Health and Social Care Standards - SCVO briefing

20 January 2017

Summary

- The third sector welcomes the decision to update the Health and Social Care Standards in Scotland.
- The adoption of a human rights based approach is a positive step but there must be accompanying efforts to promote awareness around human rights among the public and staff.
- Monitoring, evaluation and implementation are crucial to ensuring the standards are successful. Accessible dissemination, effective communications and clear inspection methodology are key.
- Health and social care staff are essential to this process. Staff training and communicating with frontline staff to ensure the spirit of the standards are fully embodied is critical.
- While the third sector has suggested some changes and additions to the standards, the draft standards are seen as a positive platform on which to build.

Our response

The Scottish Council of Voluntary Organisations (SCVO) welcomes the opportunity to respond to this consultation on the new National Health and Social Care Standards.

Social care amounts to over a quarter of the third sector's turnover and 34% of voluntary organisations in Scotland are involved in social care-related activities. Nine out of the ten charities receiving the most public sector funding are health and social care providers. Sustainable, high quality social care is therefore crucial to the sustainability of the third sector as a whole and the sector is a key stakeholder in this agenda.

There is a wealth of knowledge and experience in the third sector around health and social care. As such, the views outlined in this briefing reflect the views of our sector. These views were gathered through conversations and a roundtable discussion between third sector organisations and Henry Mathias of the Care Inspectorate, facilitated by SCVO.

While the briefing contains differing opinions and at times opposing views, we recognise this as an aspect of a thriving, diverse sector.

As far as commenting on specific language and individual standards, we would direct you towards the Health and Social Care Alliance response, which was welcomed by our sector and participants at the aforementioned roundtable.

General Comments

The decision to update the standards is welcomed by the third sector. This process is timely as there have been significant developments in health and social care delivery in Scotland which has left the outgoing National Care Standards somewhat unaligned with the current landscape.

The first person formulation of the standards is welcomed, and the similarity in this respect with the Dementia Rights Statement was noted. However, while the Rights Statement was viewed as being practical, it was felt that some of the 'real world value' of these standards has been lost. While some of this may be attributed to the respective length of each document, the outcome and experience focus of the draft standards was seen as playing a role in limiting the practical use.

In other cases, some questioned whether these standards were truly 'outcome-focused'. An outcome is not being treated with care and compassion, as this is about the nature of the process.

When redrafting the standards there is need to question *'what does this actually look like for someone?'* This way, individuals interacting with the standards, and indeed those monitoring implementation, should have clear expectations of fair, high-quality support services. At present, some of the standards are hard to quantify, such as standard 1.7 on celebrating achievements. There is no need for a focus on outcomes to mean that the standards become abstract.

There was also some concern that disability organisations had not been properly consulted or involved in the discussion to date. As a result of this, the standards are seen as having some conceptual problems for disabled individuals which will have to be considered following this consultation during the redrafting process.

Human Rights

The focus on human rights is very much welcomed, particularly given the introduction of the Scottish National Action Plan on Human Rights. The standards should become a powerful reference point for individuals, and their families, if they feel their care is not of the highest standard.

We note the work of the Health and Social Care Alliance in promoting human rights principles in social care and health care. The PANEL principles is a good means of looking at this, being about both process and outcomes. However, there was some concern that the general public, and indeed people delivering care, don't have a good understanding of human rights and what they actually mean in practical terms.

It is therefore important that the standards are accompanied by attempts to educate the

public and promote the concepts of human rights. Human rights have been subject to negative media coverage which has contributed to general misunderstanding. Through the Right Approach Campaign, our sector has recently been exploring capacity around human rights within the third sector and found that human rights language is not often used within campaigns, even when the work is directly informed by, or furthers the concept of, human rights. Awareness-raising campaigns will be necessary to build both capacity and awareness.

While the standards are focused on outcomes, human rights are often about process, rather than facilitating specific outcomes. This may be something of a contradiction that the Standards will have to rectify or incorporate. It is worth remembering that, within the context of social care, process is very important. For example, self-directed support may not have an impact on outcomes, but it is about the process of choice and control which is vitally important.

It was noted that in some cases, the rights of those receiving care or healthcare may be at odds with the rights of staff. In other circumstances, there may be some contradictions or apparent breaches of rights, but there may be very good reason. For example, CCTV may be seen as a breach of privacy but this might be necessary to protect people from abuse and to in fact, uphold their human rights.

There was some concern among some participants that some standards temper human rights. For example, within standard 6.1 around liberty, there is some implication that providers may abuse your human rights in certain circumstances or at least, may not fully respect an individual's human rights.

Language

One word with caused much debate was the use of the word 'compassion', with some preferring 'empathy'. When informed that we are perhaps stuck with the word 'compassion' within these standards, it was suggested that the term compassion could be defined within the glossary, making it clear that compassion is not pity, and thus compassion should not undermine dignity and respect. On the other hand, it was noted that 'compassion' is not necessarily a one-way process and there is a need to treat those providing healthcare or social care with compassion through mutual respect.

There was some consensus that perhaps the standards have been designed with a particular type of service-user in mind. While the standards will therefore be accessible and proportionate to that particular group they will be inappropriate for others. We acknowledge that ensuring these standards cover all bases is a difficult task. Part of the success of this approach will also depend on how the standards are introduced and the communication strategy. We hope, therefore, that third sector organisations will form a key part of the implementation and communications strategy to ensure that the Standards reach all service users and patients and appear proportional and relevant.

There were some concerns around certain standards which may appear patronising to some individuals. In particular, problems of unsuitability were raised in relation to standard 1.7 (celebrating achievement), standard 3.23 ('stimulate my interests and spontaneity') and standard 2.16 ('the risks I take in my daily life'). To overcome this issue, it was suggested that during the redrafting process the Standards should be read by the Development

Group as though it was you, yourself, receiving care and as though these principles would be applying to you.

The use of the terms *'if possible*' and '*applicable'* were also commented upon. It was questioned who would make the judgement as to whether something *was* applicable, or possible. For example with regards to the statement 1.17, 'I am supported to live in my own home if this is possible for me', it may be *possible* for someone to stay in their own home based upon their health and capabilities, but the possibility might be limited by resources. 'If possible' needs to be defined in some manner. While it is preferable to include these standards, and perhaps strengthen them, there is need for a bit more clarity around the qualifiers.

Language issues were also raised around standard 1.3 ('behaviour is challenging') as 'challenging' is open to interpretation. For some individuals, 'challenging' could mean merely expressing yourself and your opinion about care services. This should be encouraged, as feedback is an aspect of a responsive service, taking account of your rights. It was also noted that the terminology of 'challenging behaviour' is no longer used elsewhere within health and social care and that this is somewhat outdated. Indeed, people have the right to 'challenge' and therefore defining 'challenging' in the glossary won't be enough to counter this issue.

The section on 'activities' (standards 1.36-1.39) were not seen as appropriately displaying the range of things people want or require. For example, there is no mention of employment, education or indeed other key activities which enable people to live a fulfilling independent life. It has been noted that care and support staff are there to assist individuals to do what they want to do.

With regards to standard 5.6 on CCTV, there is a need to more general about monitoring devices. Data protection is applicable to other methods and in the context of dementia, there are specific issues around GPS tracking devices.

Standard two focuses on people being 'at the heart of decisions about my care and support', however, this does not truly embody the self-directed support agenda. Personalisation moves beyond individuals being 'at the heart' and instead focuses on person-led and person-controlled support. Concerns were also raised in this respect around standard 1.12 relating to 'everyday tasks'. It is not believed that 'everyday tasks' fully embodies the nature of self-directed support.

Usability

Adoption of one set of standards, rather than the previous system of 23, has the potential to be more accessible while simplifying regulatory structures and provision. However, a negative consequence of this decision was that efforts to synthase has lost the sense of diversity and applicability to specific situations that was present within legacy standards.

In light of this, plans for usability were discussed. One such option was enabling people to identify which standards apply to them, thus meaning the standards become something of a 'menu of standards'. In this way, the standards would operate upon the lines of a job description, with both essential and desirable aspects, where you picked the standards that were most appropriate to you and your support.

However, there were concerns that if the system dictated mandatory rights for all and then a ‘pick and mix’ list of aspirational standards, the focus for providers would just be on meeting the minimum standards. Participants at the roundtable stressed that essential standards should not become the default minimum standards, rather being a baseline upon which to build.

It was also noted that for those receiving palliative care, certain standards won't be applicable. For those with certain health conditions or a terminal illness, many of the standards will be inappropriate. In such situations, the priority should be to get the basics right and then add on additional aspects. In some ways, the single set of standards may set very high expectations for service-users or patients which may not be met given the relevant circumstances. For example, standard 5.25 relating to exercise and standard 1.35 relating to drinking water may be difficult to realise for some groups.

For further information on palliative care, the Marie Curie response makes some valuable suggestions to ensure the standards are responsive to those nearing end of life.

Carers

Concerns were raised about the lack of recognition of carers within the Standards, meaning that the essential role carers play in providing support is not reflected here. Within the draft there are only two specific reference to carers, whereas the Short Breaks and Respite Care Services for Adults had 23 Standards references to carers. Moreover, some standards don't meet legislative developments in this area. For example the Carers (Scotland) Act requires care assessments to take account of carers' views but this is not reflected within these standards.

On the topic of the inclusion of the vital role of carers, we direct you to the submission of the National Carer Organsiations, where they have suggested amendments under each individual standard. Unpaid carers play a pivotal role in Scotland's care provision and it is important that the Standards reflect this.

Monitoring and evaluation

There were questions as to how monitoring and evaluation will work in this system. Some felt, from the way the Standards were written, that might come from the people receiving care. It may be a positive step if individuals were able to say whether the standards have been met within the context of their own care.

There were questions as to how resources would come in to the Standards. For example, it might be 'possible' for someone to stay in their own home, but a lack of resources may prevent this. In many cases, it may be a lack of budget or resources that negate the fulfilment of an individual's rights and the realization of these standards. While the draft Standards go some way to raise expectations, continued financial restraints and issues around the recruitment and retention of staff may undermine this, ultimately raising expectations that cannot be met. This is not to say that expectations should not be raised, but merely that resources must be considered within this process.

Implementation

An important part of the health and social care standards are how these standards, and the embodied principles, are utilised in practice. For example, the inspection methodology

is pivotal if the standards are to be useful, practical and genuinely promote best practice. It is therefore important how these standards are translated into sets of indicators for inspections and evaluation. The principles are open to interpretation, which could lead to inconsistency in service across Scotland without robust training and guidance to ensure practical application of the principles contained within these Standards. Staff must be empowered by these standards and have the capability to challenge the behaviour of others also.

Staff awareness and training should be a key consideration for the Scottish Government moving forward. Ensuring that staff have the skills and knowledge to adhere to, and promote, these standards is critical to the success of this agenda. Direct training for staff before they begin working directly with those using support services is essential.

It is vital that, on completion, the Standards are communicated in a variety of formats with accessibility in mind. A one-off campaign would be insufficient and there should be an ongoing process of education and promotion. Moreover, explanatory guidance will have to detail that one principle can't be assessed or met in isolation to the other overriding principles.

It was discussed whether it was necessary to link the standards to relevant pieces of Scottish law, highlighting the mandatory obligations on care and health services and what legal authority the standard derived from. It was agreed that the best approach was to keep the standards but then behind this having a document, tying the standards to relevant pieces of law.

There was a lot of interest around the intention to apply this to non-registered services, in particular how this will fit with the situation of an individual employing someone. Additionally, it is unclear how will this apply to local services, such as those providing a walking group or lunch club. It would be worthwhile to explore how these standards can be applied to these locations and services and ensure that the final Standards and accompanying guidance is clear about this.

Conclusion

Standards are only one part of a successful system of health and social care in Scotland and it was recognized that there is a need for pragmatism about how these standards fit into everything else that is happening in health and social care. However, while we can't solve everything through the health and social care standards alone, getting these right can help shift how things are developing in health and social care.

It was agreed that the new formation of the Standards is progressive and it was believed that the consultation process has shown that the old approach wasn't right or fit-for-purpose. While some changes to this draft are necessary, the draft standards are a platform upon which to build and we hope that the consultation process will help to ensure the standards are applicable and appropriate for all service-users and patients in Scotland.

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About us

The Scottish Council for Voluntary Organisations (SCVO) is the national body representing the third sector. There are over 45,000 voluntary organisations in Scotland involving around 138,000 paid staff and approximately 1.3 million volunteers. The sector manages an income of £4.9 billion.

SCVO works in partnership with the third sector in Scotland to advance our shared values and interests. We have over 1,600 members who range from individuals and grassroots groups, to Scotland-wide organisations and intermediary bodies.

As the only inclusive representative umbrella organisation for the sector SCVO:

- has the largest Scotland-wide membership from the sector – our 1,600 members include charities, community groups, social enterprises and voluntary organisations of all shapes and sizes
- our governance and membership structures are democratic and accountable - with an elected board and policy committee from the sector, we are managed by the sector, for the sector
- brings together organisations and networks connecting across the whole of Scotland
- SCVO works to support people to take voluntary action to help themselves and others, and to bring about social change.

Further details about SCVO can be found at www.scvo.org.uk.