Background

Chest Heart & Stroke Scotland (CHSS) represents the 500,000 people in Scotland living with lung and heart disease or the effects of a stroke, offering support, advice and information. We currently provide services across many integration joint board areas, including stroke nurses, professional and community training, rehabilitation support, and a national ‘Voices’ programme which trains and supports service users to engage with health services at a strategic level. There are over 160 CHSS volunteer-led peer support groups in communities across Scotland, and we have a volunteer workforce of 1,500 people who work across our support services and retail operations.

Response to Committee’s questions

Do you know how and when you can get involved with the Integration Authorities to influence decision making?

1. Third Sector Interfaces (TSI), which are established across all local authorities as representative bodies for the sector, were intended to have a key role as advocates of the third sector in relation to the integration of health and social care, as set out in legislation. The third sector is often represented on Integration Joint Boards (IJB) by the local Interface, but in practice TSIs have often not succeeded in delivering comprehensive representation of the diversity of the voluntary sector active in the area. There is an urgent need to reconsider the model of only having a single voluntary sector representative.

2. Given that many TSIs see their primary role as representing only local third sector organisations, and that many of the TSI are service providers themselves, they have often not been able to effectively represent the views of national third sector organisations like ourselves. This leads to missed opportunities for joint working and more integrated services. At times it has also appeared that services that TSIs themselves offer are more strongly promoted than similar services offered by other third sector organisations.

3. The third sector representatives are non-voting members of Boards which limits their impact on decision making; additionally, it is not always clear who the TSI representatives are. We have only been proactively approached by one TSI to-date
informing us how to keep in touch and their plans for representation. When the representative is from the TSI body itself, their degree of experience and expertise in health and social care will vary considerably.

4. The Scottish Government’s guidance on the role of TSIs in integration stated they can “provide timely intelligence about what is happening in communities, the robustness of current assets and their development. This intelligence will be critical in both identifying the gaps and designing the service solutions.” Our experience is that this ambition has not yet been realised.

5. Many third sector organisations have considerable expertise and capacity in the IJBs’ priority areas, especially around community support and self-management. Through closer working with the sector, third sector organisations could contribute significantly to the successful delivery of outcomes. There is still a lack of recognition by some statutory organisations of the scale of the third sector, and its range and experience. Our role in delivering innovative services in communities and expertise in community engagement would better enable the co-production of new solutions by Boards.

6. As a Scotland-wide organisation there are particular challenges for us in working with the 31 Boards. There is little consistency in the structure, governance arrangements, engagement opportunities and delivery models across the 31 IJBs. Similarly, influencing locality planning is seen as key to joint strategic commissioning but making these planning structures accessible to national charities has not always been given much attention. It is proving time consuming and resource intensive to build our knowledge of navigating each individual Boards’ different structures and processes, which we require if we are to effectively advise service users, volunteers and locally based staff about who best to engage.

7. Our experience of successful involvement has been where we have worked with existing contacts who have a strong awareness of the value of working with the third sector, but the pressures of integration itself have at times impacted on existing partnership working and relationships.

8. In practice, the decision-making process is not always clear, and our opportunities to influence decision making is very limited and reliant on sometimes ad hoc engagement through existing networks, and with multiple layers of governance. There are considerable complexities in working with multiple local authority areas within Boards whose priorities may not align; we have existing service level agreements in place with some Health Boards to deliver services across local authority boundaries which are now commissioned instead at IJB level. To ensure
consistency in service provision we must therefore work across multiple IJBs, whose priorities may differ.

9. At a practical level, much of the IJBs’ engagement is on the terms of the professionals involved, without taking full account of the diverse needs of the third sector. Little notice is often provided of meetings, which makes it difficult to participate. Where good practice does exist, there should be a forum for this to be shared. We know from our own networks that a number of major health charities share these concerns.

Were you consulted in the preparation of the strategic plans or involved with the work of the Strategic Planning Group?

10. We understand that Third Sector Interfaces were usually consulted in the development of strategic plans, but are not aware of opportunities at a local level to engage directly. As discussed above, organisations with a national spread like Chest Heart & Stroke Scotland have struggled to make a coherent response when face with 31 often very different systems.

11. Better involvement of the third sector in strategic planning would help identify existing expertise and capacity, and ensure full integration of all parts of service delivery, not just statutory.

Have you been involved with the work of the Integration Authority following the publication of the strategic plan?

12. CHSS currently delivers services in partnership with number of local authorities and Health Boards, usually under Service Level Agreements. We anticipate these will increasingly become commissioned services from IJBs and we will therefore need to increasingly work directly with IJBs to ensure continuity of services, or work with them to design services which best met strategic needs. To maximise the benefit we can deliver, we need to be able to engage in the strategic commissioning process, build relationships with commissioners, and navigate the complex arrangements within IJBs described above.

13. Most of the IJBs’ work to date has been in securing the transition to the new arrangements, and so it is difficult to assess how engagement in the future will be shaped, which creates additional challenges for our business planning.

Have you been involved with the work of the localities/ what involvement would you like to have?
14. We have not yet been involved with the work of the localities, but in future we will need to in order to help shape and deliver services which best meet local needs. This would though be hugely resource intensive if each IJB continues to maintain entirely different systems and methods of engagement.

Do you think that your involvement with the IAs has had an impact on decision making?

15. Please see our response to the first question above.

What could be done to improve the communication from the IAs?

16. As described above, Third Sector Interfaces are intended to have a key role as conduits of communication with IJBs, but in practice this is very variable, and it is not always clear who key representatives are. Given the demands of working across 31 Boards we need clear information about priority areas of work, and areas of focus under discussion so that we can input expertise and the voices of service users where appropriate, enabling us to become effective contributors to achieving Boards’ outcomes.

What could be done to ensure greater collaboration and engagement in the decision making process of Integration Authorities?

17. In addition to the points raised above, there needs to be stronger, more meaningful involvement of the public with IJBs, but this will only occur when the IJBs have a commitment to an ongoing process that both supports the public voice and has clear pathways into which that can be fed. IJBs need to see meaningful involvement as not just a requirement but as a way of jointly meeting the challenges of future care/reduced budgets etc.

18. The public need to move away from seeing involvement just being about negative or campaigning inputs to instead being an active partner in tackling issues and finding solutions. To help achieve this public representatives need both training and ongoing support. Chest Heart & Stroke Scotland’s Voices Scotland has over ten years’ experience of doing such work and could be a model for IJBs to adopt. It has also been a key part in building the delivery framework for the Scottish Government’s Our Voice initiative. Resource and co-ordination is now required to roll this out at IJB level.

19. In Midlothian the IJB has supported such a venture called “Collective Voice” (a partnership between CHSS and the Thistle Foundation) in which a group of people living with long term health conditions have been trained and supported to speak up for services that support self-management and reduce reliance on traditional
models of support. This group will have a clear voice within the strategic decision making process.

20. **Voices Scotland** is a CHSS-led programme which trains and support service users to be confident in contributing their expertise and views to strategic health forums such as Managed Clinical Networks.