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Consultation on the New National Health and Social Care Standards: Analysis of Responses

HEALTH AND SOCIAL CARE

social research

Consultation on the New National Health and Social Care Standards: Analysis of Responses

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1. Executive Summary

1.1 In 2014, Scottish Ministers committed to review, update and improve the 23 National Care Standards established in 2002. New Standards were needed to reflect changes in policy and practice since 2002.

1.2 Scottish Ministers proposed a new, single set of Standards across health and social care, based on human rights and underpinned by the principles of: dignity and respect; compassion; being included; responsive care and support; and wellbeing. A Development Group, made up of a wide range of stakeholders, drafted the new Standards, in collaboration with other key partners.

1.3 Seven draft Standards were proposed and put out to public consultation on 28 October 2016 with views invited by 22 January 2017. An easy-read version of the consultation was also published. In addition, a series of 19 engagement events was held across Scotland by the Care Inspectorate and Healthcare Improvement Scotland.

1.4 440 responses were received to the full consultation and 59 to the easy-read version, making a total of 499 responses overall. Of these, 50% were organisations responding to the full consultation. Of the individuals who reported to the full consultation, 70% were working or volunteering in health and social care; 25% were service users. A summary of the responses to the both the full and easy-read version of the consultation follows.

Overarching views and themes

1.5 Overall there was substantial cross-sector support for the new Standards:

- 79% of those providing a view to the full consultation strongly agreed or agreed that they will be relevant across all health, care and social work settings.
- 74% of those providing a view to the full consultation strongly agreed or agreed that the Standards reflect the experience of people who receive care and support.
- There was much appreciation of what was perceived to be the thorough and thoughtful development work which has gone into the development of the Standards so far.

1.6 Views provided in response to the consultations (both full and easy read) ranged from a mix of very detailed drafting comments on the text of the Standards and their supporting statements, to broad, cross-cutting comments which emerged repeatedly throughout the consultation responses.

1.7 Overarching, common concerns to emerge were:

- The Standards may not apply to all settings and all circumstances.

- They appear to be aspirational in places, which may have advantages, but also posed the threat of undermining their usefulness and setting providers up for failure.
- The language could be refined in places, with various words and phrases identified as vague and ambiguous.

Views on the relevance of the Standards

1.8 Most respondents considered that the Standards will be relevant and can be applied across all health, care and social work settings. 79% of respondents to the full consultation and all but one of those responding to the easy-read version, shared this view.

1.9 The Standards were welcomed as human-rights focused and outcome-focused. They were viewed as person-centred and easy to read, and likely to promote consistency in quality of provision and expectation.

1.10 Some respondents suggested that the balance of focus of the Standards tipped towards social care contexts over health care environments.

1.11 Key concerns were that the universal approach of the Standards may result in their being too general to be useful; some perceived them to be unduly specific in some places and too general in others; many respondents expressed concern that the generalisable nature of the Standards may present challenges for inspection regimes and benchmarking.

Views on whether the Standards reflect the experience of people who receive care and support

1.12 The prevailing view was that the Standards do reflect the experience of people who receive care and support. 74% of respondents to the full consultation and all but one of those responding to the easy-read version, shared this view.

1.13 Although receiving wide support as reflective of real-life experience, the effectiveness of the Standards was perceived to be dependent on broader contexts such as adequate resourcing, appropriate organisational structures, and well-planned implementation, along with robust inspection and enforcement regimes.

1.14 The Standards were viewed as setting up the context of positive outcomes for service users in terms of being: person-centred; written in the first person; comprehensive; and clear and well-structured. Contrasting views were that the Standards were ambiguous, subjective and repetitive in places, risking different interpretations which could undermine their usefulness.

1.15 Gaps in the Standards or areas which could be given greater attention were identified as the experiences of: people receiving care at home; people with dementia; very young children, children and young people; and people in secure care settings. Some respondents considered that the Standards did not pay enough attention to the use of advocates; safety issues for the service user and service provider; and transitions and interfaces between different care and support contexts.

Views on Standard 1: I experience high quality care and support that is right for me.

1.16 89% of those responding to the full consultation and all of those responding to the easy-read version considered that this Standard described what people should expect to experience from health, care and social work services.

1.17 The Standard was perceived to be thorough, comprehensive and detailed, whilst retaining clarity. The section on wellbeing was identified as particularly welcome, as were the statements for children in their early years.

1.18 Broad concerns were raised that the Standard was more aspirational than achievable; the Standard was overly long and repetitive; some of the statements were too prescriptive; and some of the language was too subjective.

Views on Standard 2: I am at the heart of decisions about my care and support

1.19 87% of those responding to the full consultation and all but two of those responding to the easy-read version considered that this Standard described what people should expect to experience from health, care and social work services.

1.20 The Standard was viewed as being comprehensive, written clearly, and aligned with broader policy context such as self-directed support and outcome-focused models of commissioned care and support. Aspects of the Standard which were particularly welcomed included: the focus on positive risk-taking; focus on communication; significance given to the service user having choice and control; and the implied emphasis on empowerment.

1.21 A repeated view across different sectors was that contextual factors such as resources, physical structures of care settings, and staffing ratios, will impact on the degree to which this Standard can be implemented and achieved.

1.22 Some respondents considered that not all of the statements will apply in all settings, with prison and acute health care settings mentioned in this regard.

Views on Standard 3: I am confident in the people who support and care for me

1.23 90% of those responding to the full consultation and all but two of those responding to the easy-read version considered that this Standard described what people should expect to experience from health, care and social work services.

1.24 There were many supportive comments about Standard 3 as a whole, and key elements within. What was perceived as a person-centred approach was welcomed; the emphasis on communication and relationships was valued; and links with a wider context of guidance and legislation were identified. The layout of the section was viewed as helpful to providers; the Standard was seen as providing reassurance to those most vulnerable, both in its title and also under sections such as “Compassion”.

1.25 A minority view was that some of the language of this Standard was vague, and whilst its aims appeared laudable, they required adequate funding and could be challenging to ensure and enforce.

1.26 A key emerging theme was that this Standard required robust underpinning with a framework of training for paid and unpaid workers. Some queried how it would be measured and assessed, with examples requested.

Views on Standard 4: I am confident in the organisation providing my care and support

1.27 87% of those responding to the full consultation and all but one of those responding to the easy-read version considered that this Standard described what people should expect to experience from health, care and social work services.

1.28 This Standard was perceived to be well written, comprehensive, aligned with patient-centred care, and focused on human rights and participation.

1.29 A number of broad concerns were raised. Respondents queried how achievement of the Standard would be measured, evidenced and enforced. Some questioned whether service users, particularly children, would know if this Standard was being met. A repeated view was that people may not know if their human rights are being respected if they are not educated on what these are.

Views on Standard 5: And if the organisation also provides the premises I use.

1.30 81% of those responding to the full consultation and all but one of those responding to the easy-read version considered that this Standard described what people should expect to experience from health, care and social work services.

1.31 The Standard was perceived to be thorough and comprehensive, whilst retaining clarity. The section on compassion was particularly welcome as was the statement on access to the internet.

1.32 Key concerns were that: the Standard appears more aspirational than practical; the heading appears to be unfinished; “premises” needs further explanation; some words and phrases appear to be woolly and not easily measurable.

Views on Standard 6: And where my liberty is restricted by law.

1.33 77% of those responding to the full consultation and all but one of those responding to the easy-read version considered that this Standard described what people should expect to experience from health, care and social work services.

1.34 The Standard was welcomed as focusing strongly on human rights, and establishing a helpful basis for assisting in balancing issues of risks, whilst ensuring individual rights are respected. Some considered that the Standard captured well the role which restrictions play in ensuring security and wellbeing of the individual, underpinned by compassion, dignity and respect.

1.35 The most common concern regarding Standard 6 was over the word “by law” in the heading. A recurring view was that the Standard should apply also to settings where liberty is restricted due to other factors, such as safety and security of the individual.

1.36 There were mixed views on whether this Standard should be stand-alone or whether it should be mainstreamed across the other Standards. A key argument in favour of mainstreaming was that human rights should underpin all care provision rather than be associated only with settings where liberty is restricted by law. A contrasting view was that human rights merits prominence in a dedicated Standard.

Views on Standard 7: And if I am a child or young person needing social work care and support.

1.37 80% of those responding to the full consultation and all but one of those responding to the easy-read version considered that this Standard described what people should expect to experience from health, care and social work services.

1.38 The Standard was seen to be appropriate, comprehensive, yet proportionate. It was perceived to fit with wider, relevant guidance, and used positive language which reflected high expectations.

1.39 Again respondents questioned whether this Standard merited being stand-alone. A recurring view was that several of the statements were not specific to children and young people, and were equally applicable across all ages and demographics.

1.40 Several respondents perceived this Standard to duplicate elements of previous Standards; some considered the terminology to be subjective in parts.

Views on whether the Standards will help support improvement in care services

1.41 75% of those responding to the full consultation considered that the Standards will help to support improvement in care services, as did all but three of those responding to the easy-read version.

1.42 The three most common reasons given as to why the Standards will support improvement were: they are easy to understand, user-friendly and accessible; they provide a common understanding and framework which ensures shared expectations and which will promote consistency of provision; and the rights-based approach will help providers and service users to understand what is required.

1.42 A common view was that the effectiveness of the Standards could be enhanced by the provision of practice-based guidance to support providers in implementing the Standards in their setting. Another recurring suggestion was for the development of a clear inspection framework.

1.43 Although supporting the Standards, some respondents considered that they may be too broad and risked service providers and service users interpreting them differently, which could detract from their effectiveness.

1.44 Another commonly mentioned concern was that applying all aspects of the Standards to all settings will be challenging. What was perceived to be the aspirational nature of elements of the Standards was viewed as potentially undermining, whilst raising expectations which may not be fulfilled.

1.45 Some respondents considered that the Standards were too vague to be measurable or enforceable; some criticised what they saw as the "one size fits all" approach; others considered the scope for different interpretation of the Standards was too great; and a few respondents emphasised the need for a review framework for feedback on, and revision of, the Standards.

1.46 Many respondents suggested that to be successful, the Standards required to be adequately resourced; effectively launched and implemented; and robustly inspected and enforced. Training opportunities for the workforce were highlighted as important; as was awareness-raising amongst service users and workforce alike.

Views on anything else to be included in the Standards

1.47 A wide variety of suggestions was made for additional content. The four most frequent suggestions were: feedback/complaints/appeal mechanisms; end of life care including anticipatory care plans and advanced statements; management of transitions; and right to advocacy/recognition of representatives, both formal and informal.

Views on anything else to be aware of in the implementation of the Standards

1.48 The most frequently emerging view was that the current inspection regimes will need to be updated to reflect the new Standards, with these communicated widely in time for implementation.

1.49 Another common view was that the Standards will need to be made widely available and accessible, and in a variety of formats, to meet the needs of those with communication difficulties.

Views on what the new Standards should be called

1.50 Of the five options provided in the consultation, the option receiving most support amongst respondents to the full consultation was, "National Health and Social Care Standards". Amongst respondents to the easy-read version, the option with the most support was, "National Care and Support Standards".

1.51 Many other suggestions for names were proposed, with key themes emerging: "Scotland" or "Scottish" to be in the title; the person-centred approach to be reflected, perhaps using the terms "People's Standards…" or "My Standards…" or "People first Standards"; include a strapline then a title, such as "Raising Expectations, Raising Standards" followed by "National Care Standards" or similar.

Any other comments or suggestions

1.52 There was much appreciation of what was perceived to be the thorough and thoughtful development work which has gone into the development of the Standards so far. The Standards were viewed as a potential tool for partnership

working, underpinned by a shared understanding between partners of expectations of provision.

1.53 Some respondents considered that the Standards required further editing to make them shorter and more streamlined. Others suggested that links between broader, related frameworks and regulatory regimes should be made more explicit.

1.54 Whilst some respondents welcomed the universal approach of the Standards, others viewed this as too broad-brush, and masking the complexities of health and social care provision.

1.55 A common view was that whilst the Standards are generally applicable, they will need to be implemented in a meaningful and systematic way to ensure effectiveness. Respondents recommended thorough preparation before the launch of the new Standards. This was envisaged as including sufficient lead-in time to allow for structured implementation, including revised inspection regimes, awareness-raising and educating.

2. Introduction

2.1 Since 2002 the National Care Standards have played an important role in ensuring people who receive care and support get the high-quality service they are entitled to, whatever the setting. In 2014, Scottish Ministers committed to review, update and improve these Standards. The previous 23 Standards looked mainly at technical requirements such as written policies and health and safety procedures. New Standards are needed to reflect recent changes in policy and practice and to be fit for the future.

2.2 Since the 2002 Standards were introduced, there have been various significant changes. More people have been supported and cared for in their own homes; the quality of care experience is now considered as important as other aspects of care such as safety; and the establishment of Health and Social Care Partnerships means that when people use health or care services they should get the right care and support, whatever their needs. The Care Inspectorate and Healthcare Improvement Scotland continue to regulate each individually registered health and social care service, but work more closely now with other regulators and scrutiny bodies to carry out strategic inspections, looking at how the wider health, social work and social care system is working.

2.3 To support these changes, a new single set of Health and Social Care Standards is needed that applies across all care services we may use in our lifetime.

2.4 A public consultation in 2015 confirmed much support for the new Standards to be based on human rights and the wellbeing of people using services. The following Principles were approved by Scottish Ministers in 2016:

- Dignity and respect
- Compassion
- Be included
- Responsive care and support
- Wellbeing

2.5 A Development Group, made up of organisations representing people using services, unpaid carers, social care providers and commissioners of care, drafted new Standards, in collaboration with other key partners. Seven draft Standards have been proposed, the first four to apply to everyone; three further Standards to apply in specific circumstances.

2.6 The draft Standards were put out to public consultation on 28 October 2016 with views invited by 22 January 2017. An easy-read version of the full consultation was also published. A series of 19 engagement events across Scotland was held by the Care Inspectorate and Healthcare Improvement Scotland, to raise awareness of the consultation and gather views of participants.

2.7 Responses to the full consultation were encouraged via Citizen Space which most respondents used. Summaries of views from the engagement events were also submitted, by facilitators of the events, using Citizen Space. A minority of responses to the full consultation were submitted by email or post. Easy-Read consultation responses were submitted by email or hard copy. All responses, however they were submitted, were considered in the analysis.

Consultation responses

2.8 The Scottish Government received 499 responses to the consultation. Table 2.1 overleaf shows the distribution of responses by category of respondent. A full list of respondents is in Annex 3. The respondent category applied to each response was agreed with the Scottish Government policy team. Where respondents did not fit clearly into any of the sectors, a decision was made on the closest match and a consistent policy followed. Three responses were received after the closing date, which, although they have not been counted as part of the total number of official responses, will be considered by the Scottish Government policy team as part of the overall analysis.

2.9 Many respondents reported conducting wider consultation within their own organisation and membership, prior to submitting their consolidated response, demonstrating a much broader reach of the consultation over and above the 499 respondents.

2.10 50% of responses were submitted by organisations to the full consultation; 38% were from individual respondents to the full consultation; and 12% of responses were from individuals and groups to the easy-read version of the consultation. The largest category of respondent was the voluntary sector comprising 17% of all respondents.

2.11 The full consultation invited respondents to provide additional information on their involvement and experience with health and care services. Responses to this invitation were not complete, but where information was provided this indicated greatest involvement in adult social care and primary health care (GP and other community health services), followed by early learning and childcare, and acute health care (emergency care, hospitals).

2.12 Of the individual respondents to the full consultation, 70% self-reported as working or volunteering in health and social care; and 25% defined themselves as service users; the remainder did not self-define.

Analysis of responses

2.13 The analysis of responses is presented in the following 12 chapters which follow the order of the topics raised in the consultation paper. The consultation contained 14 key questions, most containing both closed and open elements.

2.14 The analysis is based on the views of those who responded to the consultation which are not necessarily representative of the wider population.

Table 2.1: Distribution of responses by category of respondent

Category	No. of respondents	% of all respondents*
Voluntary Sector	85	17
Professional Representative Bodies	24	5
Private Sector	23	5
Early Years and Childcare Services (Pre-5 focus)	22	4
Engagement Events	19**	4
Health and Social Care Partnership Bodies	16	3
Local Authority Bodies	15	3
Healthcare	14	3
Education (largely 5 – 16 years)	10	2
Housing Associations	8	2
Academic	4	1
Regulatory/Inspectorate/Scrutiny	3	1
Statutory Bodies	3	1
Other	3	1
Total Organisations	**249**	**50**
Individuals - working/volunteering in health/social care	134	27
Individuals – service users	48	10
Individuals – no further information	9	2
Total Individuals	**191**	**38**
Easy Read Consultation Respondents (Individuals and Groups)	**59**	**12**
Grand total	**499**	**100**

*Percentages may not add to totals exactly due to rounding.
** Number of events indicated.

3. Views on the Relevance of the Standards

Background

The new Standards need to be fit for purpose for assessing how well people's care needs are met on both a strategic and an individual service level. The Scottish Government proposes that a single set of Health and Social Care Standards should apply across all care services which may be used in a lifetime.

Question 1: To what extent do you think the Standards will be relevant and can be applied across all health, care and social work settings?

3.1 427 (97%) respondents to the full consultation and 57 (97%) respondents to the easy-read consultation answered this question.

3.2 Table 1 in Annex 1 shows views by category of respondent to the full consultation. Table 3.1 below summarises these views.

Table 3.1: Views on the extent to which the Standards will be relevant and can be applied across all health and social work settings

View	No. of respondents	% of all respondents
Strongly agree	131	31
Agree	207	48
Neither agree nor disagree	50	12
Disagree	39	9
Total respondents	**427**	**100**

3.3 79% of those who provided a view strongly agreed or agreed that the Standards will be relevant and can be applied across all health, care and social work settings. Individual respondents expressed stronger support than organisations with 36% of the former, compared with 25% of the latter, strongly agreeing with the statement. A significant minority (9%) respondents disagreed.

3.4 Views of those responding to the easy-read version of the consultation are summarised in Table 3.2 overleaf.

Table 3.2: Views on the extent to which the Standards will be relevant and can be applied across all health and social work settings

View	No. of respondents	% of all respondents*
Yes, agree relevant across all health and social work settings	49	86
Mixed – some agree and some agree a bit (reflecting group views)	1	2
Agree a bit	6	11
No - disagree that the Standards will be relevant across all health and social work settings	1	2
Total respondents	**57**	**100**

*Percentages may not total 100% exactly due to rounding.

3.5 All but one respondent who answered this question in the easy-read version of the consultation agreed a bit or agreed fully that the Standards will be relevant and can be applied across all health and social care settings.

General supportive views

3.6 Many respondents outlined broad features of the Standards which they particularly welcomed, the most common being:

- Human-rights focus
- Person-centred focus
- Outcome focus
- Easy to read
- Up-to-date in terms of reflecting current landscape
- Based on five principles
- Promoting consistency in provision and expectation

3.7 Other attributes of the Standards which received specific support included: their perceived flexibility across different settings/not overly prescriptive; adaptability and applicability for different settings; usefulness for those working across agencies, to have one set of Standards to adhere to; and usefulness to commissioners of services to have a common set of Standards across the board.

3.8 Many of those who were generally supportive of the Standards suggested that they fitted more with social care contexts than with health care environments.

General concerns about the relevance of the Standards

3.9 A repeated view, across a wide range of sectors, was that by attempting to apply to all settings, the Standards were too general to be useful or practical. It was considered that they presented clear principles and values, but lacked the

specifics on how to apply these in some circumstances. Several respondents called for the Standards to be supported with tailored and specific guidance to enhance their relevance in different settings. Some felt that at present the Standards provided more detail relating to some contexts than others.

3.10 A few respondents perceived the Standards to be too general in places and too specific in others to be meaningful across all health, care and social work settings.

3.11 Many respondents identified contexts which they considered were not adequately covered by the Standards, including:

- End of life care
- School care accommodation
- Care within prison
- Foster care
- Care of older people
- Homecare

3.12 Other perceived omissions included mention of “empathy” (perhaps instead of “compassion”); recognition of the role of representatives/advocates in helping service users with choices and decisions; giving prominence to “inclusive communication”, with one voluntary organisation suggesting this might merit another principle; and introducing another Standard on the assessment process for care packages.

3.13 Two voluntary organisations considered that the Standards would benefit from being organised into overarching, generally applicable statements, followed by a menu of “pick and mix” statements, or more setting-specific statements.

3.14 Whilst appreciating the human-rights focus of the Standards, several respondents, including two of the statutory bodies, suggested that relevance could be enhanced by being more explicit about how human rights can be exercised through the Standards, what this means in practice. One respondent considered that some minor editing, with a few words and phrases added, would make this important aspect of the Standards much clearer.

Specific concerns about inspection

3.15 A common concern was that the generalisable nature of the Standards could present challenges for inspection regimes. The language of the Standards was considered by some to be subjective in places, with terms such as “where possible” highlighted as too open to interpretation to form a robust basis for benchmarking. Questions were raised over how adherence to the Standards could be evidenced, with requests for case studies/examples of evidence provision in practice.

3.16 Several respondents suggested that greater clarity on terminology and definition of phrases and words (perhaps in the glossary) is needed in order to support a credible inspection regime. One regulatory body requested definition of:

“care”; “health”; “social work”; and “social services”. A representative body questioned whether the word “Standards” was appropriate, considering their view that what was proposed was more akin to a set of guidelines, underpinned by expectations and principles. A few respondents requested that “early years” be defined and be consistent in meaning to wider frameworks (for example, up to 18 years).

3.17 A recurring view was that the Standards, whilst worthy, were reflective of aspirations rather than practical application. As such, providers may be open to complaints of failing to meet expectations. It was considered that inspections should take account of the reality of planning and delivering in health, care and social care settings, perhaps providing information on how they will use specific Standards in their inspections.

Specific concerns about understanding the Standards

3.18 Many respondents commented that for the Standards to be relevant they need to be readily comprehensible to the users of services and the workers providing services. Whilst the Standards were welcomed as easy to read, some thought that there were too many statements within the Standards, and this detracted from clarity. A few considered aspects of the Standards to be repetitive and suggested that some editing may be required.

3.19 An emerging theme was that awareness-raising and educating on the Standards will be required to ensure that they are relevant to service users and staff providing care.

3.20 A few respondents expressed concern over the place of the Standards within commissioning frameworks, providing the view that common understanding of the requirements of commissioners and consistency across commissioning, will be crucial.

Specific concerns about applying the Standards

3.21 Several respondents remarked that application of the Standards should be a key focus, alongside ensuring relevance. A common view was that applying the Standards could be challenging and will require increased awareness of the Standards; shared understanding of their meaning; and additional resourcing, for example, for training of staff.

3.22 A few respondents commented that effective application of the Standards will need effective communication between agencies to track people using different parts of the system, and between inspectors across different agency contexts.

3.23 A small number of voluntary organisations, individual workers and service users emphasised their view that strong leadership, along with commitment and motivation will be necessary to implement and apply the Standards consistently and effectively.

Question 2: To what extent do these Standards reflect the experience of people experiencing care and support?

3.24 402 (91%) respondents to the full consultation and 57 (97%) respondents to the easy-read consultation answered this question.[1]

3.25 Table 2 in Annex 1 shows views by category of respondent to the full consultation. Table 3.3 below summarises these views.

Table 3.3: Views on the extent to which the Standards reflect the experience of people experiencing care and support

View	No. of respondents	% of all respondents
Strongly agree	109	27
Agree	187	47
Neither agree nor disagree	77	19
Disagree	29	7
Total respondents	**402**	**100**

3.26 74% of those who provided a view strongly agreed or agreed that the Standards reflect the experience of people experiencing care and support. Individual respondents expressed stronger support than organisations with 32% of the former, compared with 22% of the latter, strongly agreeing with the statement.

3.27 Voluntary sector respondents appeared to be more ambivalent in opinion, with almost one-third (32%) neither agreeing nor disagreeing that the Standards reflect the experience of people experiencing care and support; likewise, half of the 18 professional representative bodies who provided a response neither agreed nor disagreed.

3.28 Views of those responding to the easy-read version of the consultation are summarised in Table 3.4 overleaf. All but one respondent who answered this question in the easy-read version of the consultation agreed a bit or agreed fully that the Standards reflect the experience of people experiencing care and support.

[1] The easy-read version of the consultation posed the question, "Do you think the Standards reflect what should be prioritised?"

Table 3.4: Views on the extent to which the Standards reflect the experience of people experiencing care and support

View	No. of respondents	% of all respondents*
Yes, agree relevant across all health and social work settings	49	86
Mixed – some agree and some agree a bit (reflecting group views)	2	4
Agree a bit	5	9
No - disagree that the Standards will be relevant across all health and social work settings	1	2
Total respondents	**57**	**100**

*Percentages may not total 100% exactly due to rounding.

Interpretation of the question

3.29 Question 2 was interpreted differently by different respondents, with some stating that they were unclear as to its meaning. In particular, respondents queried whether the question referred to current or past experience, future experience, aspirations and expectations or what has been experienced on the ground. Responses reflected this mix of interpretations of the question.

Commonly held views

3.30 Common views across a wide range of sectors were that the Standards reflect the ideal experiences of people who are receiving care and support, but in reality these will vary between people and contexts. Many respondents commented that providers have to work within their means and that level of provider resources and organisational structures will impact on individual experiences of service users. Some expressed concern that the Standards raised expectations which cannot be fully met.

3.31 A recurring theme was that the experience of people receiving care and support will be influenced to some extent by the way in which the new Standards are implemented and enforced. A few respondents questioned how providers will evidence their adherence to the Standards, with suggestions made that greater emphasis should be placed on evaluation of performance.

3.32 Many respondents outlined aspects of the Standards which they welcomed as setting the context for positive outcomes for service users. These included:

- Person-centred approach.
- Written in the first person – meaningful and easy to understand.
- Holistic, comprehensive, inclusive approach, covering issues of importance to service users across all life stages.
- Clear and well-structured presentation of Standards.

3.33 In contrast, some respondents, across a wide range of sectors, held the view that the Standards were ambiguous, subjective and repetitive in places, risking different interpretations which undermined their usefulness. A few respondents, including some service users, considered that the language used in the Standards was that of professionals rather than the service user.

Views on groups not covered by the Standards

3.34 A few respondents identified service user sectors which they considered did not have their experiences adequately reflected by the Standards. The most commonly identified are below:

- Those receiving care and support at home, perhaps through self-directed support.
- People with dementia.
- Children and young people (it was felt that the Standards referred generally to the experiences of adults).
- Very young children.
- People in secure care settings.

Views of experiences not covered by the Standards

3.35 Some respondents identified experiences which they considered the Standards did not encompass sufficiently. The most commonly identified are below:

- Use of advocates.
- Safety of service user and service provider.
- Transitions and interfaces between care and support contexts.

4. Views on proposed Standard 1:

I experience high quality care and support that is right for me.

Background

The first four Standards are relevant to everyone. They are based on human rights and the wellbeing of people using services. The Standards set out what people should expect when using a care service and are intended to help them understand what high-quality care looks like. The Standards fit with other guidelines and professional codes of practice.

Question 3: To what extent do you think this Standard describes what people should expect to experience from health, care and social work services?

4.1 401 (91%) respondents to the full consultation and 59 (100%) respondents to the easy-read consultation answered this question.

4.2 Table 3 in Annex 1 shows views by category of respondent to the full consultation. Table 4.1 below summarises these views.

Table 4.1: Views on the extent to which Standard 1 describes what people should expect to experience from health, care and social work services: full consultation

View	No. of respondents	% of all respondents*
Strongly agree	186	46
Agree	173	43
Neither agree nor disagree	25	6
Disagree	17	4
Total respondents	**401**	**100**

*Percentages may not total 100% exactly due to rounding.

4.3 89% of those who provided a view strongly agreed or agreed that Standard 1 describes what people should expect to experience from health, care and social work services. Individual respondents expressed stronger support than organisations with 60% of the former, compared with 34% of the latter, strongly agreeing with the statement. Relatively few (4%) respondents disagreed.

4.4 Service users were amongst those most strongly supporting the statement with 66% of those responding to this question strongly agreeing that Standard 1 describes what people should expect to experience from health, care and social work services, compared with 46% strongly supporting the statement overall.

4.5 Views of those responding to the easy-read version of the consultation are summarised in Table 4.2.

Table 4.2: Views on the extent to which Standard 1 describes what people should expect to experience from health, care and social work services: easy-read consultation

View	No. of respondents	% of all respondents
Yes, agree with this standard	54	92
Agree a bit with this standard	5	8
No - disagree with this standard	0	0
Total respondents	**59**	**100**

4.6 All of the respondents who answered this question in the easy-read version of the consultation agreed a bit or agreed fully with Standard 1.

General views in favour of Standard 1

4.7 A few respondents expressed general views in support of Standard 1. The Standard was perceived to be thorough, comprehensive and detailed, whilst retaining clarity. The section on wellbeing was highlighted as particularly welcome; a few respondents identifying the statements for children in their early years as especially helpful. A small number of respondents praised what they perceived to be the focus on independent living.

Broad concerns about Standard 1

4.8 The meaning of the phrase “high quality” in the title of the Standard was considered to be subjective, with one respondent recommending deleting it from the title.

4.9 Four main concerns were raised about Standard 1:

- Standard 1 was seen to be aspirational rather than achievable and may raise unrealistic expectations. Not all of the statements were viewed as achievable in all settings (for example, secure accommodation).
- The Standard was considered by some to be too long, detailed and repetitive, with potential for editing and combining some of the statements.
- Some of the statements were viewed as being too specific and prescriptive.

- Some of the language was perceived to be too subjective (e.g. “warmth”; “if possible”), which may present challenges to measurement of achievement, and will be open to different interpretations.

Summary of comments relating to each descriptive statement

4.10 More detailed comments were made relating to individual, descriptive statements and are summarised in Annex 2, Table 1.

Views on omissions from the Standard

4.11 The main omissions suggested were:

- Greater distinction made between care at home and care in other settings.
- Rights and views of wider families and carers, often unpaid.
- More emphasis on being listened to and responded to.
- Greater emphasis on making the information required for informed decisions, easily accessible.
- Needs reference to effective collaboration between organisations and professionals to ensure high quality, integrated care and support.
- Reference should be made to privacy and confidentiality concerns throughout.
- Maintaining relationships and social connections should be included.
- Study support and school liaison references are missing.

5. Views on proposed Standard 2:

I am at the heart of decisions about my care and support

Question 4: To what extent do you think this Standard describes what people should expect to experience from health, care and social work services?

5.1 398 (90%) respondents to the full consultation and 56 (95%) respondents to the easy-read consultation answered this question.

5.2 Table 4 in Annex 1 shows views by category of respondent to the full consultation. Table 5.1 below summarises these views.

Table 5.1: Views on the extent to which Standard 2 describes what people should expect to experience from health, care and social work services: full consultation

View	No. of respondents	% of all respondents
Strongly agree	188	47
Agree	159	40
Neither agree nor disagree	34	9
Disagree	17	4
Total respondents	**398**	**100**

5.3 87% of those who provided a view strongly agreed or agreed that Standard 2 describes what people should expect to experience from health, care and social work services. Individual respondents expressed stronger support than organisations with 57% of the former, compared with 39% of the latter, strongly agreeing with the statement. Relatively few (4%) respondents disagreed.

5.4 Amongst the individual respondents, those working and volunteering in healthcare/social care supported the Standard most strongly, with 61% strongly agreeing that it describes what people should expect to experience. This compares with 42% of individual service users who strongly agreed.

5.5 Views of those responding to the easy-read version of the consultation are summarised in Table 5.2 overleaf.

Table 5.2: Views on the extent to which Standard 2 describes what people should expect to experience from health, care and social work services: easy-read consultation

View	No. of respondents	% of all respondents*
Yes, agree with this standard	50	89
Agree a bit with this standard	2	4
Mixed – some agree and some agree a bit (reflecting group views)	2	4
No - disagree with this standard	2	4
Total respondents	**56**	**100**

*Percentages may not total 100% exactly due to rounding.

5.6 All but 2 of the respondents who answered this question in the easy-read version of the consultation agreed a bit or agreed fully with Standard 2.

General views in favour of Standard 2

5.7 A few respondents expressed general views in support of Standard 2 in its entirety, or aspects of it. Healthcare and Health and Social Care Partnerships, in particular, considered the Standard to be comprehensive, written clearly, and fitting with the wider policy context, such as self-directed support, and outcome-focused models of commissioned care and support.

5.8 Aspects of the Standard which were especially welcomed by respondents included the focus on positive risk-taking; emphasis on play; involvement of family and friends; focus on communication; significance of service users' choice and control; and implied emphasis on empowerment.

5.9 A few respondents felt reassured that various communication needs had been encompassed by the Standard, in particular those of people who are deaf or have hearing loss.

Broad concerns about Standard 2

5.10 The title of the Standard attracted criticism from a few respondents across several different organisational sectors. They drew the distinction between "person- centred" and "person-led" decisions, with a shared view being that being "at the heart of decisions" does not necessarily mean being involved and participating in such decisions.

5.11 A repeated view across organisations and individuals was that contextual factors such as resources, physical structures of care settings, staffing ratios, and so on, will impact on the degree to which Standard 2 can be implemented and achieved.

5.12 Some respondents expressed concern that all of the statements will not apply to all settings. Prison and acute health care settings were mentioned in this context.

5.13 Various potential tensions were identified as arising from Standard 2, in particular balancing the needs of the individual against the needs of a wider group/community; balancing budgets with service provision; and balancing a person's wishes and their best interests if these are deemed to be different.

5.14 A few respondents commented that the detail contained in this Standard appeared to be overwhelming; one voluntary organisation suggested combining several of the statements to make the Standard more concise and easier to read (e.g. 2.10 and 2.11; 2.19 – 2.21).

5.15 A recurring view was that the language of the Standard was appropriate for professionals but not for some service users such as young people or people with dementia.

5.16 A few respondents expressed concern that issues of safeguarding were not clear in the Standard.

Summary of comments relating to each descriptive statement

5.17 More detailed comments were made relating to individual descriptive statements and are summarised in Annex 2, Table 2.

Views on omissions from the Standard

5.18 The main omissions suggested were:

- Reference to support plans.
- Mention of Attorney or Guardians.
- Mention of rights and responsibilities.
- Needs more emphasis on rights of adults with incapacity and the role of others where capacity varies over time (e.g. delirium).
- Mention of who the other significant people may be in a person's life and reassurance that their views will be sought and taken into account.
- More on healthcare settings. The Standard was perceived as more relevant to social care.
- Being realistic – for example, if the person's choice is novel, untested and is an alternative treatment, then other considerations may come into play.

6. Views on proposed Standard 3:

I am confident in the people who support and care for me

Question 5: To what extent do you think this Standard describes what people should expect to experience from health, care and social work services?

6.1 389 (88%) respondents to the full consultation and 56 (95%) respondents to the easy-read consultation answered this question.

6.2 Table 5 in Annex 1 shows views by category of respondent to the full consultation. Table 6.1 below summarises these views.

Table 6.1: Views on the extent to which Standard 3 describes what people should expect to experience from health, care and social work services: full consultation

View	No. of respondents	% of all respondents*
Strongly agree	179	46
Agree	170	44
Neither agree nor disagree	26	7
Disagree	14	4
Total respondents	**389**	**100**

*Percentages may not total 100% exactly due to rounding.

6.3 90% of those who provided a view strongly agreed or agreed that Standard 3 describes what people should expect to experience from health, care and social work services. Individual respondents expressed stronger support than organisations with 55% of the former, compared with 38% of the latter, strongly agreeing with the statement. Relatively few (4%) respondents disagreed.

6.4 Views of those responding to the easy-read version of the consultation are summarised in Table 6.2 overleaf.

6.5 All but 2 of the respondents who answered this question in the easy-read version of the consultation agreed a bit or agreed fully with Standard 3.

Table 6.2: Views on the extent to which Standard 3 describes what people should expect to experience from health, care and social work services: easy-read consultation

View	No. of respondents	% of all respondents
Yes, agree with this standard	50	89
Agree a bit with this standard	3	5
Mixed – some agree and some agree a bit (reflecting group views)	1	2
No - disagree with this standard	2	4
Total respondents	**56**	**100**

General views in favour of Standard 3

6.6 There were many favourable comments about Standard 3 as a whole and key elements within. What was perceived as the person-centred approach was welcomed; the emphasis on communication and relationships was valued; links with a wider context of guidance and legislation were identified.

6.7 The layout of the section was viewed as helpful to providers, with a few respondents praising what they perceived to be well-worded statements.

6.8 The Standard was seen to provide reassurance about provision for those most vulnerable both in its title, and also under sections such as “Compassion”.

Broad concerns about Standard 3

6.9 In contrast to those who welcomed the title, a few respondents considered it to be vague and lacking in meaning. One service user commented that confidence is something which has to be earned over time and may vary, therefore it cannot be presented as a discrete given. Others suggested that the word “trust” be incorporated into the heading to give it more rigour.

6.10 A common view was that the aims of the Standard are laudable but require resourcing and appear difficult to ensure and enforce.

6.11 Concerns over vague language were expressed repeatedly by organisations and individuals working in the sectors, with phrases and words such as, “courteous and respectful”, “consistent boundaries”, “warmth”, “helped to feel content” attracting particular criticism.

6.12 An emerging theme, particularly amongst those working in health and social care, was that delivery of this Standard should be underpinned by a robust framework of training for paid and unpaid workers. The Standard was viewed as assuming that workers have professional knowledge, which respondents suggested may not be the case, and which could be addressed through access to appropriate training and career development.

6.13 Many respondents queried how aspects of the Standard would be measured and assessed, with examples requested.

6.14 A recurring view was that some of the statements may raise expectations unduly, as restrictions on resources and other practicalities will limit delivery of some aspects.

6.15 Some respondents requested that issues of communication be re-visited in the Standard against the background of the workforce including many workers for whom English is not their first language, and the severe communication challenges experienced by some service users.

6.16 Whilst many considered that this Standard in particular was relevant across many settings, those respondents representing secure care including prisons, felt that some of the statements were not appropriate for them.

6.17 A question was raised over whether childminders' issues are reflected best by Standard 3 (as they work by themselves), or Standard 4 (as they themselves may be the organisation).

Summary of comments relating to each descriptive statement

6.18 More detailed comments were made relating to individual descriptive statements and are summarised in Annex 2, Table 3.

Views on omissions from the Standard

6.19 The main omissions suggested were:

- Knowledge of feedback/complaint mechanisms. Although covered elsewhere, these should be referenced here.
- Right of patient appeal.
- Statutory right to advocacy.
- Issues of safer recruitment.
- Separation of issues for regular users of care from those of occasional users of care.
- Support at transitions. For example, "I am supported in ways that are going to help me prepare for change that occurs in my life".
- Explicit reassurances regarding confidentiality of data and protocols for sharing this.
- Statement relating to respecting language and cultural preferences.

7. Views on proposed Standard 4:

I am confident in the organisation providing my care and support

Question 6: To what extent do you think this Standard describes what people should expect to experience from health, care and social work services?

7.1 398 (90%) respondents to the full consultation and 55 (93%) respondents to the easy-read consultation answered this question.

7.2 Table 6 in Annex 1 shows views by category of respondent to the full consultation. Table 7.1 below summarises these views.

Table 7.1: Views on the extent to which Standard 4 describes what people should expect to experience from health, care and social work services: full consultation

View	No. of respondents	% of all respondents
Strongly agree	164	41
Agree	182	46
Neither agree nor disagree	32	8
Disagree	20	5
Total respondents	**398**	**100**

7.3 87% of those who provided a view strongly agreed or agreed that Standard 4 describes what people should expect to experience from health, care and social work services. Individual respondents expressed stronger support than organisations with 52% of the former, compared with 32% of the latter, strongly agreeing with the statement. Relatively few (5%) respondents disagreed.

7.4 Views of those responding to the easy-read version of the consultation are summarised in Table 7.2 overleaf.

7.5 All but one of the respondents who answered this question in the easy-read version of the consultation agreed a bit or agreed fully with Standard 4.

Table 7.2: Views on the extent to which Standard 4 describes what people should expect to experience from health, care and social work services: easy-read consultation

View	No. of respondents	% of all respondents*
Yes, agree with this standard	46	84
Agree a bit with this standard	8	15
No - disagree with this standard	1	2
Total respondents	**55**	**100**

*Percentages may not total 100% exactly due to rounding.

General views in favour of Standard 4

7.6 There were a few general comments in favour of Standard 4. This was viewed as well written, comprehensive, aligned with patient-centred care, and focused on human rights and participation. A few respondents welcomed in particular what they considered was the emphasis on organisational improvement and development.

7.7 A number of statements were singled out for particular praise: 4.7 on involvement in recruiting and training, and 4.16 on making a complaint or raising a concern were notable amongst these.

Broad concerns about Standard 4

7.8 A number of broad concerns emerged repeatedly. Respondents from a range of sectors queried how achievement of the Standard would be measured, evidenced and enforced. Some questioned whether service users, particularly children would know if this Standard was being met. A repeated view was that people may not know if their human rights are being respected if they are not educated on what these are.

7.9 Several respondents suggested that for children, trust is more relevant than confidence in the organisation. A few recommended that a separate section is created within this Standard for early years.

7.10 A recurring view was that the statements were not generally applicable across all settings, with hospitals and prisons highlighted as examples. Some questioned where foster carers or legal guardians fitted within the Standard.

7.11 Many respondents identified what they perceived to be repetitive aspects of statements, with suggestions for combining or removing statements. For example, 4.2, 4.16 and 4.17 were all viewed as referring to complaints.

Summary of comments relating to each descriptive statement

7.12 More detailed comments were made relating to individual descriptive statements and are summarised in Annex 2, Table 4.

Views on omissions from the Standard

7.13 The main omissions suggested were:

- Reference to integrated services, for example, “My health and social care service is well integrated, resulting in my health and social care needs being met properly and in a way that promotes my human rights and access to the best appropriate services in a timely way”.
- Rights and responsibilities of both service user and organisation.
- More emphasis on organisations being confident in providing care according to effective quality assurance procedures.
- Reference to continuous improvement.
- Carers should be referred to throughout, e.g. “me and my carer”; “me or my carer”.
- Should be reassurances regarding confidentiality of personal health information.
- Self-directed support.
- Communication support; inclusive communication; accessible formats for complaints/support plans and so on.
- Recognition that some support is informal, for example, provided by family members.
- Need to link throughout to relevant Codes of Practice.

8. Views on proposed Standard 5:

And if the organisation also provides the premises I use.

Background

The first four Standards are relevant to everyone. It is proposed that these are complemented by three additional Standards that apply only in specific circumstances. For example, if a young person is looked after by the local authority and living in a residential unit, then Standards 1 – 4 will be complemented by Standards 5 and 7. Or, if an adult is accommodated and receiving compulsory treatment under the Mental Health (Care and Treatment) (Scotland) Act 2003, then Standards 5 and 6 apply as well as Standards 1 – 4.

Question 7: To what extent do you think this Standard describes what people should expect to experience from health, care and social work services?

8.1 376 (85%) respondents to the full consultation and 51 (86%) respondents to the easy-read consultation answered this question.

8.2 Table 7 in Annex 1 shows views by category of respondent to the full consultation. Table 8.1 below summarises these views.

Table 8.1: Views on the extent to which Standard 5 describes what people should expect to experience from health, care and social work services: full consultation

View	No. of respondents	% of all respondents
Strongly agree	143	38
Agree	161	43
Neither agree nor disagree	56	15
Disagree	16	4
Total respondents	**376**	**100**

8.3 81% of those who provided a view strongly agreed or agreed that Standard 5 describes what people should expect to experience from health, care and social work services. Individual respondents expressed stronger support than

organisations with 49% of the former, compared with 28% of the latter, strongly agreeing with the statement. Relatively few (4%) respondents disagreed.

8.4 Views of those responding to the easy-read version of the consultation are summarised in Table 8.2.

Table 8.2: Views on the extent to which Standard 5 describes what people should expect to experience from health, care and social work services: easy-read consultation

View	No. of respondents	% of all respondents
Yes, agree with this standard	46	90
Mixed – some agree and some agree a bit (reflecting group views)	3	6
Agree a bit with this standard	1	2
No - disagree with this standard	1	2
Total respondents	**51**	**100**

8.5 All but one respondent who answered this question in the easy-read version of the consultation agreed a bit or agreed fully with Standard 5.

General views in favour of Standard 5

8.6 A few respondents expressed general views in support of Standard 5. The Standard was perceived to be thorough and comprehensive, whilst retaining clarity. The section on compassion was highlighted as particularly welcome, as was the descriptive statement 5.14 on access to the internet.

Broad concerns about Standard 5

8.7 Four main concerns were raised:

- Standard 5 appears to be more aspirational than practical. A recurring view was that some well-run organisations may, through no fault of their own, be unable to meet all of the outcomes. A few respondents commented that the Standard set very good care homes up to fail. Concerns were raised that the Standard may raise expectations which cannot be met.
- The outcome heading appears to be unfinished and unclear.
- What is meant by “premises”? Questions were raised over whether settings such as foster care and school accommodation on the mainland for islanders boarding through the week, would be included under “premises”.
- The Standard appears to be subjective in places and not wholly measurable. For example, words like, “homely” and “attractive” were viewed as challenging to measure objectively.

8.8 Other concerns, less frequently mentioned, included the perception that the Standard focused too much on care homes as opposed to other settings; that not all of the Standard will apply to all settings; and that structuring the Standard around the principles appears forced in places. In particular, the descriptive statements under the "Compassion" principle were viewed as not entirely relevant to perceptions of compassion.

Summary of comments relating to each descriptive statement

8.9 More detailed comments were made relating to individual descriptive statements and are summarised in Annex 2, Table 5.

Views on omissions from the Standard

8.10 The main omissions suggested were:

- More detail required on outdoor space, including the quality of the greenery; food growing environment; smoke-free environment; garden; accessibility; safe paths.
- Smoke-free, drugs and alcohol policies and culture should be outlined.
- The Standard should make more specific reference to early years' settings to make it more relevant to this sector.
- There should be more on noise control and access to quiet areas. Noise from television was highlighted as a particular issue in some settings.
- Reception areas should be mentioned, as the maintenance and appearance of these is important for setting the tone and culture.
- Add something about being kept safe from violence and unwelcome attention from others in the setting.
- There should be more emphasis on technological advances which enable independent living: hearing loops; flashing alarms; door entry; tele-healthcare.

9. Views on proposed Standard 6:

And where my liberty is restricted by law.

Question 8: To what extent do you think this Standard describes what people should expect to experience from health, care and social work services?

9.1 373 (85%) respondents to the full consultation and 47 (80%) respondents to the easy-read consultation answered this question.

9.2 Table 8 in Annex 1 shows views by category of respondent to the full consultation. Table 9.1 below summarises these views.

Table 9.1: Views on the extent to which Standard 6 describes what people should expect to experience from health, care and social work services: full consultation

View	No. of respondents	% of all respondents*
Strongly agree	136	36
Agree	153	41
Neither agree nor disagree	65	17
Disagree	19	5
Total respondents	**373**	**100**

*Percentages may not total 100% exactly due to rounding.

9.3 77% of those who provided a view strongly agreed or agreed that Standard 6 describes what people should expect to experience from health, care and social work services. Individual respondents expressed stronger support than organisations with 36% of the former, compared with 28% of the latter, strongly agreeing with the statement. Relatively few (5%) respondents disagreed.

9.4 All of the Early Years and Childcare Services respondents who expressed a view strongly agreed or agreed that Standard 6 describes what people should expect to experience from health, are and social work services; the two statutory bodies who provided a view disagreed. Other categories of respondent were more mixed in views.

9.5 Views of those responding to the easy-read version of the consultation are summarised in Table 9.2 overleaf.

Table 9.2: Views on the extent to which Standard 6 describes what people should expect to experience from health, care and social work services: easy-read consultation

View	No. of respondents	% of all respondents
Yes, agree with this standard	42	89
Mixed – some agree; some agree a bit; some disagree (reflecting group views)	1	2
Agree a bit with this standard	4	9
No - disagree with this standard	0	0
Total respondents	**47**	**100**

9.6 All but one respondent who answered this question in the easy-read version of the consultation agreed a bit or agreed fully with Standard 5.

General views in favour of Standard 6

9.7 A few respondents expressed general views in support of Standard 6. What was perceived to be its strong focus on human rights was particularly welcomed as a basis for assisting in balancing issues of risks, whilst ensuring individual rights are respected.

9.8 Respondents considered that the Standard captured the role which restrictions play in ensuring security and wellbeing of the individual, underpinned by compassion, dignity and respect.

Broad concerns about Standard 6

9.9 The most common concern regarding Standard 6 was over the words “by law” in the Standard heading. A recurring view was that the Standard should apply to settings where liberty is restricted but not only on account of law, but due to other factors, such as safety and security of the individual. Respondents considered that the current wording is too narrow in focus, and should be amended to ensure wider applicability to settings such as mental health secure facilities. Alternative wording was suggested such as “And where my independence, choice or control is restricted”, or simply, “And where my liberty is restricted”.

9.10 Questions were raised over why this Standard does not include one of the key Principles, “Responsive care and support”, with respondents suggesting that the reason for this should be made explicit.

9.11 There were some mixed views on whether the Standard should be separate, as a stand-alone, or mainstreamed into the other Standards. A key argument in favour of mainstreaming was that human rights should underpin all care provision rather than be associated only with settings where liberty is restricted by law.

Others, however, welcomed the prominence given to human rights issues in a dedicated Standard.

9.12 A few respondents expressed concern that the Standard did not appear to reference wider, relevant legislative contexts such as mental health legislation, and requested reassurance of compatibility and alignment.

9.13 A recurring theme was that the Standard merited more discussion, consultation and detail to give it greater depth and relevance.

Summary of comments relating to each descriptive statement

9.14 More detailed comments were made relating to individual descriptive statements and are summarised in Annex 2, Table 6.

Views on omissions from the Standard

9.15 The main omissions suggested were:

- Explicit reference to recording and reviewing actions taken in the context of deploying restraint and sanctions.
- Right to independent advocacy.
- Right to access healthcare such as specialist dental care; optician.
- Rights of staff to be protected from harm.
- Requirements of staff to be fully aware of the law and understand the circumstances in which restraint is valid.
- Clarity on whether the Standard applies equally to children, young people, and older adults.
- How to deal with conflict in views and consent amongst family/individual/care providers.
- Providing for transitions between restricted liberty and liberty. Joined-up care.
- Maintaining and building relationships with family, friends and the wider community.
- In the specific context of restricted liberty, ensuring that communications' challenges are addressed and support is provided (e.g. deaf prisoners; people whose first language is not English).

10. Views on proposed Standard 7:

And if I am a child or young person needing social work care and support

Question 9: To what extent do you think this Standard describes what people should expect to experience from health, care and social work services?

10.1 361 (82%) respondents to the full consultation and 28 (47%) respondents to the easy-read consultation answered this question.

10.2 Table 9 in Annex 1 shows views by category of respondent to the full consultation. Table 10.1 below summarises these views.

Table 10.1: Views on the extent to which Standard 7 describes what people should expect to experience from health, care and social work services: full consultation

View	No. of respondents	% of all respondents*
Strongly agree	143	40
Agree	145	40
Neither agree nor disagree	56	16
Disagree	17	5
Total respondents	**361**	**100**

*Percentages may not total 100% exactly due to rounding.

10.3 80% of those who provided a view strongly agreed or agreed that Standard 7 describes what people should expect to experience from health, care and social work services. Individual respondents expressed stronger support than organisations with 47% of the former, compared with 33% of the latter, strongly agreeing with the statement. Relatively few (5%) respondents disagreed.

10.4 Voluntary sector respondents displayed a slightly different pattern of response to others, with a greater percentage (23%) neither agreeing nor disagreeing with the Standard.

10.5 Views of those responding to the easy-read version of the consultation are summarised in Table 10.2 overleaf.

Table 10.2: Views on the extent to which Standard 7 describes what people should expect to experience from health, care and social work services: easy-read consultation

View	No. of respondents	% of all respondents*
Yes, agree with this standard	23	82
Agree a bit with this standard	4	14
No - disagree with this standard	1	4
Total respondents	**28**	**100**

*Percentages may not total 100% exactly due to rounding.

10.6 All but one respondent who answered this question in the easy-read version of the consultation agreed a bit or agreed fully with Standard 7.

General views in favour of Standard 7

10.7 A few respondents expressed general views in support of Standard 7, two perceiving it to be a "priority" standard and the most important of all. The Standard was viewed as being appropriate, comprehensive, yet proportionate.

10.8 Some considered that the Standard was in-keeping with GIRFEC and other relevant guidance, and built upon these.

10.9 The language of the Standard was perceived to be positive and reflective of high expectations.

Broad concerns about Standard 7

10.10 Many respondents from a range of sectors questioned whether this Standard merited being stand-alone. A recurring view was that several of the statements were not specific to children and young people, and were equally applicable across all ages and demographics.

10.11 A common theme was that this Standard was out-of-step with earlier Standards which were universal, whereas this Standard purported to be sector-specific. Some respondents felt that the Standard should apply across settings broader than just social work, for example, school care accommodation.

10.12 Several respondents considered that Standard 7 duplicated elements of previous Standards. It was suggested that much of its content could be covered within other Standards, with the remainder addressed in relevant guidance and legislation.

10.13 One Health and Social Care Partnership expressed concern that presenting a dedicated Standard for children and young people may result in readers skipping to this Standard without referencing the relevant aspects of the previous Standards which apply also to children and young people.

10.14 The heading of the Standard attracted criticism as appearing to be unfinished, not a Standard, and omitting mention of health. It was suggested that "a baby" be inserted before "a child".

10.15 A general comment was made by several respondents that the terminology at times appeared subjective. The use of the word "normal" and the phrase, "a place that feels like a home" attracted most attention in this regard. Two organisations who represented the views of young people, suggested that the language was overly complex in places.

10.16 A few respondents voiced their concern that achievement of the Standard would be highly challenging due to decisions being made by those other than service providers, which may impact on attainment.

10.17 One respondent highlighted the existing "Health Care Standards for Children and Young People in Secure Settings" (2013) and queried why these have not been used as a template for the proposed Standard.

Summary of comments relating to each descriptive statement

10.18 More detailed comments were made relating to individual descriptive statements and are summarised in Annex 2, Table 7.

Views on omissions from the Standard

10.19 The main omissions suggested were:

- Mention of Corporate Parenting.
- Explicit alignment with relevant legislation and guidance, e.g. Children and Young People (Scotland) Act 2014; SHANARRI indicators; United Nations Convention on the Rights of the Child (UNCRC).
- Children with disability and/or additional support needs.
- Mention of support to develop a healthy lifestyle including access to smoke-free, outdoor space.
- Mention of listening to children's and young peoples' voices and ensuring their choices are taken into account in decisions affecting them.
- Support through transitions, e.g. to independent living; first tenancy.
- Role of key worker, or named person.

11. General views on the new Standards

Question 10: To what extent do you agree these new Standards will help support improvement in care services?

11.1 395 (90%) respondents to the full consultation and 56 (95%) respondents to the easy-read consultation answered this question.

11.2 Table 10 in Annex 1 shows views by category of respondent to the full consultation. Table 11.1 below summarises these views.

Table 11.1: Views on the extent to which respondents agreed that the new Standards will help support improvement in care services

View	No. of respondents	% of all respondents
Strongly agree	126	32
Agree	169	43
Neither agree nor disagree	73	18
Disagree	27	7
Total respondents	**395**	**100**

11.3 75% of those who provided a view strongly agreed or agreed that the new Standards will help to support improvement in care services. Individual respondents expressed stronger support than organisations with 40% of the former, compared with 26% of the latter, strongly agreeing. Relatively few (7%) respondents disagreed.

11.4 Amongst those individuals working/volunteering in the health or social care sectors 85% of those providing a view strongly agreed or agreed that the new Standards will help to support improvement in care services.

11.5 Views of those responding to the easy-read version of the consultation are summarised in Table 11.2 overleaf.

Table 11.2: Views on whether the new Standards will help support improvement in care services

View	No. of respondents	% of all respondents
Yes, agree that the Standards will help to make care services better	44	79
Mixed – some agree and some agree a bit (reflecting group views)	1	2
Agree a bit	8	14
No - disagree that the Standards will help to make care services better	3	5
Total respondents	**56**	**100**

11.6 All but three of the respondents who answered this question in the easy-read version of the consultation agreed a bit or agreed fully that the Standards will help support improvement in care services.

Views on why the Standards will help to support improvement

11.7 Many respondents were specific about why they considered that the Standards will help to support improvement in care services. The three most common reasons given were:

- The Standards are easy to understand; user-friendly; accessible; self-explanatory; clear and concise.
- They provide a common understanding and framework which ensures shared expectations and will promote consistency of provision.
- The rights-based approach helps providers and service users to understand what is required.

11.8 Other reasons were given less frequently:

- Person-centred.
- Comprehensive/holistic.
- The Standards link with wider Codes of Practice and guidance.
- They provide a robust benchmark across settings.
- The Standards promote empowerment and independence amongst the workforce and service users.
- They provide a clear vision, particularly important for non-regulated services.
- Outcome-focused.
- Up-to-date and relevant.

11.9 Many respondents remarked that although they considered that the Standards will help to support improvement, the wider context in which they operate will impact on their effectiveness. Limited resourcing was identified as a key contextual factor in this regard.

Views on how the effectiveness of the Standards can be enhanced

11.10 Several respondents proposed ways in which the Standards could be supported to enhance their effectiveness. The most common proposal was for practice-based guidance to help providers implement the Standards within their own setting. Some respondents suggested that examples of good practice be given, demonstrating how they could be applied in practice. It was considered that these would be particularly helpful for non-regulated services:

> "We found the previous guidance on how we can evidence meeting the standards and the good examples of evidence on the self-evaluation – "how you can do this" examples very helpful and wondered if there were any plans to develop anything like this to accompany the new standards. We also think this would help with consistency and standardisation regarding individual inspectors and their expectations." (Health and Care Partnership)

11.11 Another common suggestion was for a clear inspection framework to be developed to ensure providers and inspectors have a common understanding of expected competencies and delivery outcomes.

11.12 Other proposals were made by a few respondents:

- The Standards should be supported with a robust feedback system for service users and workforce, with staff empowered to challenge provision not meeting the Standards.
- Should be supported with an appeals process.
- Needs an extended glossary.
- Needs to be supported with a communication policy for people with communication barriers.

Views on risks to the success of the Standards

11.13 Whilst there was much support for the Standards, many respondents highlighted what they considered were threats to their successful operation. Most frequently mentioned was that the view that the Standards may be too broad, creating ambiguity and resulting in different interpretations by service providers and service users.

11.14 Another commonly mentioned risk, again associated with the broad scope of the Standards, was that applying all aspects of the Standards, in all settings, will be challenging.

11.15 The Standards were viewed by some as overly aspirational in nature, which they considered could undermine and weaken their potential, whilst also raising expectations which cannot be fulfilled.

11.16 A few respondents felt that the Standards risked becoming overwhelming and confusing, and suggested that there could be scope for rationalising.

11.17 A few respondents considered that achievement of the Standards may prove difficult to measure, and raised as a risk a lack of consistency in inspection.

Views on why the Standards will not support improvement

11.18 A few respondents specified why they considered that the Standards, as drafted, will not help to support improvement in care services. The key reasons given were:

- The Standards are too vague to be measurable or enforceable and will most likely be side-lined.
- One size does not fit all and will result in a "poor fit" for some settings and circumstances.
- There is too much scope for different interpretations which will lead to inconsistencies.
- There is no review framework, no provision for reflecting, feeding back and revising the Standards.

Views on factors which may influence the degree of success of the Standards

11.19 Many respondents considered that the success of the Standards depended on many factors, with the most frequently mentioned being:

- Adequate resourcing by Scottish Government.
- Effective launch and implementation strategy which is structured and co-ordinated.
- Robust inspectorate and enforcement regimes which are sensitive to different provider settings and take account of the commissioning and procurement activities and the role these play in service delivery and service user experience.

11.20 Less frequently mentioned factors were:

- Accessible and appropriate training opportunities for the workforce on the new Standards.
- Awareness-raising activities for workforce, particularly front-line staff, and service users.
- Proportionate approaches to evaluation which take cognisance of the setting and are not overly bureaucratic.
- Universal commitment to embracing the Standards and embedding them within different settings.

- Culture change in which priority is given to the business of caring within society, from policy-makers to the general public.
- Transparent and honest review mechanisms with a timescale for review and updating.

12. Anything else?

Question 11: Is there anything else you think needs to be included in the Standards?

12.1 349 (79%) respondents to the full consultation answered this question.

12.2 Table 11 in Annex 1 shows views by category of respondent to the full consultation. Table 12.1 below summarises these views.

Table 12.1: Views on whether there is anything else that needs to be included in the Standards

View	No. of respondents	% of all respondents
Yes	119	34
No	230	66
Total respondents	**349**	**100**

12.3 Around one-third (34%) respondents to the full consultation considered that there is something else which should be included in the Standards. Overall, a greater proportion of organisations (39%) than individuals (28%) were of this view. Amongst the organisations, over half of professional representative bodies, local authorities, and healthcare respondents considered that something else should be included.

Views on additional content for the Standards

12.4 A wide variety of suggestions were made for additional content, in addition to many respondents simply referring to comments provided in relation to previous questions. The following suggestions were made by at least three respondents and are listed from most to least frequently raised:

- Feedback/complaints/appeal mechanisms for service users and for workforce.
- End of life care; anticipatory care planning; advanced statements.
- Management of transitions.
- Right to advocacy; recognition of representatives formal and informal.
- Operational details which were present in previous Standards, such as staff ratios; minimum accommodation standards.
- Recognition of the role of wider families; family approaches.
- Links with wider guidance and legislation such as the autism strategy.
- Recognition of social and personal relationships and social opportunities.
- Supportive learning environments; educational needs; school liaison.

- Recognition of carer involvement.
- Evaluative frameworks; review framework.
- Responsibilities of service users/rights of staff and providers.
- Examples of good practice.
- Training; professional knowledge; relevant qualifications.
- Assessing care needs; involvement of service user in designing their care package; choice in care.

Views emerging from respondents to the easy-read consultation

12.5 Very few respondents to the easy-read version of the consultation suggested any further content. The following topics were key amongst the few suggestions made:

- Easy read version of the new Standards.
- Awareness-raising of the new Standards.
- Feedback/complaints procedures.
- Enforcing/policing the application of the Standards.
- Accessibility of services.
- Accessibility of internet services for personal use.
- Training of staff.

Question 12: Is there anything else you think we need to be aware of in the implementation of the Standards that is not already covered?

12.6 Responses to this question varied widely from those re-iterating views provided in response to previous questions, those not relevant to implementation, and those relating to issues of planning and executing implementation of the Standards. Views in relation to implementation are reported below.

12.7 The most frequently emerging view was that the current inspection regimes will require updating to reflect the new Standards, and the new inspection regimes communicated to providers and commissioners in good time before implementation. A few respondents suggested that the issue of updating the inspection regimes be put out to consultation; some considered that revised regimes should be piloted before finalising.

12.8 Another recurring suggestion was that the finalised Standards should be made widely available and accessible in a variety of formats prior to implementation. Easy-read and pictorial versions were advocated and user-friendly guides suggested to meet the needs of relatives, as well as the service user, and those with communication difficulties.

12.9 Many respondents considered that a large-scale awareness campaign should support implementation. Public events and promotion via a range of media were envisaged. It was suggested that awareness-raising will be required amongst the public in addition to the workforce.

12.10 A common view was that effective implementation will require appropriate financial resourcing.

12.11 Several respondents considered that a short-term implementation group should be established to plan, test, and oversee the implementation of the new Standards. Some suggested supporting implementation with written guidance on issues such as legislative context and inspection regimes. Some proposed that membership of the group should include public representation, officials from both health and social care, and people with disabilities.

12.12 A recurring theme was that effective implementation will need time to plan and execute. A realistic timetable was called for which takes into account sufficient lead-in and review times.

12.13 The need for workforce planning was raised by several respondents in relation to implementing the new Standards. Both resourcing and training the workforce were identified as part of robust planning for implementation, with time allocated for developing new training materials and formal education on topics such as rights-based approaches.

12.14 A few respondents suggested that the training of regulators and inspectors should be part of the planning for implementation. A repeated view was that these scrutineers will need time to familiarise themselves with the various care settings encompassed by the Standards, and consider how the Standards will apply accordingly.

12.15 The need to have a robust feedback/complaints regime in place from implementation was raised by a few respondents.

13. What should the new Standards be called?

Question 13: What should the new Standards be called?

13.1 404 (92%) respondents to the full consultation answered this question as did 52 (88%) of respondents to the easy-read version.

13.2 The question posed five different options for names for the new Standards but also invited further proposals for names. Table 13.1 summarises the opinions of the 400 respondents who indicated a preference for one of the options suggested.

Table 13.1: Views on what the new Standards should be called

Proposed name	Full		Easy Read		Total*	
	No.	%	No.	%	No.	%
National Care Standards	86	24	6	12	92	23
National Health and Social Care Standards	147	42	7	14	154	38
National Healthcare and Social Care Standards	36	10	11	22	47	12
National Care and Health Standards	21	6	5	10	26	6
National Care and Support Standards	61	17	20	41	81	20
Total respondents	**351**	**100**	**49**	**100**	**400**	**100**

*Percentages may not total 100% exactly due to rounding.

13.3 Overall, the proposed name receiving most support was "**National Health and Social Care Standards**", with 38% of those who provided a view preferring this over the other options. Just under one quarter (23%) of respondents preferred the status quo of "National Care Standards".

13.4 Preferences of those responding to the full consultation differed from those of respondents to the easy read version. Amongst respondents to the full consultation the name receiving most support (42% of respondents) was "National Health and Social Care Standards"; the name receiving most support amongst the respondents to the easy-read version (41% of those responding) was "National Care and Support Standards".

13.5 Amongst the respondents to the full consultation, those from the early years and childcare sector were also prominent amongst supporters of the name, "National Care and Support Standards", with 36% of those who provided a view in favour of this term.

Suggestions for other names for the new Standards

13.6 Numerous suggestions were made from respondents to both versions of the consultation for alternative names for the new Standards. The main themes emerging from the suggestions were:

- Need to include “Scotland” or “Scottish” in the name to show they are not UK-wide.
- Reflect the person-centred approach by naming them, “People’s Standards..”; or “My Standards…”; or “People first Standards”.
- Include a strapline then a title, for example, “Raising Expectations, Raising Standards” followed by “National Care Standards” or another title.

14. Any other comments or suggestions

Question 14: Any other comments, suggestions.

14.1 The final consultation question invited any further comments or suggestions. Many respondents took the opportunity to reiterate their main points already made in relation to previous questions. Some provided background information on their organisation. Several described how they had consulted across their organisation in preparing their response, demonstrating a wide engagement over and above the 499 responses submitted.

14.2 Amongst the responses to the full consultation and the easy-read version, emerged a number of broad themes, outlined below.

Support for the Standards

14.3 There was considerable support for the Standards as drafted and an appreciation of what was viewed as the thorough and thoughtful development work which had led to this stage.

14.4 The Standards were perceived to be a potential tool for partnership working, underpinned by a shared understanding between partners of expectations of provision. They were seen as helping to highlight where services need to join and work together for the benefit of service users. One respondent commented that the Standards provided a reference point for continual improvement.

Views on further refinements

14.5 The Standards were viewed by some respondents as requiring further editing to make them shorter and more streamlined. They were perceived to be overwhelming in detail in places, which some felt was off-putting.

14.6 A small number of respondents considered that some of the statements could appear patronising; one respondent suggested that the text be proofed for potentially discriminatory language.

14.7 A few respondents highlighted what they perceived to be inconsistencies in the Standards. These included:

- Broad statements along with relatively prescriptive statements.
- Mix of “hard” and “soft” aims.
- Focus alternating between outcomes and processes.
- “Jargonise” mixed with “easy-read” text.
- Lengthy statements mixed with concise, short statements.
- Mix of what were perceived to be minimum Standards with aspirational Standards.
- Word “care” used inconsistently, sometimes with “health”, sometimes with “social” and sometimes by itself.

14.8 Respondents emphasised the need for definitions in the Standards to be consistent with those used in related contexts, with the term “early years” highlighted most frequently in this regard. Suggestions were made for the glossary to include definitions of “person-centred”, “wellbeing”, “transitions” and “compassion”.

Views on linking with broader contexts

14.9 A few respondents emphasised the need for the Standards to acknowledge broader, related contexts which may have their own regulator and prioritites. An example was provided of pharmacists who have their own new Standards and a different regulator.

14.10 One respondent highlighted the need for those working in related areas to recognise that the new Standards are relevant to them. The example given was forensic medical examinations for victims of sexual assault which may be done in police or other multi-agency premises, and at which healthcare professionals and others must recognise that the Standards are applicable.

14.11 Many respondents identified related guidance and legislation which they considered should be referenced explicitly in the Standards: Excellence in Care; Quality of Care Reviews; Quality Assurance programmes; health and safety legislation and risks; Carers (Scotland) Act to be implemented in 2018; Patient Rights (Scotland) Act 2011; and the current review of health and social care targets and indicators.

14.12 A recurring theme was that implementing the Standards should be assessed against the backcloth of limited resourcing and different financial priorities across different regions.

Views on balances and tensions

14.13 There were contrasting views on the universal approach adopted by the Standards. Whilst a few respondents welcomed this as simple and comprehensive, others considered that this was too broad-brush and masked the complexities of the “diverse landscape” of health and social care provision.

14.14 Several respondents remarked on the balance of focus on health care and social care in the Standards, with a recurring view that they appear weighted towards social care. A few respondents suggested that the Standards should be aligned with the Health and Social Care Delivery Plan (Dec 2016).

14.15 Views emerging from a few of the engagement events were that there may be some conflict of interest between professional guidance and the Standards. The example of infection control vs child protection was given. Questions were raised over how the Standards would fit with various Codes of Practice.

14.16 One respondent considered that the Standards were a mix of Guidelines and Standards, and sought clarity on this.

Incapacity issues

14.17 The person-centred approach, and in particular the drafting of the Standards in the first person, led a few respondents to suggest that a key gap in the Standards is reference to supported decision-making for people with dementia, incapacity, and those with learning disabilities.

14.18 A related issue was raised by one respondent from the voluntary sector, who suggested that gathering evidence to demonstrate compliance with the Standards may be affected by individuals' capacity and the various safeguarding issues that surround them.

Moving forward

14.19 A common view was that the Standards are generally applicable, but will need to be implemented in a meaningful and systematic way to ensure effectiveness. Effective implementation was viewed as including high quality commissioning, high quality monitoring of provision, and robust inspection approaches.

14.20 Several respondents raised issues of future inspection of services and provision, with recurring views being that inspectors will need to update their training and methods to accommodate the new Standards and their universal approach; there will need to be a process for agreeing which Standards are relevant to which service; and some Standards will need further description to make them measurable.

14.21 Many respondents emphasised the need for thorough preparation before the launch of the new Standards. The challenges ahead were acknowledged with requests made for an adequate lead-in period and robust implementation strategy.

14.22 A recurring view was that the Standards need to be accessible and "portable". Different formats were envisaged to enable inclusive access, along with the development of appropriate educational resources to underpin and support implementation.

Annex 1: Quantitative tables relating to each question or Standard.

Table 1

Question 1: To what extent do you think the Standards will be relevant and can be applied across all health, care and social work settings?

Category of Respondent	Strongly Agree		Agree		Neither agree nor disagree		Disagree		Total*	
	No.	%	No.	%	No.	%	No.	%	No.	%
Voluntary Sector	19	25	32	42	14	18	12	16	77	100
Early Years and Childcare Services (Pre-5 focus)	6	26	15	65	0	0	2	9	23	100
Private Sector	6	26	12	52	2	9	3	13	23	100
Professional Representative Bodies	2	11	9	50	7	39	0	0	18	100
Engagement Events	1	9	10	91	0	0	0	0	11	100
Health and Social Care Partnership Bodies	4	29	9	64	1	7	0	0	14	100
Local Authority Bodies	5	38	4	31	2	15	2	15	13	100
Healthcare	3	23	10	77	0	0	0	0	13	100
Education (largely 5 – 16 years)	3	33	5	56	1	11	0	0	9	100
Housing Associations	5	62	3	38	0	0	0	0	8	100
Academic	1	25	1	25	1	25	1	25	4	100
Regulatory/Inspectorate/Scrutiny	1	50	1	50	0	0	0	0	2	100
Statutory Bodies	0	0	2	67	1	33	0	0	3	100

Other	0	0	1	50	0	0	1	50	2	100
Total Organisations	**56**	**25**	**114**	**52**	**29**	**13**	**21**	**10**	**220**	**100**
Individuals (working/volunteering in health/social care)	61	46	61	46	6	5	5	4	133	100
Individuals (Service Users)	10	15	29	45	14	22	12	18	65	100
Individuals (no further information)	4	44	3	33	1	11	1	11	9	100
Total Individuals	**75**	**36**	**93**	**45**	**21**	**10**	**18**	**9**	**207**	**100**
Total Respondents	**131**	**31**	**207**	**48**	**50**	**12**	**39**	**9**	**427**	**100**

*Percentages may not always total 100% due to rounding.

Table 2

Question 2: To what extent do these Standards reflect the experience of people experiencing care and support?

Category of Respondent	Strongly Agree		Agree		Neither agree nor disagree		Disagree		Total*	
	No.	%	No.	%	No.	%	No.	%	No.	%
Voluntary Sector	14	18	29	38	25	32	9	12	77	100
Early Years and Childcare Services (Pre-5 focus)	7	32	13	59	1	5	1	5	22	100
Private Sector	9	39	11	48	3	13	0	0	23	100
Professional Representative Bodies	2	11	6	33	9	50	1	6	18	100
Engagement Events	0	0	9	100	0	0	0	0	9	100
Health and Social Care Partnership Bodies	4	29	10	71	0	0	0	0	14	100
Local Authority Bodies	3	25	6	50	2	17	1	8	12	100
Healthcare	1	8	10	77	2	15	0	0	13	100
Education (largely 5 – 16 years)	2	22	5	56	2	22	0	0	9	100
Housing Associations	6	75	1	12	1	12	0	0	8	100
Academic	0	0	2	50	1	25	1	25	4	100
Regulatory/Inspectorate/Scrutiny	0	0	1	100	0	0	0	0	1	100
Statutory Bodies	0	0	1	100	0	0	0	0	1	100
Other	0	0	0	0	1	50	1	50	2	100
Total Organisations	**48**	**22**	**104**	**49**	**47**	**22**	**14**	**7**	**213**	100

Individuals (working/volunteering in health/social care)	50	37	58	43	19	14	7	5	134	100
Individuals (Service Users)	8	17	23	50	8	17	7	15	46	100
Individuals (no further information)	3	33	2	22	3	33	1	11	9	100
Total Individuals	**61**	**32**	**83**	**44**	**30**	**16**	**15**	**8**	**189**	**100**
Total Respondents	**109**	**27**	**187**	**47**	**77**	**19**	**29**	**7**	**402**	**100**

*Percentages may not always total 100% due to rounding.

Table 3

Standard 1: I experience high quality care and support that is right for me.
To what extent do you think this Standard describes what people should expect to experience from health, care and social work services?

Category of Respondent	Strongly Agree		Agree		Neither agree nor disagree		Disagree		Total*	
	No.	%	No.	%	No.	%	No.	%	No.	%
Voluntary Sector	23	31	36	49	8	11	7	9	74	100
Early Years and Childcare Services (Pre-5 focus)	11	55	9	45	0	0	0	0	20	100
Private Sector	8	35	12	52	2	9	1	4	23	100
Professional Representative Bodies	1	5	15	80	3	16	0	0	19	100
Engagement Events	1	9	10	91	0	0	0	0	11	100
Health and Social Care Partnership Bodies	4	33	8	67	0	0	0	0	12	100
Local Authority Bodies	5	38	6	46	0	0	2	15	13	100
Healthcare	4	33	8	67	0	0	0	0	12	100
Education (largely 5 – 16 years)	5	50	5	50	0	0	0	0	10	100
Housing Associations	6	75	2	25	0	0	0	0	8	100
Academic	2	67	1	33	0	0	0	0	3	100
Regulatory/Inspectorate/Scrutiny	1	50	1	50	0	0	0	0	2	100
Statutory Bodies	0	0	1	50	1	50	0	0	2	100
Other	0	0	1	100	0	0	0	0	1	100

Total Organisations	**71**	**34**	**115**	**55**	**14**	**7**	**10**	**5**	**210**	**100**
Individuals (working/volunteering in health/social care)	88	66	39	29	5	4	2	1	134	100
Individuals (Service Users)	22	46	16	33	5	10	5	10	48	100
Individuals (no further information)	5	56	3	33	1	11	0	0	9	100
Total Individuals	**115**	**60**	**58**	**30**	**11**	**6**	**7**	**4**	**191**	**100**
Total Respondents	**186**	**46**	**173**	**43**	**25**	**6**	**17**	**4**	**401**	**100**

*Percentages may not always total 100% due to rounding.

Table 4

Standard 2: I am at the heart of decisions about my care and support
To what extent do you think this Standard describes what people should expect to experience from health, care and social work services?

Category of Respondent	Strongly Agree		Agree		Neither agree nor disagree		Disagree		Total*	
	No.	%	No.	%	No.	%	No.	%	No.	%
Voluntary Sector	30	39	27	36	10	13	9	12	76	100
Early Years and Childcare Services (Pre-5 focus)	12	55	10	45	0	0	0	0	22	100
Private Sector	9	39	11	48	2	9	1	4	23	100
Professional Representative Bodies	3	18	11	65	3	18	0	0	17	100
Engagement Events	1	9	9	82	1	9	0	0	11	100
Health and Social Care Partnership Bodies	7	50	6	43	1	7	0	0	14	100
Local Authority Bodies	4	31	6	46	1	8	2	15	13	100
Healthcare	4	33	8	67	0	0	0	0	12	100
Education (largely 5 – 16 years)	6	60	3	30	1	10	0	0	10	100
Housing Associations	6	75	2	25	0	0	0	0	8	100
Academic	1	25	3	75	0	0	0	0	4	100
Regulatory/Inspectorate/Scrutiny	1	100	0	0	0	0	0	0	1	100
Statutory Bodies	0	0	1	50	0	0	1	50	2	100
Other	0	0	1	100	0	0	0	0	1	100

Total Organisations	**84**	**39**	**98**	**46**	**19**	**9**	**13**	**6**	**214**	**100**
Individuals (working/volunteering in health/social care)	79	61	42	32	9	7	0	0	130	100
Individuals (Service Users)	19	42	17	38	5	11	4	9	45	100
Individuals (no further information)	6	67	2	22	1	11	0	0	9	100
Total Individuals	**104**	**57**	**61**	**33**	**15**	**8**	**4**	**2**	**184**	**100**
Total Respondents	**188**	**47**	**159**	**40**	**34**	**9**	**17**	**4**	**398**	**100**

*Percentages may not always total 100% due to rounding.

Table 5

Standard 3: I am confident in the people who support and care for me
To what extent do you think this Standard describes what people should expect to experience from health, care and social work services?

Category of Respondent	Strongly Agree		Agree		Neither agree nor disagree		Disagree		Total*	
	No.	%	No.	%	No.	%	No.	%	No.	%
Voluntary Sector	25	35	31	44	10	14	5	7	71	100
Early Years and Childcare Services (Pre-5 focus)	11	52	10	48	0	0	0	0	21	100
Private Sector	11	50	9	41	0	0	2	9	22	100
Professional Representative Bodies	1	6	14	78	3	17	0	0	18	100
Engagement Events	1	9	10	91	0	0	0	0	11	100
Health and Social Care Partnership Bodies	7	54	5	38	0	0	1	8	13	100
Local Authority Bodies	4	33	7	58	0	0	1	8	12	100
Healthcare	3	25	8	67	1	8	0	0	12	100
Education (largely 5 – 16 years)	5	50	5	50	0	0	0	0	10	100
Housing Associations	7	88	0	0	1	12	0	0	8	100
Academic	2	50	2	50	0	0	0	0	4	100
Regulatory/Inspectorate/Scrutiny	1	100	0	0	0	0	0	0	1	100
Statutory Bodies	0	0	2	100	0	0	0	0	2	100
Other	0	0	1	100	0	0	0	0	1	100

Total Organisations	**78**	**38**	**104**	**50**	**15**	**7**	**9**	**4**	**206**	**100**
Individuals (working/volunteering in health/social care)	79	61	43	33	5	4	2	2	129	100
Individuals (Service Users)	18	40	18	40	6	13	3	7	45	100
Individuals (no further information)	4	44	5	56	0	0	0	0	9	100
Total Individuals	**101**	**55**	**66**	**36**	**11**	**6**	**5**	**3**	**183**	**100**
Total Respondents	**179**	**46**	**170**	**44**	**26**	**7**	**14**	**4**	**389**	**100**

*Percentages may not always total 100% due to rounding.

Table 6

Standard 4: I am confident in the organisation providing my care and support
To what extent do you think this Standard describes what people should expect to experience from health, care and social work services?

Category of Respondent	Strongly Agree		Agree		Neither agree nor disagree		Disagree		Total*	
	No.	%	No.	%	No.	%	No.	%	No.	%
Voluntary Sector	22	29	38	51	10	13	5	7	75	100
Early Years and Childcare Services (Pre-5 focus)	10	32	19	61	2	6	0	0	31	100
Private Sector	9	39	10	43	1	4	3	13	23	100
Professional Representative Bodies	1	14	5	71	1	14	0	0	7	100
Engagement Events	1	9	9	82	1	9	0	0	11	100
Health and Social Care Partnership Bodies	8	53	6	40	0	0	1	7	15	100
Local Authority Bodies	3	23	8	62	0	0	2	15	13	100
Healthcare	3	27	7	64	1	9	0	0	11	100
Education (largely 5 – 16 years)	4	40	6	60	0	0	0	0	10	100
Housing Associations	6	75	2	25	0	0	0	0	8	100
Academic	1	25	3	75	0	0	0	0	4	100
Regulatory/Inspectorate/Scrutiny	0	0	1	100	0	0	0	0	1	100
Statutory Bodies	0	0	1	50	1	50	0	0	2	100
Other	0	0	1	100	0	0	0	0	1	100

Total Organisations	**68**	**32**	**116**	**55**	**17**	**8**	**11**	**5**	**212**	**100**
Individuals (working/volunteering in health/social care)	78	59	45	34	8	6	1	1	132	100
Individuals (Service Users)	14	30	17	37	7	15	8	17	46	100
Individuals (no further information)	4	50	4	50	0	0	0	0	8	100
Total Individuals	**96**	**52**	**66**	**35**	**15**	**8**	**9**	**5**	**186**	**100**
Total Respondents	**164**	**41**	**182**	**46**	**32**	**8**	**20**	**5**	**398**	**100**

*Percentages may not always total 100% due to rounding.

Table 7

Standard 5: And if the organisation also provides the premises I use.
To what extent do you think this Standard describes what people should expect to experience from health, care and social work services?

Category of Respondent	Strongly Agree		Agree		Neither agree nor disagree		Disagree		Total*	
	No.	%	No.	%	No.	%	No.	%	No.	%
Voluntary Sector	18	25	35	49	14	20	4	6	71	100
Early Years and Childcare Services (Pre-5 focus)	11	52	8	38	2	10	0	0	21	100
Private Sector	8	38	8	38	5	24	0	0	21	100
Professional Representative Bodies	1	7	10	67	3	20	1	7	15	100
Engagement Events	1	9	8	73	0	0	2	18	11	100
Health and Social Care Partnership Bodies	5	36	8	57	1	7	0	0	14	100
Local Authority Bodies	3	25	6	50	2	17	1	8	12	100
Healthcare	3	25	5	42	3	25	1	8	12	100
Education (largely 5 – 16 years)	5	56	4	44	0	0	0	0	9	100
Housing Associations	1	17	2	33	2	33	1	17	6	100
Academic	0	0	3	75	1	25	0	0	4	100
Regulatory/Inspectorate/Scrutiny	0	0	1	100	0	0	0	0	1	100
Statutory Bodies	0	0	1	50	0	0	1	50	2	100
Other	0	0	1	100	0	0	0	0	1	100

Total Organisations	**56**	**28**	**100**	**50**	**33**	**16**	**11**	**6**	**200**	100
Individuals (working/volunteering in health/social care)	74	58	39	31	12	9	2	2	127	100
Individuals (Service Users)	10	24	20	48	10	24	2	5	42	100
Individuals (no further information)	3	43	2	29	1	14	1	14	7	100
Total Individuals	**87**	**49**	**61**	**35**	**23**	**13**	**5**	**3**	**176**	100
Total Respondents	**143**	**38**	**161**	**43**	**56**	**15**	**16**	**4**	**376**	100

*Percentages may not always total 100% due to rounding.

Table 8

Standard 6: And where my liberty is restricted by law.
To what extent do you think this Standard describes what people should expect to experience from health, care and social work services?

Category of Respondent	Strongly Agree		Agree		Neither agree nor disagree		Disagree		Total*	
	No.	%	No.	%	No.	%	No.	%	No.	%
Voluntary Sector	16	25	28	44	16	25	4	6	64	100
Early Years and Childcare Services (Pre-5 focus)	11	55	9	45	0	0	0	0	20	100
Private Sector	9	41	10	45	2	9	1	5	22	100
Professional Representative Bodies	3	19	8	50	5	31	0	0	16	100
Engagement Events	1	9	7	64	1	9	2	18	11	100
Health and Social Care Partnership Bodies	4	31	8	62	1	8	0	0	13	100
Local Authority Bodies	3	27	7	64	0	0	1	9	11	100
Healthcare	2	17	5	42	4	33	1	8	12	100
Education (largely 5 – 16 years)	5	50	2	20	3	30	0	0	10	100
Housing Associations	1	14	4	57	2	29	0	0	7	100
Academic	0	0	1	25	2	50	1	25	4	100
Regulatory/Inspectorate/Scrutiny	0	0	1	100	0	0	0	0	1	100
Statutory Bodies	0	0	0	0	0	0	2	100	2	100
Other	0	0	0	0	0	0	1	100	1	100

Total Organisations	**55**	**28**	**90**	**46**	**36**	**18**	**13**	**8**	**194**	**100**
Individuals (working/volunteering in health/social care)	69	53	41	32	19	15	1	1	130	100
Individuals (Service Users)	11	26	18	43	9	21	4	10	42	100
Individuals (no further information)	1	14	4	57	1	14	1	14	7	100
Total Individuals	**81**	**45**	**63**	**35**	**29**	**16**	**6**	**3**	**179**	**100**
Total Respondents	**136**	**36**	**153**	**41**	**65**	**17**	**19**	**5**	**373**	**100**

*Percentages may not always total 100% due to rounding.

Table 9

Standard 7: And if I am a child or young person needing social work care and support.

To what extent do you think this Standard describes what people should expect to experience from health, care and social work services?

Category of Respondent	Strongly Agree		Agree		Neither agree nor disagree		Disagree		Total*	
	No.	%	No.	%	No.	%	No.	%	No.	%
Voluntary Sector	18	27	30	45	15	23	3	11	66	100
Early Years and Childcare Services (Pre-5 focus)	12	57	9	43	0	0	0	0	21	100
Private Sector	5	29	8	47	3	18	1	6	17	100
Professional Representative Bodies	2	13	12	80	1	7	0	0	15	100
Engagement Events	2	22	6	67	0	0	1	11	9	100
Health and Social Care Partnership Bodies	6	46	6	46	1	8	0	0	13	100
Local Authority Bodies	4	40	3	30	1	10	2	20	10	100
Healthcare	4	40	4	40	2	20	0	0	10	100
Education (largely 5 – 16 years)	5	56	3	33	1	11	0	0	9	100
Housing Associations	1	20	1	20	3	60	0	0	5	100
Academic	1	25	1	25	1	25	1	25	4	100
Regulatory/Inspectorate/Scrutiny	1	50	1	50	0	0	0	0	2	100
Statutory Bodies	0	0	1	50	1	50	0	0	2	100
Other	0	0	1	50	0	0	1	50	2	100

Total Organisations	**61**	**33**	**86**	**46**	**29**	**16**	**9**	**5**	**185**	**100**
Individuals (working/volunteering in health/social care)	68	53	40	31	18	14	2	2	128	100
Individuals (Service Users)	12	29	17	41	7	17	5	12	41	100
Individuals (no further information)	2	29	2	29	2	29	1	14	7	100
Total Individuals	**82**	**47**	**59**	**34**	**27**	**15**	**8**	**5**	**176**	100
Total Respondents	**143**	**40**	**145**	**40**	**56**	**16**	**17**	**5**	**361**	100

*Percentages may not always total 100% due to rounding.

Table 10

Question 10: To what extent do you agree these new Standards will help support improvement in care services?

Category of Respondent	Strongly Agree		Agree		Neither agree nor disagree		Disagree		Total*	
	No.	%	No.	%	No.	%	No.	%	No.	%
Voluntary Sector	17	22	34	45	17	22	8	11	76	100
Early Years and Childcare Services (Pre-5 focus)	11	38	9	31	8	28	1	3	29	100
Private Sector	7	30	10	43	5	22	1	4	23	100
Professional Representative Bodies	1	6	7	41	8	47	1	6	17	100
Engagement Events	2	22	7	78	0	0	0	0	9	100
Health and Social Care Partnership Bodies	5	38	5	38	2	15	1	8	13	100
Local Authority Bodies	4	31	7	54	0	0	2	15	13	100
Healthcare	3	25	4	33	5	42	0	0	12	100
Education (largely 5 – 16 years)	1	10	5	50	2	20	2	20	10	100
Housing Associations	4	50	2	25	2	25	0	0	8	100
Academic	0	0	2	50	2	50	0	0	4	100
Regulatory/Inspectorate/Scrutiny	1	100	0	0	0	0	0	0	1	100
Statutory Bodies	0	0	0	0	1	100	0	0	1	100
Other	0	0	1	50	0	0	1	50	2	100
Total Organisations	**56**	**26**	**93**	**43**	**52**	**24**	**17**	**8**	**218**	**100**

Individuals (working/volunteering in health/social care)	56	43	54	42	13	10	6	5	129	100
Individuals (Service Users)	12	30	20	50	4	10	4	10	40	100
Individuals (no further information)	2	25	2	25	4	50	0	0	8	100
Total Individuals	**70**	**40**	**76**	**43**	**21**	**12**	**10**	**6**	**177**	100
Total Respondents	**126**	**32**	**169**	**43**	**73**	**18**	**27**	**7**	**395**	100

*Percentages may not always total 100% due to rounding.

Table 11

Question 11: Is there anything else that you think needs to be included in the Standards?

Category of Respondent	Yes		No		Total	
	No.	%	No.	%	No.	%
Voluntary Sector	27	44	34	56	61	100
Early Years and Childcare Services (Pre-5 focus)	4	18	18	82	22	100
Private Sector	5	22	18	78	23	100
Professional Representative Bodies	9	64	5	36	14	100
Engagement Events	4	50	4	50	8	100
Health and Social Care Partnership Bodies	1	8	12	92	13	100
Local Authority Bodies	7	58	5	42	12	100
Healthcare	7	58	5	42	12	100
Education (largely 5 – 16 years)	3	33	6	67	9	100
Housing Associations	2	25	6	75	8	100
Academic	2	50	2	50	4	100
Regulatory/Inspectorate/Scrutiny	1	100	0	0	1	100
Statutory Bodies	0	0	1	100	1	100
Other	2	100	0	0	2	100
Total Organisations	**74**	**39**	**116**	**61**	**190**	**100**

Individuals (working/volunteering in health/social care)	30	25	90	75	120	100
Individuals (Service Users)	14	42	19	58	33	100
Individuals (no further information)	1	17	5	83	6	100
Total Individuals	**45**	**28**	**114**	**72**	**159**	**100**
Total Respondents	**119**	**34**	**230**	**66**	**349**	**100**

*Percentages may not always total 100% due to rounding.

Annex 2: Detailed comments relating to each Standard

Where respondents submitted clear and substantive comments relating to individual descriptive statements, these were extracted and have been summarised in the tables below. There has been no attempt to weight or judge these comments, which may be views shared by many respondents, or the view of just one individual, but nevertheless are useful for consideration in the final editing of the Standards.

Table 1

Detailed comments relating to individual descriptive statements supporting Standard 1

Statement	Detailed comments
Dignity and respect	
1.1 I am accepted and valued whatever my needs, disability, gender, age, faith, spirituality, mental health status, background or sexual orientation.	• Adopt the protected characteristics list from the Equality Act 2010. • Insert "beliefs" before "spirituality". • Omit the list altogether here and elsewhere. Not needed.
1.2 I am not discriminated against in any aspect of my care and support.	• Prefer to see the statement presented in active terms and referring to human rights, rather than individuals passively being discriminated against.
1.3 I am supported and cared for using a positive and understanding approach, even if my behaviour is challenging to others.	• The term "even if my behaviour is challenging to others" was viewed as subjective and value-laden. Alternatives which were suggested included replacing it with "behaviour that challenges"; or taking out the reference to behaviour – "I am supported and cared for using a positive and understanding approach at all times".
1.4 If I require intimate personal care this is carried out in a dignified way, with my personal preferences respected.	• All care should be carried out in such a way. • Will this allow for preferences for a male or female carer to be respected?
1.5 If I need support managing my money and my personal affairs, I am able to have as much control as possible and my interests are safeguarded.	**This statement attracted no substantive comment.**
1.6 If I am being supported and cared for in the community, this is done	• This should apply if the person is cared for in residential/care settings too. • This is a welcome element of this Standard.

discreetly and with respect.	
Compassion	
1.7 I experience encouragement and warmth and my strengths and achievements are celebrated.	• "and warmth" considered to be subjective. • How can "celebrated" be measured? Change to "recognised".
1.8 I get the most out of life because the people and organisation who support and care for me have an enabling attitude and believe in my potential.	• Suggestion made that 1.8 is merged with 1.7. • Suggestion made that 1.8 could usefully be moved to come under Standard 4. • "enabling attitude" is open to interpretation.
1.9 I am supported to discuss changes in my life, including death or dying, this is handled sensitively and my wishes and choices are respected.	• Perhaps better under Standard 2? • Need to mention Anticipatory Care Plan. • Not appropriate for early years' children. Add "where appropriate". • Replace "handled" with "approached". • What would happen if the wishes and choices included assisted suicide?
1.10 If I experience care and support in a group, the overall size of that group is right for me.	**This statement attracted more comment than others.** • Group size that is right for me was considered to be subjective. • Some settings may not have provision for meeting the needs of all service users regarding group size. • Size of group is not the only factor of importance. Composition of group is also significant.
Be included	
1.11 I am recognised by people who support and care for me as an expert in my own experiences, needs and wishes.	• The word "expert" is not appropriate for early years' children. • The statement needs to take account of the mental capacity of the service user. • Could go further with reference to self-directed support in which personal plans are composed collaboratively between service user and others. • Should be reference to the need for the service user to have access to information, on which to base choices. • Should be mention of recognition of advocate/nominated representative of service user.
1.12 I am encouraged to take part in everyday tasks to help the running of the service if I choose to.	• This will apply in some settings more than others. • Not likely to apply in hospital settings; A&E; mental health; secure settings. • Could be health and safety issues in applying this. • Expected rather than encouraged in settings such as school care accommodation. • If service users are paying for services, they may consider this inappropriate. • Replace "tasks" with "activities".
Responsive care and support: **Assessing my care and support needs**	

1.13 My emotional, psychological and physical needs are assessed by a qualified professional at an early stage, regularly and when my needs change.	• "Qualified professional" needs further definition. • Perhaps replace with "suitably qualified" or "appropriately qualified". • Local support agencies may not have access to "qualified professionals". • The statement generally needs to reflect that needs change and response should be flexible to accommodate this. • Add "spiritual needs" to the list. • Add "cognitive, social and vocational" needs to the list. • Add "educational needs" to the list. • Define "regularly".
1.14 My care and support is right for me because I am fully involved in my assessment.	• This does not take into consideration the capacity or age of the service user. Add, "where appropriate". • "because" is perhaps misleading. This incorrectly assumes that because I am fully involved, my care and support will be right for me. • What will happen if there is a difference in view over what care and support is right for me?
1.15 If I have a carer, their needs are assessed and support provided.	• Clarity required on whether this refers to a formal or informal carer assessment, that is, a compulsory or voluntary arrangement. • Carers may choose not to have their needs assessed and this should be acknowledged. • Not all services providing care can offer carer assessments.
1.16 If the care and support that I need or choose is not available or delayed, the reasons for this are explained to me and I can get help to use a suitable alternative.	• This has significant implications – what if there is no alternative? • Clarity is required in order to manage levels of expectation. Add "if available"? • Who defines "suitable alternative"?
Responsive care and support: **Experiencing care**	
1.17 I am supported to live in my own home if this is possible for me.	• The concept of "home" may not be clear-cut, e.g. foster home; birth home; care home. • The emphasis on living at home may be misplaced. Whilst it may be possible and appropriate in some cases, this may not be the preferred choice for others. The choice to live somewhere else can be positive, not negative. Could add, "and if this is where I want to be". • Needs greater realism – a person cannot stay at home regardless of risk or cost (e.g. some people with dementia). • Replace "my own home" with "place of my choice". • Not relevant for very young children.
1.18 I am supported to manage my own care and support if this is what I want.	• Add "and if it is safe to do so".
1.19 I can access technology and other specialist equipment so I can be independent, including to call assistance and manage my own health and wellbeing.	• Add "my own specialist technology where required" to recognise the increased uptake of smart devices. • This could be very costly. Example given of blind and partially sighted people, for whom assistive technology can be expensive. • Could raise expectations which cannot be fulfilled. • Could be misinterpreted by sectors such as young people whose

	use of some forms of technology may be inappropriate. • Access to technology may not be appropriate to service users in prisons.
1.20 I fully participate in developing and regularly reviewing my personal plan.	• Need to define a personal plan. • Change to "I am supported to participate in…" • Add "where possible". • Should recognise that other significant people such as family members will be involved in this. • The timeframe for reviewing should be more closely defined. • Replace "fully" with "meaningfully".
1.21 If I have particular needs, due to a health condition, age or circumstance, I am informed about the care and support I should experience, (or care plan) that clearly sets out my needs and wishes and how these will be met.	• The wording is clumsy and could be rephrased to make the meaning clearer. • People should have access to the care plan and this should be acknowledged in the statement. • Is a care plan different from a personal plan? • "Wishes" may not be practical or safe.
1.22 If I, or others, have concerns about my health and wellbeing, these are acted on and appropriate assessments and referrals are made.	• Qualify "others". These should be appropriate others. • Who decides what is "appropriate"?
1.23 My needs, as agreed in my personal plan, are fully met, and my wishes are respected.	• This may not be met due to circumstances outwith providers' control. • "Fully" met may be overly ambitious.
1.24 I know how organisations can support my wellbeing and I am helped to contact them if I wish.	**This statement attracted no substantive comment.**
1.25 I experience proper planning and am helped when using a new service, or when I move between services.	• What is meant by "proper planning"? • Add a sentence to emphasise that all relevant information about me accompanies me promptly when I move between services. • Suggestion made that a new section is devoted to transitions between services.
Wellbeing: general	
1.26 I am in the right place to experience the care and support I need and want.	• What does "right place" mean? What if the person is sleeping rough; in prison? • Replace "right place" with "appropriate place". • Remove "and want".
1.27 I am helped to access the health care that I need and any other public services.	• Change to "I am supported to…" • Could this be combined with 1.24? • Why does this mention other public services without explanation? • Need to acknowledge that other significant people, such as relatives, may have input on what is needed.

1.28 I am supported to make healthy lifestyle choices that are right for me.	• Viewed as patronising. People should be allowed to make unhealthy lifestyle choices if they wish.
1.29 If I need help with medication, this is done safely and effectively.	• Should be more rigorous. • Needs to refer to regulated/prescribed medication. • Some medication regimes are very complex and this should be acknowledged. • Should refer to maintaining privacy as medication can be a confidential issue (e.g. HIV patients).
Wellbeing: eating and drinking	• General views about this section were that it referred more to care home settings than others, such as home settings. • It appears to assume that people can eat without assistance. • The statements were perceived to be relatively vague overall. • The section needs to make explicit mention of home environment and support with food shopping. • An extra statement is required along the lines of, “I can have meals and snacks at an appropriate time that is acceptable to me”.
1.30 I can choose suitably presented, healthy and nutritious meals and snacks, including fresh fruit and vegetables if this is right for me.	• “healthy” as a concept is not clear-cut with its meaning dependent on a variety of factors and circumstances. • When would nutritious meals and snacks not be “right for me”? • Does this statement fit with 1.33? • Depends on age and stage. Perhaps the emphasis here should be on educating on nutrition for some people. • People should be permitted to choose whatever diet they wish. • What is the relevance and meaning of “suitably presented”?
1.31 I can enjoy unhurried snack and meal times in a relaxed an atmosphere as possible.	• This may not be practical in some settings. • May run contrary to food hygiene and health and safety requirements, if food is left out for lengths of time in temperatures which may render it unsafe to consume.
1.32 I can enjoy snacks and meals alongside other people using and working in the service if appropriate and I want this.	• Drafting considered clumsy. • Remove, “if I want this”.
1.33 I enjoy meals and snacks which meet my cultural and dietary needs.	• This should aim to reflect a proportionate approach. • Vegetarian diets should have explicit mention.
1.34 If I experience care and support in a group, I can choose to make my own meals, snacks and drinks, with support if I need it.	• Some care homes may not have their own food preparation facilities. • This should refer to contexts outwith groups too. • Some care home residents would not be safe to do this.
1.35 I can drink fresh water at all times.	• Too specific. Why not refer to unlimited fluids instead, to encompass the range of fluids which the person may prefer. • Some people will be “nil by mouth” and this should be acknowledged, perhaps adding, “if this is right for me”. • Some people need assistance drinking, e.g. drink through a tube.
Wellbeing: Activities	

1.36 I can have an active life and fulfil my aspirations by being supported to take part in activities that are important to me, in the way I like.	• This should be set within the context of managing risk. • May not be possible due to staffing levels.
1.37 I am supported to participate in a range of recreational, social, physical and learning activities.	• Add "vocational" and "spiritual". • Add access to outdoor space. • Add "if I wish" or "opportunities are there for me to be supported…" • Add reference to participation in social media activities.
1.38 If I experience care and support in a group, or in my own home, I can choose to do creative and artistic activities every day, such as art, crafts, music, drama, and dance.	• Too specific regarding activities. By including these, others are excluded. • Might be impractical to offer such choice every day. • This is already covered by 1.36. • May have financial implications.
1.39 I am supported to participate fully as a citizen in my local community.	• "Community" needs further explanation – this might be a geographical community, or a community of interest. • Could include encouragement to participate in employment community.
Wellbeing: Protection	• Generally missing from this section is reference to the human rights requirement to take practical steps to address situations where there is real and immediate risk to life (Article 2, ECHR). • Need something on staff training.
1.40 I am listened to and taken seriously if I have a concern about the safety and wellbeing of myself or others.	**This statement attracted no substantive comment.**
1.41 I am protected from all forms of abuse and exploitation.	• Use the word "harm" rather than "abuse". This fits with the Adult Support and Protection (Scotland) Act 2007. • Needs to reflect that people do not always make choices which are in their own best interests in this context.
1.42 I am helped to develop personal resilience and ways to keep myself safe.	• "Personal resilience" is not a term which most people will understand.
1.43 If I might harm myself or others, I know that people have a duty to protect me and others, which may involve contacting relevant agencies.	• This is information rather than being part of a Standard. Perhaps it should be rephrased to state that people will be informed if other agencies are contacted. • Not sure if needed. • Perhaps need to mention that minimum restraint may be used in circumstances where people are in danger of hurting themselves or others.
1.44 The people who support and care for me are alert and responsive to any signs that I may be unhappy or at risk of harm.	• Should this go further to state that the people who support and care for me will know how to respond to these signs and take action? • "Unhappy" is vague and too generic for this context.
Wellbeing: for children in	• Some service users and participants in engagement events

their early years	considered that these statements would be better mainstreamed across the other statements rather than meriting their own section.
1.45 I have fun as I develop my skills in understanding, thinking, language, literacy, numeracy, investigation and problem solving.	• Whether someone has "fun" depends on their personal preferences. The statement implies that all education is fun. • These should be tailored to different ages and stages.
1.46 I can take part in pretend play and storytelling.	• Already covered in Curriculum for Excellence and not needed here. • Replace "pretend play" with "imaginative play".
1.47 I spend time outdoors every day and this is a significant part of my day if I attend full-time, where appropriate.	• Wording is cumbersome. • Should not apply just to those attending full-time. • Could apply equally to other settings, e.g. for people with dementia.
1.48 I can regularly explore, and be creative in, a natural environment.	• What does "natural environment" mean?
1.49 If I attend all day and I am under school age, I can if needed have a sleep on a sleeping mat or bed with my own bed linen.	• May not be realistic. • Add "where appropriate".
1.50 I can choose to grow, cook and eat my own food, if possible.	• Depends on many variables, including age and stage. • Too specific. • Not realistic.

Table 2

Detailed comments relating to individual descriptive statements supporting Standard 2

Statement	Detailed comments
Dignity and respect	• Another statement was suggested, "I can decide who takes part in planning and reviewing my care and support".
2.1 I am empowered and enabled to be as independent, and as in control of my life as I want and can be.	• Replace "want" with "choose". • Insert "supported" after "empowered". • Who decides what I can be? • Not always applicable in some settings, for example some young people are in care because they have not respected boundaries. • Why not state simply, "I am empowered to be as independent as I want to be". • Add "…and I receive appropriate support, rehabilitation and training needed to enable me to achieve/sustain independence".
2.2 I receive and understand information and advice in a format or language that is right for me, including using independent advocacy if I want or need this.	• This could usefully be divided into two separate statements or sentences, one about receiving information and the other about using advocacy. • More specificity required on "information and advice". • Need something on access to translation services. • Add, "or another representative" after "advocacy".
2.3 I am as involved as I can be in agreeing any restrictions to my independence, control and choice and these are justified, uphold my human rights and are kept to a minimum.	• Insert another few words to say that restrictions will be reviewed regularly. • Tensions may emerge between what is agreed for an individual and what is best for the community within which they are receiving care. • Need to be explicit that the least restrictive option will be adopted. • Change "uphold" to "respect". • Need to clarify that restrictions will be in line with Mental Welfare Commission guidance. • Reference should be made to the particular circumstances of young people in secure care.
Compassion	
2.4 I am supported to communicate in a way that is right for me, at my own pace, by people who are sensitive to me and my needs.	• Communication is a key aspect of high quality care and merits a Standard in its own right. • Include reference to professionals having to demonstrate that they have communicated in a way which is appropriate for the person and that the message has been understood. • Need something on staff training to use equipment aimed at addressing sensory loss. • The wording is confusing. Change to, "I am supported to communicate in a way that is right for me".
Be included	• An overarching statement is required referring to checking understanding and not simply conveying information. • The role of the corporate parent should be included across this section. • This generally appears more for the parents/carers than the service users.

2.5 I can access translation services and communication tools where necessary and I am supported to use these.	• This should cross-cut all Standards. • Expand to include reference to specific information formats such as Braille, easy-read, and so on. • Could be merged with 2.4 • Add "Communication support is explored with me to identify tools or aids that are appropriate for me". • Add that services interacting with me may also need to access translation services. • Need to refer to sustained access to such tools.
2.6 I have time and help to understand the planned care, support, therapy and intervention I will receive, including any cost, before deciding what is right for me.	• Not specifically relevant to children under age 16. • Not relevant to those in secure care. • Transparency of costs merits its own Standard. • If this refers to service user agreements, then this needs to be stated. • This should be moved to "Responsive Care and Support".
2.7 If possible I can choose who will provide my care and support and how this will be provided. If possible, I can visit the service before deciding and/or meet the people who	• Statement incomplete due to typo. • Likely to raise unrealistic expectations. • Not always possible to arrange visit beforehand, e.g. in context of hospital admission for a procedure. • "If possible" allows wriggle room. • For whom is it "possible"?
2.8 If there is limited choice, this is explained to me so I understand the reasons for this.	• How will this be enacted? • Limited choice cannot be resolved by providing reasons. Not viewed as helpful unless accompanied with something about what is going to happen to address the limited choice.
2.9 If I need or want to move on and start using another service, I will be fully involved in this decision and helped to find a suitable alternative. If I am moving from a service for children to one for adults, I am helped with this transition.	• This is worded as if this applies largely to children, but it applies more generally to adults too. • The person may not be able to be fully involved – e.g. if anaesthetised during the transition to another care setting. • This is often influenced by capacity of the person which should be acknowledged. • Use the word "supported" through the transition as this is more respectful and empowering. • Add "…and am provided with a choice of services". • Add, "If I move on from a service I should be able to continue relationships with those who provided my care and support, if this is safe and I decide I want to do this". • Omit "need or want to".
2.10 If I am unable to make my own decisions, the views of those who know my wishes, my carer, advocate or representative will be sought and taken into account to establish what my wishes would be.	• Insert "legal" before "representative". • Give examples of who "representatives" can be. • Mention Anticipatory Care Plan. • Needs to mention specifically parents' and carers' involvement. • What does "taken into account" mean?
2.11 If I have expressed my own views and choices, these will be respected if I lose capacity.	• This raises ethical issues as people's preferences may change even amongst those who have lost capacity and have an advanced statement in place. • Need to explain the term, "lose capacity". • Should this be under the "Dignity and respect" principle?

	• Add a record of my views need to be "… easily accessible and kept up-to-date".
2.12 I am able to resolve conflict, negotiate boundaries, agree rules and build positive relationships with other people as much as I can.	• Does "all relationships" include staff? • Replace "able to" with "supported to" or "enabled to". • Could usefully be split into two separate statements, one on conflict and rules and the other on building relationships.
Responsive care and support	
2.13 I am supported to manage my relationships with my family, friends and/or partner in a way that suits my wellbeing.	• Too vague and ambiguous. Could be open to interpretation. • Add "carer" to the list. • Need to set firm parameters to ensure the inclusiveness of this statement to encompass LGBT and others.
2.14 If I am living in a care home, I can receive visitors in private and have a friend, family member or partner to sometimes stay over in the home.	• Could be difficult to implement in all settings, e.g. childcare; criminal justice. • Could include children and young people by mentioning them specifically and adding, "…if this is assessed as being safe for me and for the other people who live with me". • Not just relevant for care homes, but also for other settings such as hospices, private psychiatric hospitals. • This could come under Standard 5 as it relates to premises. • Raises costs and safeguarding issues. Who will be charged for this? • Will depend on availability of accommodation in settings. • Could pose risk to others, e.g. exceeding numbers for fire regulations. • Appears aspirational rather than achievable. • Add "… my family and friends are made as welcome as possible, while they recognise that this is a community and other people live here".
Wellbeing	• Each of the statements in this section should have caveat, "If I am able".
2.15 I make choices and decisions about all day to day aspects of my life, including managing my own money, how I dress, what I eat and how I spend my time.	• The list should be left out as it is limiting. • Add "what I drink". • This is open to interpretation and does not acknowledge that people make choices sometimes not in their best interests. • Replace "choices" with "preferences". • Overlaps with 2.1. • Needs to be combined with 2.16. • Not generally applicable in secure care settings. • Insert "informed" before "choices". • This does not recognise capacity issues. Add, "supported to".
2.16 I make informed choices and decisions about risks I take in my daily life and am encouraged to take positive risks which enhance the quality of my life.	• What is "positive risk" taking? • Who will determine what acceptable risks are? • This could place professionals in breach of their Code of Professional Conduct. • Professionals are likely to err on the side of caution – staff would need the support of their organisation to implement this. • Risks taken should be documented and the documentation made accessible.

	• Replace “encouraged to” with “able to” to reflect self-directed support. • Need to balance individual risks with the impact on others in the setting. • Not suitable for all settings – e.g. school care accommodation.
2.17 I am helped to understand the impact and consequences of risky and unsafe behaviour and decisions.	• Subjective. What professionals regard as risky and unsafe may not chime with those which the individual regards as such. • Replace the statement with, “I am able to discuss the benefits and drawbacks of things I would like to do, and reach a decision about whether or not I will do it. If I am able to do it, I am supported to do so as far as it is possible”. • Replace statement with, “I am helped to understand the impact and consequences of behaviour and decisions that are considered to be risky and unsafe”.
Wellbeing: For children in their early years	• Section is unnecessary. Could be mainstreamed into the general Standards. • Agree with this section. • Appears more for younger children than older.
2.18 I have the right to control my own play in the way that I choose.	• This appears contradictory to 2.21. • Too absolute – need to consider the rights and wellbeing of other children in the same setting. • Younger children need more direction and guidance – this statement is too open. • Does not reflect best practice where a balance is expected between child-led and adult-led organisation and activity. • Replace “play” with “activities” and incorporate with 2.15.
2.19 I can freely access a wide range of experiences and resources suitable for my age and stage, which stimulate my natural curiosity, learning and creativity.	**This statement attracted no substantive comment.**
2.20 I enjoy extended play and activities that develop my confidence, self-esteem and imagination.	**This statement attracted no substantive comment.**
2.21 I can play flexibly and creatively using open-ended and natural play materials and I experience a balance of organised and freely chosen activities.	• Insert, “and learn” before “flexibly”. Concern that there is a lack of focus on learning in the early years’ sections of the Standards. • There is an implication of choices of activity at all times, which is clearly not what is intended. • Could be adapted for broader range of service users, such as people with dementia (e.g. by replacing references to “play” with references to “recreation”).

Table 3

Detailed comments relating to individual descriptive statements supporting Standard 3

Statement	Detailed comments
Dignity and respect	• Needs some reference to individual beliefs and culture. • Needs reference to safe and effective care.
3.1 I experience people speaking and listening to me in a way that is courteous and respectful, with my care and support being the main focus of people's attention.	• Add something about people communicating in a way that the service user understands the message. • People have different values and understanding of what is courteous and respectful, for example someone with autism may perceive this differently to others. • Simplify this, "People speak and listen to me in a way that…." • Replace with, "Workers listen to me and make sure I am involved in making changes".
3.2 If I experience care and support at home, people are respectful when they visit my home.	• Simplify this, "People providing care and support are respectful if they visit me at home". • This should be the case whether at home or elsewhere. • Should be expanded to include respect for my family, friend and other carers. • Should expanded to cover my possessions within my home.
3.3 I am supported and cared for by people who challenge discrimination and bullying and stand up for me and my rights if I need this.	• As currently phrased, this puts the service user in a passive light. Could be more empowering if drafted to say that the person will be supported to stand up for themselves where appropriate. • Could be split in two to reflect standing up for oneself and someone else doing this on your behalf. • Add that if I behave in this way I expect to be challenged. • Could be combined with 3.21.
3.4 I am treated as an individual by people who get to know me and understand me, my lifestyle and choices.	• Insert "and respect" after "know me". • Does not fit well with primary care.
Compassion	
3.5 I am greeted warmly by people, and, if I do not know them, they introduce themselves.	• "Warmly" is vague and will be difficult to measure. • Replace "warmly" by "positively". • Who are "people"? • Replace statement with, "People who do not know me will introduce themselves". • People will need to introduce themselves every time for people with dementia. • Need to review this to make it appropriate for people with autism.
3.6 I experience a warm atmosphere because people who support and care for me	• Are these relationships with me or with others in their organisation, or across organisations? • What is meant by "warm atmosphere"?

have good working relationships.	• Could be removed. • Good relationships may not necessarily result in my experiencing a warm atmosphere.
3.7 I can build relationships with the people who support and care for me in a way that we all feel comfortable with.	• This raises issues about professional boundaries and Codes of Conduct. • May blur boundaries as open to interpretation. • Insert “appropriate” before “relationships”. • For homecare workers, this may not be realistic. • Delete “in a way that we all feel comfortable with”.
3.8 I experience warmth, kindness and compassion in how I am supported and cared for, including physical comfort when appropriate for me and the person supporting and caring for me.	• Mixed views on including physical comfort – some respondents welcomed the explicit inclusion of this, others considered it open to interpretation and possible abuse. • Would need to be supported by clear guidance for workers. • Why not spiritual or emotional comfort too? • Finish sentence at, “cared for”.
3.9 I am helped to feel content and at ease by the people who support and care for me.	• May be inappropriate for people with dementia. • Already covered by 3.8. • Perceptions of “feeling content” cannot be controlled by workers. • Replace by, “I should be encouraged to discuss the things that may make me content”.
Be included	• Need reference to common aids which help inclusive communication.
3.10 I know who provides my care and support on a day to day basis and what they should do. If possible, I can have a say on who provides my care and support.	• This does not reflect the realities of provision of care which will involve shift workers, emergency workers and rotation in workforce. • Add that I know how to make contact with them. • Not relevant for short-stay hospital settings. • Does this refer to knowing individual staff or knowing the provider organisation? • Delete “if possible”. • What does “knowing” constitute?
3.11 I can understand that the people who support and care for me when they communicate with me.	• Could have implications for recruitment of people who speak/do not speak English as first language. • Service users will represent a range of ethnicity and language which may not be able to be matched by workers. • There could be profound communication impairments and difficulties for the worker to overcome.
3.12 I am supported to be part of the local community, to enjoy family life and to develop interests if this is what I want.	• Difficult to achieve in certain settings such as prisons, short term transitional arrangements and emergency-based services. • Change “local” to “my”. • Challenging if scheduled worker visits do not coincide with local community activity. • Could require additional resourcing.
3.13 I experience appropriate	• What does this mean?

and consistent boundaries, guidance, and care.	• Include that I have an input in setting these. • Add that these are mutually agreed. • "Boundaries" is concerning. Need guidance on what is age appropriate. • Some adults living at home have full capacity to make their own boundaries. • Should this not refer to consistent approaches to boundaries rather than consistent boundaries?
Responsive care and support	• This section raises issues about relevance for sessional staff and high turnovers of staff.
3.14 My needs are met by people who are trained, competent and skilled to support me, and able to reflect on how they do that, and follow their professional codes.	• Service users are not likely to be aware of the professional codes. • Will all workers be reflective practitioners? How will this be assessed? • Would the professional codes apply to all settings? What about foster parents/unqualified and unpaid carers/interpreters? • Add, "where available" at the end. • Instead of "trained" state "appropriately qualified". • Delete the statement – covered by 4.19. • People providing care also need to be knowledgeable (e.g. about dementia; HIV).
3.15 I am supported by people who understand my needs, choices and wishes.	• Typo in "understand". • Covered by 3.14 and 3.4. • Insert, "and respect" after "understand". • Add, "and my religious or personal beliefs".
3.16 I am supported sensitively by people who anticipate issues and are aware of and plan for any known vulnerability or frailty.	• Rather than "anticipate issues" state that people "take circumstances into account". • There may be vulnerability and frailty which cannot be planned for. • Covered by 3.14.
3.17 My needs, wishes and choices are met because I am supported by the right number of people with the right skills and experience.	• What is the "right number"? Who decides this? • The previous Standards set out clear expectations on ratios and this is felt lacking here. • Important that people have the right attitude as well as the right skills and experience. • Providers address needs but can only take account of wishes and choices. • Replace "right" with "relevant and appropriate". • Add, "….and which fits with the support provided by my carer". • Need illustrations of how this will be assessed. • Add, "at the right time".
3.18 People have enough time to support and care for me and to speak with me.	**This statement attracted more comment than others.** • Viewed as aspirational but not relevant in context of limited resources, short length of scheduled visits, limited staff, work pressures. • Could lead to challenges and complaints. • Dependent on resources. • "Enough" is vague. • Add "and listen to me".

3.19 I am supported by people who respond promptly when I ask for help.	• What does “promptly” mean? There will be different perceptions. • Replace “promptly” with “in a timely manner”. • Dependent on resources.
3.20 My care and support is consistent and stable because people work together well.	• Statement is not necessary. • Remove “stable”. • What does “people” refer to? Unpaid carers? Multi-disciplinary teams? • Needs reference to record-keeping and sharing information. • Replace “work” with “communicate”.
Wellbeing	
3.21 I am supported and cared for by people who have a clear understanding of their responsibilities to protect me from discrimination, neglect, abuse and avoidable harm.	• Replace “abuse” with “harm”. • Remove “avoidable harm”. • Entire workforce will need training in adult support and protection. • Duplicates 1.41. • How will this be evaluated?
3.22 I am helped to feel safe and secure in the area where I live.	• Care services cannot be responsible for determining whether an area is safe. • Does this mean community/neighbourhood or home/care setting? • Implies geographical area. Replace with “environment”. • Delete statement. • Should encompass an environment that enables active travel.
3.23 The people who care for me stimulate my interests and spontaneity.	• “Spontaneity” considered an odd word requiring clarification. • Achieving this is likely to require one-to-one care which may not be available in some settings. • Outings require planning and cannot usually be conducted without planning. • How would this be measured? • Replace with, “I am provided with opportunities that encourage spontaneity and support me to develop interests”.
3.24 People help me to extend my learning and development, and they ask open questions and involve me in genuine dialogue.	• Appear to be two different aspects to this statement, which could be separated. • “Open questions” is too specific. • Raises expectations which may not be fulfilled, for example, home care workers in a 15-minute scheduled visit. • Finish statement at “development”. • Should reference wide value of learning and development and involvement in dialogue (Convention on the Rights of Persons with Disabilities (Article 25(1)).

Table 4

Detailed comments relating to individual descriptive statements supporting Standard 4

Statement	Detailed comments
Dignity and respect	
4.1 I am confident and experience that my human rights are central to the organisation that supports and cares for me, and that it helps to tackle inequalities.	• The statement would be better split into two parts dealing with human rights and tackling inequalities, respectively. • How will people know what their human rights are? • Add another statement: "I am helped to understand what my rights are and how I can get help and support to realise them, including independent advocacy". • Add reference to empowering people to understand their human rights. • Take out "and experience". • Jargonistic; clumsy; unclear. • Needs to be more specific about which inequalities are to be tackled. • "Challenge" inequalities rather than "tackle" them? • Should make mention of workforce human rights being central too. • Suggest rewording, "I believe that the organisation that supports and cares for me always puts my human rights and best interests first. I also believe that the organisation does all it can to challenge inequalities". • Add that I am confident that the care and support I receive is in line with Scottish legislation. • Appears to refer to a service rather than a group of services which make up care in a care setting.
Compassion	• These statements may sit better under Dignity and Respect. • Need reference to attending to and recognising emotional and psychological needs.
4.2 I receive an apology if things go wrong with my care and support or my human rights are not respected and the organisation takes responsibility for its actions.	• Simplify this to, "I receive an apology if things go wrong", or end the sentence at "not respected". • Insert "prompt" before "apology". • 4.3 should come before 4.2. • An apology in itself does not right wrongs. Ineffective if no action taken to put things right. • Unrealistic to expect an apology in a culture of liability and there may be valid reasons why things have gone wrong, for example, the service user may be the cause. • May be better to focus on achieving transparency and candour rather than seeking apology. • Also need to recognise that service users have responsibilities.
4.3 I use a service where all people are respected and valued.	• Remove "all" to simplify. • How would the user know if this is being achieved? • Remove this. Not needed as it repeats the overarching principle of dignity and respect. • Perhaps add another statement, "I know what the organisation is called and what it does and the responsibilities of senior staff and

	who to contact for compassionate support".
Be included	• This should recognise that some people do not wish to be included. • 4.4 – 4.7 unrealistic. • Needs reference to circumstances where person does not have capacity. • Needs to recognise that families, friends and other advocates may be involved too
4.4 I am informed of the organisation's aims and I can be involved in decisions about how it works and develops.	• Change emphasis to encouragement, or given the opportunity, to be involved, if this is desired. • May not be workable in all settings, such as emergency and drop-in services. • Insert "meaningfully" before "involved". • Insert, "in a way I understand" after "aims".
4.5 I am actively encouraged to be involved in improving the service I use, in a spirit of genuine partnership.	• Change "encouraged" to "empowered". • "..in a spirit of genuine partnership" appears an unnecessary add-on. • 4.5 overlaps with 4.6 and 4.10.
4.6 I give feedback on how I experience my care and support and the organisation uses learning from this to improve.	• Amend to make this the providers' duty to be proactive in seeking feedback. • Add that the person needs to know what happened to the feedback after it was given. For example, "I am notified of all the changes which affect me as a result of the feedback I provided". • There may be an element of fear of retribution for those giving negative feedback. • Person may need to be supported to give feedback, and this should be added.
4.7 I can take part in recruiting and training people who provide my care and support if possible.	• Not practical nor desirable in all settings. For example, would not work for short break respite; hospitals; clinics. • Children should not be involved in recruitment. • Businesses have business issues to consider when recruiting. • Does this refer to formal training or could informal training, ad hoc learning from each other about needs, be included? • Too ambiguous – what is meant by "if possible"?
4.8 I am supported to make use of relevant screening and healthcare programmes.	• Add, "if I wish". • Seems out of place here. Perhaps better to include in Standard 1? • Almost a repeat of 1.27.
Responsive care and support	• Some of the statements are not achievable and could lead to complaints.
4.9 I experience high quality care and support based on relevant evidence, guidance and best practice.	• Add "… and legal requirements".
4.10 I am involved in shaping	• How does this differ from 4.5 and 4.6?

how my service can continually improve to meet everybody's needs, choices and wishes.	• Perhaps examples would help.
4.11 I receive appropriate notice and I am involved in finding an alternative if the service I use plans to close.	• There are two separate issues covered in this statement and it could be divided accordingly. • "Appropriate notice" is ambiguous. Replace with "sufficient" notice. • Replace with, "I am involved in finding an alternative if the service I use plans to close or my placement ends". • This could be moved to Standard 5. • Refer to the service no longer able to support my needs; or changing the type of service provided.
4.12 I am looked after in a planned and safe way, including if there is an emergency or unexpected event affecting the premises.	• Replace "looked after" with "supported/assisted". • Change the end of the statement to, "..or if a change in my condition there is an appropriate anticipatory care plan with the equipment required to enact this. This plan is accessible by professionals who may be involved in my case".
4.13 I continue to experience stability in my care and support from people who know my needs, choices and wishes, if there are changes in the service or organisation.	• Could be difficult to deliver if the service closes. • Insert "will" before "continue". • Add "or changes in location". • Similar to 4.14 – do not need both.
4.14 I am supported and cared for by people I know so that I experience consistency and continuity.	• Not achievable due to nature of care provision with high turnovers of staff and use of agency staff. • People's needs change and they may need different forms of care provided by different people. • Person may not know the people providing care although they are providing consistency and continuity. • Add "where possible".
4.15 If I am supported and cared for by a team or more than one organisation, this is well co-ordinated so that I can experience consistency and continuity.	• Need to refer to good anticipatory care planning and information that can be readily shared. • Who performs the "co-ordinating" role?
4.16 I know how to make a complaint or raise a concern about my care and support.	• Could be strengthened by mentioning that some people may need help to do this. • Refer to access to independent advocacy or the help of a representative if required. • Should make explicit that there should be an explanation about the action taken in response to the complaint or concern raised. • Add, "I will be written to in a format I can understand telling me the outcome of my complaint". • Should refer to making compliments and positive feedback as well as complaints.
4.17 If I have a concern or complaint, I know this will be	• Add that if the complaint is not upheld, "I will be provided with an explanation and if still not happy I can approach the Care

acted on without negative consequences.	Inspectorate". • Add "to me". • There could well be negative consequences arising, for example, if the person makes numerous complaints which impact on efficient service delivery. • Replace the statement with, "I can be confident that I can raise a concern or complaint about my service and this will be investigated without any negative consequences for me about raising the concern". Or, "If I have a concern or complaint, I know this will be taken seriously and dealt with in a fair and impartial manner without negative consequences for me. I will be supported to participate in this process and the result will be explained to me". • How will the service user know whether there were negative consequences arising from the concern/complaint?
Wellbeing	• How will these statements be evidenced? • Need a statement on quality assurance and leadership.
4.18 I am confident that the service I use and the organisation providing it are well led.	• Too vague. What does "well led" mean?
4.19 I am supported and cared for by people who have been appropriately recruited.	• What does "appropriately" mean? • Add that people have been trained and supervised and supported. • Could replace 3.14. • Replace with, "I am supported by people who have received the necessary training to meet and respond to my needs".
4.20 I am supported to reach my full potential by people who are encouraged to be innovative in the way they support and care for me.	• How would a service user know that people had been encouraged to be innovative? • Replace "by people who" with "an organisation which". • Need to refer to positive risk taking and proportionate risk management.

Table 5

Detailed comments relating to individual descriptive statements supporting Standard 5

Statement	Detailed comments
Dignity and respect	
5.1 I experience an environment that is well looked after and attractive, with clean, tidy and well-maintained premises, furnishings and equipment.	• Too broad and subjective. • Remove the word "attractive". • Add, "…where my particular needs are taken into account".
5.2 I can use an appropriate mix of private and communal areas, including an accessible outdoor space.	• Outdoor space should be qualified with: well maintained; safe; secure (particularly for people with dementia). • Add "…and facilities to worship, meditate or reflect according to my belief or faith". • Insert, "safe and supported" before "private and communal. • May not always be achievable in some settings, such as hospitals with limited outdoor space. • Important to have this included as people need to be able to get away from the television. • Mixed views over specifying "private" areas with respect to children.
5.3 I can easily access a toilet from the rooms I use and I can use a toilet when I need to.	• This needs to reflect the requirement for privacy of those who require incontinence products changed.
5.4 If I live in a care home, I have ensuite facilities with a shower and can choose to have a bath if I want.	**This statement attracted much criticism.** • Not universally achievable depending on age and design of building. • May raise unrealistic expectations. • Could have significant financial implications for providers. • Not desirable nor safe in some circumstances.
5.5 I have a secure place to keep my belongings.	• Add "…in my room". • Add "…which I can access whenever I need to". • Add that I should be able to lock my room. • Add a reference to keeping medicines in a secure place in order to protect privacy.
5.6 If CCTV is used, I know about this and how my privacy is protected.	**This statement attracted more comment than others.** • CCTV is only one form of monitoring device, and the statement should be broadened to reflect this, e.g. "surveillance and monitoring devices". • Use of such equipment should be proportionate and based on legitimate reason. The statement should reflect this. • The impact on other staff and visiting friends and relatives should be taken into account. • Data protection and privacy regulations should be consulted prior to implementation. • The presence of CCTV appears incongruous with homeliness.

5.7 For children in their early years: if I wear nappies, there is a suitable area with a sink and some privacy for me to be changed.	**This statement attracted more comment than others.** • Too specific to children. This statement should apply to people of all ages who have incontinence-wear or nappies. • The word "nappies" can be embarrassing, even to small children who would prefer another term. • Not needed as covered by 5.19. • Replace with a more general statement, "I will be treated with respect and my dignity will be preserved at all times". • "Some privacy" is not sufficient; must be total privacy. • This must cater for LGBT needs too.
Compassion	
5.8 I experience care and support in a homely environment.	• "Homely" is a subjective and has different meanings depending on the context. • Better to express this in terms of an environment which is in-keeping with the preferences and needs of the person. • Not needed as 5.10 covers this.
5.9 I experience homely care and support in a service that is the right size for me.	• Who determines what is the right size? • Vague. • Delete.
5.10 If I live in a care home, the premises are designed and organised so that I can experience small group living and an environment that is right for me.	• May be difficult to achieve according to the definition in the glossary. • Depends on what space is available. • People may not want to experience small group living. Should focus more on what people prefer.
5.11 If I experience care and support in a group, I can use a cosy area with soft furnishings to relax.	• What is meant by "cosy"? Replace this with, "informal"; "an area that feels comfortable". • There could be financial implications for providers. • Some people may want bland and neutral furnishings (people with autism were given as an example). • Combine this with 5.8. • Language could be perceived as condescending.
Be included	
5.12 I experience a service as near as possible to people who are important to me and my home area if I want this and if it is safe.	• Providers may not be able to influence this if they are not involved in decision-making over who is placed in their setting. • Specialist services may be centralised and not local. • Challenging in some rural areas. • Replace with, "I am able to choose the service that is best for me even if it is some distance from my current home".
5.13 The location and type of premises enable me to experience care and support free from isolation and for me to be an active member of the local community if this is appropriate.	• What is "community"? There are different types of community, such as the community of people with autism. • Not all care homes are in residential areas with local communities. • Perhaps this needs to be split into two different issues: one relating to location; and the second relating to feeling valued as part of a community.
5.14 If I experience 24-hour care, I have access to a	**This statement attracted more comment than others** • Very important for some people to have access to the internet.

telephone, radio, TV and the internet so that I am connected.	• Not all of Scotland has access to the internet. • There may be some parts of the building without internet access depending on the position of the router. • Unsupervised access to the internet for young people is a safety issue. There would need to be restrictions. • It would need to be made clear that access may not be on an individual basis, but may be shared. • Too specific, for example, radios may be of no use to deaf people. Better to make a more general statement about access to technology that supports inclusion. • Need to add access to current printed media.
5.15 I can independently access all parts of the premises I use and the environment has been designed to promote this.	**This statement attracted more comment than others.** • It may not be appropriate or safe for people to access all parts of the premises. Areas off limits were identified as staff areas; laundry/sluice; office areas; other people's bedrooms. • If the kitchen is to be accessed, then this should be stated explicitly. • Some people may not be able to access areas independently and may need support. This should be stated.
5.16 If people who support and care for me have separate facilities, these do not take away from the homeliness of the service and my feeling of being at home.	**No specific comments made.**
5.17 If I live in a care home, I can control the lighting, ventilation, heating and security of my bedroom.	• Add, "if this is safe" or "when safe to do so". • This is vital for some people, such as those with motor neurone disease. • Providers cannot facilitate this in all cases.
5.18 If I live in a care home, I can decide on the decoration, furnishing and layout of my bedroom, including bringing my own furniture where possible.	• Not practical nor realistic. • Could this be changed to say I can customise or personalise my bedroom? • Cleaning and safety standards could restrict choices of décor, furnishing and layout.
Responsive care and support	
5.19 The premises I use are designed, adapted, equipped and furnished with my care and support needs in mind.	• This will not be true for many settings, particularly older ones. • This focuses on physical infrastructure rather than responsive care. • Insert, "in advance" before "furnished. • Insert, "and equipment" after "premises". • Add something about timescales. Particularly important in relation to those nearing the end of life.
Wellbeing	
5.20 I experience a secure and safe environment that is suitable for me.	• Not needed. • Already covered by 5.21 and by other statements.
5.21 My environment is relaxed, welcoming, peaceful	• Replace "smells" with "odours". • Important statement in view of the TV noise and smell of other

and free from avoidable and intrusive noise and smells.	residents which can be unpleasant.
5.22 I can enjoy a pleasant environment, with plenty of natural light, fresh air, space and a comfortable temperature for me.	• What does, “plenty of natural light” mean? • What is a “comfortable temperature for me”? • Add something about accessing indoor and outdoor environments.
5.23 I have enough physical space to meet my needs and wishes.	• What comprises “enough”? Too subjective. • In some settings all the rooms are exactly the same size.
5.24 I am able to access a range of good quality equipment and furnishings to meet my assessed needs, wishes and choices.	• What does “good quality” mean in this context? • Perhaps need to add, “appropriate for my particular needs”.
5.25 I am able to participate in a variety of creative and physical activities, including exercise both indoors and outdoors.	• Add “regular” before “exercise”. • Need to add something about easy access. • Perhaps change to, “there should be sufficient outdoor and indoor space that meets my needs”. • Should not be confined to creative and physical activities, but broadened to activity/occupation of choice. • This should apply only if relevant to the person.
5.26 If I am an adult living in a care home, I have my own bedroom that meets my needs.	• Could this be combined with 5.4?
5.27 If I am an adult living in a care home, I can choose to live with and share a bedroom with my partner, relative or close friend.	• It could be very beneficial for some people to be with someone they know well. • Could be challenging for care homes which single room occupancy only. • Needs clarity on whether the additional person is a paying resident; living in the setting on a short-term or longer-term basis; needing care themselves.
5.28 As a child or young person, I might need or want to share my bedroom with someone else and I am involved in deciding this.	• Concerns about young people being allowed visitors in their own bedrooms unsupervised. • This needs to be reviewed in the context of safeguarding individuals. • Perhaps add, “where assessed as appropriate”. • Perhaps add, “where there is sufficient space to do so”.
5.29 If I experience 24-hour are, I have a bedside cabinet and light and there is enough space for me to sit comfortably with a visitor in my bedroom.	• This suggests that the person experiencing 24-hour care is bed-bound, which may not be the case. • 5.26 covers this already. • Not always appropriate for children and young people in care. • May not be best to have such furnishing beside beds for people with visual impairments.
5.30 If I live in a care home and I want to keep a pet, the service will try to	• Specific mention should be made of “assistance dogs” as opposed to pets. • Young people often request this and if not permitted, then there

accommodate this request.	should be an explanation given and the decision reviewed on a regular basis. • The therapeutic role of pets should be acknowledged and requests for pets accommodated as far as possible. • Drawbacks to keeping pets in care homes include: adding to falls risk; staff may end up caring for the pets; some people may be allergic to pet hair; some people may be frightened of pets; staff may not wish to work in an environment with animals.

Table 6

Detailed comments relating to individual descriptive statements supporting Standard 6

Statement	Detailed comments
Dignity and respect	
6.1 I experience my human rights being protected when my liberty is restricted and this complies with the relevant legislation.	• People need to know what their human rights are for this to be effective. Perhaps this should include an intention to educate on human rights? • Replace "liberty" with "independence, choice and control"
6.2 I am helped to understand how and why my behaviour affects my rights, including the use of any physical intervention, sanctions or incentives.	• Change the focus from decisions being made about me, to supporting me to understand. Could do this by replacing "helped" with "supported". • It reads as though "behaviour" justifies being deprived of rights, and meriting "sanctions". Behaviour may not be a choice, but part of a condition. Inappropriate to link "behaviour" with sanctions in this way. • Perhaps insert "people's interpretation of" before "my behaviour.
6.3 I only experience restraint as a last resort and for the minimum time necessary by people who are properly trained.	**This statement attracted more comment than others.** • What is meant by "last resort"? • Should be supported by a statement about the need to review actions taken and assess them for appropriateness. • "Properly trained" should encompass regular reviews of training to ensure it is up-to-date and relevant. • Clarity is needed on the scope of "restraint". Physical restraint is only one aspect, but other forms could include medication, curfews, inclusion/exclusion zones, alcohol bans, restorative practices, and so on. • Need to be clear that actions (such as giving medication without consent) will comply with current legislation. • A child-friendly term such as "safe hold" should be considered as an alternative to "restraint".
6.4 I will only be searched if there are clearly identified concerns and I am told what these are.	• Clarify that an individual and their room may be searched. • Add that if a search takes place, the reasons will be clearly recorded with detail of how human rights were upheld. • Add, "…and appropriate legislative processes have been followed".
6.5 If I am restrained or searched, this will be carried out sensitively.	• "Sensitively" is vague and needs to be clarified. • Needs to make clear that action will be carried out "in the least restrictive way and in line with relevant legislation and guidance". • Add "safely" after "carried out".
Compassion	
6.6 I am supported by people who anticipate challenges with my or others' behaviour and they work creatively to help manage this.	• Language considered patronising and assumptive. • Needs reference to wider family and carers, social contacts and recreational activity as a broader, supportive network. • Emphasise that actions will be legal and safe. • How can challenges by "anticipated"? • Needs some recognition that behaviour may change depending on

	the right support being given. • Rephrase to, “When my behaviour can be difficult for people to handle, they think of creative and compassionate ways to deal with it”.
Be included	
6.7 I can be with my peers, including other people who use the service, except where this has been properly assessed as unsafe.	• Replace “properly” with a more suitable word. • Expand this beyond “peers” to family, community, professional support services, and so on. • Add “if I wish” as not everyone will want this. • Ensure authorised, legal and human rights compliant. • Add that if request to spend time with peers is denied, the reasons for this are recorded and subject to regular review. • What is “unsafe”? • The statement should reflect more of an emphasis on enabling the individual to work towards inclusion and independence.
Wellbeing	
6.8 The environment is specially designed and managed to minimise the risk of me harming myself or others.	• Not all settings in which liberty can be restricted will be purpose-built, although they will comply with relevant standards. • Include reference to minimising the risk of harm from others. • Wording was perceived as relatively negative rather than presenting a positive promotion of wellbeing activity, albeit risk-assessed.

Table 7

Detailed comments relating to individual descriptive statements supporting Standard 7

Statement	Detailed comments
Dignity and respect	
7.1 I am cared for by people who are ambitious for me, champion my needs and enhance my life chances.	• What is meant by "ambitious"? • How would this be measured? • Need to change focus from others having ambitions for me, to my being supported in my ambitions. • Could this be changed to, "I am cared for by people who want the best for me, support me and make sure I achieve whatever I want in life". • Perhaps an additional descriptor is needed, "The choices I make in order to express my identity are treated with respect".
Compassion	
7.2 I live in a place that feels like a home and I am supported and cared for by people who make me feel valued, special, loved and safe.	• Language open to interpretation and subjective. • Change "feels like a home" to "feels like home". • How would this relate to prison settings? • What is meant by "special"? This has connotations of abuse.
7.3 I am supported to develop a positive view of myself and to form and sustain trusted and secure relationships.	**There were no specific comments about this statement.**
7.4 I am supported and cared for by people who are fully informed about my history and understand what I am communicating.	• Concerns about people knowing my personal details which may not be relevant and without my permission. • Data sharing will need to be thought out. • "History" is an odd word to use, and could be replaced with "life". • Is the statement about communication challenges too and young people expressing their needs?
7.5 I am helped to overcome any previous experiences of trauma and neglect so I am emotionally resilient and have a strong sense of my own identity and belonging.	• Appears to presume that experiences of trauma and neglect can be overcome by children and young people, which may not be the case. • Change "so I am emotionally resilient" to "supported to build resilience". • Not all trauma is caused by neglect, so this should read, "trauma and/or neglect".
7.6 I am responded to with sensitivity and the people who support and care for me anticipate and reduce any conflict, with difficulties sorted out in a low-key way.	• "Low key" perceived to be subjective and difficult to measure.

7.7 I am helped by the people who support and care for me to understand the consequences of any difficult or unsafe behaviour and I am supported to take responsibility to change this.	**There were no specific comments about this statement.**
7.8 I have as normal an upbringing as possible and I am helped by the people who support and care for me to achieve this.	• Replace “normal” with “positive” or “secure” or “healthy and nurtured” (a GIRFEC term).
Be included	
7.9 I am encouraged and supported to make friends with people my own age.	• Too prescriptive. Friends can be different ages and across generations. • Change to: “I am encouraged and supported to make friends.”
7.10 I am helped to understand decisions taken in my best interests and why sometimes it might not be possible to act on my wishes.	• Needs to be more explicit about ensuring children and young people have an input to decisions about them. For example, “I am included and supported to make decisions”. • To be UNCRC compliant the statement could read, “I am always supported and encouraged to be included in decisions about my care and support and if a decision is taken against my wishes I am supported to understand the reasons for this”.
7.11 I am fully included in all aspects of family life if I am fostered.	• Why is this specific to fostering? All looked-after children should be included in this statement (e.g. kinship care). • “Family life” may need further definition – is this foster or birth family life? • There are other settings such as small group living which should be reflected here.
Responsive care and support	
7.12 My needs and wishes are assessed in good time and an assessment for a permanent placement is done within 12 weeks.	• Could this be combined with 7.13? • The timescale of 12 weeks is unrealistic in all cases, e.g. adoption. This does not recognize the complexities of issues which can arise. • Clarity is required on when the timescale begins. • Clarity is required on what a “permanent placement” comprises. • Another statement may be required relating to inter-agency working and communication where there are siblings under the care of different providers. • Is this in line with GIRFEC?
7.13 My need for permanent care and support is assessed and met.	• Could this be combined with 7.12?
7.14 I experience stable care and support with minimum disruption, from people who can nurture and form strong attachments with me.	• Replace “attachments” with “bonds” to reflect attachment thinking. • Young people talk of “relationships” rather than “attachments”. • A similar statement should also appear under Standard 1 and Standard 2 under Responsive Care and Support.

7.15 If I need and want this, I am placed with wider family members (kinship care) alongside my brothers and sisters where possible and where it is safe.	**There were no specific comments about this statement.**
7.16 People making decisions about me, including fostering and adoption panel chairs and advisers, know me and have the right skills, training and experience to decide what's best for me.	• Chairs of panels will be independent and are unlikely to know the child.
7.17 I am supported to have safe contact and continuity of relationships with family and people who are important to me by people who understand the importance of maintaining attachments.	• Although there may be instances where it might be better, on balance, for the contact to cease. • Include, "and opportunity to remain in current schools if I choose to". • Attachment is wider than maintaining contact and continuity of relationships, and there should be a separate statement dedicated to this.
7.18 I continue to be supported and cared for into adulthood.	• Add "…if I choose". • What level of support and for how long will this continue?
7.19 I experience different organisations working together for my benefit.	• Difficult to evidence. • There may be only one organisation involved. Reword to, "When different organisations are involved in my case, they……." • Better to refer to one clear point of contact.
Wellbeing	
7.20 I am supported to achieve my potential in education and employment.	• Add "fully" before "supported". • Add sentence, "This will include advocacy from the people that care for me." • Insert "training" before "and employment". • Add "and meaningful activity/occupation". • Add "and other life activities".
7.21 I am supported to develop my independence while protecting myself from unsafe situations.	**There were no specific comments about this statement.**
7.22 I am supported to become increasingly safe from neglect, abuse, grooming and sexual exploitation, self-harm, bullying, misuse of drugs or alcohol and going missing.	• The list appears to be negative and stereotyped. • Should not be a list as it cannot be exhaustive or future-proofed. • Instead, insert "from risks such as" before "neglect…" • Replace with, "I am supported to become increasingly safe from all forms of neglect and abuse". • "Increasingly safe" is odd. Remove the word "increasingly".
7.23 I am supported by people who seek to understand why I have been	• This should come after 7.24. • Could merge 7.23 and 7.24. • It could be unrealistic for carers/staff to go searching if they have

missing and work with me to minimise future risks.	other people to look after. • Delete “work with me to minimise future risks”. Instead, this could read, “If I go missing, people will take urgent action to find and protect me”. • Replace “work with me to minimise future risks” with “take action to address the reasons why I became missing”.
7.24 If I go missing, people take urgent action to protect me, including looking for me and liaising with the police and other agencies, and my family.	• This should come before 7.23. • Could merge 7.24 and 7.23. • Add another statement, “If I go missing, I am offered choices about where I return to once I am found”.

Annex 3: List of Respondents

Respondents were 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 placed into one category in order to avoid double-counting.

Many respondents requested that their response should not be published, or that they should remain anonymous. The names of these respondents have been removed from the list of respondents below. The total number of organisations in each category is indicated below, but names of organisations have been removed, as requested.

Academic = 4

Centre for Excellence for Looked After Children in Scotland
Centre for Youth and Criminal Justice
My Home Life, University of West of Scotland
West Lothian College

Health and Social Care Partnership Bodies = 16

Aberdeen City Health and Social Care Partnership
Angus Health and Social Care Partnership
Dundee Health and Social Care Partnership
Dundee Health and Social Care Occupational Therapy Service
Falkirk Health and Social Care Partnership
Moray Health and Social Care Partnership
North Ayrshire Health and Social Care Partnership
Renfrewshire Health and Social Care Partnership
Renfrewshire Health and Social Care Partnership – Learning Disabilities
Scottish Ambulance Service & NHS 24
West Dunbartonshire Health and Social Care Partnership

Early Years and Childcare Services (pre-5 focus) = 22

Ferguslie Pre-five Centre
First Adventures Nursery
Jaybees (Childcare) Ltd.
Little Scholars Day Nursery
Papillon Nursery Ltd.
Rimbleton Nursery Fife Council
Thank Evans Childcare Agency Ltd.
Vicki Allan Childminding Services

Education (largely 5 – 16) = 10

Edinburgh Montessori Arts School
Hilltown Out of School Care
Mill of Mains Out of School Care Dundee
Rothes Primary School and Nursery
Scottish Out of School Care Network
Ullapool High School Residence

Engagement Events run by Care Inspectorate/Healthcare Improvement Scotland = 19

Healthcare = 14

National Coordinating for Healthcare and Forensic Medical Services for People in Police Care
NHS Education for Scotland
NHS Greater Glasgow and Clyde
NHS Highland
NHS Lothian
Tayside Nutrition MCN

Housing Associations = 8

Dumfries & Galloway Housing Partnership
Methodist Charity and Housing Association

Local Authority Bodies = 15

Aberdeenshire Council Housing Outreach Support Service
Dumfries and Galloway Council Social Work Services
Falkirk Council Social Services Assessment Centre
Fife Childcare Services
Fife Council
Moray Council
Positive Steps, City of Edinburgh Council
Renfrewshire Council Children's Services
South Lanarkshire Council
West Lothian Council

Private Sector = 23

Blackwood Homes and Care
Braes Home Care Ltd.
Brighterkind
Bupa Care Services
Four Seasons Healthcare c/o Campsieview Care Home
HC-One Ltd.
Hector House (Glasgow) Ltd.
Lifecare Edinburgh Limited
Nursing Home Elderly
Oakminster Healthcare Ltd.
Rainbow Services (UK) Ltd.
Social Care Alba
The Richmond Fellowship Scotland

Professional Representative Bodies = 24

British Dental Organisation
British Dietetic Association
Coalition of Care and Support Providers in Scotland
Community Pharmacy Scotland

General Pharmaceutical Council
National Carer Organisations
National Day Nurseries Association
National Pharmacy Association Ltd.
Royal College of Nursing Scotland
Royal College of Ophthalmologists
Royal College of Paediatrics and Child Health
Royal College of Physicians of Edinburgh
Royal Pharmaceutical Society
Scottish Care
Scottish Childminding Association
Scottish Council for Voluntary Organisations
Scottish Executive Nurse Directors and Scottish Association of Medical Directors
Scottish Federation of Housing Associations and Housing Support Enabling Unit
Scottish Independent Hospitals Association
Social Work Scotland
United Kingdom Homecare Association

Regulatory/Inspectorate/Scrutiny = 3

Care Inspectorate
Health and Safety Executive
Scottish Social Services Council

Statutory Bodies = 3

Children & Young People's Commissioner Scotland
Mental Welfare Commission for Scotland
Scottish Human Rights Commission

Voluntary Sector – providers; organisations; and service user representative groups = 85

Action for Children
Action on Hearing Loss Scotland
Addaction (Scotland)
Age Scotland
Alzheimer Scotland
ARC Scotland
Ayr Housing Aid Centre
Bobath Scotland Cerebral Palsy Therapy Centre
Camphill Scotland
C-Change Scotland
CrossReach, Social Care Council of the Church of Scotland
Cyrenians
Deafblind Scotland
Dean and Cauvin Trust
Down's Syndrome Scotland
East Ayrshire Women's Aid
East Dunbartonshire Women’s Aid
East Park

Enterprise Childcare
Faith in Older People
Families Outside
Food for Life Scotland (part of Soil Association Scotland)
Grampian Regional Equality Council
Grounds for Learning
Headway (Dumfries and Galloway) Association Ltd.
Health and Social Care Alliance Scotland
Hebrides Alpha Project
Highland Senior Citizens Network
HIV Scotland
Homeless Action Scotland
Hospice UK
Inclusion Scotland
Leuchie House National Respite Centre
Life Changes Trust – People Affected by Dementia Programme
Marie Curie
Mindroom
Monklands Women's Aid
Moray Public Partnership Forum
Nazareth Care Charitable Trust
National AIDS Trust
National Deaf Children's Society
National Older People's Oral Health Improvement Group
National Parent Forum of Scotland
Outside the Box
Parkinson's UK in Scotland
Paths for All
Play Scotland
Promoting a More Inclusive Society
Real Life Options
Redwoods Caring Foundation
Royal Blind
Royal National Institute of Blind People (RNIB) Scotland
Sacro
Scottish Commission for Learning Disability
Scottish Council on Deafness
Scottish Independent Advocacy Alliance
Scottish Older People's Assembly
Scottish Out of School Care Network
Scottish Women's Aid
Sense Scotland
Sue Ryder
The Salvation Army, Scotland Office
Thistle Foundation
Turning Point Scotland
Turning Point Scotland – Perth and Kinross Service
Voluntary Health Scotland

Who Cares? Scotland
Women’s Aid South Lanarkshire & East Renfrewshire
Women's Aid Orkney
Your Voice
Ypeople
4 Communities Development Trust

Other = 3

Scottish National Action Plan for Human Rights

Individual respondents = 191

Easy Read respondents = 59

social research

The views expressed in this report are those of the researcher and do not necessarily represent those of the Scottish Government or Scottish Ministers.

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