Education and Lifelong Learning Committee

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Date: **22nd September 2004**

Venue: **National Assembly for Wales, Cardiff Bay**

Title: **This paper sets out an outline of the respective prime and ultimate responsibilities of the education and health sectors in the co-ordination and delivery of speech and language therapy (SLT) provision in Wales. It also seeks to describe the funding arrangements that currently exist between the health and education sectors in terms of the delivery of certain services.**

Purpose

At their meeting on 18 June 2003 the Committee agreed to undertake a policy review of special educational needs (SEN) and, as an initial phase of the review to consider procedures in place for early identification and intervention.

On 7 July 2004 the Committee also considered a draft report of its findings of the review and requested further clarification in relation to the prime and ultimate responsibilities and the funding arrangements between the health and education sectors, specifically in relation to the delivery of speech and language therapy (SLT).

This note seeks to set out these arrangements in more detail and provides an overview of the Welsh Assembly Government's proposed way forward in tackling current anomalies in this area and a strategy to improve the delivery of services to children and young people with speech, language and communication difficulties (SLCD). In doing so, this note also considers the scope of the Health Partnership Act 1999 in the development of joint commissioning and pooled budget arrangements across the NHS and local authorities.

Summary/Recommendations

The "prime and ultimate" anomaly under which health has the prime responsibility for the delivery of

SLT but for children with statements of SEN, the local education authorities (LEAs) have the ultimate responsibility for ensuring that the service is delivered, has caused tension between the two statutory agencies which represents a risk factor in terms of the effective delivery of services.

In July 2003, the Minister for Health and Social Services and the Minister for Education and Lifelong Learning launched a consultation paper "Working Together" relating to services for children and young people with SLCD. The consultation paper consisted of over 80 recommendations to which there were over 180 responses. A summary of the responses will be available at www.learningwales.gov.uk by late September.

Respondents clearly supported the principles of close and collaborative working between health and education. This recognises the fundamental relationship between language development and educational attainment. The difficulties identified are, however, not just in respect of recognised disabling conditions such as hearing impairment, autistic spectrum disorders and specific language difficulties but extend to the relatively large group of children and young people whose attainments are adversely affected by impoverished language experience. There is also an accepted relationship between poor language skills and difficulties in social relationships/behavioural difficulties, which again impacts significantly on young people's development.

The Working Together consultation document suggested (7.10.5) " Local health boards (LHBs) and local authorities should work within the partnership arrangements as described within the Health Partnership Act 1999 for the delivery of speech and language services to children and young people."

The following recommendations were agreed by both the Ministers for Education and Lifelong Learning and Health and Social Care at a bi-lateral meeting in June. Ministers intend to make a joint announcement on the recommendations later in the year. These recommendations outline details of how this collaboration could work in practice, taking account of the comments received from the consultation exercise and considers the delivery of services from both the commissioning and provider perspective.

Commissioners of such services should separately identify, commission & ring-fence those speech & language services for children & young people and those for adults (e.g. services for stroke victims). Commissioners should include in the specification for children and young people’s services all necessary criminal records bureau/ child protection procedures. The children & young people’s service should be 0-19 to align with education responsibilities for the purposes of delivering speech and language services.

LHBs and LEAs should establish a Commissioning Partnership to jointly commission services. They should determine what specialist services for speech & language difficulties are required for their area by undertaking a needs assessment. They should establish integrated models of care and care pathways. Such specialist services can consist of speech & language therapists, specialist teachers (based at LEA level), speech & language therapy assistants, and specialist learning support assistants. It is important to stress the distinctiveness of each profession, speech & language therapists and specialist teachers are not

interchangeable and each bring their own expertise. It is not the intention to create a single profession, local areas need to consider an appropriate skill mix. The roles that could be undertaken by therapy assistants and learning support assistants need to be critically assessed. All practice must, of course, be evidence based from both a health and education perspective.

Any needs assessment should feed into the local Health, Social Care and Well Being Strategy and into the Children and Young People's Framework in order to assist in planning for future services.

It is a corollary of joint commissioning that it is the responsibility of both commissioning agencies to fund services for children and young people with speech and language difficulties and commissioners will need to agree their respective contribution and this should be contributed into a pooled fund. The overall size of this pooled fund should be sufficient to provide services to meet the assessed need.

In commissioning the service, Commissioners must ensure that statutory responsibilities in respect of Statements of SEN are carried out.

The highest level of collaboration between the NHS and LEAs would be achieved if NHS Trusts and LEAs provided services in an integrated way, allowing different professionals to work under one management structure (as permitted under the Health Act 1999). Since NHS Trusts (as employers of speech & language therapists) are not coterminous with LEAs, this integrated service could best be organised in some parts of Wales at a geographical level higher than an individual local authority, for LEAs this is permitted by the Education Act 2002. The groupings set out in WHC (2003) 63 between NHS Trust areas and LA areas for secondary care commissioning groupings suggest a good model for how this might be organised. This is likely to mean distinctive services for children and young people and for adults. This splitting of services was a recommendation of the Carlile Report but services would need to fully consider the practical HR and training difficulties this may cause.

For effective integrated working the providers need to have resolved that there are clear management structures, professional accountability, clear performance management of the service and a joint location of the service and proper administrative support. Further work is needed to work out details of how this could be achieved and what are the appropriate organisational models, as well as practical issues of implementation.

It was agreed that a co-ordinator be appointed to establish two pilot projects working across LEAs, LHBs and NHS Trusts from April 2005, to introduce partnership arrangements on a wider scale than previously developed. These projects would then be evaluated against improvement measures in service delivery and National Guidance would be developed to ensure total coverage across Wales, thereby ensuring equity and a framework for such partnership arrangements.

Background

The Speech and Language Therapy Action Group (SALTAG) was established by both Ministers in

August 2002, following growing concerns over the escalating demand for speech and language therapy services and the lack of a coherent approach, by the statutory agencies, to meet the needs of children and young people with SLCD. The group consisted of representatives of all the key stakeholder groups and identified the following key issues:

Conflicting policies and priorities across health and education services have led to variations in the way in which the speech, language and communication needs of children and young people are prioritised and met. This has led to inequities in service provision across Wales.

There is a lack of co-ordinated working arrangements between health and education as providers of services, as well as between all other stakeholders, including parents/carers and the voluntary sector.

There are inadequate systems to facilitate the development of a joint evidence base on current levels of needs and service provision available across agencies.

There is a lack of equity over the funding arrangements for the delivery of services to children and young people with SLCD in a school based context, together with varying priorities between health and education services in the allocation of resources.

NHS Trusts, are the primary providers of SLT services. However, it is LEAs that have the ultimate responsibility for ensuring provision of such services for children whose statements of SEN specify that the provision is an educational requirement. This legislative framework can lead to tension across agencies and is often confusing for parents seeking appropriate levels of support for their children. Such tension can then be heightened with the increasing use, by parents and carers, of the Special Educational Needs Tribunal for Wales (SENTW) to settle disputes, as well as increased litigation.

There is an escalating demand for SLT services from all stakeholders. This, in turn, has led to unmanageable caseload sizes and poor professional morale, which impacts on the recruitment and retention of SLTs.

There are insufficient SLTs to meet demand and too few are currently undertaking training. There are, particularly, too few Welsh/English bilingual SLTs. Similarly, there is a shortage of specialist teachers and support staff, including bilingual staff, within education with specific qualifications in teaching and supporting children with SLCD.

There is a lack of flexible and bilingual training arrangements to ensure the use of a wider skill mix of competent personnel across both health and education.

There are insufficient resources generally and, more specifically, through the medium of Welsh and bilingually.

The Working Together document considers each of these specific issues in detail. However, this report

will concentrate on the issues that relate specifically to the prime and ultimate responsibilities and funding arrangements for the delivery of speech and language services to children and young people across the NHS and LEAs.

Prime and Ultimate Responsibilities

Primary responsibility for meeting the primary health care needs, including speech therapy needs, of the general population rests with the Local Health Boards under the National Health Service Reform and Health Care Professions Act 2002. LHBs were established in 2003 and took over the functions of the Health Authorities for planning and commissioning of health services to meet local needs. This covers the commissioning of primary care as well as secondary care services delivered by NHS Trusts, such as speech and language therapy provision.

The Education Act 1996 places a duty on LEAs to make appropriate provision for children and young people with special educational needs as defined by the SEN Code of Practice for Wales. The SEN Code of Practice gives practical guidance in respect of the discharge of a LEA and governing bodies functions in this regard and the statutory assessment and statementing framework.

Case law has established that speech and language therapy can be regarded as either educational or non-educational provision, or both, depending upon the health or developmental history of each child. It could therefore, appear in either Part 3 (educational provision) or Part 6 (non-educational provision) of a statement of special educational needs or in both. However, since communication is so fundamental in learning and progression in addressing speech and language impairment the SEN Code of Practice for Wales suggests that this should normally be recorded as educational provision unless there are exceptional reasons for not doing so.

The Education Act 1996 also places a duty on Health Authorities (prior to the establishment of LHBs), subject to resources, to meet any reasonable requests from LEAs for health services in the discharge of their functions, specifically in meeting provision specified in a child’s statement of special educational needs.

If a LHB or NHS Trust determines that it cannot meet such a request from a LEA, the LEA remains ultimately responsible under the legislation for ensuring that the provision specified in the statement of SEN is made, including any primary health care service that may be specified. If the NHS Trust cannot provide the services required, then the LEA must look to alternative arrangements for meeting their statutory responsibilities in respect of statements of SEN. Where the NHS does not provide speech and language therapy for a child whose statement specifies such therapy as educational provision, ultimate responsibility for ensuring that the provision is made rests with the LEA, unless the child’s parents have made appropriate alternative arrangements.

Members will be interested to note that a new Education Act in Scotland has established a duty on all statutory agencies to work together to meet the needs of children and young people with SEN and to

provide any support deemed necessary within a child's continuous support plan.

Funding Arrangements

The legal situation outlined above can cause a great deal of frustration for the statutory agencies and not least for parents trying to secure appropriate levels of provision for their children.

Local authorities receive specific funding through their RSG for supporting all children with special educational needs and in addition can access funding through the Better Schools Fund (BSF) for the delivery of school-based speech and language services.

LHBs receive specific funding for the commissioning of speech and language therapy services within their area as part of their general allocation. Respondents to the consultation exercise suggested that this is not given a high priority by LHBs and NHS Trusts against other demands on service provision such as acute services.

LEAs remain concerned that they are held responsible for securing SLT provision for children yet are not in control of the funding for SLT services. Due in part to the current shortage of SLTs in Wales and increasing demands on SLT services LEAs are having to find additional resources to fund speech and language therapists either on a private contract basis or through local NHS trusts to meet their statutory requirements.

As part of their review of services SALTAG undertook an Audit of SLT services in Wales to establish the various funding streams currently in operation. Managers were asked to identify the funding steams from various agencies with regard to the employment of SLTs in pediatric services. It was suggested that the nature of short-term contracts by LEAs, SureStart and flexibilities grants was likely to deter the more experienced SLTs applying for posts and can lead to recruitment difficulties.

77.8% of all posts in Wales are funded by the NHS which represents 124.1 SLTs working with children and young people.

22.2% of other posts are funded by other agencies which represents 27.59 SLTs working with children and young people.

The SureStart initiative posts suggest that in areas of deprivation across Wales there is a lack of equity of funding of SLT provision. It is widely recognised that the development of language and communication are the key skills, which are depressed in children living in areas of high deprivation.

In 1999 the Association of Directors of Education in Wales undertook a questionnaire audit of SLT provision across LEAs in Wales. A summary of collated responses suggests a wide variation in the contributions to NHS trusts from education to fund SLTs or SLT assistants. Some LEAs made no contribution to their local NHS Trust for SLTs. A number of LEAs commented that the joint funding of

services to assists pupils with SLCD is focussed narrowly on the contribution of SLTs and SLT assistants. It should be noted that all LEAs provide support to pupils with SLCD through teachers (some with specific specialist qualifications in this area), NNEBs, support staff, accommodation and material costs in speech and language resource based units and teacher/classroom time in implementing speech and language programmes.

The National Assembly Therapy Working Group (2000) considered this issue in detail and concluded that transferring funding from health to education will not in itself solve this problem. Such arrangements were introduced by Scotland in the early 1990's but further evidence suggests that conflicting health and education priorities remained and in addition there were contracting employment issues particularly where localised shortages of therapists occurred. It was apparent that transferring funding was not in itself the answer. This is being addressed as outlined earlier in their new Education Act.

SALTAG (2002) undertook a full option appraisal of ways in which this anomaly could be resolved and concluded that there were inherent difficulties in transferring resources from one organisation to another without impacting on a whole range of professional issues and statutory requirements. They further suggested that LEAs should lead commission services for children of school age with SLCD. Responses to this consultation recommendation raised a number of concerns from both health and education professionals in view of the possible fragmentation of services and potential loss in flexibilities and specialisms within SLT services. SALTAG did however suggest a pooled budget approach, joint assessment framework and an integrated approach to the delivery of services, which received a very favourable response.

A change in primary legislation was considered but, given case law in this area, it was suggested that such a change would impact on the whole of the statutory assessment and statementing framework. Further this would not bring about any short/medium term solutions to the current difficulties experienced in accessing appropriate provision.

Consideration

Health Partnership Act 1999

New powers to enable health and local authority partners to work together more effectively came into force on 1st April 2000. These were outlined in Section 31 of the 1999 Health Partnership Act. The Health Act 1999 Flexibilities Guidance and The NHS and Local Authorities Partnership Arrangements (Wales) Regulations were launched by the Minister for Health and Social Services, in November 2000.

The Flexibilities Framework is designed to facilitate improved collaborative working across NHS organisations, local government and other local partners and to aid in the development of partnership arrangements. The Flexibilities provisions enables closer joint working than was possible under previous legislation. Some of the benefits include co-ordinated management and common objectives; integrated

planning; and a reduction in the duplication of services. This should ultimately lead to the delivery of more seamless services for users and their carers.

The provisions allow the use of three types of ‘Flexibility,’ which can be used on their own or in conjunction with each other. The three Flexibilities are Pooled Budgets; Lead Commissioning; and Integrated Provision.

Pooled funds - the ability for partners each to contribute agreed funds to a single pot, to be spent on agreed projects for designated services

Lead commissioning - the partners can agree to delegate commissioning of a service to one lead organisation

Integrated provision - the partners can join together their staff, resources, and management structures to integrate the provision of a service from managerial level to the front line

The aim of the Flexibilities Framework is to enable the partners to achieve improved outcomes through joint working arrangements.

Pooled Fund Arrangements

A pooled fund arrangement provides an opportunity for the partners to bring money together, into a discrete fund, to pay for the services that are an agreed part of the pooled fund arrangement for the client group who are to benefit from one or all of the services. Instead of users being inconvenienced by disputes about health and local authority responsibilities, organisations must agree at the outset the range of health and local government services to be purchased and provided from a pooled fund.

The partners who agree and contribute to a pooled fund can be LHBs, NHS Trusts, and local authorities. A NHS trust, which provides a NHS service covered by the pooled fund, can be a partner to the arrangement, and with the agreement of the LHB can commit funds. Each partner agrees a level of contribution. The contributions they commit can be used on any of the services in the pooled fund. The pool is managed to fulfil the agreed outcomes within the budget that has been allocated.

Each partner retains statutory responsibility for their functions carried out under the pooled fund. So there must be a carefully worked agreement drawn up between the partners over governance arrangements which address accountability, how the budget is to work, and who manages expenditure and care packages. Comprehensive monitoring arrangements must be put in place that assure partners that their shared aims are being fulfilled.

One of the advantages of the pooled fund is that health and local authority staff identified in the agreement are able to access and take decisions on the use of the resources in the pool, according to the process agreed locally between those staff and the pooled fund manager. There must be an agreed

process to authorise identified staff to do this. They assess each individual in line with the eligibility criteria for services, which are part of the agreed functions to be fulfilled. There are no legal obstacles to health staff using pooled funds in the exercise of local authority functions, and vice versa.

Lead Commissioning

Lead Commissioning provides an opportunity to commission, at a strategic level, a range of services for a client group from a single point and therefore provides a level of co-ordination, which improves services for users, and provides an effective and efficient means of commissioning. In effect, one agency takes on the function of commissioning of services, which are delegated to them. Local authorities, LHBs or NHS Trusts may be partners in this. The partners must decide what functions are to be delegated to the lead commissioner, and what money to transfer to finance the services commissioned. There must be a written agreement setting this and other key issues out, as identified in the Regulations.

Lead Commissioning is similar to Joint Commissioning, which many authorities have used in learning disabilities, mental health services, equipment services, etc. Authorities wishing to use the lead commissioner arrangement need to notify the NHS Regional Office of their partnership.

Integrated Provision

Integrated provision provides an opportunity to provide services in a more co-ordinated way by allowing different professionals to work within one management structure, and to arrange provision from one statutory organisation.

Local partners need to determine the balance between the use of the partnership arrangements and their continued accountability, and the effectiveness of the monitoring arrangements. The integrated service may be provided through a contract with the independent or voluntary sector. However, as with use of all the Flexibilities, the statutory partners remain responsible for the functions.

As the use of this Flexibility involves the delegation of functions from one agency to another, which is likely to lead to the transfer of staff who perform those functions, there are sensitive human resource issues to consider. This is particularly important where Integrated Provision involves the delegation of functions to a partner that has not previously managed those functions.

Partnership Arrangements

Following consideration of all relevant issues, the partners can enter into a legal partnership arrangement. As specified by The NHS and Local Authorities Partnership Arrangements (Wales) Regulations 2000, the agreement must be in writing and must specify:

The agreed aims and outcomes of the arrangements;

The payments to be made and how the payments will be varied;

The functions which are the subject of the arrangements;

The persons and the kinds of service(s) which the arrangement will relate;

The staff, goods, services or accommodation to be provided by the partners;

The duration of the arrangements and provision for the review or variation or termination of the arrangements; and

The monitoring arrangements that will be in place.

To support the legal agreement, the partners may wish to develop an implementation plan which may include:

Risk assessment

Project plans

Checklists of key tasks

Timescales and milestones

Lead Owners

The Social Services White Paper "Building for the Future" the NHS plan "Improving Health in Wales" and the SEN Code of Practice for Wales set out the Assembly's commitment to common goals and joint working for health, education and social services. Local authorities also have a corporate role in achieving shared goals across their public health, education, housing, environmental and leisure responsibilities.

Planning mechanisms assist in the identification of local needs which require a collaborative approach to commissioning and/or service delivery. The result of such joint planning and working should be the provision of a service, which is superior to services provided separately.

The Flexibilities mechanisms should become an integral part of the local commissioning and service

delivery processes and not a separate initiative. They should become embedded in every day practice where they can provide the added value of improved efficiency or the bringing together of an increased range of skills and experience.

Financial Implications

The post of co-ordinator to establish pilot projects and draft national guidance on future service delivery will cost approximately £100k over a two year period commencing January 05 and will be accommodated jointly within existing administration costs budgets across health and education. Additional funding for LEAs to support the establishment of the pilot projects, their evaluation and roll out across Wales from April 05 will be dependant on the results of the BPR:

11. £000

12. 05/06
13. 06/07
14. 07/08
15. Roll-out Pilot Projects – funding for LEAs to commit to pooled budgets
16. 500
17. 1000
18. 1500

It should be noted that LEAs and LHBs will be establishing pooled budgets including existing resources that are currently allocated to LHBs, LEAs and NHS Trusts for the delivery of services to children and young people with SLCD. For education this may include teacher and LSA time as well as other material costs used as part of specialist SEN resource bases. The total amount of resources within each pooled budget will be dependant on local needs assessment. The education funding that could be provided by the National Assembly for Wales, dependant on BPR, is to assist in the LEA contribution to the pooled budget as no specific funding otherwise is available to LEAs to meet the costs of speech and language therapy which are not covered by the general allocation for SEN as part of the RSG and BSF. The costings illustrated above will allow the National Assembly for Wales to roll out this programme to all LEAs by 2008.

Action for Subject Committee

To note the contents of this report.

Name: Jane Davidson
Minister for Education and Lifelong Learning
Contact Point: Mair Watkins, Pupil Support Division 1, ext: 6077