considered was unhelpful.

5.21 Three voluntary organisations all proposed a similar alternative format: a flow/driver diagram or "journey narrative". One described their vision thus:

> "...the rights and entitlements should be set out for each stage of interacting with (the) service, even if this necessarily produces repetition, it would make the document more clear for a vulnerable individual who would see their interaction with the service as a series of stages and be able to check on their rights and entitlements accordingly" (Befriending Networks).

5.22 One local authority advocated an "audit format" for setting out the care standards in which service providers could self-evaluate their performance against the standards.

5.23 Seven respondents across four sectors recommended maintaining the format of the current care standards and simply updating this. They argued that this would enable a smoother transition to the new standards, with less need for education on how to work with the new ones.

Views on additions to the proposed example

5.24 A common view was that the inclusion of specific examples and case studies would provide a useful supplement to what was proposed in the consultation document, making the standards more meaningful and applied. One suggestion was for the addition of a third column to accommodate this. Some respondents called for greater specificity over service provision and support, whilst others expressed their view that greater detail is required in order for service provision to be readily measured.

5.25 A recurring theme was that the standards should refer to related policy documents and standards such as the Dementia Standards, clinical standards, government policies, public sector equality duty and UNCRC.

5.26 13 respondents called for the standards to provide clear information on how users can speak up, have their say, and claim rights they feel are not being met. Other additions suggested by only a few respondents were:

- reference to self-directed support
- reference to the safety agenda
- reference to quality of service
- access to independent advocacy

Summary of main findings

- It was generally agreed that the National Care Standards should be written simply, in a jargon-free manner, which enables identification of any breach of standards by service providers.
- Respondents requested that the standards be published in a variety of accessible formats.
- Many respondents praised the presentation of the standards which was proposed in the consultation document in which the rights of service users were set against the responsibilities of service providers.

6 ACCOUNTABILITY AND ENFORCEMENT

Background

6.1 The Scottish Government proposes that the new overarching standards should sit above all existing standards, principles and codes of practice for health and social care. They also propose that the CI and HIS should hold services they regulate to account for meeting these essential requirements and use the aspirational elements of the standards to help services improve where needed.

6.2 Some services are not regulated by the CI and HIS and consideration needs to be given to how these services comply with the standards.

6.3 The Scottish Government considers that there is a role for the CI and HIS to take forward the development of the suite of specific standards for particular aspects of care, circumstance or need, in consultation with partners, professionals and people using services to ensure they are firmly focused on best practice and meeting users' needs. These specific standards would set out in detail the essential components that a service regulated by the CI and HIS must demonstrate.

Question 4a): Do you think the CI and HIS should hold services they regulate to account for meeting the proposed overarching standards, the general standards and the suite of specific standards?

6.4 423 respondents (89% of all respondents) provided a response to this question (although several others provided related commentary but did not indicate clearly whether they agreed or disagreed with the proposal). Of these, 373 (88%) agreed that the CI and HIS should hold services they regulate to account for meeting the proposed overarching standards, the general standards and the suite of specific standards. 12 respondents (3%) disagreed, 2 respondents had mixed views and 36 respondents (9%) did not know. Five individual respondents were amongst those opposing the proposal, with the remaining seven representative of a range of different sectors.

Views in favour of the CI and HIS holding services they regulate to account for meeting the standards

6.5 The most common reason to support the proposal was that without this, the standards would be rendered ineffective, with patchy take up. Holding services to account was seen as a way of **supporting improvement in provision of care**. Typical comments included:

> "We would ask, if providers are not held to account then why have a set of standards?" (United Kingdom Homecare Association).
>
> "There is no point in developing standards if they are not implemented and achievement against them measured" (Individual respondent).

6.6 Several respondents commented that the proposal represented a **transparent, independent scrutiny process** which would promote consistent standards of care. This was seen as particularly important for users moving between different settings, for example, supported accommodation to hospital. A few respondents highlighted the importance of both regulatory bodies holding services to account, in view of the integration of the health and social care domains.

6.7 Some respondents expressed surprise at the question, stating that this falls clearly within the remit of the CI and HIS anyway and will not require additional inspection services to be established.

6.8 A dominant theme was that incorporating these standards within these regulatory regimes will help to make **expectations of service provision clearer** for both service providers and service users.

6.9 Another prevailing theme throughout many responses was that there needs to be a consistent approach to inspection. Some felt that this has not been achieved, but the proposal could help to promote **greater consistency in inspection approach.**

6.10 Two respondents considered that the proposal would **boost public confidence in health and care service provision**, in the knowledge that services are being held to account for delivery of the standards by these regulatory bodies.

Views on how best to implement the proposal

6.11 A dominant view was that there should be **clarity on the criteria against which providers will be held to account**, what good practice looks like, and what evidence is required to demonstrate that standards are being met. A typical comment was:

> “It is ..... vital that the Scottish Government, the Care Inspectorate and Healthcare Improvement Scotland, as well as any other regulatory body who may be involved in scrutiny of services, ensure that the expectations and practicalities for service delivery are clearly defined, including support for providers in relation to how practice may be evidenced” (Alzheimer Scotland).

6.12 Some suggested that examples of areas of excellence are identified and rolled out nationally or shared across providers.

6.13 A few individuals recommended a bedding in period during which existing services are given time to understand the new requirements and put in place provision to achieve these. One private organisation suggested that the proposal be piloted in the first instance to see if it is feasible and robust in practice.

6.14 Several respondents urged that commissioners of services in addition to service providers are included in the inspection regime.

6.15 An emerging theme was that of the need to implement the new scrutiny processes within **a supportive context** in which services are supported in their actions to work towards the standards. Some felt this could require additional resources to finance services; others identified making reviews easy to comprehend, clear and accessible, with help such as staff training offered where services fell short of meeting standards.

6.16 Another prominent theme was that of making the scrutiny process more than simply a paper exercise, by ensuring that the **regulators involve users,**

carers and staff in their inspections, seeking their views on more qualitative aspects of the standards. One respondent remarked:

> "There was general agreement that Inspectors should spend more time speaking to the people and reduce the amount of paper checking that is done at present" (Scottish Consortium for Learning Disabilities).

Another agreed:

> "The most comprehensive reflection of our service has always come from the people who use our services. They are able to give a realistic and honest account of what we do and how we do it. It is vital that people are consulted well within this process and the written feedback forms need to be improved to make them more accessible to people with learning difficulties" (Edinburgh Cyrenians).

6.17 Several respondents called for **an open process** in which concerns can be raised by users, families and staff to feed into the regulatory process It was felt that "whistle-blowers" should be protected and some form of systematic and independent complaints procedure should be in place to support the proposal. One voluntary organisation emphasised the need for clarity on who to complain to, in view of the different regulatory bodies involved.

6.18 One individual respondent urged that users and their families are informed by the regulators of any interim measures that will be put in place should a provider fail to meet the new standards.

6.19 A few respondents considered that **greater liaison between regulators and service providers** would be beneficial in promoting compliance with the standards, particularly in helping to move towards the aspirational aspects. Greater collaboration in working was viewed as relieving the pressure which can build for providers around inspections. Six respondents recommended unannounced visits by inspectors; one voluntary organisation advocated "secret shoppers".

6.20 A recurring theme was that the proposal required to be **implemented consistently** by CI and HIS inspectors, with some respondents providing their view that that this is not always the case at present.

6.21 Issues were raised by respondents over the **relationship between existing codes of practice and regulatory regimes and the proposed regime**. Views were divided on whether rationalisation is required, with some respondents calling for all other standards such as those relating to health and safety, environmental health, children and young people, and so on, being incorporated within one inspection process to avoid duplication and promote streamlining. However, others expressed concern that the proposal may result in current standards, such as Care for Dementia, becoming sidelined.

6.22 Several respondents highlighted areas of provision which they felt required **specialist advisors to assist the CI and HIS**. Included in these were equality and human rights issues and learning disability and autism, where some respondents felt that inspections could benefit from expert knowledge.

6.23 Other views on implementation were put forward by only a few respondents:

- The proposal will only work if the standards are supported with penalties for non-compliance.
- The proposal will need to work within the current variety of accountability models such as the Scottish Government's management of the NHS Boards, and as such will require other bodies to develop complementary improvement and action plans.
- More inspectors will be required to carry out the proposal.
- The education model of inspection is one from which lessons can be learned.
- Implementation of the proposal should be proportionate and not result in a burden on service providers.

Concerns over the proposal

6.24 A broad concern was that the proposal could lead to **confusion and duplication,** with inspections of all three sets of standards imposed over and above existing regulatory regimes and inspections. Some felt that holding services to account for meeting the standards constituted just a **"tick-box exercise"** focusing too much on paperwork instead of examining the day-to-day experience of users.

6.25 Two voluntary organisations cautioned that the overarching standards may **not be readily measurable.** A housing association considered the proposal to represent a challenge for both sets of inspectorates to apply consistently across all of the environments they covered.

6.26 One representative organisation commented that the **National Care Standards cannot be enforced** as part of a regulatory regime, as they constitute "good practice" only, without the backing of legislation.

Additional queries raised

6.27 A small number of additional queries were raised in response to the question:

- How can services appeal against conclusions of inspectors?
- Should commissioners of services be assured that the services they procure meet the National Care Standards before going forward with the commission?
- Who will monitor the inspectors to ensure they are carrying out their inspections consistently?
- What will happen if a service is not meeting standards due to lack of funding? Will they get funding support?

Question 4b): How should we ensure that services not regulated by the CI and HIS comply with the new standards?

6.28 347 respondents (73% of all respondents) provided a response to this question. Several more respondents (largely individuals) felt that they could not respond as they were unclear about aspects of the question such as the difference between regulated and non-regulated services and the remits of the regulatory bodies. It was highlighted by respondents from a range of sectors that the implementation of self-directed support makes it much more likely that non-regulated services may be procured by users, increasing the current challenge around ensuring compliance with standards.

6.29 Amongst those who responded, two day care centres argued that there is no reason for insisting on compliance with the new standards for services that are not regulated. Two other respondents (Vol, Ind) commented that compliance will be virtually impossible to ensure amongst non-regulated services. A local authority remarked that if the standards are to be applied to non-regulated services then these will need to be very clearly defined, with subsequent monitoring of compliance difficult in the absence of any contractual specification. Three further respondents (two local authorities and one individual) cautioned that imposing the national standards on services run largely by volunteers could be discouraging and could result in a fall in numbers of volunteers. One respondent (Vol) argued that service users should have the right to be able to choose their service from a regulated or non-regulated body.

6.30 A common concern was that some bodies providing health and social care (particularly where they are responsible for vulnerable people such as those with learning disabilities) are not regulated. 55 respondents (38 of them individuals) considered that **any health and social care service provider should be required to become regulated**. Two private organisations suggested that ancillary workers within a registered service and those working under 2 hours each week, neither of whom are currently subject to regulated requirements, be brought within the umbrella of the regulations

6.31 A few respondents acknowledged that some small providers did not require to be regulated, and that the cost and bureaucracy associated with regulation could be disproportionate in some circumstances. Instead, ideas were put forward on various **compromises** involving registration with some form of quality scheme which members of the public and commissioning bodies could view and take into account in their choice of procurement. Recommendations included:

- kite mark
- certificate of merits
- quality status
- affiliation to a body already regulated
- quality assurance scheme
- voluntary registration with a code of conduct (it was highlighted that Codes of Practice for Social Service Employees applies to all workers, not just those subject to regulation)
- time-limited “licensing.

6.32 35 respondents (26 of them individuals) proposed that the **inspectorate bodies have their remits extended** to encompass monitoring of compliance amongst non-regulated service providers, even if this is conducted on an “informal” basis (LA). One respondent (Ind) suggested that non-regulated providers be offered the opportunity to pay (a small sum) to request an inspection on a voluntary basis, thus providing them with the chance to be recognised as adhering to the standards. A few professional representative bodies commented that the inspectorate bodies could work in collaboration with other regulators such as the Scottish Housing Regulator, Mental Welfare Commission, or Scottish Public Services Ombudsman to undertake some form of monitoring of non-regulated services.

6.33 Another common recommendation (34 respondents across a wide range of sectors) was for **commissioners of services** (e.g. local authorities, local health and social care partnerships) to be responsible for monitoring adherence to standards amongst the services they procure, with compliance specified in the service contracts. Comments included:

> "All services which fall within the scope of the care standards should be held accountable whether or not they are regulated. Anyone commissioning these services should inspect and assess the service being provided for them. It should not always be left to the regulatory body to follow up, there should be constant reviews to ensure standards set do not drop below what is contracted for in accordance with the relevant standards" (Association of East Lothian Day Centres).

6.34 One local authority, however, questioned the integrity of this, suggesting that there may be a possible conflict of interest if the commissioner is also the regulator. Another commented that they would prefer to adopt a best practice model than be required to regulate the services they had procured. One respondent (CHCP) argued that non-regulated services should not be commissioned in the first instance.

6.35 A prevailing theme was that **awareness-raising of the standards** amongst service providers and service users could go some way to ensuring shared, high expectations of service provision with failure to achieve these more readily identified by all. One voluntary organisation remarked:

> "While non-regulated services cannot be made to comply with the new standards, correct presentation of the standards and the communication of their importance could encourage non-regulated services to strive towards meeting the minimum requirements. By establishing a good knowledge of the standards amongst service providers, and by encouraging service participation in the employment of the new standards, a culture of adherence could be naturally fostered" (Scottish Consortium for Learning Disabilities).

6.36 To support this, recommendations were made for emphasising the merits of **self-regulation** by non-regulated bodies with reports on findings made accessible, perhaps strengthened by a requirement that the reports be submitted to regulators. Calls were made for provision of **staff training**, and ongoing support and advice to non-regulated providers to help them understand and comply with the standards. Others argued for discreet **complaints procedures** in which users and whistle-blowers can air their grievances in confidence without fear of retaliation. One respondent recommended "citizen models of regulation" (Ind); others (Vol, Ind) suggested that **independent advocacy** be made more available to help users to understand their rights and identify if these are being breached.

6.37 A few respondents (six clear mentions) alluded to the possibility of establishing **another independent review/regulatory body** to carry out the function of monitoring compliance to the standards amongst non-regulated services.

6.38 Six respondents considered that the **current legislation (e.g. Equality Act 2010) and various codes of conduct provided a strong framework** in which non-regulated bodies could be held to account for standards grounded in human rights.

Question 4c): We suggest that the CI and HIS, consulting with others, should develop the suite of specific standards. Do you agree with this?

6.39 412 respondents (87% of all respondents) provided a response to this question. Of these, 350 (85%) agreed that the CI and HIS, consulting with others, should develop the suite of specific standards. 35 respondents (8%) disagreed, 1 respondent had mixed views and 26 respondents (6%) did not know. Amongst the 35 respondent who opposed the suggestion were 14 individuals, eight private organisations, seven voluntary organisations and four local authorities.

Views in support of the suggestion

6.40 Many of the respondents who supported the suggestion provided their reasons for expressing support:

- These inspectorates are well placed to take part in developing the standards in view of their expertise and experience.
- They are also well placed to ensure wide engagement with stakeholders.
- Developing the standards in consultation with others will ensure common understanding of the final standards.
- The standards developed in this way will be meaningful, realistic and achievable and cover all the relevant aspects of care.
- This process will engender trust and confidence in the standards.
- The standards will be easy to understand if a wide range of stakeholders are involved in their development.
- In keeping with public service reform.
- In keeping with a rights-based approach.
- Inspectorates should be involved in developing the standards they subsequently inspect.
- This will ensure the suite of specific standards will be affordable (the view of one private organisation).

6.41 Many respondents emphasised their view that the process of developing the standards should go beyond “consultation” which implied, for some, the inspectorate producing the first draft for others to comment on. They advocated a co-productive process with collaborators working alongside each other, and engaging specialists where greater expertise is required relating to some standards (for example, learning disability).

6.42 13 respondents called specifically for the process to be meaningful and not simply tokenistic. One commented:

> “Includem would welcome discussion to develop meaningful involvement of, and consultation with service users, in the development of specific standards. However if not given sufficient attention this risks becoming a tokenistic exercise with little benefit or sense of real empowerment or ownership to those involved” (Includem).

6.43 Three respondents recommended flexibility in response formats if service users are involved in providing input, with one specifically requesting that responses are accepted both on-line and also in other formats (Vol).

6.44 Other suggestions were made for formats for consultation:

- organisations hold their own national meetings which feed back to the development team
- reference group of users
- core groups of stakeholders consulted
- multi-staged consultation, with further consultation following initial drafts
- not dominated by professionals and service providers.

6.45 Whilst a few respondents remarked that the word “others” was vague, many made recommendations for who the “others” should be:

- service users
- service providers
- carers/families
- professionals/regulators/education/social work/statutory bodies
- members of the public
- staff
- self advocacy groups
- other stakeholders receiving only a few specific mentions: NHS/Health Boards; GPs, commissioners of services; police; those in the criminal justice system.

Concerns regarding the suggestion

6.46 The most frequently raised concern was that scrutiny bodies should not be involved in developing the standards they will subsequently scrutinise, as this lacks independence and rigour. 11 respondents from a range of sectors alluded to this. A typical comment was:

> “Regulators should not be responsible for developing standards. They should confine themselves to regulation. The development of standards is part of a democratic process to be done by the Government not independent bodies” (Braeburn Home).

6.47 A few respondents commented that Scottish Ministers should be responsible for preparing and issuing the standards which is aligned to the principle on which the Regulation of Care Act 2001 National Care Standards was based, separating the responsibility for standards from the upholding of them.

6.48 One local authority felt that the two inspectorates did not reflect the breadth of service provision with a voluntary organisation remarking that in their view they do not have sufficient expertise and experience in equality and human rights relating to minority ethnic communities.

6.49 A question was asked about how conflicting views would be balanced in the consultation (Ind). Another respondent (DC) expressed concern that wide consultation could result in the standards trying to achieve too much. One individual respondent cautioned that involving others in developing the standards may result in undue influence given to affordability (although one respondent reported in 6.37 above considered this to be an advantage).

Summary of main findings

- A large majority of respondents agreed that the CI and HIS should hold services they regulate to account for meeting the proposed overarching standards, the general standards and the suite of specific standards.
- Many respondents called for greater consistency in approaches to inspection and clarity on the criteria against which providers will be held to account.
- Common views amongst individuals (as opposed to organisations) were that all providers of health and social care services should become regulated; or that inspectorate bodies should have their remits extended to encompass the monitoring of compliance amongst non-regulated service providers.
- There was much support for the CI and HIS to lead on the development of the specific standards, in order to ensure they had credibility, were meaningful and realistic.

7 ASSESSING IMPACT

7.1 The consultation sought views on potential impacts of the proposals, particularly with reference to the “protected” characteristics of age; disability; gender reassignment; pregnancy and maternity; race; religion and belief; sex and sexual orientation. Views provided will inform a full Equality Impact Assessment and help in considerations of whether any further work is required in this area. Views were also sought on potential costs or savings that may occur as a result of the proposals.

General comments on impacts

7.2 Many respondents simply provided general support for the proposals, indicating that they expected there to be positive impacts for protected characteristic groups (although it was noted that the online response form did not list the protected characteristic groups and this could account for the lack of specific reference to them in most responses). A few respondents stated that it is too early to say, and they would put off judgement until the final standards had been confirmed and implemented.

7.3 It was generally agreed that there may be short-term challenges for providers and users as they become acquainted with the standards, and providers make any required adjustments to their current operations and reporting systems. Over the long term, however, most respondents viewed the proposals as having positive impacts.

7.4 Two respondents (Oth, Ind) recommended robust monitoring systems to be in place in order to identify experiences and outcomes arising from the proposals. One (Ind) called for case reviews and formal complaints to be monitored as indicators of service delivery standards.

7.5 Various respondents advocated Equalities Impact Assessments and/or Health Inequality Impact Assessments as part of the identification of impact. One respondent remarked:

> “Equalities legislation is in place to ensure certain characteristics are protected. However, looking at this in the context of inequalities and involving people in decision-making, the most deprived and disadvantaged in society may or may not be included within protective legislation or protected groupings. We would therefore recommend that equalities assessments be extended to include health inequalities impact assessments as a systematic way to consider how a policy or plan may affect people differently” (Voluntary Health Scotland).

Views on positive impacts

7.6 The aspect of the proposals most frequently identified as positive for those with protected characteristics, and for other service users, was the **grounding of the new standards in human rights.** Respondents from a wide range of sectors viewed the human rights-based approach as contributing to placing the individual user at the centre of the service provision, having control over their care and being listened to. This approach was seen as promoting equality of access to and provision of care. Typical comments included:

> "A human rights-based approach will have positive impact on all groups - if the standards clearly indicate they are linked to rights people have in law in all aspects of their lives - not just in relation to support services. The Human Rights based approach may raise general awareness - a good thing!" (Scottish Disability Equality Forum).

> "We believe that the standards provide an opportunity to put the individual service user at the heart of their care provision and the PANEL approach will recognise that not everyone with a common diagnosis has the same care needs and encourage a person centred approach to care" (Mental Welfare Commission for Scotland).

7.7 Another benefit of the proposals identified by respondents from a range of sectors, was that they would result in higher standards of care, with users more likely to be protected from harm and services tailored more to their individual needs.

7.8 Other potentially positive impacts were each raised by only a few respondents:

- The standards will be more easily understood with people more aware of them. For example:
  "It seems that generally, the care standards are being changed to make them easier to read, whether you are looking for a care provider or a care provider yourself. This should have a positive impact on anyone looking for information about what they should expect from a care provider, especially for those that felt confused by the current system with its many different versions of the standards and so much duplication of information" (Assistance in Care Services).
- They will promote a consistency in approach by service providers.
- They will help people to live independently in the community.
- Stigma will be reduced by everyone being treated the same.

7.9 A few respondents identified positive impacts for service providers, including the reduction in bureaucracy as the system becomes more streamlined, the sharing of good practice between organisations, and generally, more respectful services for staff, management and users.

7.10 Some respondents qualified their support by stating that positive impacts will emerge only:

- If people with protected characteristics are involved in the development of the standards.
- If service provider staff have training to help them implement and deliver the standards.
- If the standards are well publicised, accessible and presented in a constructive manner.
- If the standards are written clearly and in formats for all communication needs.

Views on negative impacts

7.11 The most prominent concern was that service users with cognitive impairment, dementia, learning disabilities and/or those with communication challenges may find the changes to the standards confusing. Some respondents considered that even those without these difficulties may perceive the multi-layered standards to be complex and vague. Many respondents emphasised the need for the standards to be produced in range of formats including easy-read and using different media to suit a wide range of communication needs.

7.12 A few respondents remarked that due to difficulties with understanding the new standards, more use may need to be made of advocacy and interpreting services, which would need to be resourced.

7.13 Another key concern amongst many respondents was that the streamlining and rationalisation of standards could lead to some people, particularly those with protected characteristics, falling between different categories of service. Hard-to-reach groups were identified specifically in this respect, along with those moving between children's and adults' services.

7.14 Other potential negative impacts of the proposals were each identified by only a few respondents:

- The promotion of self-directed support could result in a two-tier quality of service, one regulated, the other not.
- Service user expectations may be raised too high by words such as "rights".
- The human rights-based approach may lead to carers feeling left out with their rights of lesser importance than the rights of those they care for.

7.15 Negative impacts were also predicted for services with concerns largely focused on possible increased workload related to implementing the proposals. One private organisation cautioned that the proposals may result in focusing on evidencing standards rather than delivering excellent care. Three respondents considered that should the system become too bureaucratic, then some private service providers may be forced to close down. There was also concern that the proposals may require extra resourcing which some organisations would struggle to find in the short term.

General views on potential costs or savings

7.16 The consultation sought views on any potential costs of savings that may occur as a result of the proposals. There was a broad agreement amongst many respondents that costs would increase in the short term, particularly associated with implementing the proposals, but over the longer term there would be savings to be made, or the costs could be neutral. Some felt that it was too early to predict costs or savings, particularly as the standards were still subject to consultation. A few respondents remarked that resource considerations should not be the main focus, and instead, achieving better outcomes should drive the change. One respondent commented:

> "Should there be a concern about the cost of regulating good care? I know it costs money to provide good care and to ensure good care standards are being delivered, but in the long run better public knowledge means better care, which means less burden on the health care system. It will take time but there should be a light at the end of the tunnel so to speak" (Ind).

Identification of potential costs

7.17 A recurring view was that costs would be incurred initially associated with **implementation** of the new standards. 69 respondents from a wide range of sectors referred specifically to potential costs linked with **training staff**.

7.18 Another cost identified repeatedly (35 mentions, around half from voluntary organisations) was that of **promoting the new standards** through advertising, marketing, awareness-raising, and production of literature in appropriate formats.

7.19 Initial **re-working of regulatory and guidance materials** was identified by 12 respondents as potentially increasing costs at the start; and five respondents referred specifically to costs of further **consultation and piloting** of the new standards.

Costs specific to service providers

7.20 Many respondents identified potential costs to be incurred by service providers as a result of the proposals. Costs were associated with ongoing staff training, adapting internal procedures and monitoring systems, increased evidence-gathering and investment in the human and operational resources needed to meet standards (aspirational standards were referred to particularly here). Some respondents identified particular items of additional expenditure such as BSL interpreters and structural adaptations of premises.

7.21 Several respondents commented that whilst recognising what is required to meet the standards, many service providers may fall short due to lack of funding. One respondent remarked:

> “A particular tension may exist between the capacity and resources of a service and the specific standard that a regulatory body may be seeking to impose. It would, therefore, be important to encourage and foster partnership working from the start and where services are failing to meet a particular standard that they are actively supported where appropriate” (NHS Education for Scotland).

7.22 Other potential costs for service providers each identified by only a few respondents were:

- keeping users involved, consulting with them and raising awareness
- new administrative costs for unregulated providers who may be brought within the scope of inspection
- possible increase in the regulation fee
- addressing need which was previously not identified and not met
- longer-term erosion of quality with impacts on remedial action due to the standards being too vague and not relevant.

7.23 Costs specific to regulators
A minority of respondents identified potential ongoing costs associated with the regulators. 17 respondents referred specifically to the need to expand the inspectorate workforce and ensure it has the expertise to undertake specialist inspection and be more than merely a process and “desk top” review mechanism.

7.24 A few respondents considered that the proposals could incur potential costs for regulators other than the CI and HIS (the Scottish Housing Regulator mentioned in this regard).

7.25 The prospect of the inspection encompassing non-regulated providers was also identified by a few respondents as potentially increasing costs.

7.26 Two voluntary organisations referred to possible increased need for independent advocates with the costs possibly falling to local authorities.

Views on potential savings

7.27 As highlighted above, many respondents commented in broad terms about the potential for longer-terms savings as a result of the proposals. Some were more specific about where they felt that savings could accrue:

- Streamlined standards resulting in less bureaucracy, rationalisation of inspection, information all in one place, shared expectations.
- Simplification of processes resulting in reduced staff training costs and resource materials/paper.
- Opportunities for shared training between agencies and providers.
- Rationalisation of inspection function, combining the work of CI and HIS
- Better standard of preventative work leading to less remedial action required in the longer term;

> "If commissioning is properly held to account as part of the inspection process linked to human rights based standards, then costs may be saved later by ensuring people get the right support, at the right time, in a way that suits them. Too often, people with complex support needs are passed from pillar to post because commissioning agencies (not necessarily commissioners - often finance staff) have tried to cut back on cost at an early stage, leading to disastrous consequences" (Scottish Disability Equality Forum).

> "If oral health care requirements were made explicit in the revised standards this would likely help improve the daily preventive oral care practice in care homes, and NOPOHIG feel the potential savings to the health sector could be significant" (National Older People's Oral Health Improvement Group).

- Lower legal costs due to reduced cases of litigation associated with alleged poor practices.
- Boosted staff morale could lead to lower staff turnover and associated costs.

Summary of main findings

- There was general agreement that positive impacts would be evident in the longer-term following a period of short-term challenges in which service providers and users become acquainted with the new standards and make necessary adjustments to procedures.
- Grounding the standards in human rights was viewed as particularly positive for people with protected characteristics, ensuring the individual user remains at the centre of service provision, having control over their care and being listened to.
- There was some concern that service users with cognitive impairment and/or communication challenges, may find the changes to the standards confusing.

8 ADDITIONAL COMMENTS

8.1 Respondents were invited to submit any further comments over and above those already provided in response to the previous specific questions. General themes to emerge from many responses were:

- The new standards should be meaningful, widely publicised and enforced.
- The level of detail of the standards will need to be pitched appropriately in order to avoid being vague, yet be generally applicable but not prescriptive.
- Complaints procedures including appeals processes and protection for whistle-blowers should be addressed alongside establishing the new standards.

8.2 Much support was provided for proposals for **further consultation** but calls were made across sectors for this to be inclusive in order to get views from a variety of perspectives. Some felt that the consultation made little reference to the Adults with Incapacity (Scotland) Act 2000 and recommended that more thought is given to seeking the views of those with incapacity. A small number of respondents criticised the easy-read version of the current consultation stating that it had not been easy for some service users to understand and respond to:

> "The easy read document does not satisfactorily explain the changes taking place. The questions in the easy read document are repetitive, too long, not in simple enough language and therefore requiring considerable explanation and interpretation" (Ind).
>
> "This form was far too complicated for a learning disabled service user to comprehend. X understood very little and was unable to make any comments of her own" (Ind).

8.3 Many respondents urged that that the new National Care Standards be produced in a wide range of formats including pictorial and in short leaflet form.

8.4 A recurring view was that the new standards should be **widely and systematically publicised** using a variety of media including radio, TV and social. Other ideas were deploying theatre, DVD and videos to help publicise the standards. Adverts on buses were envisaged. Several respondents commented that the current standards are not widely known about, or understood. One remarked:

> "I train staff on meeting the care standards and how to improve the service and still find staff (not managers usually) have not even read the document let along know and understand the impact they have on practice and the service" (Ind).

8.5 One local authority criticised the images used on the front of the consultation document for what they considered to be stereotyping (no male carers depicted) and inappropriate (all laughing and having fun), emphasising that providers deliver services in situations which can be emotionally charged and challenging.

8.6 Some respondents raised the issue of **implementation** of the new standards, with a few criticising the proposed date of April 2015 as ambitious. One respondent (Reg) recommended a phased approach to implementation; three respondents advocated piloting the system before national roll-out.

8.7 Three respondents suggested that users and carers are provided with information about the new standards in an incremental fashion, bit by bit, in order for them to become familiar with them and not feel overwhelmed.

8.8 Several respondents praised the proposal for the standards to be outcome-focused, viewing this as making them **more meaningful** for providers and users. There were calls for the standards to contain many examples of good practice. One respondent remarked:

> "Any standard proposed must carry clear information on how it is to be practised within a care service. Without this, care providers will waste precious time deciphering vague statements, only to face their inspector who happens to have a totally different interpretation of the same statement" (Ind).

8.9 Two respondents suggested that the word "care" in the **title of the standards** could create difficulties as all providers may not see themselves as providers of care and some users do not seek or receive this.

8.10 A recurring view was that quality of delivery of service does not take place in a vacuum but is very much **linked with resourcing**. Several respondents felt that procurement should take this into account and that delivery of standards should be supported by a level playing field with regards to funding. Comments included:

> "We would suggest a separate set of standards is developed around Commissioning & Procurement. The ability of providers to deliver high quality, responsive and personalised services is very much linked to commissioning and procurement practice" (Shared Care Scotland).

> "Currently, service managers experience frustration at the lack of connection between the inspection of services and the commissioning of those services. It was felt that there needed to be recognition within the National Care Standards and the inspection process of factors outwith the control of providers of services that impact on service standards, i.e. an insufficient individual budget for a person may compromise them Reaching Potential; similarly insufficient contract values..." (Capability Scotland).

8.11 Concerns were raised that a gap may develop between what providers aspire to and what they can afford with inspectors' remarks being out of step with what commissioners are willing to resource.

8.12 Another relevant tension identified by a small number of respondents was what they perceived to be the **imbalance** between healthcare, which is free at point of delivery and is regulated tightly, and social services which differ on these counts, being perceived as less strictly regulated. It was felt that these imbalances should be addressed as part of consideration of the new standards.

8.13 A recurring theme was that the new standards will need to be **systematically enforced** with transparency about actions taken where services are deemed to be failing to achieve. Calls were made for inspectors to ensure they listen to different voices when making their inspections.

8.14 A few respondents advocated clear timings for **reviewing the standards** be put in place from the start.

8.15 Other significant issues (which had not already been covered in detail in response to previous consultation questions) were raised by only a few respondents:

- Clarification is required on how the new standards will apply in relation to self-directed support.
- It may be helpful to examine international evidence on related standards, their implementation and effectiveness.
- The training needs of inspectorate staff should be identified in relation to the likely greater need for specialist knowledge.
- There needs to be a clearer link between the registration process for social work and social care staff and the National Care Standards. This is currently perceived to be unclear and confusing.
- The place of self assessment within the new standards needs to be addressed further.

Summary of main findings

- Support was expressed for further consultation on the new standards before they are finalised.
- Many respondents called for the new standards to be widely publicised using a variety of media.

ANNEX 1: LIST OF RESPONDENTS

Respondents have been allocated a category for the purposes of the analysis. It is acknowledged that in some cases respondents may fit into more than one category, but have been grouped into one category in order to avoid double-counting.

Academic
Centre for Excellence for Looked After Children in Scotland
OPENspace research centre

Community Health and Care Partnership Bodies
CHCPs within NHS Greater Glasgow and Clyde, Glasgow, East Renfrewshire, West Dunbartonshire, East Dunbartonshire, Inverclyde and Renfrewshire
Dumfries and Galloway Older People's Consultative Forum
East Ayrshire Health and Social Care Partnership Day Care Service Adult Group
East Dunbartonshire Public Partnership Forum
East Renfrewshire Community Health and Care Partnership
Inverclyde Community Health and Care Partnership
West Dunbartonshire Community Health and Care Partnership
West Lothian Community Health and Care Partnership

Day Care of Children Services
Abbey Nursery Houston
Abor Green Nursery
Arnhall Day Nursery
Dreghorn Pre-school and Creche
Eigg Primary School Nursery
Enchanted Forest Nursery
First Adventures Nursery
Flowerpots Childcare
Glencoats Lodge Nursery
Gullane Playgroup
Hammy's out of school care
Little Acorns Nursery
Pear Tree Nursery
Peekaboo Nursery
Precious Moments Childcare
Treasure Island Nursery Ltd.

Education
Balnacraig School
Elphinstone Primary School and Nursery Class
St John's RC Academy

Housing Associations
ARK Housing Association
Dumfries and Galloway Housing Partnership
Eildon Housing Care and Support Services
Loretto Care
Trust Housing Association
Viewpoint Housing Association

Local Authority Bodies
Angus Council
Angus Council's People Directorate
City of Edinburgh Council
City of Edinburgh Council Children and Families
Convention of Scottish Local Authorities (COSLA)
Dumfries and Galloway Council Social Work Services
Dundee City Council
East Dunbartonshire Council
Falkirk Council Social Work Service
Mackinnon Centre, Service User Representative Group
North Ayrshire Council
North Lanarkshire Council
Perth and Kinross Council
Perth and Kinross Council Education and Children's Services, Early Years and Childcare
Renfrewshire Council
Stirling and Clackmannanshire Councils' Shared Social Services
South Lanarkshire Council
Streets Ahead, Direct Provision, Social Services, Stirling Council

NHS
National Older People's Oral Health Improvement Group
NHS Dumfries and Galloway
NHS Education for Scotland
NHS Fife
NHS Greater Glasgow and Clyde Area Pharmaceutical Committee
NHS Greater Glasgow and Clyde Pharmacy and Prescribing Support Unit
NHS Health Scotland
NHS Lanarkshire
NHS National Services Scotland
Scottish Ambulance Service

Private Sector
Abbotsford Care
Assistance in Care Services
Balhousie Care Group
Bachlaw Projects
Barchester Healthcare
Blackwood
Braeburn Home
Bright Horizons Family Solutions Ltd.

British Healthcare Trades Association
Canterbury Care Limited
Care in the Community Ltd.
Childcare Scotland Ltd.
Glaxosmithkline
Gowrie Care Ltd.
Greyfriars Care Home
Keane Premier Healthcare
MACS
Margarot Forrest Care Management Ltd.
Meallmore Ltd.
Orchar Nursing Home
Social Care Alba
SPS Social Care
St David’s Care Home
Tailor Maid Home Care Limited
Unique Care Solutions
Your are at Home Ltd.

Professional representative bodies
Allied Health Profession’s Children’s Services Forum
British Medical Association
British Psychological Society
Child Health Commissioner’s Group
Coalition of Care and Support Providers in Scotland
Community Pharmacy Scotland
Educational Institute of Scotland
Greater Glasgow and Clyde Area Psychology Committee
Health and Social Care Alliance Scotland
Healthcare Improvement Scotland’s Public Partners
National Carer Organisations
National Day Nurseries Association Scotland
NHS Health Scotland Representative Body
RCGP Scotland
Royal College of Nursing
Royal Pharmaceutical Society
Scottish Care
Scottish Council of Independent Schools
Scottish Independent Hospitals Association
Scottish Partnership for Palliative Care
Social Work Scotland
United Kingdom Homecare Association

Regulatory/Inspectorate/Scrutiny

Care Inspectorate Early Years Team
Care Inspectorate and Healthcare Improvement Scotland joint response
Care Inspectorate Registration Management Team
Health and Safety Executive
Scottish Social Services Council

Voluntary sector – providers, organisations and service user representative groups

Aberlea House
Aberlour Child Care Trust
Action for Children
Action for Sick Children Scotland
Action on Hearing Loss Scotland
Advocacy Project
Age Scotland and Health and Social Care Alliance Scotland Dumfries event
Age Scotland and Health and Social Care Alliance Scotland Dundee event
Age Scotland and Health and Social Care Alliance Scotland Edinburgh event
Age Scotland and Health and Social Care Alliance Scotland Glasgow event
Age Scotland and Health and Social Care Alliance Scotland Irvine event
Age Scotland Inverness event
Alzheimer Scotland
Angus Special Playscheme
ARC (Scotland) – Scottish Transitions Forum
Association for Real Change Scotland
Association of East Lothian Day Centres
Barnardo’s Scotland and Children 1st
Befriending Networks
Birchwood Highland
British Red Cross
Brothers of Charity Services (Scotland)
BTHA Renfrew Project
Camphill Scotland
Capability Scotland
Care and Learning Alliance
CEMVO Scotland
Citizens Advice Scotland
Community Integrated Care
Cornerstone
CrossReach
Deaf Connections
Down’s Syndrome Scotland
Dumfriesshire & Stewartry Women’s Aid
East Park
Edinburgh Cyrenians
Edinburgh Health Forum
ENABLE Scotland
Faith in Older People
Geeza Break
Glenurquhart Care Project Users

Hayfield Support Services with Deaf People
Health Foundation
Housing Support Service Users
IAPK Learning Disability Workshop
Includem
Inclusion Glasgow
Inclusion Scotland
KEY Community Supports and Community Lifestyles
LifeCare (Edinburgh) Limited
Macmillan Cancer Support
Marie Curie Cancer Care
Minority Ethnic Carers of Older People Project
Moving on Transition Service
National Osteoporosis Society
Nazareth Care Charitable Trust
National Deaf Children's Society
National Society for the Protection of Cruelty to Children
Neurological Alliance of Scotland
One Parent Families Scotland
Outside the Box
Our Voice – Sense Scotland's Service User Consultation Group
PAMIS
Parkinson's UK in Scotland
People First (Scotland)
Perth Thursday Evening Advocacy Group
Places for People Scotland Care and Support
Positive Steps
Quarriers
Quarriers Homelife South Ayrshire
Real Life Options
RNIB Big Say Group
Royal National Institute of Blind People Scotland
SACRO
Scottish Centre for Children with Motor Impairments
Scottish Consortium for Learning Disabilities
Scottish Council on Deafness
Scottish Disability Equality Forum
Scottish Independent Advocacy Alliance
Scottish Older People's Assembly: A City for All Ages Advisory Group
Scottish Out of School Care Network
Scottish Recovery Network
Seniors Together
Shetland Arts
Shared Care Scotland
Simon Community Glasgow
St Joseph's Services
Stepping Stones for Families
Stonewall Scotland
TACT Foster Care Service
The Aged Christian Friend Society of Scotland

The Food Train
Together for Short Lives
Turning Point Scotland
“Us and the Housing” Learning Disability Housing Forum
User and Carer Involvement “Speaking Up Group”
Voluntary heath Scotland
Who Cares? Scotland
WithScotland
Women’s Aid South Lanarkshire
Your Voice (Care Leavers)
Your Voice (Disability Group 1)
Your Voice (Disability Group 2)
Your Voice (Parent/Carer)
Your Voice (Residential Care 1)
Your Voice (Residential Care 2)

Other
Equality and Human Rights Commission
Mental Welfare commission for Scotland
Scotland’s Commissioner for Children and Young People
Scottish Human Rights Commission
Scottish Public Services Ombudsman

Individuals
248 respondents

Social Research series
ISSN 2045-6964
ISBN 978-1-78544-153-0

web only publication
www.gov.scot/socialresearch

Produced for the Scottish Government by
APS Group Scotland
21 Tennant Street, Edinburgh EH6 5NA
PPDAS45766 (03/15)

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