

Voluntary Health Scotland Response to Health and Social Care Standards 20/01/17

Introduction

1. Voluntary Health Scotland (VHS) is the national intermediary and network for voluntary health organisations in Scotland. Our aim is to promote greater recognition of the voluntary health sector and support it to be a valued and influential partner in health and care.
2. The views expressed in our response have been informed through a consultation process with a group of 40 member organisations and stakeholders including large national organisations, social care providers, community organisations, representatives from Integrated Joint Boards along with some service user input. We have added the notes from our consultation meeting in the appendix for your information.
3. We commend to you the responses submitted by Marie Curie, Scottish Council for Voluntary Organisations (SCVO) and The Health and Social Care Alliance Scotland.

What works well?

4. VHS welcome the streamlining of the National Care Standards down from the current 23 sets. We also believe the general principles have the potential to positively impact services and the experience of service users.
5. We welcome the introduction of a single set of national standards which are relevant to all care settings and patient groups and encompass both health and social care. In light of current efforts to integrate Health and Social Care, having standards that apply to all services will go a long way towards achieving the aim of delivering the same high quality of care throughout a person's health and care journey.

Human Rights based approach

6. VHS welcome the human rights based approach to the standards, which has emerged as a strong priority during consultation with members and other stakeholders. We believe that adopting a human rights based approach is a

practical way of making sure that the rights of people who access support and services are respected.

7. Our consultation event also highlighted two emerging perspectives on strengthening the rights based approach to explicitly state rights given in legislation.
8. Many participants felt that rights granted in legislation should be explicitly stated as people should know what they are entitled to, for example standard 1.15, which refers to a Carers Assessment, which is a right given under the Community Care and Health (Scotland) Act 2002¹. Alternatively, some service providers felt that this may raise people's expectations. For example, Independent Advocacy, although a statutory right for people with mental health issues, has limited provision and as such may not be available for everyone who needs it.
9. We believe that the standards should be worded to raise service users' awareness of their rights and make clear how service providers responsibility is delimited. For Instance; to provide information on entitlement, explain how those rights apply to service users' particular health and social care setting and to help users access those rights. We believe that clarifying the responsibilities of service providers and the rights of service users benefits both parties. Whilst empowering service users and assuaging possible concerns on behalf of service providers over unwarranted attribution of fault, this emphasis will also better highlight areas lacking in provision.
10. It is 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 SCVO Right Approach Campaign², 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.
11. The reference to "tackle inequalities" in standard 4.1 should become a separate statement as follows "The support and care I receive actively tackles inequalities and takes action to ensure I have an equitable experience". This statement also makes valuable reference to human rights. We believe the Scottish Government

¹ <http://www.careinfoscotland.co.uk/topics/your-rights/legislation-protecting-people-in-care/community-care-and-health-scotland-act-2002/>

² <http://www.scvo.org.uk/right-approach/>

should consider making reference to empowering people to understand what their rights are and how they apply to their particular health or social care setting.

Person/Client Centred

12. We welcome the person/client centred nature of the standards and recognise that this is a step away from the service focused approach used by the health services. The fact that the standards are written in the first person not the third person will help people apply the standards to themselves and their particular health or social care setting.

Language

13. We welcome the positive language used in the standards, words such as compassion, courteous, warmth and kindness, however, we feel such words are hard to measure and would like clarity about how they may be regulated. We would also like to know how staff will be provided with training and continuing professional development so they treat service users compassionately and courteously.
14. It is also important to note that the language used may not transfer across both health and social care, for example, the term 'safety' means different things in Health and Social Care.

How well do the standards link to other policy and legislation?

15. We welcome the fact that the standards have been developed to fit in with a range of legislation and Scottish Government priorities relating to Health and Social Care. However, we feel that more needs to be done to link the standards to existing policy and legislation relating to the wide range of circumstances people may face. For example, Mental Health (Scotland) Act, Adult Support and Protection (Scotland) Act, Patient's Rights (Scotland) Act and the Equality Act to name a few.
16. We would also expect any specific standards and statements to link to and build on existing guidance, clinical standards and legislation. For example, Marie Curie have highlighted the importance of any standard on palliative care being cross-

referenced with the Strategic Framework for Action on Palliative³ and End of Life Care and clinical palliative care guidelines⁴.

17. We are also keen to understand how these standards will interact with existing targets and Key Performance Indicators in health.

18. Statement 3.24 should refer to the wider value of learning and development and involvement in dialogue. The Convention on the Rights of People with Disabilities⁵ requires “lifelong learning directed to (a) the full development of human potential and sense of dignity and self-worth, and the strengthening of respect for human rights, fundamental freedoms and human diversity; (b) the development by persons with disabilities of their personality, talents and creativity, as well as their mental and physical abilities, to their fullest potential; (c) enabling persons with disabilities to participate effectively in a free society.” This requirement should be adopted into the standards.

What is missing or needs Improved?

19. There is concern that essential standards have the potential to become the default minimum standards to which services are provided. In implementation, these standards must be presented as a floor from which to build rather than the default.

Monitoring and Regulation

20. During our consultation meeting there were concerns raised over regulatory and inspection processes. We would like clarity over how these will be performed.

Proactive

21. Standards should clearly promote and support the active participation of people who use support services in the decision-making processes that affect them. We believe that further emphasis could be placed on the co-production of health and

³ <http://www.gov.scot/Publications/2015/12/4053>

⁴ <http://www.palliativecareguidelines.scot.nhs.uk/>

⁵ <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html>

social care services with people who use them and their unpaid carers. The Scottish Government is currently considering its strategic approach to the future of co-production in Scotland and this should be reflected by a further iteration of the standards.

22. To promote real co-production, you need to have positive action in order to create a culture where people are encouraged and supported to speak up – not only that there is an option to do so. This will also mean that all voices are heard not only the loudest. Therefore standard 4.6 should be strengthened to make sure a pro-active responsibility of the service is to regularly seek and act upon feedback, rather than the responsibility of the person who uses the support or service.
23. We believe that standard 1.12 does not adequately reflect the shift towards co-production. If people are to be genuinely involved this goes beyond ‘everyday’ tasks, for example, overall service design, finances, delivery etc.

Information and Education

24. It is imperative that promotion and education is ongoing to raise and maintain public awareness regarding the new standards.

Accessibility

25. The standards should be available in a number of languages and formats to make them as accessible as possible to the widest patient/client group.
26. Standard 2.5 makes reference to “translation services” this should include alternative information formats including Braille, accessible email, Word or text file, Easy Read and websites. This should also go beyond simply “access to translation” to reference “sustained access to translation”.

Workforce development

27. The standards alone will not necessarily drive improvements in care services. They need to be accompanied by a framework of mandatory education and training for all health and social care staff. We further believe that staff should be empowered to act upon these standards and challenge others’ behaviour if necessary.
28. Statement 4.19 should be revised to say “I am supported and cared for by people who have been appropriately recruited and trained to deliver the care that I need”.

This should include reference to on-going training and support through continuing professional development and regular updates to maintain standards of care.

Practical elements

29.5.9 There should be clarification on what is meant by a “service that is the right size for me”. This could refer to the number of staff in a service, the size of the buildings or even the number of people that are receiving support. We understand the complexity of prescribing specifics such as room sizes and staff ratios however, we feel that there should be some kind of reasonable expectation regarding these specifics and recommend that this be given more thought.

Standards 5-7

30. We understand that the first 4 standards are to be applied to every health and social care setting and standards 5-7 are to be applied to specific sectors. However, we believe that several standards in sections 5-7 would also be applicable to other services. For example, standard 7 relating to children and young people could easily also apply to very frail or elderly people, or other vulnerable people. We have concerns that by only including these statements in a specific children’s standard, they will not be embraced in other services. For example, statement 7.16 could easily apply to patients with advanced Dementia or Alzheimer’s disease and could refer to power of attorney and anticipatory care planning which apply to a variety of stages in life.

Conclusion

31. We believe that the new Standards are progressive and a step in the right direction from the old approach which is outdated and no longer fit-for-purpose. We hope that the draft standards will become a platform upon which to build and 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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Appendix 1 - Notes from the VHS Meeting on the New Health and Social Care Standards

Question 1: What aspects of the New National Health and Social Care Standards do you welcome or think will work well?

- I think standards are very good and know where changes need to be made they will be made, but for the beginning they do serve the purpose
- Person centred approach/client centred nature of the standards
- Focus on rights/rights based approach
- Focus on relationships
- Same standards for all services
- Standard 6 – a move away from specific standards for mental health which was in many ways discriminatory
- Agree with the principles underpinning the standards
- Absence of specifics has the potential to offer positives and negatives (specifics as in room size, staff ratio)
- Compassion is a real support
- Potential to positively impact patient and care providers
- It is everybody's business
- The standards empower staff members to vocalise issues/gaps in delivering principles
- Bringing services and people closer together the very essence of integration
- A umbrella that covers a lot of services "all for one and one for all"
- Underpinned by 5 principles that run through all standards
- Appropriate language
- Inclusive of health and social care – this will help to overcome tensions. Health services in particular have a long way to come
- Psychological/emotional dimension
- Easier for both parties to identify where things went right or wrong and why – sets up a requirement for dialogue
- Focus on individual outcomes/expectations
- Standardises aspirations
- Holistic approach to individual clients/holistic approach to individual
- If it comes to fruition no negative sides
- Continuous appraisal of compliance
- There is nothing negative
- Supportive of integrated services – and if both national and local government work together we can make services much better and special for those who use them and care for those who require them

- Size
- Outcomes focus
- Inclusion of both health and social care
- Standards apply in all settings (with some extra for special circumstances) very useful
- The person centred focus is excellent and is vitally important particularly to health services which remains service focused

Question 2: Do you think the new standards link well to pre-existing policy and legislation? What policy and legislation do you think they should link to?

- New standards should have all protected characteristics as specifies in Equality (Scotland) Act. So if any new protected characteristics is added then standards should automatically apply for them.
- The standards should add to not take away from existing legislation
- Should link through all legislation e.g. education sector and schools
- How will these standards fit with existing targets and KPI's in health and also the work around renewing national outcomes and indicators
- Should not be standalone but intertwined with existing policy and legislation for example: Mental Health (Scotland) Act, Adult Support and Protection, Patients Right Act, Community Care and Health (Scotland) Act 2002.

Question 3: What do you think is missing or needs to be improved in the standards?

- Implementation: there should be no one off campaign but promotion and education should be ongoing
- Not easy to provide when there are financial and time restraints
- Public awareness
- Individual focus can make it difficult for organisations to know how this translates into practice
- Danger of setting very high expectations for service users/patients which can't be met
- 5.7 does not only apply to children – what about incontinent adults?
- Harder to see how inspections happen on social work/case work level?
- Process of deciding what your needs are – needs to be part of the standards
- No reference to spirituality
- No reference to economic wellbeing
- Needs to be ever present at the bottom not just for people at the higher levels
- Needs to be an emphasis on 'locality' especially to allow family and friends support to be present
- Comparisons on performances (however you measure it) with other IJBs, hospitals, carers. An expectation on delivery

- Shifting responsibility too far 7.23
- 7.7 “I am helped by people who understand why I might be exhibiting certain behaviours...” areas of expertness – more clarity needed
- Epic tyranny of qualified professionals
- Role for third sector to help people better understand what they should expect to get will help make it real!
- More discussion around where problems are actually happening
- Breadth of activity – still not quite reaching co-production – still feels a bit like collusion between health and social care (despite the language and the focus change)
- Greater distinction between medical care and social care. These two things have differing priorities and it seems to me that call both ‘health’ can be very confusing and may make it more difficult to provide the right level of care.
- How do you turn 177 statements into rigorous sets of indicators for inspection and evaluation purposes?
- The standards are hugely varying which will inevitably cause problems
- The more open and vague a standard is the more difficult it is to uphold it.
- I understand why some A&E practitioners may say they do not provide ‘care and support they provide treatment’. It is much easier to assess whether a treatment was appropriate for the case presented, than it is to assess whether what was provided was caring and supportive. Sometimes in A&E I expect the pressure of medical emergency means that this is what needs to take priority over the ‘softer’ skills
- The language of the standards whilst positive may not transfer well into clinical services in the health sector
- Words such as compassion are hard to quantify
- Who is this aimed at – perspectives can be conflicting for example 1.3 ‘challenging behaviour’ or behaviour that challenges?
- To promote real co-production you need to have positive action in order to create a culture where people are encouraged and supported to speak up – not only that there is an option to do so. This will also mean that all voices are heard not only the loudest
- Do these standards represent target? For example, this is what should be achieved or are they a minimum – a floor to build on? Also how does this affect how they are monitored and evaluated?
- Whilst the human rights based approach is welcomed is strong enough? Will people know and learn that they have a right to things for example Independent Advocacy or carers assessments?