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Health and Sport Committee
Comataidh Slàinte is Spòrs

Are they involving us? Integration Authorities' engagement with stakeholders

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Health and Sport Committee

To consider and report on matters falling within the responsibility of the Cabinet Secretary for Health and Sport.

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healthandsport@parliament.scot

0131 348 5524

Committee Membership

Convener
Neil Findlay
Scottish Labour

Deputy Convener
Clare Haughey
Scottish National Party

Tom Arthur
Scottish National Party

Miles Briggs
Scottish Conservative
and Unionist Party

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Scottish National Party

Colin Smyth
Scottish Labour

Maree Todd
Scottish National Party

Brian Whittle
Scottish Conservative
and Unionist Party

Introduction

1. Integration Authorities (IAs) are a key area of scrutiny for the Health and Sport Committee. To date our primary focus has been on the mechanisms of budget setting by IAs. An issue raised in this process has been IAs' approach to engagement with their stakeholders. As all IAs are now into at least their second full year of operation we decided we could reasonably consider this issue further.

2. Our short inquiry has sought to assess the extent to which stakeholders (including the public, the service users, the third sector and the independent sector) are being involved effectively in the work of IAs.

3. We issued a general call for written views to patient and carers representatives, NHS and social care staff and third sector organisations. We received 51 responses.

4. This was followed by oral evidence at two meetings. On 25 April 2017 we heard from both stakeholders and integration authority representatives. On 13 June 2017 we took evidence from the Cabinet Secretary for Health and Sport.

5. We are very grateful to all those who have given up their time to provide us with information and evidence on this inquiry.

Background

6. The Public Bodies (Joint Working) Act 2014 (the Act) sets out the legislative framework for integrating health and social care.

7. During passage of the Act the then Cabinet Secretary for Health and Well-being stated “the third and independent sectors will be embedded in the process as key stakeholders in shaping the redesign of services" . [1]

8. The Act sought to achieve this vision by placing a duty on integration authorities to ensure stakeholders were fully engaged in the preparation, publication and review of strategic commissioning plans.

9. Scottish Government guidance on strategic planning states services should be "planned and led locally in a way which is engaged with the community (including those who look after service users and those who are involved in the provision of health and social care)". [2]

10. The guidance details that the aim is to ensure a wide and diverse engagement results in a strategic commissioning plan that is not simply controlled by the small number of people on the Strategic Planning Group but rather the population that will be affected by its findings. The guidance advises that this should include the involvement and engagement of existing representative fora, such as joint planning groups, advocacy organisations, locality planning groups and those involved in local community planning. [3]

11. The guidance to involve and engage is not explicit beyond the strategic planning stage. However, the duty to involve, inform and consult is embedded in the twelve integration principles which underpin the approach IAs should take in improving the wellbeing of service users. A number of IAs have produced participation and engagement or communication strategies. These strategies set out the respective IAs vision and shared principles with respect to participation and engagement of its stakeholders.

12. The Scottish Government has produced a Communications Toolkit which contains practical resources and information to help IAs to communicate the purpose and outcomes of health and social care integration. Healthcare Improvement Scotland also runs iHub which is expressly about supporting health and social care integration.

13. We considered a series of reports, from Audit Scotland, the Alliance and the Coalition of Carers, that indicate IAs engagement with stakeholders may not be working as well as it could. These reports, along with the written and oral evidence we have received, highlight challenges that need to be overcome to ensure the vision of stakeholders being embedded in IAs and ultimately service design is being realised.

14. Our report highlights some of the issues around the meaningful involvement of stakeholders by IAs which we consider need to be addressed.

How can public awareness of Integration Authorities be improved?

15. A recurring issue raised during the course of our inquiry was the lack of public awareness about the establishment of IAs.

16. Diabetes Scotland highlighted that people in its network of local groups had limited understanding of the structures, process and outcomes of IAs. [4]

17. Inclusion Scotland felt there was little awareness of the engagement carried out by IAs. It suggested there was a tendency for IAs to engage with organisations already known to health boards and local authorities rather than to seek to engage new or seldom heard groups. [5]

18. In oral evidence, North Ayrshire Health and Social Care Partnership acknowledged that, to date, there had been limited work done to promote (to the public) the existence of IAs and improve knowledge of IAs' responsibility to shift the balance of care. [6]

19. North Ayrshire suggested whilst there was a local responsibility to share information about IAs to the public, there was also a role for a national campaign to help support this work. [7]

20. **The Scottish Government has emphasised integration is one of the biggest changes in the way health and social care services are run in decades.**

21. **However, knowledge of this fundamental change in the way parts of the healthcare system operates does not appear to be high amongst the general population.**

22. **To ensure health and social care integration is a success it will require the support of the populations they serve. There is an onus on each individual IA to make sure their communities know of their existence and role. However, the reconfiguration of services is a change that is of national, as well as local, importance. We therefore recommend the Scottish Government take every opportunity to promote IAs and the shift in the balance of care at a national level. We also believe IAs, health boards and local authorities have an important role to promote integration at a local level.**

How can engagement be meaningful?

Avoiding a box-ticking exercise

23. We heard that stakeholders' experiences of engagement with IAs on local service planning were very mixed. A common theme was that engagement with stakeholders needed to be meaningful rather than a 'box-ticking' exercise. By that we mean engagement should be done with a purpose and a desire to involve stakeholders in meaningful decision making before such decisions are determined. Public involvement should be embedded.

24. We received some examples of good practice, where engagement seemed to be working fairly well, for example in South Lanarkshire. Voluntary Action South Lanarkshire explained the third sector fed into the different structures within the IA. This included being represented by the Chief Executive on the IA.

25. Fife Health and Social Care Partnership also suggested going forward it was looking at a "genuine co-production model with our partners". This included recruiting a mix of service users, staff and carers to look at the options for change around urgent care in Fife. It had also held a redesigning care together event with the independent sector in order to help shape investment in new models of care in Fife. [8]

26. These examples suggest that when engagement is meaningful, it can help create a system of 'co-production' with the third sector and other stakeholders on the IA.

27. However, this approach did not appear to be universal, with many stakeholders telling us they were finding it hard to contribute to local service planning.

28. The term used repeatedly by witnesses during the course of our inquiry was that engagement was 'tokenistic' and was not delivering the co-production that was required. [9] Witnesses commented that IAs needed to do more than just consult others for views. For co-production to be achieved stakeholders need to be involved at the start of the process.

29. Alzheimer Scotland told us about an occasion where they had attended meetings at which resourcing decisions were discussed by members of the IA. However it was made clear Alzheimer Scotland's role was to communicate decisions rather than to contribute to the decision making process. Alzheimer Scotland commented "engagement is about bringing people with you and doing things with them, rather than just communicating decisions that have already been made". [10]

30. The Coalition of Carers in Scotland also raised similar concerns about IAs' approach to engagement. It gave the specific example of an IA producing three options for a revised approach to mental health services but only consulting on one. This resulted in carers being unhappy that ultimately the new approach to mental health services appeared to have been agreed before consultation began. [11]

31. Whilst some witnesses suggested that the acute sector and medical staff had more prominence in IAs than other stakeholders, the Royal College of Physicians of

Edinburgh raised concerns about the extent to which clinician input was valued. Experience had been mixed, however it felt there is "no real sense that the IA or Integrated Joint Board are taking action to recognise or acknowledge the clinical voice". [12] In oral evidence the Royal College suggested the approach taken by IAs could be "overly top down" and the experiences of front-line clinicians are not being allowed to influence the approach being taken. [13]

32. RCN Scotland presented a similar picture for its members. In its written submission it stated "At present, the RCN has found that nurse board members, nurses and the RCN as an organisation have not always been fully engaged or listened to by all IAs." [14]

Improving transparency of information

33. Meaningful engagement is also made more difficult where there is a lack of transparency about how IAs operate and where information on the aims and work of the IA is not forthcoming. This can make it difficult for stakeholders to know how to contribute their views.

34. Diabetes Scotland told us it had found involvement with the IAs at a strategic and a locality level to be "somewhat challenging" and IAs' "communication channels to be a bit abstract and opaque". [15]

35. Diabetes Scotland also found it hard to obtain information from IAs on their priorities for diabetes. Many IAs were non responsive. Ultimately Diabetes Scotland had had to issue FOI requests to IAs for the information. Even then, the information received from the FOI requests had been mixed. [16]

Case study- Petition PE1628

36. Petition PE1628 raised another example where engagement with stakeholders had been considered not to have been meaningful.

37. During our work on the inquiry we took the opportunity to look at the petition as a case study of how engagement could be improved.

38. The Petition related to Argyll and Bute IA and the decision of its Locality Planning Group to change the use of a residential care home (Struan Lodge) to a reablement facility. According to the IA, this decision would reduce the number of care home beds but increase the capacity for people to remain independent and in their own homes for longer.

39. The Petitioner and a dedicated local group did not support this decision and argued consultation was inadequate. They raised concern the process of consultation for the integration of health and social care was not clear

40. In evidence Argyll and Bute IA noted the challenges it faced in helping people to understand the case for shifting the balance of care. One of the issues that arose

was that individual facilities rather than a bigger picture of overall services became the focus of the discussion in the local community. Argyll and Bute IA discussed the need to build communities' confidence in community services. [17]

41. In the case of Struan Lodge, Argyll and Bute IA conceded it had not taken the time to consult with stakeholders regarding the service changes. The IA explained they had "apologised and said to the community that we did not get it right. There was an absolute error in judgement in the making of decisions that were very focused on budget". [18]

42. The IA told us as a result it had paused the changes for six months. It had held community engagement events and issued questionnaires which had resulted in the Struan Lodge Development Group producing an action plan offering different approaches to the future of the care home. Although no consensus had been reached, the IA indicated it would take account of the feedback it had received when determining its future approach.

Scottish Government views

43. We raised the question of how to achieve meaningful engagement with the Scottish Government. The Cabinet Secretary for Health and Sport indicated the importance of engagement by IAs both at the strategic planning and the locality level. She told us "those who know best how services should be delivered are those who receive the services and those who provide them". [19]

44. However she emphasised this approach should not be a barrier to ensuring integration authorities engage fully and widely with all stakeholders. [20]

45. She said there were examples of good practice in relation to IA engagement, however she acknowledged the situation was "still work in progress". Some IA had improvements to make to ensure engagement resulted in stakeholders being placed at the centre of planning and decision making. [21]

46. The Cabinet Secretary discussed the Scottish Government's role in sharing IAs best practice through the provision of guidance and support. She also emphasised the role for the Scottish Government in highlighting the merits of IAs adopting a co-production approach.

47. **The case studies brought to our attention have demonstrated the importance of having meaningful engagement by IAs. This engagement must not be a tick box exercise. We were concerned to hear there had been occasions where organisations, keen to engage with an IA, had to resort to issuing FOI requests to receive basic information about the approach the IA was taking to service delivery. There is a clear need for greater public transparency around this sort of information.**

48. **Integration offers an opportunity to improve the involvement of communities in decisions around the shift in the balance of care.**

49. **We understand at times there will be challenging decisions to be made involving competing priorities and it may not always be possible to satisfy all the wishes of community representatives. However at the very least it is important the reasons for a decision are properly explained, even if the decision itself might not be supported. This can also be helped by communities having a feeling of involvement in the entire process. At present there does not appear to be a mechanism or guidance in place to facilitate this.**

50. **IAs must make sure communities are fully involved and have confidence in the engagement being undertaken. IAs must learn from occasions where engagement has clearly not worked as well as it should have to date. We believe IAs must involve relevant stakeholders in consultation planning. We also believe IAs should work with stakeholders on the evaluation of engagement and public involvements activities. IA need to ensure they take account of the time and resource implications for individual and third sector stakeholders in this work.**

Reducing the costs and complexity of engagement

The costs associated with engaging

51. We heard evidence of some practical barriers which were hindering engagement with IAs.

52. Some witnesses raised concerns carers and service user representatives on IAs were incurring costs as a result of their engagement. The Coalition of Carers in Scotland explained there were instances where carers were not getting their transport and replacement care costs fully reimbursed for attending meetings. [22]

53. Corinne Curtis, Service User Representative on the Strategic Planning Group in Orkney felt it was unfair public representatives on IAs should be expected to volunteer their time without compensation. She believed no one should be at a financial disadvantage as a result of being a public representative. Corinne Curtis called for a standard Scotland-wide approach to be taken to address the issue. For example the self-employed could be paid a day rate for attendance at meetings and carers given additional paid care hours. [23]

54. The Alliance said “If we truly value public involvement in the boards, we need to pay for it and budget for it, and ensure that people are able to attend and are financed to do so.” [24]

55. The Cabinet Secretary, in response to concerns about the costs incurred by some representatives to participate in the work of IAs, agreed they should not be disadvantaged. She explained “We expect the integration authorities to ensure that those who participate in the process can do so without detriment, and I would be concerned if that were not the case.” [25]

Making the process of engagement less complex

56. We also received evidence that the complexity and length of meeting papers for IA and sub-group meetings presented challenges for carers and service user representatives in engaging with the work of the IA. Meeting papers often did not take into account their needs. The papers contained inaccessible language, for example.

57. There was also a high volume of paperwork with papers often only available shortly before a meeting. This meant representatives had little time to consider the papers and even less time to confer and debate issues raised in the papers with other organisations prior to meetings. [26]

58. The way some meetings were conducted was also noted as a barrier for stakeholder engagement. Some meetings could be quite ‘high level’ and hard to follow. [27] There was also variation in the approach taken by different IAs to

stakeholders being able to put items on the agenda for consideration at meetings. In some instances there was no mechanism to do this. [28]

59. However, we received some examples of good practice. The Coalition of Carers highlighted examples of additional resources being provided to support the carers and service user representatives on IAs. It highlighted some IAs holding development sessions with Carer Reps every other month, between formal Board meetings. [29]

60. **We are concerned there are instances where there appears to be a lack of support for individuals and third sector organisations to mitigate the time, resource and money required to be properly involved in local planning.**

61. **We agree with the Cabinet Secretary no one should be financially disadvantaged as a result of engagement with an IA. However we are concerned by reports that people have incurred financial costs associated with their participation in IAs. We ask the Cabinet Secretary for details of how she intends to address these concerns, noting her comments representatives should be able to participate without detriment.**

62. **Whilst there are examples of IAs ensuring that the additional needs of carers and service users are taken into consideration to facilitate meaningful engagement, we do not believe there is consistency across IAs in meeting these needs. We expect the additional support and accommodations needed to ensure the barriers to involvement to be provided across all IAs. We call upon the Scottish Government to indicate how it will ensure this is achieved.**

Changes needed to IA governance?

63. One issue raised with us was whether changes to the voting rights on IA boards might help increase the influence of stakeholder representatives, and improve the equality of the relationship between participants on IAs.

64. Currently third sector organisations and carers representatives do not have voting rights on IAs.

65. The Coalition of Carers highlighted expanding voting rights on IAs was something they had lobbied for when the relevant legislation was being scrutinised by the Scottish Parliament.

66. The Alliance told us at the IA governance level, the relationship between the statutory sector and the third sector, the independent sector and people who use supporting services is "inherently unequal, because of the nature of voting rights and the number of people on the boards". [30]

67. However, we also heard that, for many organisations, the key objective was not voting rights but the ability to influence the approach taken to the provision of services, prior to this decision-taking stage. Some witnesses also highlighted that with voting rights came the possibility of seeming to endorse a decision they did not agree with. Ultimately not being able to vote could provide more freedom. [31]

68. The Cabinet Secretary acknowledged the debate about the voting rights of individual board members. She explained the reasoning for the approach taken "The conclusion was that it was proper for voting rights on use of such significant public budgets to be held only by board members who are publicly accountable- in other words, elected council members and non-executive member of health boards." [32]

69. **We are concerned that the relationships between board members at IA governance level are 'unequal'. We note the call by some witnesses to extend voting rights to other members of IA boards to address these concerns. However we also note the challenges which changes in governance relationships would pose if voting rights were extended to board members who are not publicly accountable like council and non-executive members of health boards. We conclude that at this stage other approaches should be prioritised to address this perceived inequality before considering changes to IA governance arrangements. In this report, we have outlined improvements which could be made.**

Improving engagement at a locality level

70. There are lots of ideas regarding how to facilitate and achieve engagement at a local level. We heard evidence about the goodwill and strong desire by stakeholders to be involved in the work of IAs but concerns these were being frustrated by the current system.

71. We received evidence about the important work being undertaken by representatives of carers and the third sector on IAs. However, we also heard about the challenges in ensuring these representatives truly reflect the range of views being expressed at a local level.

Challenges

72. Corinne Curtis, Service User Representative on the Strategic Planning Group in Orkney expressed frustration with her role—

> "As a service user representative— I cannot represent, because I do not have a network to feed back to or to get information from. [….] Now that I have attended a few meetings, I have come to the realisation that my job is to act not as a representative but as someone who monitors public participation." [33]

73. The Coalition of Carers explained for the carer on the IA board to operate as an effective representative there needed to be a community of other carers for them to communicate and engage with. [34]

74. Some IAs had adopted, or were considering adopting, the approach of having an elected representative from the third sector on the IA. We heard from East Lothian Health and Social Care Partnership this was an approach they were giving some consideration to. [35]

75. Corinne Curtis' experience however, suggested only a (small) minority of people were willing, able and could afford to participate as service user representatives. Her view was that an election process may not result in the individual being any more representative. [36]

Role of Third Sector Interfaces

76. We heard the use of Third Sector Interfaces (TSIs) could provide another way for IAs to access the views of a wider range of local views.

77. As set out in the Public Bodies (Joint Working) (Scotland) Act 2014, TSIs have a key role as an advocate in relation to the role of the third sector and the integration of health and social care. "TSIs are positioned to act as the conduit for the third sector in relation to integration activities." [37]

78. We heard some evidence the approach to the IAs' use of TSIs was developing in some areas.

79. Voluntary Action South Lanarkshire commented that whilst it was impractical to expect the 1,600 community groups and organisations in South Lanarkshire to sit round the table together it viewed the TSI as the "conduit for passing out information". [38]

80. However some witnesses noted there was variation in the approach taken by TSIs across the country, which resulted in variation in their effectiveness. Some suggested there were challenges for national organisations to engage with TSIs in some areas. Alzheimer Scotland stated "there is great variation in the capacity and willingness of the TSIs to work with their members-particularly those of us that are national organisations". [39]

81. A Marie Currie written submission suggested TSIs were facing a difficult task to "represent a sector that is simply not representable, due to its size, shape and nature". It explained the needs of a large charity with a significant local presence delivering a frontline service in healthcare were considerably different to those of a small, local based charity delivering support services in social care. [40]

82. The Scottish Government highlighted the funding it had made available to TSIs to provide local support to the third and voluntary sectors to engage with integration. The Scottish Government explained £8m had been made available until March 2018 and a further £4m to September. [41]

Role of the Scottish Health Council

83. We also explored the question as to whether the remit of the Scottish Health Council (SHC) should be formally expanded to assist IAs with their engagement. Currently its role is to support health boards with their public engagement.

84. The Scottish Health Council highlighted in its written submission that whilst its current role did not formally extend into social care, it had been working with IAs to support their public engagement activities through its Our Voice framework.[Scottish Health Council and Healthcare Improvement Scotland written submission]. This framework, initiated by the Scottish Government, aims to enable people who use health and social care services, carers and the public to engage purposefully with health and social care providers in order to continuously improve services.

85. Diabetes Scotland suggested, given the SHC's current role with health boards, the SHC could develop best practice for engagement and involvement for IAs. [42]

86. North Ayrshire Health and Social Care Partnership suggested a similar role for a national body like the SHC or Alliance to distil and share good practice regarding engagement across all IAs. [43]

87. Diabetes Scotland suggested the focus should be on ensuring there were engagement channels up from the local networks. Diabetes Scotland emphasised the need for a 'menu of communications' for people to engage rather than there being "just one mechanism and one organisation". [44]

88. The Coalition of Carers also emphasised the need to support local engagement. It believed there was a small role for national support but as things developed it expected the role of engagement at a local level to strengthen. [45]

89. Several organisations emphasised the real opportunity to influence and engage lay people at the locality level. In its written submission Arthritis Care Scotland explained "key investment is more likely to be at locality level and this needs to be prioritised when looking at systems that support consultation with service users". [46]

90. Some submissions called for a specific role for an individual responsible for public engagement within each IA. In its written submission Marie Curie suggested it had been considerably easier to engage with those IAs where the IA had appointed staff with stakeholder engagement in their remit and titles. It called for consideration to be given to all IAs to adopting this approach. [47]

91. Harold Massie, a former Patient and Service User Representative on the Shetland Integration Authority recommended in his written submission there should be a full time, paid support worker employed by the SHC. He called for the individual to have responsibility for maintaining public representation and supporting public consultations at locality and IA area level. [48]

92. We received views from an engagement event involving service users, carers and third sector representatives who sit on IAs. This had been facilitated by the Alliance and the SHC, in collaboration with the Coalition of Carers in Scotland. Some people at the event had suggested the introduction of legislation to require national standards for IAs to ensure accountability. They also supported the idea of a dedicated staff member in post with responsibility for ensuring meaningful engagement at all levels across localities and communities.

Conclusions on engagement at a locality level

93. **When discussing the delivery of meaningful public involvement emphasis is often placed on the importance of a local presence and the need for direct involvement with individuals and local groups.**

94. **We recognise there are challenges in ensuring representatives of carers and the third sector on IAs truly reflect the range of views being expressed at a local level. We also recognise the challenges TSIs face in assisting IAs to obtain the views of community organisations. Clearly there are variations in how TSIs have been operating. There are difficulties inherent in trying to capture views from a broad range of organisations, some of which operate nationally whilst others operate on a small-scale local level. The diversity of the third sector means it cannot be treated as a single homogenous group, which makes designing an approach to third sector engagement particularly challenging.**

95. **We note the Scottish Health Council's current role remains under review and we expect revisions to the SHC's role to be made reflecting the changed health and social care landscape.**

96. **In addition, we can see the advantages in identifying within each IA a single individual taking responsibility for public involvement and engagement. While we do not wish to see accountability for this diluted and passed to a single individual many organisations have argued such a role would improve the profile of public engagement and support others in carrying out this work. We are attracted to the idea of a dedicated community development staff member in each IA or TSI. Their explicit role would be to link and co-ordinate public and stakeholder engagement. The post holder could also seek to identify and mitigate some of the practical barriers to engagement. We recommend that each IA appoint a dedicated community development staff in their IA or TSI accountable directly to the chief officer. We ask the Scottish Government how it could encourage and support such an approach to be taken by IAs.**

Overall conclusion

97. **Health and social care integration is a fundamental change to the way health and care services are planned and delivered. For IAs to achieve this change they require not only the population at large to understand and support the approach taken to local service delivery, but ultimately for them to be involved in driving the changes forward.**

98. **Engagement of stakeholders should be done with a purpose and desire to involve them in meaningful decision making before such decisions are determined. We have found evidence of a willingness and strong desire from stakeholders to achieve this co-production.**

99. **However whilst we have found examples where stakeholder engagement has been working well this is not consistent across all IAs. Stakeholders are not embedded in decision-making processes across all IAs and at all stages in determining the approach taken to delivering local services. This must be improved. All IAs are now into at least their second full year of operation and this piecemeal approach to engagement with stakeholders cannot continue. For IAs to be a success this core issue of co-production must be addressed.**

100. **We also recognise that at times there will be challenging decisions to be made by IAs involving competing priorities, the priorities of the local community, financial proprieties and the priority to deliver the shift in the balance of care. In the Scottish Government's response to this report we request it provide further information on the guidance and assistance it provides to IAs in supporting their navigation through these often competing priorities. We ask the Scottish Government to provide further detail on the extent to which Scottish Government guidance is directed at shifting the balance of care and examples of this approach in operation. We also ask the Scottish Government how the shift in the balance of care is being measured and how it is to be specifically reported allowing the shift to be identified and collated.**

Annex A - Minutes of meeting

15th Meeting, 2016 (Session 5) Tuesday 13 December 2016

1. Work programme (in private): The Committee considered and agreed its work programme.

4th Meeting, 2017 (Session 5) Tuesday 07 February 2017

2. Integration Authorities Consultation with Stakeholders (in private): The Committee considered and agreed its approach.

11th Meeting, 2017 (Session 5) Tuesday 25 April 2017

2. Integration Authorities Engagement with Stakeholders: The Committee took 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; and
- Sonia Cottom, Director, Pain Association Scotland;

and then, in roundtable format, 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); and
- David Small, Chief Officer, East Lothian Health and Social Care Partnership.

6. Integration Authorities Engagement with Stakeholders (in private): The Committee considered the main themes arising from the oral evidence heard earlier in the meeting and agreed to invite the Scottish Government to give evidence at a future meeting.

16th Meeting, 2017 (Session 5) Tuesday 13 June 2017

12. Integration Authorities Engagement with Stakeholders and Draft Budget 2017-18: The Committee took evidence from—

- Shona Robison, Cabinet Secretary for Health and Sport;
- Geoff Huggins, Director for Health and Social Care Integration; and
- Christine McLaughlin, Director of Health Finance

all Scottish Government

14. Integration Authorities Engagement with Stakeholders and Budget 2017-18 (in private): The Committee considered the evidence heard earlier in the meeting.

18th Meeting, 2017 (Session 5) Tuesday 5 September 2017

5. Integration Authorities Consultation with Stakeholders (in private): The Committee considered and agreed a draft report.

Annexe B - Evidence

Written Evidence

- Amy Anderson
- Arthritis Care Scotland
- CHAS
- Diabetes Scotland
- Alex Stobart
- Heidi Tweedie
- Alzheimer Scotland
- Ayrshire Independent Living Network
- British Lung Foundation Scotland
- Pain Association Scotland
- Corinne Curtis - Orkney
- Harold Massie
- Law Society of Scotland’s Health and Medical Law Sub-committee
- The Alliance
- National Carers Organisation
- P3 (Patient Partnership in Practice)
- Colin Angus
- Royal College of Physicians of Edinburgh
- Volunteer Health Scotland
- Accord Hospice
- Inclusion Scotland
- Marie Curie
- Sue Ryder
- North Lanarkshire Partnership for Change
- West Dumbartonshire CVS

- Ardgowan Hospice
- Coalition of Care Providers in Scotland
- Moira Robertson
- Royal National Institute of Blind People Scotland
- Scottish Care
- Scottish Health Council and Healthcare Improvement Scotland
- SCVO
- St Columbas Hospice
- Voluntary Action South Lanarkshire
- Royal College of Nursing Scotland
- Fife Voluntary Action
- PAMIS
- Sport Aberdeen
- Care Inspectorate
- Paths for All
- ALLIANCE and the Scottish Health Council on behalf of service user and carer Integration Joint Board representatives
- Parkinson's UK Scotland
- Kenny Matheson
- Patient Opinion Scotland
- Andrew Muir
- Max Barr
- Chest Heart & Stroke Scotland (CHSS)
- Anonymous
- Camphill Scotland
- Hamish Greig
- Argyll and Bute Health and Social Care Partnership

Official Reports of Meeting

Tuesday 25 April - Evidence from stakeholders

Tuesday 13 June - Evidence from the Cabinet Secretary

1 Health and Sport Committee. *Official Report, 1 October 2013*, Col 4401.

2 Scottish Government. (2015) Strategic Commissioning Plans Guidance

3 Scottish Government. (2015) *Strategic Commissioning Plans Guidance*

4 Diabetes Scotland. Written submission

5 Inclusion Scotland. Written submission.

6 Health and Sport Committee. *Official Report 25 April 2017*, Col 45.

7 Health and Sport Committee. *Official Report 25 April 2017*, Col 45.

8 Health and Sport Committee. *Official Report, 25 April 2017* , Col 24.

9 Health and Sport Committee. *Official Report, 25 April 2017*, Col 21.

10 Health and Sport Committee. *Official Report, 25 April 2017*, Col 25.

11 Health and Sport Committee. *Official Report, 25 April 2017*, Col 12.

12 Royal College of Physicians of Edinburgh. Written submission.

13 Health and Sport Committee. *Official Report, 25 April 2017*, Col 28-29.

14 RCN Scotland. Written submission.

15 Health and Sport Committee. *Official Report, 25 April 2017*, Col 4-5.

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