SCOTTISH GOVERNMENT CONSULTATION ON THE INTEGRATION OF ADULT HEALTH AND SOCIAL CARE

RESPONSE FROM EAST AYRSHIRE COUNCIL

East Ayrshire Council welcomes the opportunity to response to the Scottish Government proposals for the integration of Adult Health and Social Care.

Our response has been informed by 15 engagement sessions including those held with Elected Members, Council Officers, statutory partners within Community Planning and the third sector and public partnership forum.

Over recent years partnership working between East Ayrshire Council and NHS Ayrshire and Arran has delivered many positive outcomes for our local communities. Hospital retraction programmes for adults with mental health problems or learning disabilities has delivered a significant shift in the balance of care from institutional to community living. Services to older people have also evidenced success both in the reduction in the number of continuing care hospital beds and enormous progress in addressing the issue of delayed hospital discharge. More recently this partnership approach has been enhanced by re-ablement programmes that are supporting older people to meet their aspirations to live at home longer, rather than being admitted to care homes.

All of the above is achieved through development of a community infrastructure that encompasses Social Work, Health, Housing and Leisure Services working in partnership with the third sector and unpaid carers.

The Council agrees with Scottish Government that to further improve outcomes whilst addressing challenges of demographic change will require a whole system approach to direct resources from reactive spend and unscheduled care to early intervention and preventative approaches. The proposed integration will, we believe, be a significant contributor to this agenda.

We also believe that the proposed integration requires to be seen within the context of wider public sector reform and emerging legislation including the review of Community Planning, the Community Empowerment and Renewal Bill, The Children and Young People Bill and Self Directed Services.

We believe that the proposals contained within the consultation for locality planning and commissioning of services, offer an important opportunity to contribute towards the delivery of these wider policy objectives within strong Community Planning arrangements.

In our response, whilst supporting the overall proposals, we have highlighted areas we consider require further examination, detail, in particular, this includes financial and practice governance arrangements and democratic accountability.

EAST AYRSHIRE COUNCIL'S RESPONSE TO THE SCOTTISH GOVERNMENT CONSULTATION ON PROPOSALS FOR THE INTEGRATION OF ADULT HEALTH AND SOCIAL CARE

Consultation Questionnaire

The case for change

Question 1: Is the proposal to focus initially, after legislation is enacted, on improving outcomes for older people, and then to extend our focus to improving integration of all areas of adult health and social care, practical and helpful?

Yes ☐ No ☐

It is welcome that the proposals recognise that the scale of organisational and culture change envisaged will require time to be fully and effectively implemented.

A staged approach to implementation will, we believe, be essential. We also support the development of a suite of outcome measures for older people. It may, however, be over simplistic to focus the improvement of outcomes on any one group, such as older people.

If the ambition in promoting community based care through developing more preventative services, including early intervention, is to be achieved and supported by inclusion of local universal services, then partnerships require to be able to focus on those parts of the system that will deliver a shift in resources. On a local basis this is likely to, as a priority, include further development of anticipatory care for older people and also for people with long term conditions and in relation to alcohol related conditions.

To improve outcomes for older people requires action in many crosscutting services, telecare, addiction, financial inclusion, unpaid carers, advocacy, housing and leisure. These services require to be enabled to operate and report across service areas.

In terms of governance, inequity could be created for some service groups, with the primary focus of interest being in older people services.

In terms of organisational behaviour, care would be required that disproportionate focus and subsequent human / financial resources are not targeted to evidence / achieve performance targets to the detriment of other equally important areas.

We require to ensure that the proposed changes do not create divides in Social Work and other Council services that impact negatively on services and outcomes for children and vulnerable families.

Outline of proposed reforms

Question 2: Is our proposed framework for integration comprehensive? Is there anything missing that you would want to see added to it, or anything you would suggest should be removed?

Yes□ No □

No the proposed framework is not presently comprehensive and it is appreciated that the proposals will be developed further as a consequence of consultation and further consideration.

The proposals in current presentation require clarification in a number of areas, including those outlined below:

Clarity is required in respect of shared understanding of the term adult social care and other terms of primary care, community health etc;

The role of the Jointly Accountable Officer, the Chief Executive and the Leader of the Council within the governance proposals;

The scope of the integrated budgets. It is welcomed that budgets for Acute Hospital Care are recognised as integral to the proposals but require further detail. If we are to provide sustainable services in the next decade and beyond the shift in resources identified as essential in the Reshaping Care for Older People Programme, from buildings based services to community based services will require to be delivered. This must include the means to shift resources to follow patient care from hospital to community;

The interdependence of Social Care Services with, Housing, Leisure, Educational and Cultural Services requires clearer recognition and protection within the proposals;

The proposals for locality service planning and devolution of decision making to local communities, clinicians and care professionals is welcome. These will build upon our nationally acclaimed co-location centres which provide a one door approach to a wide range of public services including Health and Social Care. We are committed to a programme of Transforming our Relationships with the Communities we Serve, which builds on local knowledge, strengths and ambition; these proposals fit well with our local programme;

As delivery of services become more integrated, accountability for services, including complaints management, also require to be developed to ensure a seamless service to the public; and

The proposals at present have little focus on integration and development of public health, health improvement and services to address health inequalities. Further development of this area would be essential.

National outcomes for adult health and social care

Question 3: This proposal will establish in law a requirement for statutory partners – Health Boards and Local Authorities – to deliver, and to be held jointly and equally accountable for, nationally agreed outcomes for adult health and social care. This is a significant departure from the current, separate performance management mechanisms that apply to Health Boards and Local Authorities. Does this approach provide a sufficiently strong mechanism to achieve the extent of change that is required?

Yes ☐ No ☐

We are supportive of the proposal for Councils and Health Boards to be held jointly and equally accountable for a suite of nationally agreed outcomes.

Within current delivery arrangements the principle of joint accountability for outcomes is established practice in East Ayrshire and is embraced fully through community planning.

The Community Planning Partnership (CPP) provides a strong focus for shared local outcomes, through the Community Plan with accountability shared through the SOA. Locally the Community Health Partnership leads on the Improving Health and Wellbeing theme of the Community Plan and has responsibility for delivering health related local outcomes within Community Planning structures.

Within East Ayrshire the Community Plan is recognised by all partners as the sovereign planning document and this ensures that the totality of partners budgets are utilised to deliver on agreed outcomes. This partnership focus requires to continue.

In delivering through this mechanism we are able to ensure the focus is on delivering outcomes for individuals and communities and draw on strengths from across the CPP. Local Leisure Services are integrated in a wide range of activity from Falls Prevention to Alcohol Brief Interventions; Housing Services support directly and through structural links to Registered Social Landlords in programmes from Supported Accommodation, to Care and Repair house adaptations and health and homelessness; Education and cultural services support from alcohol education programme to engagement with older people with dementia and drama and music activities with people who have learning disabilities.

As delivery arrangements change, Councils and Health Boards will want to ensure that if they are accountable for outcomes, then they have effective structures and mechanisms to direct strategy, agree delivery models and monitor performance.

We believe partnership models founded on local Community Planning mechanisms for lines of accountability provide a cornerstone of this activity.

Question 4: Do you agree that nationally agreed outcomes for adult health and social care should be included within all local Single Outcome Agreements?

Yes ☐ No ☐

Community Planning in East Ayrshire provides a clear focus for joint accountability. Given that HEAT targets and Social Care performance targets are already included in East Ayrshire SOA; therefore, the principle is welcomed as something already adopted by the CPP.

It should be noted that many community care outcomes, particularly those in relation to early intervention and prevention depend on strong local partnerships in relation to social work, housing, leisure (including community health improvement), education, and cultural services. In terms of civil contingencies and business continuity, these partnerships are extended further to encompass other Council neighbourhood services, including roads and planning.

Future planning, governance and delivery models will require local mechanisms and a suite of indicators across services e.g. to ensure these outcomes are achieved.

Governance and joint accountability

Question 5: Will joint accountability to Ministers and Local Authority Leaders provide the right balance of local democratic accountability and accountability to central government, for health and social care services?

Yes ☐ No ☐

The principle of joint accountability, and local democratic accountability for health and social care is welcome.

The proposal from a Local Authority perspective that this accountability is vested in the Council Leader requires consideration.

Democratic accountability for Council Services and performance is vested in the Council as an organisation. The Council Leader has no specific decision making powers. The proposal to hold the Leader accountable is likely to require significant revision to the respective roles of the Council and the Leader and the respective relationship between the Council and the Leader. It is the Council as a statutory partner that remains responsible for delivery of the outcomes and it is the Council that will be held to account for performance. Accordingly, any proposal to alter the current arrangements are seen as weakening the Council's accountability to its residents in the first instance and to government in the second.

Differential practice in this area would be inconsistent with other Council responsibilities such as Corporate Parenting, Educational Attainment and Regeneration.

The proposal would also appear to prevent the Council Leader being a member of the Health and Social Care Partnership Committee; which could impede the successful integration of resources and alignment of priorities beyond those within the control of the new Partnership.

Question 6: Should there be scope to establish a Health and Social Care Partnership that covers more than one Local Authority?

Yes ☐ No ☐

The majority of Scottish Local Authorities work within long established arrangements that respective health boards deliver services across Council boundaries, indeed only 3 mainland Councils are co-terminus with NHS Boards.

While we agree that arrangements should be open to local discretion, it is our belief that the advantages of delivery of local Health and Social Care Services, integrated within single Council Community Planning Partnerships, with well established partners, including voluntary, community and statutory sectors, outweigh any disadvantages.

Delivery of good quality services that achieve these positive outcomes will always be the highest priority and this will require effective and reliable partnership arrangements at community, Council, NHS Board and National levels.

At a single Council level, there is clear joint accountability as described within the proposals. The direct accountability of Councils would be less transparent and diluted in cross boundary arrangements.

Any such arrangement, which extended beyond a single authority boundary, would require to demonstrate equity of decision making both within and across Council areas and it is not apparent how this would be achieved without establishing sub governance arrangements that would negate the initial cross council premise.

In such arrangements, the role of the JAO would require to be considered as they would potentially be accountable to 4 or more Chief Executives.

In Ayrshire, the three councils have, over many years, taken differing approaches to the delivery of outcomes in social care to meet the differing local needs and priorities of our communities. This includes, for example, the balance of directly delivered / procured services and models of early intervention/partnership with universal services.

This arrangement extends to different models of engagement with communities. We believe the H&SC partnership and locality planning arrangements within require to be integral to wider local community engagement and this is best served at Council level.

In terms of Finance and Governance, a multi Council approach would pose challenges as to how resources contributed to the partnership could be identified so as not to "lose their identity" Council would require to be assured

of financial governance and appropriate spend of funding in local areas before committing.

Question 7: Are the proposed Committee arrangements appropriate to ensure governance of the Health and Social Care Partnership?

Yes ▫ No ▫

The proposed arrangements are appropriate as long as their coverage is for a single Council area. The proposals have many similarities to the current arrangements in Ayrshire for Community Health Partnerships.

Current arrangements are, however, in respect of partnership activity rather than management governance / decision making arrangements.

The proposed committee arrangements provide a clear framework within a single Council arrangement, although they would require clarification in respect of any other arrangement before a commitment could be made.

In any cross Council arrangement, responsibility / accountability of committee members, particularly local authority elected members, for services in geographic areas outwith their Council, would require clarity. As outlined previously, Councils make strategic decisions on cross cutting policies, including Social Care, in response to local need and circumstances. It would appear iniquitous that decisions on local services could be made by a committee where the majority had no local connection, but statutory responsibilities remained with the authority.

The number of members a local authority would seek for the committee to ensure robust local democratic representation is likely to exceed the minimum number of members proposed. We recognise the challenge this brings to Health Boards in respect of the number of non-executive members and further clarification would be welcome.

Given the proposal to introduce legally enforceable national outcomes and the accountability arrangements for those, there seems no good reason why membership numbers from each body needs to be equal. It is more important that membership is reflective of the democratic composition of the Council and limiting the number of members in the way described mitigates against that.

Committees will require to be resourced in terms of support / advice to ensure informed decision making. This may require particular focus in delegated finance / partnership models.

Question 8: Are the performance management arrangements described above sufficiently robust to provide public confidence that effective action will be taken if local services are failing to deliver appropriately?

Yes ☐ No ☐

Performance management proposals to address failure are consistent with existing experience of Councils and partnerships through the Care Inspectorate and Joint Improvement Team respectively. If these arrangements only applied to older (or adult) aspects of outcomes within the SOA then this would be iniquitous.

It is also noted that Intervention to address poor performance is to the HSCP and not parent bodies. This could be seen as direct national governance / direction of the HSCP when legislative accountability lies with Councils and Health Boards.

We require to own the local agenda as we do our SOA and resolve issues at a local level. The reporting framework for the SOA to National Government works well but accountability clearly lies with the Council/CPP.

In terms of public confidence we believe this will be driven at an individual level by transparent integrated systems to address complaints (this will be required (at a community level by engagement in locality planning) and transparency that the HSCP is integrated with other local services.

Question 9: Should Health Boards and Local Authorities be free to choose whether to include the budgets for other CHP functions – apart from adult health and social care – within the scope of the Health and Social Care Partnership?

Yes ☐ No ☐

Local systems should have the scope but not the requirement to include budgets from other services as appropriate. As the proposals remove CHPs from the statute, a number of services outwith Adult Health and Social Care will be impacted upon. The ability to include other functions within the new arrangements has the potential to reduce the need for duplicate management costs.

In terms of Health services, and given current understanding of terminology around primary care and community health, it is difficult to see how, without creating significant additional structures, the NHS would fail to include other services in the partnership.

A driver for integration is to improve outcomes for people and support sustainable services by facilitating a shift in resources from buildings based services to community and preventative spend. Partnerships at a local level will wish to consider which resources should be included in the partnership to facilitate this change. The Integrated Resource Framework essentially clarifies

existing spend and provides a baseline for discussion.

Integrated budgets and resourcing

Question 10: Do you think the models described above can successfully deliver our objective to use money to best effect for the patient or service user, whether they need "health" or "social care" support?

Yes ▢ No ▢

As indicated earlier we are supportive of the proposed integration. The most important focus requires to be on improving outcomes for local people and communities. The model of integrating resources (people and funding) potentially provides both the greatest opportunity and challenges to the proposals. Both models presented address some boundaries in respect of community health and social care but create other boundaries in respect of other Council services.

The body corporate model would require a dedicated infrastructure, of finance, human resources, legal, administration and IT. This needs to be minimised by developing support arrangements through one or both parent bodies. An outcome whereby the limited resources available required to be directed away from front line services would be unacceptable.

In delegation models it is likely that there will be a significant transfer of employees between partners. This provides inherent risks in terms of alignment of terms and conditions, including potential conflicts with other developing legislation in respect of self directed services.

We believe that within an overall legislative framework, discretion should be available to local partners to consider what structures are required to achieve the agreed outcomes.

If models are developed across council areas, it is likely the HSCP would be larger in terms of employees and financial resources than the parent bodies. The Joint Accountable Officer would also appear to be working to several managers all at Chief Executive level.

The delivery of outcomes from such a model is likely to require either locality or service area management structures and reporting arrangements within the localities they service. The costing of this and other models would require further consideration.

Irrespective of the model of delivery there are a number of issues that will require further consideration at a national level.

<u>Finance</u>

- **VAT – The treatment of VAT is a potential issue which would require serious consideration. The implication of establishing a new Corporate Body in terms of VAT treatment is a significant risk with the potential loss of the Council's favourable treatment in respect of recovery of VAT.**

- **The role of the Council's Statutory Section 95 Officer in giving assurance to the Council in respect of financial governance. This is particularly evident in relation to the proposed delegation of financial authority to the JAO.**
- **Any arrangement that envisaged pooled budgets across Councils will require mechanisms to ensure proportionate delivery of service in each respective area. This potentially significant overhead would be avoided where HSPCs are co-terminus with existing council boundaries.**

People

- **The alignment of terms and conditions within a single delivery arrangement.**
- **Staffing Issues – such as TUPE and the potential difficulties in respect of bringing together staff groups with distinct and separate pension arrangements and other terms and conditions of employment was also highlighted as a potential difficulty, depending upon the model adopted. Again this could be minimised if HSCP's covered only one authority area.**
- **In any proposed change, issues of professional leadership require to be transparent, this will include, but not solely focus on, the Role of the Chief Social Work Officer and Mental Health Officers.**

Estate and Property Issues

- **such as ownership and maintenance responsibilities are a potential difficulty, depending upon the model adopted.**

Support arrangements, Legal, Finance, Human Resources, Administration, Procurement need to be efficient, effective and able to be delivered at equal or lower costs than under current arrangements.

Question 11: Do you have experience of the ease or difficulty of making flexible use of resources across the health and social care system that you would like to share?

Yes ☐ No ☐

The Council and NHS Ayrshire and Arran have utilised Resource Transfer mechanisms over many years to shift resources from Hospital based services to the community. This has seen very positive outcomes for individuals in respect of resettlement back into the community from long stay Mental Health and Learning Disability institutions and also addressing delayed discharges by building community infrastructure.

The ability to shift resources from acute hospital settings to community is less well evidenced, people already experience shorter stays in hospitals (post operation etc) but resources have not followed the person to the community.

Question 12: If Ministers provide direction on the minimum categories of spend that must be included in the integrated budget, will that provide sufficient impetus and sufficient local discretion to achieve the objectives we have set out?

Yes ▫ No ▫

Whilst we in East Ayrshire are absolutely committed to achieving the objectives set out and indeed are already performing well in these areas, it is appreciated that this position may not be replicated in every area of Scotland.

Direction in this area will be required if partnerships are to address the challenge of inequality in services across the country. Direction may also help focus implementation on the delivery of outcomes rather than the scope of the partnerships.

As indicated above the scope of resources included should be focused on delivering the desired outcomes. If this is to shift the balance of care for people to be supported and cared for in communities, rather than hospitals and care homes, then the appropriate budgets require to be either directly included or clear mechanisms need to be put in place to facilitate the transfer of resources.

It is also recognised that the new arrangements will require time to grow and develop and any prescription of minimum categories would require to take cognisance of this.

Jointly Accountable Officer

Question 13: Do you think that the proposals described here for the financial authority of the Jointly Accountable Officer will be sufficient to enable the shift in investment that is required to achieve the shift in the balance of care?

Yes ▫ No ▫

The proposals in respect of financial authority are not clearly set out within the consultation document and in some respects are contradictory. For example the proposal to give a level of delegated authority to the Joint Accountable Officer from the Health Board and Local Authority in respect of integrated budgets without the need to refer back to partner organisations (para 4.7) is in direct contradiction to the proposal under options for integrating budgets at 5.13, which suggests that there would be a requirement for the integrated budget managed by the Jointly Accountable Officer to be subject to the respective financial governance arrangements of each partner.

The proposals in respect of control of delegated budgets by the Jointly Accountable Officer may also create difficulties in relation to the responsibilities of the Section 95, Chief Financial Officer, within the Council. Clear guidance, covering detailed financial issues such as the management of financial risk; including overspends and the potential for any new Corporate Body to manage underspends and use these to build up reserves, will also be required.

The broad thrust to enable all of the resources available to be employed

in a way that ensures the best possible outcomes for individuals is indeed welcome but care needs to be taken to develop governance arrangements which are commensurate with this whilst minimising the range of risks which will arise.

Question 14: Have we described an appropriate level of seniority for the Jointly Accountable Officer?

Yes ☐ No ☐

Given the strategic responsibility and scope of the partnership, we agree that the Jointly Accountable Officer should be of a senior level that reports to the Chief Executive of the NHS and Chief Executive of the Council.

We believe that any arrangement where one individual is responsible across Council areas (i.e. to 3+ Chief Executives) could be problematic in terms of focus, governance and accountability.

Issues of professional leadership across agencies require to be addressed, including but not exclusively, the role of the Chief Social Work Officer/Chief Nursing Officer/Allied Health professionals.

Professionally led locality planning and commissioning of services

Question 15: Should the Scottish Government direct how locality planning is taken forward or leave this to local determination?

Yes ☐ No ☐

We believe that locality planning provides a significant opportunity within the proposals to engage with local communities and professionals in the strategic planning and delivery of services to meet local priorities and need. In so doing, it will be important that these local arrangements feel empowered to grow and develop in influence.

We believe that the Scottish Government should primarily focus the legislation on the outcomes partnerships require to achieve, the accountability of stakeholders in the delivery of these outcomes and any necessary legislative mechanisms to implement change.

In respect of locality planning, whilst we recognise there may be a requirement for government to direct baseline minimum expectations, local systems will require sufficient scope to determine arrangements that take account of the needs, strengths, demography and characteristics of local communities.

Question 16: It is proposed that a duty should be placed upon Health and Social Care Partnerships to consult local professionals, including GPs, on how best to put in place local arrangements for planning service provision, and then implement, review and maintain such arrangements. Is this duty strong enough?

Yes ☐ No ☐

If the new arrangements are to achieve the desired outcome of good quality, sustainable, community based health and social care services then local professionals require to be fully engaged alongside, service users, unpaid carers, the third sector and wider communities. We believe the proposals could be strengthened to underline the importance of also consulting with local service users, unpaid carers and the voluntary sector. The legislation requires to be balanced in requiring meaningful engagement across all stakeholders, whilst recognising that accountability for the delivery of outcomes will ultimately lie with Councils and the NHS.

Question 17: What practical steps/changes would help to enable clinicians and social care professionals to get involved with and drive planning at local level?

Capacity requires to be made available to enable meaningful local partnership arrangements. This may include support to unpaid carers to enable them to attend meetings, resources for independent contractors to attend and protected time for other stakeholders.

In East Ayrshire we have established a number of local partnership arrangements that include Social Work, Education (Head Teachers), Housing, Leisure, General Practice, Police and voluntary organisations.

The proposals provide an opportunity to systematically build on this practice across all our communities with engagement of stakeholders.

We require to ensure that the proposed changes do not create divides in Social Work and other Council services that impact negatively on services and outcomes for children and vulnerable families.

Question 18: Should locality planning be organised around clusters of GP practices? If not, how do you think this could be better organised?

Yes ☐ No ☐

We believe locality planning should be around natural communities rather than GP practices. In reality if there is flexibility in the design of "localities" then there will be little difference between the 2 models. In rural areas most people will attend a local GP. In urban areas several GP's may be based in town centres with people from across a town attending. If the locality is seen as the town then both criteria are addressed.

In the urban model if rigid interpretation is imposed, people living next door to each other with different GP's could be in different locality clusters. This could restrict our ability to direct services and resources towards disadvantaged communities and have integrated services based in these communities.

Question 19: How much responsibility and decision making should be devolved from Health and Social Care Partnerships to locality planning groups?

Local HSCP will be charged with the delivery of national outcomes on behalf of Councils and the NHS. In doing so they will wish to establish arrangements with locality planning groups around how this is achieved in a local area within available resources (human and financial). Local partnerships will require a transparent scheme of delegation to locality planning groups.

Question 20: Should localities be organised around a given size of local population – e.g., of between 15,000 – 25,000 people, or some other range? If so, what size would you suggest?

Yes ▫ No ▫

Localities should be formed in relation to natural recognisable communities. The size is likely to show considerable variation in relation to local populations and geography. Decisions on this should be left to local arrangement.

Annex F **Respondent Information Form**

Integration of Adult Health and Social Care in Scotland

RESPONDENT INFORMATION FORM

Please Note this form **must** be returned with your response to ensure that we handle your response appropriately

1. Name/Organisation

Organisation Name

East Ayrshire Council

Title Mr ☐ **Ms** ☐ **Mrs** ☐ **Miss** ☐ **Dr** ☐ ***Please tick as appropriate***

Surname

Fraser

Forename

Eddie

2. Postal Address

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Ayrshire		
Postcode KA3 7BU	**Phone** 01563 576546	**Email** eddie.fraser@east-ayrshire.gov.uk

3. Please indicate which category best describes your role/group or interest in health and social care integration. (Tick one only)

NHS Health Board	☐
Other NHS organisation	☐
General Practitioner	☐
Local Authority	☐
Other statutory organisation	☐
Third sector care provider organisation	☐
Independent/private care provider organisation	☐
Representative organisation for professional group	☐
Representative organisation for staff group e.g. trade union	☐
Education/academic group	☐
Representative group for patients/care users	☐
Representative group for carers	☐
Patient/service user	☐
Carer	☐
Other, please state	☐

5. Permissions **- I am responding as…**

			Individual				**/**	**Group/ Organisation**						
			☐		***Please tick as appropriate***						☐			

(a)	Do you agree to your response being made available to the public (in Scottish Government library and/or on the Scottish Government website)? ***Please tick as appropriate*** ☐ **Yes** ☐ **No**							**(c)**	The name and address of your organisation ***will be*** made available to the public (in the Scottish Government library and/or on the Scottish Government website).					

(b)	Where confidentiality is not requested, we will make your responses available to the public on the following basis								Are you content for your ***response*** to be made available?					
	Please tick ONE of the following boxes								***Please tick as appropriate*** □ **Yes** ▱ **No**					
	Yes, make my response, name and address all available					▱								
						or								
	Yes, make my response available, but not my name and address					▱								
						or								

	Yes, make my response and name available, but not my address					▢								

(d)	We will share your response internally with other Scottish Government policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for Scottish Government to contact you again in relation to this consultation exercise? ***Please tick as appropriate***													

	riate ☐ **Yes** ☐**No**													