HEALTH AND SPORT COMMITTEE

AGENDA

11th Meeting, 2017 (Session 5)

Tuesday 25 April 2017

The Committee will meet at 9.30 am in the James Clerk Maxwell Room (CR4).

1. **Public petitions:** The Committee will consider its approach to the following petitions—

   PE1628: Consultation on service delivery for the elderly or vulnerable; and
   PE1605: Whistleblowing in the NHS - a safer way to report mismanagement and bullying.

2. **Integration Authorities Engagement with Stakeholders:** The Committee will take evidence from—

   Claire Cairns, Coordinator, The Coalition of Carers in Scotland, representing The National Carer Organisations;

   Heather Petrie, Future & Specialist Delivery Team Leader, Voluntary Action South Lanarkshire;

   Linda McGlynn, Regional Engagement Manager Scotland, Diabetes Scotland;

   Sonia Cottom, Director, Pain Association Scotland;

   and then from—

   Christina West, Chief Officer, Argyll and Bute Health and Social Care Partnership;

   Michael Kellet, Chief Officer, Fife Health and Social Care Partnership;

   Amy Dalrymple, Head of Policy, Alzheimer Scotland;

   Margaret McKeith, National Lead, Partners for Integration, Scottish Care;
Corinne Curtis, Service User Representative (Orkney Integration Authority Strategic Planning Group);

Dr Marion Slater, Consultant Geriatrician and elected member of the Council, Royal College of Physicians of Edinburgh;

Jo Gibson, Principle Manager, North Ayrshire Health and Social Care Partnership;

Andrew Strong, Assistant Director (Policy and Communications), Health and Social Care Alliance Scotland (the ALLIANCE);

David Small, Chief Officer, East Lothian Health and Social Care Partnership.

3. **NHS Governance**: The Committee will discuss last week's informal evidence session with NHS senior managers.

4. **Healthcare in Prisons (in private)**: The Committee will consider a draft report.

5. **Sport for Everyone (in private)**: The Committee will consider a revised draft report.

6. **Integration Authorities Engagement with Stakeholders (in private)**: The Committee will consider the main themes arising from the oral evidence heard earlier in the meeting.

David Cullum
Clerk to the Health and Sport Committee
Room T3.60
The Scottish Parliament
Edinburgh
Tel: 0131 348 5210
Email: david.cullum@parliament.scot
The papers for this meeting are as follows—

**Agenda item 1**

Approach paper PE1628  
HS/S5/17/11/1

Approach paper PE1605  
HS/S5/17/11/2

**Agenda item 2**

PRIVATE PAPER  
HS/S5/17/11/3 (P)

Integration Authorities submissions  
HS/S5/17/11/4

**Agenda item 4**

PRIVATE PAPER  
HS/S5/17/11/5 (P)

**Agenda item 5**

PRIVATE PAPER  
HS/S5/17/11/6 (P)
Health and Sport Committee

Petition PE 1628: Consultation on service delivery for the elderly or vulnerable

PE1605

Petitioner: R Maxwell Barr on behalf of Struan Lodge Development Group and Dunoon Community Council

Petition summary

Calling on the Scottish Parliament to urge the Scottish Government to ensure that all changes to service delivery for elderly and/or vulnerable groups by Integrated Joint Boards responsible for health and social care are underpinned by the principles of openness and accountability and are therefore subject to detailed public consultation and full democratic scrutiny before final decisions are made and those decisions implemented by the Boards.

Webpage  parliament.scot/GettingInvolved/Petitions/PE01628

Background

Public Petitions Committee consideration

1. The Public Petitions Committee last considered this petition at its meeting on 2 February 2017. At that meeting the Committee took evidence from R Maxwell Barr, Chair, Struan Lodge Development Group and Kenneth Mathieson, Convenor, Dunoon Community Council. The Committee agreed to write to the Scottish Government, Scottish Health Council, NHS Scotland, Audit Scotland and COSLA.

2. At its meeting on 20 April 2017 the Public Petitions Committee agreed to refer the petition to the Health and Sport Committee under Rule 15.6.2 of Standing Orders.

3. The most recent note by the Clerk to the Public Petitions Committee (attached at Annex A) provides an overview of some of the issues raised during the course of the Petitions Committee’s consideration of the issue.

Health and Sport Committee consideration

4. The Petitioner R Maxwell Barr has made a submission to the Committee’s Inquiry on Integration Authorities Consultation with Stakeholders. The Petitioner refers to his experience in Argyll and Bute. Argyll and Bute Health and Social Care Partnership are due to give evidence today as part of the Committee’s roundtable on its integration inquiry.

Action

5. The Committee is invited to consider the Petition and the evidence the Public Petitions Committee has received in connection with the Petition as part of its current inquiry on Integration Authorities Consultation with Stakeholders, including today’s evidence session on the inquiry.
Petitioner
R Maxwell Barr on behalf of Struan Lodge Development Group and Dunoon Community Council

Petition summary
Calling on the Scottish Parliament to urge the Scottish Government to ensure that all changes to service delivery for elderly and/or vulnerable groups by Integrated Joint Boards responsible for health and social care are underpinned by the principles of openness and accountability and are therefore subject to detailed public consultation and full democratic scrutiny before final decisions are made and those decisions implemented by the Boards.

Webpage
parliament.scot/GettingInvolved/Petitions/PE01628

Introduction
1. The Committee last considered this petition at its meeting on 2 February 2017. At that meeting, the Committee took evidence from R Maxwell Barr, Chair, Struan Lodge Development Group and Kenneth Mathieson, Convenor, Dunoon Community Council. The Committee agreed to write to the Scottish Government, Scottish Health Council, NHS Scotland, Audit Scotland and COSLA.

Committee Consideration
2. Audit Scotland’s written submission highlighted its report on Health & Social Care Integration, which was published in December 2015. Audit Scotland explained–

The proposed governance arrangements of the IAs [integration authorities] are complex, with some uncertainty about how they will work in practice. This will make it difficult for staff and the public to understand who is responsible for the care they receive.

Partners need to set out clearly how governance arrangements will work in practice, particularly when disagreements arise. This is because there are potentially confusing lines of accountability and potential conflicts of interests for board members and staff. There is a risk that this could hamper the ability of an IA to make decisions about
the changes involved in redesigning services. People may also be unclear who is ultimately responsible for the quality of care.

3. The Scottish Health Council’s written submission agreed that the existing guidance requires further consideration, noting–

Guidance on Identifying Major Health Service Changes was published prior to the integration of health and social care services. It therefore does not take account of the current context for decision-making in relation to integrated services, or the ambitions for services which are outlined in the Scottish Government’s Health and Social Care Delivery Plan (Dec. 2016), which refers, for example, to regional and national centres of expertise.

There is therefore a risk of confusion and ambiguity given the current guidance does not reflect a very different landscape of decision making, accountability and more integrated models of care. The Scottish Health Council firmly believes that the CEL 4 (2010) guidance and the supplementary Guidance on Identifying Major Health Service Changes should be reviewed and revised with the current context in mind.

4. COSLA’s written submission explained that

…we do not believe that there are systemic problems across IAs and therefore do not feel that issuing further national guidance (or extending NHS guidance) is the best course of action.

…Rather than adding further consultation requirements to what is already a substantial body of regulation and guidance, we need to focus on supporting those involved with Integration Authorities to bed-in the various groups and arrangements outlined above, and to consolidate the relationships which support them.

5. In relation to accountability and public consultation, COSLA noted–

COSLA is aware that CEL 4 sets out consultation requirements for NHS Boards, and that there are associated Ministerial powers to call-in decisions about certain NHS services. COSLA believes that this runs counter to the policy aims of integration, which are about delegating functions and resources to IAs and empowering them to make difficult decisions about shifting the balance of care from unaffordable institutional care to the community; and from acute/crisis care to prevention and early intervention.

6. The Director General for Health and Social Care’s submission explained in relation to the existing guidance–

We introduced CEL 4 (2010) to support NHS Boards in their statutory duty to inform, engage and consult with patients, the public and stakeholders. We do not plan to update this as Chief Executive Letters
provide direction and guidance to NHS Boards rather than Integration Authorities.

7. The Scottish Government explained that it has reviewed all strategic commissioning plans published by Integration Authorities for 2016-19. The review concluded that “the reach and quality of engagement in the development of Integration Authorities’ strategic commissioning plans was comprehensive and generally of good quality”.

8. In relation to harmonising the guidance and advice relating to public consultation developed to support the Act with the advice and guidance to health boards in the Chief Executive Letter CEL 4, the Scottish Government explained—

I understand that local systems have largely approached this matter on the pragmatic basis that, if the service is a healthcare service then it would be subject to CEL 4 and if it is a social care service (directly provided or externally procured) it would be subject to the local consultation processes developed by the relevant Local Authority, underpinned by the National Standards for Community Engagement.

9. The petitioner’s written submission set out his view that the consultation and engagement requirements or guidelines should be standardised and readily accessible to communities and the public. Mr Barr welcomed the Scottish Health Council’s view that the Guidance on Identifying Major Health Service Changes should be updated.

Scottish Parliament consideration

10. The Health and Sport Committee agreed, as part of its budget scrutiny, to examine Integration Authorities’ (IAs) approach to engagement with stakeholders and whether or not IAs are doing enough to involve patients, carers, the third sector and other stakeholders over the design and future of health and social care in their local area.

11. A call for written evidence was issued on Monday 13 February seeking views from patient and carers representatives, NHS and social care staff, third sector organisations. The call for views closed on 8 March. The petitioner made a written submission in response to the call for views on the inquiry.

12. The clerks understand that the Health and Sport Committee is provisionally scheduled to consider this inquiry again at its meeting on 25 April 2017.

Conclusion

13. The Committee is invited to consider what action it wishes to take. Options include —

- To refer the petition to the Health and Sport Committee.
To take any other action the Committee considers appropriate.

Clerk to the Committee

Annexe

The following submissions are circulated in connection with consideration of the petition at this meeting—

- PE1628/A Scottish Government submission of 10 March 2017 (57KB pdf)
- PE1628/B: Director General of Health and Social Care submission of 16 March 2017 (44KB pdf)
- PE1628/C: Scottish Health Council submission of 17 March 2017 (78KB pdf)
- PE1628/D: Audit Scotland submission of 21 March 2017 (79KB pdf)
- PE1628/E: COSLA submission of 5 April 2017 (73KB pdf)
- PE1628/F: Petitioner’s submission of 7 April 2017 (51KB pdf)

All written submissions received on the petition can be viewed on the petition webpage.
Health and Sport Committee

Petition PE1605 Whistleblowing in the NHS – a safer way to report mismanagement and bullying

PE1605
Petitioner: Peter Gregson, on behalf of Kids not Suits

Petition Summary: Calling on the Scottish Parliament to urge the Scottish Government to establish an independent national whistleblower hotline for NHS staff to replace the current helpline. It would differ in that it would investigate reports about mismanagement and malpractice, often without recourse to NHS managers.

Webpage: parliament.scot/GettingInvolved/Petitions/WhistleblowerHotlineNHS

Background

1. The Public Petitions Committee considered the above petition at its meetings on 15 September and 24 November 2016, and 2 February and 2 March 2017. Over the course of these meetings the Committee took evidence from the petitioner, Public Concern at Work (provider of the National Confidential Alert Line), the City of Edinburgh Council, UNISON Scotland, the Scottish Government’s Director of Health Workforce and Strategic Change, and Paul Gray, Director-General Health and Social Care and Chief Executive of NHS Scotland.

2. Having heard this evidence, the Committee agreed to refer the petition to the Health and Sport Committee under Rule 15.6.2 of Standing Orders for consideration as part of its inquiry, “NHS Governance – Creating a culture of improvement”.

3. The most recent note by the Clerk to the Public Petitions Committee (attached at Annexe A) provides an overview of some of the issues raised during the course of Petitions Committee’s consideration of the issue.

Action

4. The Committee is invited to consider the Petition and the evidence the Public Petitions Committee has received in connection with the Petition as part of its current inquiry on NHS Governance – creating a culture of improvement.
Petitioner: Peter Gregson, on behalf of Kids Not Suits

Petition summary: Calling on the Scottish Parliament to urge the Scottish Government to establish an independent national whistleblower hotline for NHS staff to replace the current helpline. It would differ in that it would investigate reports about mismanagement and malpractice, often without recourse to NHS managers.

Webpage: parliament.scot/GettingInvolved/Petitions/WhistleblowerHotlineNHS

Purpose:
1. This is a continued petition, last considered by the Committee on 9 February when the Committee took evidence from Public Concern at Work, City of Edinburgh Council and UNISON Scotland.

2. At this meeting, the Committee will hear evidence from Paul Gray, Director General of Health and Social Care and Chief Executive of NHS Scotland. The Scottish Government’s correspondence of October 2016 and the petitioner’s submission of 9 November 2016 are included at the annexe to this paper.

Committee consideration:
3. In its submission, the Scottish Government indicated that it is confident that the policies that are in place to encourage and promote whistleblowing, and to support staff that whistleblow, are “robust and fit for purpose”. It highlighted the National Confidential Alert Line, Non-executive Whistleblowing Champions and the Independent National Whistleblowing Officer as examples.

National Confidential Alert Line (NCAL):
4. At the time of its submission, which was provided in advance of publication of the six-month review of the helpline covering August 2015 to January 2016, the Scottish Government acknowledged the fall in the number of cases raised through the Alert Line, but had “no evidence to suggest that this is because staff do not have confidence in the service”.

---

1 NHSScotland Confidential Alert Line (NCAL) Six Month Review: 1 August 2015 – 31 January 2016.
5. In response to a question on this issue during oral evidence on 9 February, the Chief Executive of Public Concern at Work (PCaW), the Alert Line service provider suggested that a possible reason might be due to a better understanding of the purpose of the line, such that “concerns that are coming through are more along the lines of public interest issues and less about seeking advice on private issues”.

6. There was further discussion around the understanding of the current helpline. Tam Hiddleston, representing UNISON Scotland at the Committee meeting on 9 February said that he had experienced examples of this, where a “member of staff can be advised that [the issue] should be dealt with as a grievance or through the bullying and harassment policy”. He added—

“There is still an issue of distinguishing between the two and deciding whether something is a whistleblowing matter – a major incident – or whether it can be dealt with through the board’s policies and procedures.”

7. Kirsty-Louise Campbell, head of strategy for City of Edinburgh Council explained how its external hotline facility operated, and compared to the facility the council previously had in place, which she described as a “standard public interest disclosure policy for staff”. She noted that due to internal culture, there were challenges in encouraging staff to raise concerns as the council would have liked.

8. She noted that, while there is no pattern or trend to the number of disclosures made through the new hotline facility, City of Edinburgh Council has found that “through having that independent approach … we have actively built the culture of, and trust in, the staff’s ability to raise concerns and they are now able to see how those concerns are addressed”.

9. To demonstrate the change in confidence, Kirsty-Louise Campbell said that, prior to the introduction of the hotline, the Council received three public interest disclosures over an eight year period. By comparison, since the hotline was established in 2014 it received 53 calls, 11 of which resulted in major investigations. She said—

“To me, that shows a sense of confidence in the [independent external hotline] and that colleagues feel that there is a trusted route for them to raise those concerns.”

10. In its written submission, the Scottish Government noted that—

“… the key feature requested in the petition (referral for external scrutiny) already exists, as NCAL can, if appropriate, pass cases to the appropriate Regulatory or scrutiny body on behalf of the staff member for further investigation.”

11. However, in evidence to the Committee, Public Concern at Work said—
“I entirely agree that the independent investigation process is an absolutely essential part of good whistleblowing arrangements. However, it is not part of the offer in the service we provide, so there is a mismatch between what has been commissioned and what is being asked for in the petition”.

12. The Committee also considered the mode of contact, anonymity, the role of unions, and any additional difficulties created with the introduction of Integration Joint Boards (IJBs).

13. Tam Hiddleston referred to an app recently developed by UNISON Scotland, which allows staff and members “to raise concerns that go to Unison regionally, while the same email or message goes to the director of nursing in the health board concerned”.

14. The City of Edinburgh Council’s main method of contact is by telephone, while Andrew Pepper-Parsons of PCaW noted that while there may be a “temptation to assume that everybody wants to raise things anonymously or via some sort of electronic means”, that is not always the case.

15. Cathy James from PCaW expanded on this, referring to research conducted by the University of Greenwich and the Association of Chartered Certified Accountants (ACCA) which states that “a multitude of channels is needed in order to build trust”. She noted that—

“At one point, people might use the channel of anonymity. If lots of concerns are raised anonymously, that is perhaps a sign that people are not quite sure; they will choose anonymity if they do not feel that they will be protected.”

16. She added that choices “ebb and flow as new initiatives come out” and that “people’s trust will change over time”.

17. Tam Hiddleston suggested that the introduction of IJBs “exacerbates the problem of where a whistleblower goes to” because, as different employers, local councils and health boards have widely differing terms and conditions.

Non-executive Whistleblowing Champions and the Independent National Whistleblowing Officer (INO)

18. The Whistleblowing Champion role was developed in response to the Freedom to Speak Up Review. The Scottish Government’s submission emphasises that this role does “not form any part of whistleblowing policy”. The purpose of the Champion is to “provide independent assurance at local level”. The oversight and assurance role includes—

- a conduit role, working closely with the named Whistleblowing Policy contact(s)
- assurance that the benefits of raising concerns about patient safety and malpractice are highlighted and publicised
assurance that staff have access to the appropriate mechanisms and support available to discuss concerns about patient safety or malpractice
• discussing the number and nature of concerns at the Staff Governance Committee

19. In addition, the Whistleblowing Champion is key to providing assurance that investigations are being handled fairly and effectively by ensuring that regular updates are provided, appropriate support and regular updates are provided to staff members who report concerns, and resultant actions are progressed.

20. The Scottish Government also advised that, “to complement existing policies and provide independent and external review on the handling of whistleblowing cases in NHSScotland, it was establishing an INO which will “contribute to better patient safety and also encourage an open and honest reporting culture”.

21. In response, the petitioner questioned the role of the INO. He argued—

“…the INO will have no sense of the scale of the problem; only the most persistent of whistleblowers will get to them [and] without a hotline, how will they know when the whistle is being blown and when the whistleblower has been victimised?”

22. Cathy James acknowledged that it “is a challenge to set up something that is truly independent when it is part of the Government” but referred to the national guardian role which operates under a tripartite system – involving NHS England, the Care Quality Commission and NHS Improvement - to build independence.

23. Tam Hiddleston expressed UNISON’s support for the INO, but cautioned that there “is still a lot about the officer’s role to be considered” if it is to be effective sitting alongside the helpline.

24. Cathy James noted that this was a challenge in the creation of the national guardian. Uncertainty about the role created uncertainty, which could lead to a lack of trust. She considered that learning from the challenges faced in establishing the national guardian in England would “improve the process for a similar appointment in Scotland”. She added that another new development in England is the establishment of a healthcare safety investigation branch and suggested that it would be “really innovative to combine what is being done in that branch with a national officer in Scotland”.

Parliament action

25. The Health and Sport Committee has recently launched an inquiry, NHS Governance – Creating a culture of improvement. The inquiry will cover three main strands: staff governance; clinical governance, and corporate governance.
Action
26. The Committee is invited to consider what action it wishes to take on this petition. Options include—

- To refer the petition to the Health and Sport Committee under Rule 15.6.2 of Standing Orders for consideration as part of its inquiry, “NHS Governance – Creating a culture of improvement”

- Any other action the Committee considers appropriate.

Clerk to the Committee
**Introduction**

Alzheimer Scotland is Scotland’s leading dementia voluntary organisation. We work to improve the lives of everyone affected by dementia through our campaigning work nationally and locally and through facilitating the involvement of people living with dementia in getting their views and experiences heard. We provide specialist and personalised services to people living with dementia, their families and carers in over 60 locations and offer information and support through our 24 hour freephone Dementia Helpline, our website ([www.alzscot.org](http://www.alzscot.org)) and our wide range of publications.

**General Comments**

Due to the extremely short timescales set by the Health and Sport in place for this call for evidence, Alzheimer Scotland’s response is limited to providing an overview of the experiences of people with dementia and their carers, as well as with Alzheimer Scotland as a third sector organisation.

In addition, the committee must recognise that the large number of Integrated Joint Boards (IJBs) mean that practice is highly variable across Scotland. Whilst some areas engage well and have strong processes in place for engagement of people who use services and the third sector, the majority of areas do not.

**Third Sector Engagement**

As a third sector organisation supporting people with dementia, their families and carers in Scotland, Alzheimer Scotland aims to engage with every IJB in Scotland, seeking to ensure that the experiences and views of people with dementia help inform the planning and delivery of health and social care services.

Colleagues engaging with IJBs have reported that the ability to engage and influence strategy and service delivery is limited. IJBs frequently only engage in relation to high level information and strategy, with invitations to contribute being purely consultative in nature, around themes which have already been broadly agreed; there is little scope for change rather than anything close to a co-productive process. This level of engagement cannot be said to be meaningful, and does not demonstrate commitment to co-production or partnership working.

Whilst understanding that services and support for people with dementia must be delivered within the wider context of provision of health and social care services for other conditions, the recognition of the distinct nature of dementia as a progressive condition which requires evolving and increasingly complex and intensive care and support is not recognised; it is too often subsumed under generic ‘mental health’, ‘older people’ or ‘long term condition’ headings.

From our experience, there is limited further engagement and opportunity to be involved in the work of the IJB once the Strategic Plan has been developed and published. In areas where this does take place, it is largely limited to invitations to events.

In some IJB areas, we have had some positive engagement in relation to IJBs working at the locality levels to establish the type of engagement we would like to have. However, this is not widespread across Scotland and we believe there is greater potential for these to be used to ascertain the issues
which matter most to people who use services, carers and third sector organisations, and how these groups may be involved in a way which is accessible, meaningful and purposeful. In doing so, Third Sector Interfaces could perform their role as intermediaries between the local sector and IJBs in a more effective and representative manner. This would allow IJBs to ensure that both the strategic planning and delivery of services more closely reflects the needs and wishes of people in the sector.

As many IJBs are still undergoing structural and personnel changes, many of the barriers to effective engagement and involvement are the result of these ongoing structural developments. However, where local engagement is in place, the representation and ability to engage in local groups is variable. Alzheimer Scotland has its own local networks of people with dementia and carers who are keen to be involved and influence change to improve the lives of people with dementia and their carers, however, the ability influence these is sporadic. From our experience, some areas use existing networks of people who use services and carers to engage and ensure these groups are informed about how they can be involved, however, this is not universally done by all IJBs.

We are aware that in one IJB area, the TSI actively recruited a Third Sector rep for the Board, differing from the majority of TSIs who have undertaken the role themselves. This area has a reference group of voluntary sector providers that meet the day before the IJB meeting, allowing them to review the agenda items, gathering views and opinions on these. In this area, the Third Sector rep also sits on the Strategic Planning Group.

However, we are aware that in the majority of IJB areas, the TSI takes on the role of the Third Sector representative and our experience has been that communication and engagement from these representatives has been poor, with no ability to feed into how the third sector can contribute to health and social care integration or what issues the third sector as a whole would like raised at these meetings. Additionally, in these areas, it is not always clear who represents the third sector on the Strategic Planning Groups. If the TSIs are to continue to represent the third sector on IJBs, we believe there is an imperative for them to more thoroughly engage and consult with the third sector within their IJB area and localities.

The provision of accessible information by IJBs to the public is highly variable across Scotland. The ability to find and access information about those who sit on the IJBs, how the boards operate, find meeting papers and minutes, and contact details for members or how to become involved in the decision making process, is inconsistent at best. We believe that IJBs, as a minimum, should have this information available online and easily accessible to the public.

**Engagement of people with dementia and carers**

Through our work with people with dementia at a national and local level, Alzheimer Scotland understands the importance of providing support to these groups to ensure that they are involved in decision making around the development and delivery of services, policy and strategy where it is likely to impact on them. As part of this, meetings and conversations must accommodate their specific needs.

We have heard from carers that those involved in this area, including IJB meetings and sub-groups often receive little or no support going through papers. This means that lengthy papers, which may be complex or include jargon, may be inaccessible and difficult to understand. Often these papers are provided at short notice, with no alternative formats (e.g. easy read, plain English etc.), and no opportunity for a pre-briefing or to ask questions in advance to allow the person to meaningfully take part in a meeting or event. In addition, carers often need to make complex arrangements to
ensure the cared-for person is supported whilst carers attend the meeting; this can be particularly challenging in rural settings. Alzheimer Scotland is aware of instances where locations have been changed at short notice which has resulted in the carer being unable to attend the meeting. It is therefore essential that the additional needs of both people with dementia and carers are taken into consideration, with IJBs providing additional support and accommodations to ensure that these barriers to involvement are removed.

Alzheimer Scotland is aware that some work is beginning to be undertaken by national organisations to support both people who use services and carers to participate meaningfully and effectively on IJBs. It would be helpful for this work to be coordinated and undertaken in such a way as to complement each other, but also to link into IJB and locality level to ensure that the work supports people and responds to their specific needs.

Alzheimer Scotland understands that carers are often involved on the IJBs in an ad-hoc manner, which means they rarely have an established network of carers behind them to consult on issues being discussed at meetings. In addition, they are given little or no support to network with carers to gather feedback; where it does happen, the burden of responsibility is primarily left to the carer. From our experience supporting carers to be involved in both internal and external meetings, if involvement is to happen in a meaningful way there must be resources put in to help this process. By not having these structures in place IJBs are often hearing the voice of a lone, activist carer as opposed to a more collective voice.

Alzheimer Scotland is happy for this evidence submission to be published on the committee’s website. A copy will also be placed on Alzheimer Scotland’s website.
Corinne Curtis

Submission by Corinne Curtis, Service User Representative on Strategic Planning Group (Orkney)

1. I did not know anything about how to have involvement in IAs until I was asked to put myself forward as a public representative by a colleague who works in Voluntary Action Orkney. I still don’t understand how a member of the general public could influence decision making. As a community social worker in New Zealand prior to returning to the UK, I had a lot of involvement in facilitating service user views and input to health services, so I both understand and have a strong interest in public engagement in health and social care planning and service delivery, and yet I have not found it at all easy to have any involvement here in Orkney. Since becoming a service user representative I still have absolutely no idea how any other member of the public can have useful or effective input. I have concerns that the IA does not respect public representatives’ situations at all or do anything to address the difficulties in taking on these roles. It doesn’t seem fair at all to me that public reps are expected to volunteer their time without compensation – no one should be financially disadvantaged for becoming a public rep, whether that means paying self employed people a day rate for meetings, or providing additional paid care hours for carers. I believe some regions are looking at addressing this, but it needs to be a standard process across all regions of Scotland.

2. I am a member of the Strategic Planning Group, but to date I don’t believe the Orkney SPG has done any strategic planning at all. We seem to be presented with documents to put our stamp of approval on with very limited discussion and no information to put anything into a wider context or allow prioritisation. The statistical data presented has not been of a quality or depth to give any useful information for service planning or change. I have been very disappointed by the lack of proper analysis of data or analysis of broader Scottish data in a local context. There has been no attempt to grade quality of evidence or cross check data, and much of the Draft Strategic Plan appears to be based on broad census data. The Strategic Plan at the moment is a huge document that is extremely difficult for any member of the public to comment on – both because of its length, and because it is so broad and general, there is nothing specific enough to be relevant for any individual or service user group to comment on. There is also no feedback mechanism for anyone (individual or group) to understand how their feedback may be influencing planning. The membership of the SPG seems to be largely people representing the interests of different professional groups – so it makes for a process that is more akin to union reps ensuring their occupational group doesn’t suffer, than for proper strategic planning. The time frame for meetings (2.5 hours every three months) also doesn’t make for good planning. In my previous experience (in New Zealand) production of a document such as the Strategic Plan would have been done as a minimum of a full day workshop, with the resources of a health researcher to properly analyse data and grade quality of evidence.

3. I continue to be involved as a member of the Orkney SPG. As a service user representative I remain totally frustrated at the lack of a proper strategy for public engagement, or an easy way (or any way?) in which members of the public can comment on and influence parts of the Strategic Plan that they are interested in or that impact on their lives. It feels to me that the “public engagement” box has been ticked by having public reps on the committees, and that the IA doesn’t feel it necessary to do anything much more.
4. Localities planning in the Isles locality of Orkney seems to have been a one-off public meeting with a combined agenda, largely managed and promoted by Voluntary Action Orkney (see appendix 1, poster for this meeting on Westray). I didn’t attend our local meeting because I misunderstood the poster advertising it – it had nothing on it apart from an Orkney Health and Care logo that indicated that it was intended to be the public engagement meeting for localities planning. The two questions in the Voluntary Action Orkney managed survey (noted on the poster) relating to health and care were so vague and general that it would not be possible to use any responses as quality evidence for planning. At a previous Localities planning training day that I attended (along with other committee members) it had been quite clear to me that the senior staff and managers were extremely nervous about, and reluctant to have open public meetings. This seems to have led to the decision to have a combined community planning and participatory budgeting meeting in the isles locality areas, and for the IA to rely on Voluntary Action Orkney to organise or promote this. Neither Orkney NHS nor Orkney Health and Care (OHAC) has had a dedicated public engagement officer post for many years, with Orkney NHS “devolving” (but not monitoring) responsibility for public engagement to individual service areas. It would appear that the new requirement for public engagement has similarly been “devolved” to Voluntary Action Orkney (VAO). While VAO is equipped to speak on behalf of the third sector, it is a complete cop-out for OHAC to assume that VAO can, or is able to, meet requirements for public consultation or public engagement.

5. I do not believe my involvement in the Strategic Planning Group has had any influence on planning. In particular, although I believed at the time of the localities planning day I had been able to influence the way the public meetings would happen, I was extremely disappointed to find that nothing that I had identified as important (including things backed up by other people at the meeting) had been taken into account. This included things like ensuring that there was good information available to the public to be able to have a sensible discussion, and that there were key (specific) questions to focus discussion and provide practical and usable input. I have also on many occasions questioned the data available and asked for better analysis of statistics, relating of statistics to local context, and some kind of grading of quality of evidence. I also question the commitment of the IA to public involvement when they can’t even time their meetings to ensure that Isles residents don’t have to leave the meetings early to get their transport home.

6. Public engagement is at the heart of the new legislative requirements, and yet this doesn’t seem to have sunk in. The IA (at every level of planning and decision making) needs to really understand and accept that they must involve the public in an effective way at every level of service delivery and planning. Talking with the public (as individuals and as groups of people with common interests) should be the primary way to get information and evidence for future planning, not an afterthought. Orkney really does need to have a dedicated public engagement officer who believes in the processes and understands how to network and create dialogue and feedback loops (i.e. someone with a community development interest and background, rather than purely a health service background). Putting out a 60 plus page document (written in such vague, general but very formal language that doesn’t give any real detail) for public comment is guaranteed to turn the public away from having any real input. There also needs to be some kind of external monitoring and review built into any public engagement protocols to make sure it is
happening effectively (and that includes external monitoring of the role of organisations such as Voluntary Action Orkney where they are being used as an integral part of public engagement)

7. The only way greater collaboration and engagement in decision making is going to happen is if there is a major shift in attitude from top down and through all levels of Health and Care service management and provision. If IA’s were required to give far more detail of how, in practical terms, they are going about public engagement it might be easier to monitor. If IA’s actually used the Participation Guidelines produced by Scottish Health Council that would make a huge difference. If IA’s stopped thinking they have ticked the box for public engagement by just having reps on every group that would help. If IA’s recognised that service user reps can’t actually “represent” all the service users, that would help. If there was more resourcing set aside for expert facilitation of formal and informal meetings of service user groups, that would help.

Corinne Curtis

Service User Representative on the Orkney IA (Orkney Health and Care) Strategic Planning Group.
Appendix 1: The poster used to advertise the Isles Locality Planning public meetings in Orkney. Note that this poster does not identify any opportunity for the public to directly influence IA locality planning. The excuse I heard for combining meetings was that the public was suffering “consultation fatigue”. I believe we get consultation fatigue when we continue to have such general broad “consultation” exercises with no feedback or evidence that our input is going anywhere. I believe the public will turn out to discuss issues when they issues are relevant to them, and when they know their view will have an impact.
Diabetes Scotland welcomes the Health and Sport Committee inquiry into “Integration Authorities Consultation with Stakeholders”.

Scotland has the fifth highest incidence of Type 1 diabetes in the world and has an increasing prevalence of people with Type 2 diabetes.

With over 285,000 people with diabetes in Scotland and around 1 million at increased risk of developing Type 2 diabetes; one in five people have diabetes or at risk of developing the condition. There are more people living with diabetes than with coronary heart disease. Two and a half times more people have diabetes than all cancers combined. At any time between 15 – 20% of patients in Scottish hospitals have diabetes.

Diabetes has a massive impact on the wellbeing of people living with diabetes and their families. It affects people’s physical, mental and emotional health. For example depression is at least twice as common in people with diabetes as in the general population, but this common comorbidity is frequently underdiagnosed and undertreated.

It is not surprising, therefore, that diabetes costs NHS Scotland around £1 billion each year, of which 80% (£800 million) is spent treating potentially avoidable complications. Furthermore, 12% of the total inpatient budget in Scotland goes on treating diabetes and its complications.

Integration authorities clearly need to understand the impact of diabetes on their local population and the potential savings to be made through prevention of Type 2 diabetes and appropriate treatment and support for people living with Type 1 and Type 2 diabetes to reduce the risk of serious complications and improve quality of life.

To help in forming a response, Diabetes Scotland asked its network of local groups, which operate in communities across Scotland, of their experiences of integration to date. Below we have collated the responses of the 20 groups that participated.

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

A typical response from our groups is given below:

“There were news bulletins at the inception of the IJB but no one really understands their work or the relationships and lines of authority between various bodies on the IJB and the expected outcomes of the IJB.” Diabetes Local Group

Seven respondents said that they or someone in their group had received information from the Integration Authority with regard to health and social care integration. Two of these were because of representations from Diabetes Scotland. None of the groups or individuals knew how to contact their local Integration Authority.

“I am surprised at how little I know about this partnership. I have never seen it advertised and would have no idea at how I could have become involved. With three members of my family with Type 1 and myself having Type 2 we like to keep in touch
with changes. I was involved with the first SIGN guideline for children/young people and fully participated by reading all the research papers and scoring them and it was pointed out to me at that time how important input from people living with diabetes was to them…. I feel it is extremely important that more members of the public should be actively involved especially at this time when everyone is looking at cutting budgets.”

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

Only three of the local groups which provided responses have had some involvement with their locality plans. Given the significance of the prevalence rate of diabetes, this is a large oversight from the strategic planning groups.

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

Only two groups responded that they have been involved in work with the Integration Authority following the publication of the strategic plan. They were engaged with the Carer and Service Users Group.

It is not clear who to contact with the Integration Authorities. Diabetes Scotland submitted Freedom of Information requests to Integration Authorities and Health Boards as there was confusion regarding responsibility for diabetes services carried out by primary care. The responses we received were disappointing: Integration Authorities passed responsibility to local Health Boards and the same in reverse. This is highly concerning regarding accountability for some key areas of diabetes treatment.

**Have you been involved with the work of the localities/what involvement would you like to have?**

One response said they would like the Managed Clinical Network patient representative to be able to report back what is happening with the Integration Authority.

The localities should have a clear workplan for the year, published well in advance and each workstream should publish arrangements for consultation on reshaping of services and on budgetary changes.

Due to the complex nature of diabetes, this will not mean that people are only consulted on “diabetes” services, but on the complex range of services that people living with diabetes receive – podiatry, ophthalmology, mental health services, etc.

The care of people living with non-complex Type 2 diabetes is coordinated by primary care and so large numbers of patients have an interest in how that care is delivered through GP practices, with current intelligence suggesting wide variation in care.

Type 1 diabetes has a serious impact on young people, on their schooling, and their ability to live a full life outside of school. The impact on parent carers can be enormous. Families need to be consulted about changes to young people’s services.

A disproportionate number of people with diabetes are of South Asian origin who may develop the condition at a younger age. Their specific voice needs to be heard in service design.
Do you think that your involvement with the Integration Authorities has had an impact on decision making?

There was only one response Diabetes Scotland believed that their participation had an impact on decision making due to their involvement in a local working group that fed into the Integration Authority. No other respondents believed that they had any impact on decision making.

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

As the leading charity for diabetes across Scotland there has been no formal consultation with the organisation regarding to strategic planning from any of the 32 Integration Authorities. To a large extent this has been replicated over our local groups with a small number being on patient focus groups. Integration Authorities must be more transparent, accountable and easier to contact.

The majority of responses were focused on greater Integration Authorities interaction. In addition there needs to be a clearer understanding of the aims, objectives and who to contact. Examples included:

“Integration Authorities need to inform the public who the members are and how they can be contacted.”

“If the Integration Authority came up to meet people it would be a good place to start.”

“Integration Authorities should clearly state or more particularly restate their aims and objectives together with the costed business plans to the (diabetes) group so that members can make informed contributions to help the Integration Authorities discussion and decision making.”

“The relationship between Local Authorities, Health Boards and other agencies should be explicitly detailed so that the overall picture can be understood by our group, empowering us to make the best contributions possible to the work of the Integration Authority as and when required.”

“Dialogue and constructive, collaborative relationships with local groups should ensure that an informed and tailored diabetes service is delivered locally.”

Diabetes Scotland suggests to the Committee that involvement of people living with diabetes and their caregivers/families, in Integration Authorities planning and consultation has been woefully inadequate. The diabetes community is one of the biggest constituencies in Scotland. Failure to address their needs will not only lead to poorer health outcomes, but will also miss the opportunity to reduce unnecessary spending on diabetes complications.
The National Carer Organisations welcome the opportunity to provide evidence on Integration Authorities’ approach to engagement with stakeholders. We are pleased that the Health and Sport Committee are looking into this important issue.

In this submission we have focussed on how Integration Authorities have engaged with unpaid carers. In doing so we have drawn on evidence gathered from the Carers Collaborative project.

**Background**
The Carers Collaborative is a project facilitated by the Coalition of Carers in Scotland that seeks to

- Research the current landscape in relation to Carer Representation on Integration Joint Boards (IJBs)
- Develop and facilitate a forum for Carer Representatives on IJBs
- Make recommendations for future work in relation to ongoing support and training of Carer Representatives, and support for local Integration Authorities in relation our Equal and Expert Best Practice Standards for Carer Engagement.

The Collaborative ran events and research activities between March and October 2016, involving 38 Carer Reps from 27 local authority areas, leading to the report ‘Equal, Expert and Valued’. A copy of the report is included with this submission.

**Q1. How carers are involved with the Integration Authorities to influence decision making?**
Carer Reps have worked hard to be ‘representative’, but their visibility to other carers remains an issue. Some carers’ centres support Carer Reps to represent local carer networks. Some areas struggle to engage carers, and most would like more carers in networks ‘underneath’ IJB board level. Where carers have been able to make contributions these appear to be valued (writing strategies, supporting consultations, improving governance, assisting inspections, contributing to commissioning etc.). It is important to note that strategic plans should reflect the issues which have been identified as priorities by Carers, not just carers’ responses to consultation on pre-determined issues.

<table>
<thead>
<tr>
<th>Examples of good practice</th>
<th>Examples of practice to be improved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some areas have good support structures to encourage different levels of involvement and coordination of carers’ views. Carers Reference Groups and Carers Voice Networks have been particularly helpful, as have pre-Board meetings with other public representatives.</td>
<td>These are often facilitated by Carer Centres or Third Sector Interfaces, but not always resourced by Integration Authorities.</td>
</tr>
<tr>
<td>‘Carer forums’ can help ensure Carer Reps hear and represent the wider views of carers. Some IJBs raise Carer Representatives' profiles by including their photos, biographies and an IJB email address on their websites.</td>
<td>Some areas do not have good carer networks to connect carers at different levels.</td>
</tr>
<tr>
<td>Some areas are further ahead in ensuring carers are represented at Strategic Planning Groups ‘underneath’ the IJB and at a locality level and that there are good lines of communication between the different planning structures and the IJB</td>
<td>This work is still developing in some areas and carers are not fully involved at a strategic planning level and locality level</td>
</tr>
</tbody>
</table>

**Q2. Involvement of carers in the preparation of strategic plans**
Carer Rep effectiveness appears to increase when they are included on Strategic Planning Groups, Carer
Forums and IJB Agenda groups. Those with access to agenda-setting meetings report feeling more included and productive. There are some good examples of IJBs being trained in Carer Awareness (e.g. Dumfries and Galloway, North Ayrshire). However across Scotland Carer Reps’ equality and expertise are still far from universally accepted.

<table>
<thead>
<tr>
<th>Examples of good practice</th>
<th>Examples of practice to be improved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some IJBs are actively preparing for the Carers Act, for example discussing it at Board level; reviewing their Strategic Plans in readiness; scheduling development days on the Act; and asking Carer Reps to prepare Board papers or presentations on the Act.</td>
<td>Several IJBs have not discussed or begun preparing for the Carers Act.</td>
</tr>
<tr>
<td>A small number of Strategic Plans use several indicators for National Health and Wellbeing Outcome 6, giving a rounded measure of carer outcomes. Some IJBs have worked with Carer Reps and carer centres to develop appropriate indicators.</td>
<td>Most areas use just the one indicator (“I feel supported to continue caring”).</td>
</tr>
</tbody>
</table>

Q4. How have carers been involved with the work of the localities what involvement are they likely to have?

The localities are at different stages of development. Some areas are further ahead and have carers represented at locality level. In other areas localities are still being established.

One of the current issues experienced by Integration Authorities is recruiting and supporting enough carer representatives to populate the IJB, strategic planning groups and localities. Local carer centres are often asked to identify and support carers to take on this role, but few areas provide sufficient resources to adequately reimburse carer representatives for the full costs of their involvement and to provide an adequate framework of support to ensure they can be effective in their role.

<table>
<thead>
<tr>
<th>Examples of good practice</th>
<th>Examples of practice to be improved</th>
</tr>
</thead>
<tbody>
<tr>
<td>In some areas, carers are provided with travel expenses for attending meetings. In others, replacement care is provided for time spent in meetings.</td>
<td>Some areas do not provide travel expenses or replacement care. Where replacement care is provided, this does not cover time spent reading papers and preparing for meetings.</td>
</tr>
<tr>
<td>Some IJBs identify a Carers’ Champion or lead officer who can work directly with Carer Reps and Carer Centres.</td>
<td>It is not always know who the local Carer Lead is, or what their role is.</td>
</tr>
<tr>
<td>Carer Reps find IJB development sessions beneficial – some IJBs schedule these every other month, between formal Board meetings.</td>
<td>Some Carer Reps have received no induction or training.</td>
</tr>
</tbody>
</table>

In addition, many carers are put-off from becoming involved in strategic planning groups and localities because of the time-commitment and number of meetings. At a recent Carers Collaborative meeting one carer representative said she already had 40 meetings in her diary relating to her involvement in the work of the Integration Authority. All of this is provided on a voluntary basis.

Q5. Has carer involvement had an impact on decision making?

As part of the work of the Carers Collaborative we undertook scoping work between May and October 2016, sourcing and analysing the three most recently available sets of minutes from each IJB or shadow board (pre April 2016).
References to Carer Representatives’ inputs were used as indicators of the nature and level of carer involvement in meetings and their impact on decision making (though this is a relatively crude measure, as carers commonly reported having more of a voice in other meetings and didn’t necessarily expect these to be recorded in IJB minutes). Each area’s Strategic Plan was also searched for references to unpaid carers. This was used as an indicator of the extent to which carers and carers’ outcomes had been identified and prioritised.

The findings show that at October 2016, 30 Strategic Plans were publicly available, 27 of which included outcomes for carers. 26 areas had made their meeting dates available, and 28 had published their minutes. Carers were referenced in the minutes of 17 IJBs.

<table>
<thead>
<tr>
<th>Strategic Plans available</th>
<th>Carer outcomes included</th>
<th>Meeting minutes available</th>
<th># IJBs minuting references to carers</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 plans</td>
<td>27 plans</td>
<td>28 areas</td>
<td>17 IJBs. (Total number of mentions: 29)</td>
</tr>
</tbody>
</table>

We found that one of the barriers to carers having an impact on decision making is the way in which IJB meetings are conducted. There are some examples of good practice where meetings are felt to be inclusive and carers feel they are viewed as equal partners in decision making. Other carer reps report that they feel they are not able to contribute to meetings effectively, as communication is often poor, they do not have any influence over the agenda or content of the meetings and often the meetings are taken up by organisational issues.

<table>
<thead>
<tr>
<th>Examples of good practice</th>
<th>Examples of practice to be improved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meetings are made accessible to Carer Reps. For example, one rural area rotates its</td>
<td>Barriers to involvement include long or unfocused meetings; jargon;</td>
</tr>
<tr>
<td>meetings around the region. Video links can help, but need careful planning and</td>
<td>meetings being conducted at high speed; and an emphasis on process.</td>
</tr>
<tr>
<td>facilitation.</td>
<td></td>
</tr>
<tr>
<td>Papers are made accessible by being provided in time to let carer prepare, in electronic</td>
<td>Papers are frequently lengthy and sent too late to allow Carer Reps</td>
</tr>
<tr>
<td>and paper versions. In one area papers can be collected from a local access point. One</td>
<td>to prepare. Several Carer Reps are not included in ‘green paper’</td>
</tr>
<tr>
<td>IJB provides Carer Reps with I-pads. In some areas, Carer Reps receive confidential</td>
<td>circulation.</td>
</tr>
<tr>
<td>‘green papers’ including financial information, which helps them fulfil their governance</td>
<td></td>
</tr>
<tr>
<td>role.</td>
<td></td>
</tr>
<tr>
<td>Carer Representatives are able to request agenda items and submit papers via Agenda</td>
<td>Several Carer Reps have no way to influence or contribute to agendas.</td>
</tr>
<tr>
<td>Committees, SPG Chairs, IJB Committee Services, pre-Board meetings or under ‘Any Other</td>
<td></td>
</tr>
<tr>
<td>Business’.</td>
<td></td>
</tr>
</tbody>
</table>

Q6 What could be done to improve the communication from the IAs? & Q7. What could be done to ensure greater collaboration and engagement in the decision making process of Integration Authorities?

We have developed five recommendations and 12 straightforward suggestions for improving carer involvement, all drawn from real life experience of what works for Carer Representatives across the country. Most of these recommendations would also improve the experience of other stakeholder groups who are experiencing the same issues.

Include Carers’ Representatives in decision making
1.1 Find ways to involve carers in consultation and decision-making: It is important to recognise the demands on carers’ time. Frequent or formal meetings can be a barrier to attracting or retaining carers. IJBs would benefit from sessions that enable carers to contribute more effectively, such as ideas exchanges. They should also consider ways to provide appropriate recognition and reward for Carer Reps.
1.2 Include Carer Reps in different groups: Ensure carers are represented on different groups within the wider structures of the Integration Authority, particularly groups that set agendas or agree decisions. Arrange collective voice meetings for service user reps, service provider reps, Carer Reps, and third sector reps – before agenda deadline dates. If you don’t have one, establish a carers’ advisory group.

1. Increase awareness and profile

2.1 Raise profile of Carer Reps: Ensure that the Carer Rep’s identity and role are clearly signposted on relevant websites, with contact details so other carers can get in touch. Give Reps an email address so they don’t have to use their own. Business cards are a nice touch. Use locality groups to ensure carer issues are accessed and represented.

2.2 Raise IJB awareness of carers: Chairs, Chief Officers and other partnership staff can learn a lot about the impact of their decisions by attending carers’ centres and meetings. Making Carers Awareness Training available for all IJB members has also been a popular and effective way to do this.

2. Value and resource Carer Representatives

3.1 Value Carers Representatives and their contributions: Valuing Carer Reps can be as simple as inviting, minuting and acknowledging their contribution to meetings. The real test is then to listen, act and follow through.

3.2 Train and support Carer Representatives: Carer and User Representative training is essential to good involvement – and governance. Arrange regular training or development days for the whole IJB. Arrange inductions for new members, for example meetings with key officials. Supportive mentoring increases confidence.

3.3 Resource representation: Take steps to make sure Carer Representatives are not worse off as a result of contributing to the IJB’s work. Provide travel costs and replacement care for the time they spend carrying out their IJB duties.

3.4 Ensure Carer Representatives have a clear remit: Agree clear roles for and with Carer Representatives. Make sure everyone knows what is expected of them.

3. Share practice and learning

3.1 Share practice between IJBs: Arrange exchanges with other IJBs to improve each other’s practice. Support IJB Carer Reps to meet up to share ideas from different areas (it’s where everything in this report came from!).

4.2 Improve communication: Ask what Carer Reps need. Make sure your agendas and minutes are publicly available. Carers can be fantastic conduits for ‘bottom up’ and ‘top down’ communication when supported by the right networks and structures.

4. Make meetings better

5.1 Create structures to allow agenda items to be raised: If you don’t already, establish a pathway for agenda items to be raised. Set clear deadlines, establish an agenda setting meeting, committee or process. Join the dots between IJB and SPG meetings.

5.2 Make meetings, minutes and papers accessible: Produce minutes, agendas and meeting papers as promptly as possible. This lets representatives get feedback to and from their carer networks. It’s especially helpful when officers identify issues affecting carers and seek advice before papers are tabled.

About the National Carer Organisations

The National Carer Organisations are brought together by a shared vision that all Scotland’s unpaid carers will be valued, included and supported as equal partners in the provision of care and will be able to enjoy a life...
outside of caring. They are Carers Scotland, the Coalition of Carers in Scotland, Minority Ethnic Carers of Older People Project (MECOPP), Carers Trust Scotland, the Scottish Young Carers Services Alliance, Crossroads Caring Scotland and Shared Care Scotland.
Introductory Remarks

The Pain Association Scotland, which was founded 27 years ago, is a small Third Sector organisation that has pioneered the role of self-management in helping those in the community burdened with all forms of chronic pain, by addressing the non-medical issues that have an impact on people’s daily lives. It does so by providing courses and meetings on the basis of Service Level Agreements, mainly with NHS Boards.

As the Association’s remit is Scotland-wide, it has faced serious challenges in terms of trying to maintain continuity of services in a variety of localities during the integration process. One aspect of this challenge has been the decision by the majority of NHS Boards to cease to offer the 3-year SLAs that were previously the norm. These have been replaced in many cases by 1-year Agreements, making longer-term planning more difficult and having an adverse impact on the willingness of Primary Care to refer patients because of GPs’ express concerns about the Association’s viability longer term. There has also been the challenge of attempting to find out within each Integration Authority where responsibility now rests for the commissioning of services. This has proved extremely difficult. The impression at the moment is that a new layer of bureaucracy has been created, destroying in the process old and well-established relations with NHS Board staff. Where it has been possible to identify the new commissioners of services, it has then proved extremely difficult to convince them of the value of the Association’s work, in spite of the priority the Government gives to chronic pain (SIGN Guideline 136), the highlighting of self-management in the document “Chronic Pain in Scotland” produced in April 2016 by the Government’s Lead Clinician for Chronic Pain and the considerable body of evidence that exists of the effectiveness of self-management in reducing the drugs bill associated with chronic pain as well as the significant reduction it produces in return visits to primary or secondary care.

It is quite impractical for a small, national organisation to maintain an awareness of the way in which each Integration Authority is developing its services, as each seems to have adopted a different approach. This problem is compounded by the varying ways in which IAs have decided to tackle the development of their localities, some of which have had budgets and responsibility for decision-making devolved to them but many others not. It would be at least a full-time job to study and comment on each and every strategic commissioning plan, workforce plan and other key documents produced by the Integration Authorities and their localities. Even then, the plans we have commented on have been at such a high level that we have found them unhelpful as a vehicle for reflecting our concerns.

We had expected that we might be able to rely for assistance on the generic work of The ALLIANCE, which has received considerable funding from the Government to give a strong voice to the Third Sector in the development of integrated services. Our clear impression is, however, that The ALLIANCE too has struggled to grasp the process and has therefore been unable so far to provide any practical advice on how organisations such as the Association could engage with the new commissioners of services.
We are concerned that the process has developed to such an extent without the voice of Third Sector organisations such as the Association having been heard, in spite of the First Minister’s clear wish that the Third Sector should be seen as equal partners in the integration process. From our experience, services have been commissioned not on a person-centred basis, as had been hoped, but on the basis of trying wherever possible to make budgetary savings. The opportunity to make worthwhile changes to services that reflect the approach and contribution the Third Sector can make seems to have been lost, making the likelihood of such developments in the future even more unlikely.

Against that background, the Association congratulates the Committee on its decision to investigate the issue of IAs’ engagement with stakeholders, and welcomes the opportunity to offer comments.

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

No. These issues remain a mystery, even in areas where the Association has provided services over many years. During the past 2 years, as we struggled with this issue, we were told by those responsible for overseeing the integration process that the key people to contact in each area were the Third Sector Interfaces (TSIs). It proved impossible, however, to obtain contact details for these people. We are now advised by The ALLIANCE that these TSIs are not best placed to advise on local commissioning arrangements and that we should instead get in touch with those responsible for public relations in each IA.

We have commented on a handful of strategic commissioning plans, but have seen nothing to suggest that those comments have been or will be taken into account. Even in areas where we already offer services, there has been no spontaneous attempt by the IAs to contact us. In one strategic plan, produced by NHS Fife, the plan demonstrated that the IA was simply unaware of the Association’s work in the Board area over many years, as the relevant Annex contained no reference to the Association’s work in the list of services provided by Third Sector organisations.

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

No. No Strategic Planning Group has contacted the Association while preparing its strategic plan, nor has the Association been invited to participate in the work of any Strategic Planning Group. This is in spite of the Government priority given to chronic pain, and the fact that its prevalence throughout Scotland is such that in every locality there will be significant numbers of people living with, and attempting to cope with the effects of, chronic pain.

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

The Association’s Director has been invited to become a member of the Perth & Kinross Third Sector Health & Social Care Strategic Health Forum. This has simply
served to underline the immense amount of detailed information that has to be assimilated in relation to a single locality, and the great demands that trying to keep up even in this one geographical area can make on the Director’s time.

Apart from this invitation, the Association has had no other direct involvement with the work of any IA following publication of its strategic plan.

*Have you been involved with the work of the localities / what involvement would you like to have?*

Apart from the Perth & Kinross example mentioned above, the Association has had no involvement with the work of the localities. The organisation does not have the resources to engage directly with each and every locality, especially in the light of the markedly different ways in which these seem to be evolving and the different status and responsibilities each of them seems to have.

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

As the Association’s involvement with IAs has been so slight, there is little likelihood of its having had any impact on decision-making. Given that The ALLIANCE itself appears to have struggled with the whole process, we believe that the whole of the Third Sector can have had little impact on IAs’ decision-making.

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

There needs to be clear information about who in each IA is responsible for the commissioning of services. Only then can the Association be in a position to make the case for the creation of an SLA covering the services we can provide.

In the light of the statutory duty placed on IAs in terms of engagement and consultation, the minimum requirement would seem to be the creation by every IA of a list of all the Third Sector organisations active in each area, or whose services would be of benefit to the resident population of each IA. These lists would need to be published by the IA so that they would be checked for comprehensiveness.

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

IAs need to take much more initiative in informing Third Sector organisations of opportunities to influence commissioning in the future.
Royal College of Physicians of Edinburgh

The Royal College of Physicians of Edinburgh (“the College”) is pleased to respond to the Committee’s call for views on Integration Authorities Consultation with Stakeholders. The College is an independent clinical standard-setting body and professional membership organisation, which aims to improve and maintain the quality of patient care. Founded in 1681, we support and educate doctors in the hospital sector throughout Scotland and the world with over 12,000 Fellows and Members in 91 countries, covering 30 medical specialties.

In order to inform our response, the College sought the views of our Fellows who work in specialities such as Care of the Elderly and would therefore have an interest in the work of Integration Authorities.

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

Our Fellows have mixed views on this. Some have had no engagement at all, while some are aware of the process but have found in practice that it is overly difficult to get involved with barriers to participation.

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

Again, there have been mixed experiences in this regard. Some Fellows have not been involved while others are members of the strategic planning groups. However, Fellows who are involved have expressed the view that their role on that group is unclear; there is little in the way of clinical input and no real sense that the Integration Authority or Integration Joint Board (IJB) are taking action to recognise or acknowledge the clinical voice.

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

The experience of Fellows has been that they have not been involved and still await initial contact.

Have you been involved with the work of the localities/ what involvement would you like to have?

Fellows have either had limited or no involvement to date. A view was expressed that there was a very “top-down” approach and there has not been widespread clinical engagement. In some hospital settings, this approach has caused friction within departments with some staff supporting the proposals and others feeling there is no solid evidence for the changes, such as international studies or analysis, and that to take on the suggested developments will be to the detriment of the already over-stretched acute service.
Fellows agree that strategic planning and implementation at a local level is crucial and needs widespread clinical engagement which has so far not materialised.

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

Fellows have not felt that their input has made an impact on decision making. Some have reported that there is a real sense of frustration that some IJBs appear not to value clinical opinion and there is a very big cultural gap between health and social care, which is a significant barrier to genuine integrated working.

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

Fellows seek a real cultural shift in this regard, and the assistance of senior staff and managers across health and social care to emphasise the importance of integrated working and communication in every setting.

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

Improved transparency and awareness raising of stakeholder meetings and engagement would be helpful. Fellows also seek to see Integration Authorities mandated to have a much greater clinical voice. At present, the experience of our Fellows is that there is no integration in anything other than name and the cultures of health and social care have not changed enough to embrace integration.

1 March 2017
Scottish Care welcomes this opportunity to contribute to the Health and Sport Committee’s inquiry into Integration Authorities consultation with stakeholders.

Scottish Care is a membership organisation and the representative body for independent social care services in Scotland.

Scottish Care represents over 400 organisations, which totals almost 1000 individual services, delivering residential care, nursing care, day care, care at home and housing support services.

Our membership covers both private and voluntary sector provider organisations. It includes organisations of varying types and sizes, amongst them single providers, small and medium sized groups, national providers and not-for-profit voluntary organisations and associations.

Our members deliver a wide range of registered services for older people as well as those with long term conditions, learning disabilities, physical disabilities, dementia or mental health problems.

The independent sector has a significant contribution to make to health and social care in Scotland, and therefore to Integration Authorities and their decision-making and planning processes.

The Scottish independent social care sector contributes to:

- The employment of over 100,000 people
- The employment of over 5,000 nurses
- The provision of 85% of care home places in Scotland
- The delivery of over 50% of home care hours for older people.

In fact, this sector is the majority provider of social care for older people in most partnership areas. Yet aside from the sheer levels of care and support provision the independent sector delivers, which alone make its engagement essential, it offers a wide range of knowledge and skills which make it a valuable partner. With statutory bodies continuing to divest in social care, the independent sector provides a real option for maximising resource use and investment to provide innovative, quality services. However, it can only do so if it is involved and engaged in planning and decision-making.

For these reasons, Scottish Care has long argued that the independent care sector (covering, in the formal language of health and social care integration legislation, commercial and non-commercial providers of social care) must be meaningfully and consistently engaged in Integration Authorities. Disappointingly, the sector’s representation on Integrated Joint Boards was not made a statutory requirement through the Public Bodies (Joint Working) (Scotland) Act 2014. However, it was made an explicit part of the accompanying guidance on Roles, Responsibilities and Membership of the Integration Joint Board:


Whilst there is a required minimum membership for inclusion on the Integration Joint Board, there is also local flexibility for the Integration Joint Board to add additional members. The Independent
Sector for example provide a significant proportion of social care services and will therefore play a key role in the successful delivery of integrated services in local areas.

It is also a statutory requirement that commercial and non-commercial providers of social care (the independent sector) are represented on the strategic planning groups of Integration Authorities.

However, our experience to date is that the independent sector is represented on only six of the 32 Integrated Joint Boards across Scotland.

We know from experience that instances where high level decisions regarding the direction and delivery of care and support are made without providers, barriers and concerns are often encountered at the implementation level which would have been easily surmountable had the independent sector been involved in the making of those early decisions. By failing to secure the sector’s place on integration joint boards, the opportunity to make use of its knowledge, expertise, skills and resources is being missed. Not being at the table makes it extremely difficult for the independent sector to meaningfully contribute to the success of health and social care integration. What’s more, disregard for the role of the independent sector in the planning of local care bestowed a lack of value on its vast, skilled workforce and on the needs of older people, who comprise the majority of those supported by the independent sector.

It is only through the sector’s full participation in planning and setting the strategic direction that the most effective local proposals can be agreed and effected to deliver positive outcomes – both for integration itself and for the health, wellbeing and lives of local people.

The independent sector has an established infrastructure to enable participation and engagement with Integration Authorities at both a local and national level. At present, local structures include both a network of care providers and a team of 22 independent sector Local Integration Leads, employed through Scottish Care but funded in collaboration with Health & Social Care Partnerships, who work in 25 of the 32 partnership areas to promote and facilitate independent sector engagement in relation to integration. It is important to recognise and make use of this valuable resource and the wealth of expertise these individuals can offer to Integration Authorities with regards to the independent sector. For instance in Argyll & Bute, strong working relationships have been established between the independent sector and the health and social care partnership, which has led to positive joint working around areas of quality, workforce development, joint shaping of services and new models of care delivery for homecare. This has led to increased joint training opportunities for the health and social care sector workforce within the health and social care partnership, including the recent successful placement of Allied Health Professional students in care homes as part of their training. However in other areas, Local Integration Leads are struggling to establish their seat at the table and to have the crucial role of the independent sector understood and valued. These difficulties are to the detriment of positive planning and delivery of services and delay the progress that can be made in improving the access, availability, sustainability and effective use of the overall resources and services in a locality.

It must be clearly noted that the sector is willing, able and committed to being a positive partner in local integration arrangements. In the six areas where the sector is represented on Integrated Joint Boards, namely Glasgow, Fife, Dumfries & Galloway, South Ayrshire, North Ayrshire and Argyll & Bute, it has demonstrated its ability to be a responsible partner. We know that this partnership has been welcomed and valued by colleagues in other sectors at a local level. Where the sector has been
fully involved and engaged, real partnership working has been nurtured and practical benefits have been explicitly realised for those who receive health and social care services.

Conversely, where there has been a failure to embed the independent sector’s involvement in joint boards, we have seen progress, continuity and opportunities which would have resulted from constructive working relationships being at best, not maximised and at worst, jeopardised. The reasons for resistance to involvement have varied, but tend to centre on concerns of conflicts of interest in relation to the planning and delivery of services. This argument is undermined by the fact that local authorities and health boards are themselves both commissioners and providers of local services, and that the sector does not have voting rights on Integrated Joint Boards.

Scottish Care has welcomed the emphasis placed on the role of the independent sector in strategic planning within Integration Authorities. Indeed, as highlighted earlier, it is impossible to plan, develop and deliver efficient and effective care and support services without the central involvement of the majority provider of these services in Scotland and without utilising the capacity, skillset, resources and flexibility that this sector can offer to local partnerships. However, we remain concerned about the inconsistency which prevails in relation to the independent sector’s involvement across different health and social care partnerships. Whilst the regulations state that Integration Authorities must ‘treat the third and independent sectors as key partners’, this is left open to local interpretation of what ‘key partners’ look like strategically and operationally. What is being experienced by the sector at a local level ranges from very positive and proactive engagement with the sector with mutually beneficial outcomes, to reluctant inclusion and in some cases, open hostility to the sector’s involvement which is unhelpful and damaging not only for the sector but for the people it employs and supports. What we also find is that these variations are often determined by local personnel and their own views on the independent care sector’s value – where these individuals change, there is often a resulting change in relation to the sector’s engagement which creates uncertainty and instability.

Scottish Care therefore believes that, moving forward, there must be stronger guarantees in place that non-statutory partners will have a significant voice and contribution in the planning and delivery of integrated health and social care. In a time of constrained resources, it is essential that health and social care partnerships are able to work efficiently and effectively to achieve the best outcomes for local people. The independent sector provides a way to do this through supporting the preventative care agenda, addressing delayed discharge and inappropriate hospital admissions and by providing innovative solutions to local need, to name but a few. It can do this in a cost-effective, high quality way but only if it is involved in designing solutions – not by being excluded until the point of delivery.

What’s more, the voices of those who work in social care services and those who access these supports must be engaged with more meaningfully in local planning processes, and the independent sector represents one conduit for this. Scottish Care has recently adopted a policy of ensuring front line worker engagement and presence on all of its strategic and operational planning groups, in recognition of the vital contribution of these experienced individuals. This has been evidenced in Scottish Care’s recent reports, Voices from the Nursing Front Line and Trees that Bend in the Wind.

---

which through the eyes of front line care staff present the reality of the challenges and opportunities in
the care sector at present, and recommendations for strategic and operational improvement.
Additionally, our recently created Conventions on the Human Rights of adults and older people in
receipt of independent sector social care services highlight how valuable the voices of people who
access supports are in driving improvement and enabling focused attention to be paid to what matters
to people. Scottish Care would like to see this principle of active partner contribution being adopted
by Integrated Joint Boards to ensure that the particular issues pertaining to the independent care
sector, the social care workforce and older people’s care agendas are not being inadvertently ignored
by Integration Authorities.

Scottish Care would welcome further opportunities to discuss our submission with the Health and
Sport Committee and if further information is required, would be more than happy to supply this.

3 Trees that Bend in the Wind: Exploring the Experiences of Front Line Support Workers Delivering Palliative
and End of Life Care (Scottish Care, 2017). Available at: http://www.scottishcare.org/wp-
content/uploads/2017/02/PEOLC-Report-final-.pdf
4 Convention on the Rights of Adults and Older People Receiving Care at Home or Housing Support (Scottish
Care, 2016). Available at: http://www.scottishcare.org/wp-content/uploads/2016/06/Care-at-Home-
Convention.pdf
Convention on the Rights of Residents in Care Homes for Adults and Older People (Scottish Care, 2015).
Available at: http://www.scottishcare.org/wp-content/uploads/2016/06/Convention-on-the-Rights-of-Residents-
in-Care-Homes-for-Adults-and-Older-People-3.pdf
The Health and Social Care Alliance Scotland

The Health and Social Care Alliance Scotland (the ALLIANCE) is the national third sector intermediary for a range of health and social care organisations. It brings together over 1,800 members, including a large network of national and local third sector organisations, associates in the statutory and private sectors and individuals.

Our vision is for a Scotland where people of all ages who are disabled or living with long term conditions, and unpaid carers, have a strong voice and enjoy their right to live well, as equal and active citizens, free from discrimination, with support and services that put them at the centre.

Effective engagement is necessary to ensure that the redesign and delivery of health and social care services works to the benefit of communities and individuals. We would, however, welcome a Health and Sport Committee inquiry that looks beyond “consultation” and engagement to consider to what extent the processes that foster new ways of working alongside people who use support and services are being enabled by the new systems and structures. These were, after all, the principles that were intimated in the Policy Memorandum underpinning the Scottish Government’s initial Bill; are espoused in the guidance that has supported implementation; and are an essential element of enabling the transformative service reform that is required.

“This is consistent with principles of co-production, which underpin the Government’s vision for mutual and person-centred public services, which encourage the utilisation of the talents, capacities and potential of all of Scotland’s people and communities in designing and delivering health and social services. In addition, it will be important, and is intended through secondary legislation, to involve and consult carers and users of health and social care services in all aspects of the integrated arrangements.”

Public Bodies (Joint Working) (Scotland) Bill, Policy Memorandum, May 2013

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

Between March and July 2016 the ALLIANCE’s Third Sector Health and Social Care Support Team scoped the third sector experience of integration¹. Many of the barriers and frustrations reported then persist, although there are early signs that things are beginning to improve.

In general terms, the sector who do not serve on local governance and planning groups still find it difficult to source information and do not feel they are able to influence the outcome. Communication mechanisms have a significant impact on this, as even public facing documents can be difficult to find online. However, some Partnerships also appear reluctant to share information about their intentions and short-term priorities. Most Partnerships have also not invested in local support to enable the third sector’s contribution. Feedback indicates that the sector feel significantly more empowered, and initiate more action, when it is easy to access appropriately detailed information and they have support to use it.

At governance and planning group level, most third sector advocates are still not fully embedded in decision-making processes and many report that their statutory partners view implementation plans and decision-making as operational processes. As a result, some advocates report that they do not have access to relevant data and information and many groups do not make decisions. When third sector advocates are engaged in ongoing dialogue and have access to the operational detail or are kept abreast of developments they generally feel they can contribute and have information to discuss with the sector.

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

Our research suggests that in most areas, there was extensive engagement regarding the strategic plan, much of it facilitated by Third Sector Interfaces. For most, however, the process used to develop Strategic Plans felt consultative rather than co-productive and finished when the initial high-level plan was drafted. Many also expressed concerns that the suggestions made by individuals and organisations were not incorporated into the final plans and that participants received little or no feedback about why.

**North Ayrshire Health and Social Care Partnership**

Representatives from the third and independent sectors, along with statutory sector colleagues formed a group to write the initial draft of the plan before moving to engage with a diverse local audience. The group drew on the expertise of some local peer researchers, who had been trained by the local Alcohol and Drug Partnership and regularly supported their work, to formulate an engagement plan. This included: process design, question development, data collection and analysis.

During February 2015, 6 peer researchers based themselves in three sites across North Ayrshire. They interviewed 279 members of the public about North Ayrshire Health and Social Care Partnerships Strategic Priorities. The strategic plan was altered to reflect the feedback received through these interactions. The Partnership then held a number of public engagement events in communities across North
Ayrshire to gather views on the revised Plan and again, updated the Plan to reflect the feedback captured.

In many areas there continues to be a perceived lack of clarity about the role and purpose of Strategic Planning Groups (SPGs), and in several areas it is still seen by the sector as „only there to fulfil the requirements of the legislation“. In several areas, the SPG was concerned solely with the formulation and review of the Strategic Plan, and not with its ongoing monitoring and implementation and hence did not meet regularly. Furthermore, in many areas the Strategic Planning Group does not contain the diversity of voices that would accurately reflect the ethos of the legislation.

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

In some areas, the third sector is firmly embedded and woven through the work of the SPG and Integration Authority and the vast majority of areas evidence a wish to increase the sector’s level of involvement. There is third sector involvement in the evaluation and monitoring of the Integrated Care Fund, Public Social Partnership work, and there are also a few areas where the third sector is linked into operational process.

However, many third sector organisations are still struggling to connect in, and do not know, for example, who to contact when their Single Level Agreement is reaching the end of its contract period, and find it difficult to find information that would enable them to enhance their contribution. In the vast majority of areas where there is higher engagement with the third sector, this is supported by investment in an enabling resource.

In the vast majority of cases the Strategic Plans are high level documents that provided little operational detail about how the change envisaged in them will be delivered. These are also often the only documents available to the sector, making it difficult for the sector to contribute to the ongoing implementation of the Plans.

**Perth and Kinross Health and Social Care Partnership**

Perth and Kinross Health and Social Care Partnership have formally recognised the Third Sector Health and Social Care Strategic Forum, facilitated and supported by the local TSI, as its main conduit to and from the Third Sector.

The third sector representative on the Integrated Joint Board produces a written precis of the Board papers in the period between the papers being published and the forum meeting. The forum meetings have been deliberately scheduled to fall
between the papers being published and the Integrated Joint Board meeting to allow for the representative to gather views and seek feedback. The representative also reissues the board paper precis with updates following the Integrated Joint Board meeting.

The seven third sector representatives who sit on the Strategic Planning Group (selected to ensure that a width of communities of interest were represented) attend the forum and provide regular feedback and updates.

Have you been involved with the work of the localities/what involvement would you like to have?

Although operational delivery structures have developed at locality level in most areas, most do not yet have fully operational locality planning groups (as described in the legislation and guidance). In the areas where locality planning is more advanced, the Groups are chaired or co-chaired by the Third Sector Interfaces (TSIs), leading to a welcome perception of being an equal partner. In most cases these Groups are however still in their infancy and require to be nurtured and developed as there have been instances where stakeholders have felt disenfranchised when their ideas have not been listened to or implemented, as they were not seen as aligning with the strategic priorities detailed in the strategic plan.

There are also continued concerns about how locality planning will work for services hosted by one locality that deliver across more than one locality or Integration Authority, as there is no clear information about how the wider population will influence the service shape and design of such services.

Argyll and Bute Health and Social Care Partnership

In Argyll and Bute, it is felt that the third sector has its most influence through the Locality Planning Groups (LPGs) and currently, the TSI co-chair two of the LPGs, and is involved in the Communication and Engagement Group of each. Each locality has its own devolved budget from the Integrated Care Fund.

The Partnership and the TSI held a series of workshops across each locality, Collaboration, Co-Production, and Communities, engaging with the third sector and the public around the HSCP’s strategic priorities, to consider how to develop innovative services that benefitted from partnership working. Reports from these events have now gone to each of the LPGs for consideration of how the work should be progressed.

Do you think that your involvement with the IAs has had an impact on decision making?
The experience of third sector advocates varied significantly across Scotland with some feeling excluded and others embedded. Where the sector advocates sat on this continuum appears to be largely a function of the history of the organisation, the previous experience of all partners, the stability of personnel and the strength of the sector’s connection with Integration Authority personnel.

In many areas, decision-making was still viewed as happening in operational meetings without input from the third sector or “outside the room”. Often this is because the statutory sector still viewed the third sector as sub-contractors who could draw competitive advantage from their involvement, rather than as partners in the process. Despite these barriers, some sector advocates and TSI staff were still able to contribute to the process and keep in the loop of what was happening by using their own knowledge of the system and connections within it. However, it is the ability to network with the wider sector, including sparing the resource necessary to enable 2-way information flow, that still proves challenging.

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

- Provision of well-structured, regularly updated information online, including opportunities to get involved away from meetings (e.g. polls).
- Sharing ideas before fully formed and developed, to allow room for others input.
- Sharing of improvement plans.
- Signposting to priorities (including short, medium and long-term), and set out and publish planned activities for next 3 months.
- Provision of clear and regular information which outlines who is responsible for what in each partnership.
- Don’t focus solely on “big ticket” items (e.g. strategic plans or savings proposals) without prior engagement and contextual information about the challenges faced by the Partnership.
- Share good news stories and progress.

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

- More investment of time and energy in building the foundations of the new way of working and a shift away from a focus on traditional statutory services and system driven targets evidenced in strategic documents is required.
- The Review of Targets and Indicators enabling a more co-produced approach.
- Partnerships entering into early and frequent dialogue with the third sector about its priorities, alongside support that enables this.
- More emphasis should be placed on capacity building opportunities like the Our Voice programme which is developing peer networks across Scotland of the
carer, service user and third sector representatives who sit on Integration Joint Boards.

- Support Strategic Planning Groups to develop and clearly define their role in the implementation phase.
- Following the Council Elections in May, rapid and targeted induction process for new councillors who sit on Integration Joint Boards to strengthen their knowledge and skills in enabling co-productive ways of working.
- Investment in enabling support for the sector (e.g. capacity for ongoing outreach as well as to respond to enquiries).
- Support and training to design and implement new decision making processes.
- Support to increase understanding of strategic commissioning and co-production within partnerships.
Do you know how and when you can get involved with the Integration Authorities (IAs) to influence decision making?

VASLan (Third Sector Interface for South Lanarkshire) and the Third Sector are now fully engaged and involved. VASLan and Third Sector representatives participate on the Locality Planning Groups; Strategic Commissioning Group and Integrated Joint Board. There are also Third Sector representatives with subject matter specialisms e.g. Mental Health on themed groups.

Involvement has grown from a light touch tokenistic attendance to a position of full engagement / empowerment alongside partners. The transition phase reflects the development of ‘both parties’ (Voluntary Sector & Statutory bodies) as relationships were established and encouraged to flourish. It is appropriate to acknowledge there is now shared understanding and acceptance of the capabilities of the Voluntary / Third Sector.

In the last few months South Lanarkshire has appointed a new Director of Health and Social Care, following the retirement of the predecessor. She regularly puts out a blog detailing updates on progress and regularly asks for people’s views and thoughts on Health and Social Care. VASLan also distributes the blog through their e-newsletter to the Third Sector. The new Director has also taken time to meet with relevant third sector organisations involved in the process and there are numerous indications of seeking a wider productive relationship between the Sector and Integration Authorities.

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

VASLan and the Third Sector were fully involved in the development phase of the strategic plans. Several events were held across South Lanarkshire with representatives of health and social care staff and the third sector (as well as carers etc.). People were asked to consider the main priorities and rate them in order of funding levels (additional, same level or less funding). The information was used to prioritise the key themes under strategic commissioning.

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

Yes. A Partnership decision following the production of the strategic plan recognised a funding investment within the third sector - (£650,000 allocated per year initially for a three year period but subsequently reduced to two years as a result of unexplained process delays). Third Sector organisations were invited to identify a series of interventions complementary/additional to statutory services and beneficial to communities. All funded projects were required to identify where the project linked to the 9 national health and wellbeing indicators. The application process commenced in November 2015. Additional leverage was highlighted by 76% of the approved applications having identified match funding in support of their application.

Funding was approved at the Strategic Commissioning Group on 11th March, 2016. The funded projects included: Self-management of conditions; health education; peer support; information and signposting; alternative therapies; encouraging independence; respite; one-to-one support; physical health; social prescribing; connectivity; mental health and befriending.

VASLan monitors the projects on a quarterly basis to ensure they continue to deliver the outcomes, monitoring results are reported to health and social care partners.
Have you been involved with the work of the localities/what involvement would you like to have?

Within South Lanarkshire there are four Locality Planning Groups. As stated earlier, VASLan and a Third Sector Representative (currently the Chair of the Third Sector Forum) attend all of the Locality Planning Groups. Also involved are representatives from Carer organisations and Locality Health and Social Care Forum (formerly Public Partnership Forum). These meetings are still in their infancy stage (4 meetings) and the appointment of Locality Planning Managers holding specific responsibilities is a very recent development. Additionally the change in leadership of the Director of Health and Social Care has introduced another influence which will have a bearing on the future shape and format of the local planning bodies.

VASLan’s third sector data (Locator Tool which highlights third sector organisations and activities by locality) is a prominent information tool which is accessed via the VASLan website and available for Communities, public sector organisations, third sector etc. to use.

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

It is not immediately evident that any Third Sector input has had a significant bearing within or in the decision making process. Given the slow rate of progress however this is not surprising as we are only beginning to build momentum as an IJB. The Third Sector have been involved from day one and are key to bringing alternative and potentially innovative solutions to the complexities of the integrated health and social care agenda. The Third Sector in co-production with Partners were instrumental in identifying wide ranging issues in the process of compiling the Strategic / Commissioning Plan. Within the wider picture very small steps but symbolically a very significant direction of travel for partnership development.

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

The involvement and inclusion of the Third Sector Interface facilitates a range of communication and establishes a vital bridge to communities and organisations. It is essential that Partners recognise and support the flow of information to ensure the continuity of the message. VASLan are currently looking at how we can improve our communication on Health and Social Care. Currently we publish health and social care items in our e-newsletter, and feedback to the third sector at our locality Third Sector Forum events, these are currently held quarterly in four localities.

We are also reviewing our communication practices following feedback from the Third Sector Forum events with a view to providing additional information related to health and social care through our website.

We also work closely with the Health and Social Care Communications Officer for South Lanarkshire, who we accommodate in our office one day per week. We ensure that all health and social care communications are posted to our website and in our e-newsletter. This good relationship means that we are able to signpost the Communications Officer to promote third sector improvements/stories under health and social care.

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

There has been an acknowledged change of greater collaboration since the appointment of the new Director of Health and Social Care in South Lanarkshire. Previously there could have been a perceived feeling of tokenism. Also, with the introduction of funding to third sector there has been more involvement with a range of key public sector officers enhancing understanding and providing practical opportunity to demonstrate and confirm capability of the Third Sector as an untapped resource.
Integration Authorities should ensure that Third Sector Interfaces are the conduit between statutory partners and third sector organisations, thus ensuring no commissioning advantage is gained by an individual organisation. TSI’s regularly health check third sector organisations; help upskill organisations and encourage co-production. With these checks in place, plus robust monitoring TSI’s can ensure that the third sector can effectively deliver cost effective support to health and social care authorities.

We also need to ensure that Health and Social Care boards follow the National Standards for Community Engagement; asking the public for their views, in an open, transparent way and not giving them closed options.

The agenda we are faced with is advancing and increasing relentlessly! Be prepared to explore the unthinkable and take the risk. Without risk we will be successful in achieving nothing!