CCPS/SFHA Response to the Scottish Government National Care Standards Review Consultation – September 2014

CCPS is the Coalition of Care and Support Providers in Scotland. Our mission is to identify, represent, promote and safeguard the interests of third sector and not-for-profit social care and support providers in Scotland, so that they can maximise the impact they have on meeting social need.

CCPS membership comprises over 70 of the most substantial care and support providers in Scotland's third sector, providing high quality support in the areas of community care for adults with disabilities and for older people, youth and criminal justice, addictions, homelessness, and children's services and family support. All our members provide services registered with the Care Inspectorate and are covered by the existing national care standards.

SFHA is the national representative body for housing associations and co-operatives in Scotland some of whom provide care and support services regulated by the Care Inspectorate and are therefore subject to the national care standards.

The HSEU, a joint initiative of CCPS and SFHA, works with providers of housing support across Scotland in the voluntary and private sectors.

CCPS and SFHA welcome the opportunity to contribute to the review of the care standards. With the support of the HSEU, we have gathered views from members through a variety of meetings and focus groups, some of which ran in tandem with discussions about the review of the Care Inspectorate inspection methodology. Some of the comments below relate to the links between standards and the inspection process, as the two are difficult to view in isolation.

General points:

- Providers want to see a clearer link between the national care standards and the inspection of care and support services.

- Providers experience frustration at the lack of connection between the inspection of services and the commissioning of those services. In other words, there needs to be recognition within the National Care Standards and within the inspection process of factors outwith the control of providers of services that impact on service standards, e.g. an insufficient individual budget for a person may compromise their dignity; similarly insufficient contract values or an unwillingness to approve variations in care to accommodation increased need of individuals, may compromise the options offered and the quality of a service and therefore a person's participation in exercising choice. The budget insufficiency lies outwith the provider's sphere of control. A whole system approach to inspection would go some way to addressing this issue.

Question 1

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

We agree that this is an appropriate approach to the new care standards. However we have a number of points to raise in relation to this:

- How will we ensure these standards are made a reality for individuals (i.e. how will individuals be supported to recognise and understand behaviours/service design, etc. that promotes these)?

- The standards should be outcomes focused so that they can facilitate outcome focused support planning and provision as well as outcome focused inspection processes; and be accompanied by strong guidance and specific examples that will address concerns about consistency of interpretation in inspection.

- In addition to outcome focused standards, there need to be standards that clearly set out how people should be treated.

- Against the background of personalisation and personal interpretation, how will inspectors ensure consistency of inspection and clarity on how adherence to the human rights principles will be identified and measured?

- Many of the relevant human rights principles, including dignity, respect, compassion, and participation depend on the establishment of a relationship between the person providing support and the service user. Developing relationships with people takes time. There is a danger that we pay lip service to the human rights principles if there is no underlying commitment to properly resource quality care and support by ensuring that people have sufficient time to

devote to the relationship between carer and service user as well as the resources to train and develop the workforce appropriately.

Question 2

a. Do you agree that overarching quality standards should be developed for all health and social care in Scotland?

- In the context of the integration of health and social care policy agenda, it seems sensible for the overarching standards to cover both health and social care. However, there is some concern about the proliferation of different standards and shared outcomes and how they will relate to each other and which ones should take precedence or are most effective at supporting the best possible end result for service users. Any overarching standards need to be developed in consideration of the parallel development of shared health and wellbeing outcomes under the Public Bodies (Joint Working) (Scotland) Act 2014, the existing outcomes and indicators under GIRFEC (including SHANARRI), the SDS monitoring and evaluation outcomes framework, the Standards of Care for Dementia, and other related initiatives.

- There is a concern that the merging of health and social care standards may result in a set of standards that is 'dumbed down' to a level of generality that loses any meaning or effectiveness.

- There is also a concern that shared health and social care standards may be too strongly influenced by the medical model as a result of the very different targets and outcomes the NHS works toward, as compared to the national care standards that currently apply to social care.

- Whether or not the standards cover both health and social care, they will have to walk the difficult line between being over specified (leading to reduction in service creativity, innovation and personalisation) and being too vague and thus not something that can be upheld or inspected in a consistent way.

b. Do you agree that the overarching quality standards should set out essential requirements based on human rights?

We agree that this is appropriate – however we have some comments to make:

- Rights based standards imply that others are under a corresponding duty and this should be clearly set out so that service users understand the scope of their rights and so that providers and commissioners of services understand the scope of their responsibilities under the standards.

- In the event of standards not being upheld how can individuals address the failure of others to respect their human rights?

c. 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, although as set out above, the challenge will be to ensure these are outcomes focused and illustrated in a way which is flexible enough to accommodate and encourage the wide range of circumstances and personal aspirations they need to relate to.

d. Do you think general standards should set out essential requirements and aspirational elements?

- This question raises the tension between the regulator's enforcement and improvement roles. Improvement support requires the development of trust through building good relationships and 'getting alongside' the organisation looking to improve.
- The standards should set out requirements clearly for providers and for those using services in order to help promote a rights based approach.

- Providers support the inclusion of aspirational elements. They want clear guidelines about what good practice looks like in advance of an inspection and want clear guidance on improvement when services fall short of required standards. Equally, this means inspectors need to have clear guidelines about what good practice looks like and a more proactive role in supporting improvement.
- Several providers have suggested that standards are accompanied by examples of good practice across a range of services.

- Providers also noted the potential valuable role of inspection reports in supporting improvement and suggested that reports should distinguish clearly between what constitutes an acceptable standard and what constitutes improvement or aspiration, and what the provider needs to do to improve a service.

e. Do you agree that a suite of specific standards are developed for particular aspects of care, circumstances or need?

- There are mixed views on this question. However, a significant number of members have concerns that the creation of suites of specific standards could result in a recreation of the existing system, i.e. an overly complex scheme of multiple standards.

- There were concerns that the specific standards should not be divided up by client group, e.g.: older people, learning disability, children's services, or fall in to a narrow type of service: home care, palliative care, etc. Inspection and standards should be consistent across client groups and many service users will fall in to several categories: e.g. a disabled child with learning disabilities and physical impairments.

- Providers often highlight the problems of registration categories which make it very difficult to fit support services into the system. There is strong support for a change in the registration categories. With the development of SDS, there are a growing number of examples of support services that no longer fit into the existing framework. Providers may be supporting someone with a wide range of activities in the community, and with personal care, cleaning, managing money, etc. There is a danger that specific standards may not work in a world of fully personalised, outcomes based support. CCPS has recently published a report based on work with providers and the Care Inspectorate that highlights many of these difficulties and makes some suggestions for change. They include 'considering ways in which to ensure the registration system fits with personalised support provision that may no longer include area teams and local services'.

- In the case of housing support, we would strongly support a review of registration categories rather than creating suites of specific standards.

- If suites of specific standards are developed, it will be important to illustrate these in a way that avoids being overly prescriptive. We do not want to create an inflexible regime that risks limiting innovation.

- We need to avoid a situation where services users who use a variety of services, e.g. a short break in a care home plus a care at home service, become burdened by elements of the inspection process, particularly where different sets of care standards might apply.

Question 3

a. What are your views on how standards should be written?

- The standards should be written in plain English. They should be made available in the most common alternative formats, including different languages, BSL, braille, large print, Easy Read, audio, etc., at the same time as the new standards go 'live' (as should any further consultation documents), and the Care Inspectorate should have ready access to supplies to immediately respond to demand.

- Standards should be supported by a robust and measurable indicator set. This is important because it can often be difficult to 'see' or evidence a social care outcome directly. Indicators make outcomes visible and measurable and give a basis for measuring impact. The set of indicators should be developed collaboratively with providers and users, and include examples of practice to illustrate each indicator. Examples of how this could work are attached at Annex A.

b. 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?

- We support the suggestion that the standards should be written from the point of view of the supported person with a 'mirror' statement from the provider perspective, reflecting the rights and the corresponding duties and what each looks like.

- The example set out on page 19 of the consultation document could be extended to set out outcomes and indicators in order to help make the standards real for people using services, providers and inspectors, as noted above.

Question 4

a. Do you think the Care Inspectorate and Healthcare Improvement Scotland should hold services they regulate to account for meeting the proposed overarching standards, the general standards and the suite of specific standards?

Members understood this question in different ways.

- There is general support for the Care Inspectorate and HIS holding to account for all three levels of standards (subject to our views about the third level of specific standards set out above).

- However, we do not support a system of accountability that does not take into consideration all the elements that make up the care and support system. In other words, the CI and HIS should hold accountable the commissioning process, alongside services.

- There are also some concerns about the way that the CI and HIS hold services to account. In this regard, while not directly related to the development of the care standards, providers raised a few issues with the inspection process,

including a strong desire to move away from a highly paper-based process-oriented approach. Instead, providers believe the inspection process would be much more effective if inspectors spent more time with service users and staff, and explored the quality of the interaction between them and how it contributes to service users' personal outcomes.

- As noted above, providers want more clarity on expectations, what does 'good' look like and what do providers need to do to improve. There is a strong appetite for an improvement focused relationship between providers and the Care Inspectorate, based on a set of outcome-focused care standards.

b. How should we ensure that services not regulated by the Care Inspectorate and Health Improvement Scotland comply with the new standards?

Again, members approached this question from different angles.

- Is it about the issue of non-regulated care providers, including personal assistants? If so, this is not strictly speaking a provider issue, insofar as our member organisations will all be providing regulated services. However, we note that the question of why one group of care providers is regulated while another is not remains unresolved.

- Self-directed Support (SDS), where supported people can take a greater degree of control of the budget for their support, may bring in increased use of unregulated services as part of someone's wider support package. An example of this might be a person purchasing a gym membership to help them increase their mobility. We consider the extension of health and social care standards to this type of service to be unnecessary and potentially unduly restrictive of the person's choice as to how they spend their budget. Scottish Ministers have been clear that there is no intention to regulate personal assistants. We offer the observation that any planned extension of the standards to this area of unregulated services could be viewed as regulation 'by the back door' by the disabled people's movement.

- Is the question about the interaction between different regulators? Whilst we support the idea of overarching standards across regulated and non-regulated services, we urge close cooperation between regulators and an acknowledgement of the role these other regulators have in promoting the overarching standards. Housing associations, for instance, are regulated by the Care Inspectorate and the Scottish Housing Regulator where they provide care/support as well as housing. It would be unhelpful, and indeed does not appear to be the intention of the Scottish

Government's review of care standards, to confuse the roles of the regulators by encouraging them to scrutinise areas of business regulated by another. The application of standards across services not regulated by CI or HIS must take into account the way other regulators are involved.

b. We suggest that the Care Inspectorate and Healthcare Improvement Scotland, consulting with others, should develop the suite of specific standards. Do you agree with this?

- CCPS has reservations about the care standards being developed and drafted by the same bodies whose job it is to inspect against them. We think that the principle on which the Regulation of Care Act 2001 national care standards were based is a sound one, i.e. that it is the Scottish Ministers who prepare and issue the standards. This ensures a clear line of political responsibility for the standards and a clear separation between the government and the independent administrative body responsible for upholding the standards.

- Whatever practical process is set up to develop the standards, providers believe that it must be inclusive, to reflect a genuine co-production between key stakeholders, including providers, supported people, their representatives, carers and other regulators, rather than a process whereby one body develops a draft set of standards and then 'consults' on them.

Question 5

a. Please tell us about any potential impacts, either positive or negative, you feel any of the proposals set out in this consultation paper may have on particular groups of people, with reference to the 'protected characteristics' listed above.

n/a

b. Please tell us about any potential costs or savings that may occur as a result of the proposals set out in this consultation paper and any increase or reduction in the burden of regulation for any sector. Please be as specific as possible.

- Costs associated with training staff about the new care standards and implications for inspection

- The application of standards across services not regulated by CI nor HIS must take into account the way other regulators are involved e.g. the Scottish Housing Regulator.

- The existing memorandum of understanding in place between the Care Inspectorate and other bodies such as local authorities and other regulators should be reviewed in the light of the development of overarching care standards. This will be important to promote information sharing in order to avoid the need to provide similar information to different bodies – something which adds to the cost of providing services.

Question 6

Please tell us if there is anything else you wish us to consider in the review of the National Care Standards that is not covered elsewhere in the consultation paper.

- The relationship between the new care standards and workforce registration is one which could usefully be set out in more detail as employers need to plan ahead in terms of recruitment and training.

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ANNEX A

Outcomes and indicators for the whole system (person, service, system)

- The person's outcome is the mirror of the provider outcome
- The indicators given are examples
- The indicators allow measurement of quality across the wider system.

Person living in sheltered housing	Provider of sheltered housing	Indicator (person)	Indicator (service)	Indicator (system)
I am able to continue to live at home for as long as possible. (maintenance outcome)	We identify changing needs. We provide support that postpones the need to move into residential care. We provide support that helps people make choices about housing adaptations, community support and other services to help them stay at home.	People who do move onto residential care tell us: They remained at home as long as they felt able to. They felt their choices about housing were respected.	Number of housing adaptations, care at home, support, telecare link with community services put in place People still in touch with family and friends.	Number of People living at home in their last 6 months of life.

Thematic outcomes and indicators – in this example:

- The person's outcome is the mirror of the provider outcome
- The indicators are specific- recognising the personalisation required to support a person
- The outcomes and indicators are then grouped against the relevant themes (from the overarching standards)

Person	Provider	Example (indicator) from the person's perspective	Example (indicator) from the provider's perspective	Theme
I make choices about my daily life	We offer and actively support choices about daily life	I choose what I am doing each day by using a picture calendar of activities	We got communication support advice to work with the person to develop the picture calendar so they could communicate their choices to us.	Choice Dignity Personalisation

Wellness Recovery Action Planning (WRAP) group facilitator outcomes (Scottish Recovery Network)

An example of a live quality system that is based on outcomes, WRAP is a recovery tool designed to support individuals with mental health problems have more control over their wellbeing. WRAP facilitators are accredited by SRN through observed practice against outcomes and indicators. Those accrediting the facilitators are trained to take a coaching/improvement approach and to document examples of practice against each indicator for discussion with the facilitator.

More information from john.moody@scottishrecovery.net

Outcomes and Indicators

Outcomes	Indicators that the facilitator is meeting these outcomes are:
1. There are good group dynamics	Invites, recognises, respects and validates participant experiences and strengths
	Uses recovery focused language and challenges the use of medical/diagnostic language in the group where appropriate
	Works with the group as a whole to create a high quality group experience for all
	Shows respect for the group and themselves by demonstrating effective planning and preparation for the workshop
2. There is a sharing and empowering environment where people participate and learn together	Reacts to difficult feelings and behaviours with compassion and support
	Effectively manages difficult conversations that could lead to conflict
	Encourages and supports people to empower themselves and participate in the group
	Takes account of different learning styles and preferences
	Encourages shared responsibility and collective decision making
	Makes intentional use of their own story to illustrate aspects of WRAP
3. All are treated with dignity, compassion and respect	Is mindful of their own needs, wellness and the actions needed to nurture that wellness
	Makes effective use of the group agreement
	Checks in with the values and ethics checklist between sessions and at the end of the workshop
	Avoids making judgements