The Highland Council / NHS Highland

16th December 2010

Agenda Item	
Report No	

Improving Joint Service Delivery – A new Partnership Model

Joint Report by Chief Executive, The Highland Council & Chief Executive, NHS Highland

Summary

This report outlines the shared values and principles underpinning our joint approach to service delivery for Adult Community Care and Children's Services, summarises the reasons why the leadership of the Highland Partnership believe a new model for service planning and delivery is needed, considers a variety of possible models, highlights the preferred model, and proposes further work to continue the momentum towards significantly improved arrangements to deliver better outcomes, increase effectiveness and achieve further efficiencies.

The report recommends that the Council and NHS Board agree in principle:

- To commit to a pathway for integration of health and social care services that would provide both Authorities with the joint responsibility for specifying the outcomes to be achieved for service users, and the totality of resources to be allocated to each of the two service areas, and would put in place single lead agency arrangements for Adult Community Care Services and for Children's Services.
- That the most appropriate single lead agency for the delivery of Adult Community Care Services is NHS Highland and that the most appropriate single lead agency for the provision of Children's Services is The Highland Council.
- A formal Implementation Programme Plan is developed to progress detailed planning and implementation with a view to the new arrangements being fully in place by April 2012.
- That this Plan is brought, by May 2011, to the Council and Health Board for formal endorsement and commitment to proceed.
- To receive and consider further reports on progress, and participate in a special workshop in the new year to explore the issues in depth with input from Partnerships elsewhere who have developed and implemented similar proposals.

1. Background

1.1 The Highland Council / NHS Highland Partnership (The Highland Partnership) has improved significantly in recent years. Integrated Children's Services are evolving through the GIRFEC approach pioneered in Highland. Adult Care is being modernised through the Transformational Change Programme. Joint Leadership and Governance arrangements have been in place for some time. Coordinated management is improving. Common values and principles underpin service delivery.

1.2 However, through our engagement processes such as community care planning, and from direct feedback from services users, their families, constituency members and community representatives, and indeed our staff, people are telling us that these improvements have not delivered the quality and effectiveness of services that people want. The need for improved joint working and preserving independence has been highlighted through consultation on the Community Care Plan.

1.3 It is recognised that, in part, our failure to deliver to date is down to organisational and structural constraints that impact on the ease and speed with which we can realise our joint ambition to ensure that the right services are in place at the right time and at the right cost, to achieve the right outcome for service users. This paper and the proposals therein, are in response to these concerns.

1.4 National policy direction is clear, and locally there is consensus on the general principles underpinning the direction for both Children's Services and Adult Community Care Services. We have developed extensive mechanisms for engagement with local communities and stakeholders and we are all familiar with the changing demographics of the area and the need to plan for this.

1.5 Whilst the medium to longer term fiscal climate is not yet fully clear, what is evident is that if we are to meet the growing expectations our communities have of the range and quality of services we provide in the current climate, we will need to do things differently in the future.

1.6 Continuing to plan and deliver services in the way we currently do will not serve our local communities, nor our staff or other stakeholders, well in the future.

2. Shared Values and Principles Underpinning Service Delivery

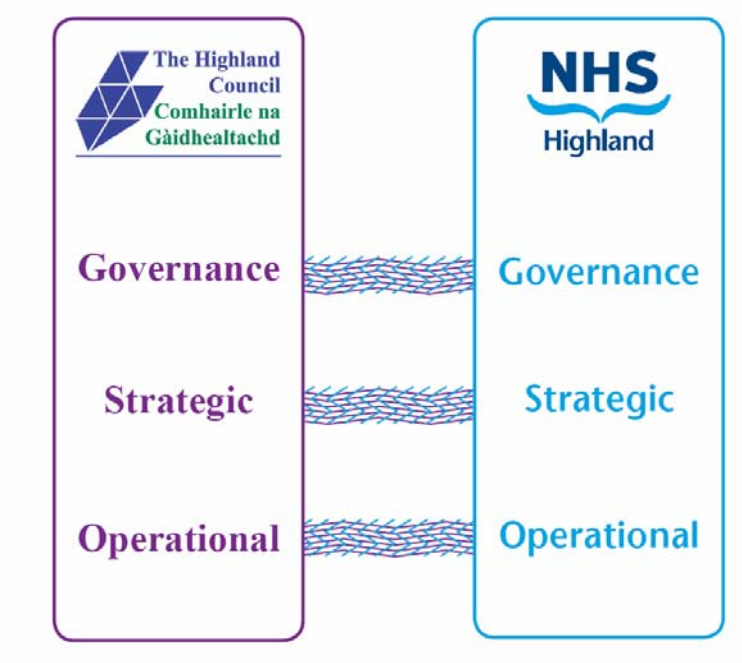
2.1 A common set of shared values and principles that underpin service delivery have evolved in recent years as joint work has developed. These values and principles have been directly informed by what service users, staff and other stakeholders have told us (for example during the recent widespread consultation on the draft Joint Community Care Plan, and throughout the evolution of GIRFEC) and they reflect national policy direction. The shared values and principles that underpin Adult Community Care and Children's Service delivery are detailed in **Appendix 1**.

2.2 These shared values and principles can be expressed as a statement of intent by the Highland Partnership:

The Highland Partnership is committed to achieving the best possible outcomes for our population and service users. We believe that services should be person centred and enabling, should anticipate and prevent need as well as react to it, should be evidence based and acknowledge risk. We will improve the quality and reduce the cost of services through the creation of new, simpler, organisational arrangements that are designed to maximise outcomes and through the streamlining of service delivery to ensure it is faster, more efficient and more effective.

3. Current Arrangements

3.1 The current arrangements involve The Highland Council and NHS Highland collaborating to achieve complementary goals. However, the two organisations are heavily shaped by their individual priorities and pressures, and by the accountability structures within which they operate. Valiant attempts are made to collaborate in the interest of services users and in order to improve outcomes. However **these current arrangements place significant reliance on operational managers and staff spending time and energy on overcoming the constraints of a system that is not designed to support efficient and effective joint working**. The diagram below reflects the current arrangements.



3.2 A review of the current planning and delivery arrangements suggests that significant further improvements in the experience of and outcomes for service users, and in **the efficiency and effectiveness of services, cannot be achieved within the current organisational arrangements.**

4. Alternative arrangements to support improved delivery, outcomes and efficiency.

4.1 The leaders considered a number of different scenarios for new organisational arrangements that could deliver the better outcomes desired and reflect the agreed values and principles. North East Lincolnshire, for example, has introduced new arrangements and this has provided valuable learning for us. Discussions are also underway between NHS Highland and its other local authority partner, Argyll and Bute Council. Any decision here is not however dependent upon the outcome of these discussions.

4.2 To guide consideration of these scenarios, a set of criteria against which they could be judged was agreed. These are listed in full in **Appendix 1** and are summarised here:

- *The arrangements must make sense to our Public and to Service Users*
- *They will be Outcomes Focused*
- *They must be Efficient and Cost Effective*
- *There must be sound Leadership, Governance and Accountability*

4.3 Three options for new organisational arrangements that will support achievement of better outcomes were explored and weighed against the above criteria. These are dealt with in turn in the following pages.

4.4 The **first model** considered would see the introduction of **single operational management** (by existing local authority or health service manager) within each operational area, reporting into the current, separate organisations in respect of operational and strategic governance. Single operational managers would be responsible for decision making using a devolved budget. Operational accountability would be back to both organisations and governance would also be back to both organisations possibly via a joint delivery board. The diagram below reflects this model.

4.5 This model would remove some of the barriers to progress at the front-line operational management level but operational managers would remain accountable to two organisations, continuing to have to negotiate single agency priorities, requiring duplication of reporting. In short, **this model would still be subject to many of the constraints of the current system.**

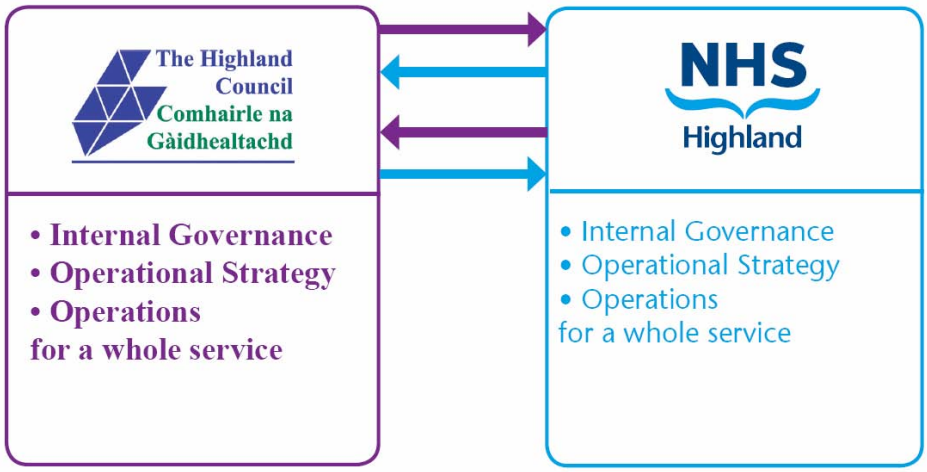
4.6 The **second model** considered would see a completely new relationship developed between the partners. The statutory bodies would remain jointly accountable for the determination of the outcomes to be achieved, and the totality of resources committed to these outcomes, but a **new body** would be established to deliver these outcomes within agreed resources, possibly a new Trust established by the Partners. All aspects of business delivery strategy, internal governance and operational delivery or commissioning of services would then sit within that single body which would be fully accountable for the delivery of agreed outcomes. This is reflected in the diagram below.

4.7 **This model was felt to run the risk of creating a separate organisation that would assume its own priorities** that could develop beyond those of the partners. It was **seen as unnecessary and too complex**. It was thought that it would introduce new dynamics that would be difficult to manage.

5. The Recommended Model

5.1 The framework of a **third model** was developed to build on the advantages of the second as described above, but minimising the identified disadvantages and risks.

5.2 This model involves **single lead agency** arrangements, and would leave both organisations jointly accountable for determining outcomes and the resources to be committed. The lead agency would assume responsibility for all aspects of business delivery strategy, internal governance and operational delivery or commissioning of services and would be fully accountable for the delivery of agreed outcomes. It is reflected in the diagram below.



5.3 **This model would recognise that whilst core responsibilities and accountabilities cannot be discarded, they can be discharged in a very different way than currently.**

5.4 Critical would be the relationship between the Partners at the highest strategic level. There would need to be a very clear and jointly agreed and understood process for setting overall direction and for accountability. The relationship at this level would be around determining outcomes and standards, and the resources the partners would commit.

5.5 This arrangement would mean:

- Specification of outcomes and resource commitment by the Partners
- Strategic commissioning of outcomes from the lead agency
- Single agency completely responsibility for delivery
- Operational commissioning of services, and direct delivery, by the single agency
- High level accountability for outcomes back to commissioners
- Arrangements established by contract for a period; annual reporting on delivery

5.6 **The leadership of the Highland Partnership believe that single lead agency arrangements founded on our joint values and principles offer the most appropriate, efficient and effective model to achieve our joint ambitions**.

5.7 It is therefore **recommended that elected Members and NHS Directors commit to a pathway for integration of health and social care services** that would provide both Authorities with the joint responsibility for specifying the outcomes to be achieved for service users, and the totality of resources to be allocated to each of the two service areas, and would put in place single lead agency arrangements for Adult Community Care Services and for Children's Services.

5.8 It is believed that this approach would attract specific transition funding.

6. The Recommended Model - Accountability and Governance

6.1 Critical to the success of the recommended model would be to ensure that the new accountability and governance arrangements were robust and mutually developed, understood and applied, and that democratic accountability was not diminished, indeed enhanced.

6.2 The following arrangements would be integral to the success of this model:

Strategic level

- Both organisations, in partnership with each other and engaging wider stakeholders, would be jointly responsible for developing the 'strategic intent' for Adult Community Care and for Children's Services. This would be captured in 'outcomes' terms and would define the quality standards to be delivered.
- Both organisations would be responsible for agreeing the totality of resources to be allocated to each of the two services areas
- These aspects would be agreed by the Council and Health Board and would provide the 'commission' to the delivery partner for an agreed period, say three years.

It is envisaged that a joint mechanism would be established for setting strategic direction and articulating sought-for outcomes.

Delivery level

At a delivery level, all aspects of business delivery strategy, internal governance and operational delivery or commissioning of services would sit within the single body, and the lead agency would be responsible for establishing its own scrutiny and performance management arrangements for this.

- The 'delivery organisation' would therefore be responsible for arranging services (either by directly providing them or by commissioning them) in order to meet the strategic intent. It would directly control all relevant staff and other assets. It would determine how to organise and manage delivery without referral back to the other partner.
- Internal governance mechanisms would apply; effectively delivery would be by an operating division of the parent organisation, and this

'operating division' would account for routine operational delivery through appropriate internal governance mechanisms to the parent body.

Accountability

At the end of each year, the delivery partner would formally account for delivery against the strategic intent to both its parent organisation and the partner organisation. This might take the form of a joint meeting of both The Highland Council and the NHS Highland Board. The parent bodies would satisfy themselves (or otherwise) that the intent was being delivered. In this way both organisations would discharge their legal accountabilities.

6.3 The detailed application of these aspects and the implications of the changes on governance and accountability would need to be worked through so that the design is robust and roles and responsibilities are fully understood.

6.4 A key part of accountability and governance will be the role of the Council's Members, as the elected representatives, in the new arrangements. The detailed principles around which accountability and governance would be built at strategic and delivery levels are outlined in **Appendix 1**.

6.5 Elected Members would have a critical role at all levels:

Strategic level

- They would be instrumental in setting and endorsing the high level strategic intent between the partners (as would NHS Board members). This would be a much more explicit process that at present, and would link more directly with the SOA and provide a greater clarity of outcomes and standards for services.

Delivery level

- A number would serve on the Committees responsible for the oversight of the delivery of the service area (as would NHS Board members). This would bring formal input by democratic representatives to the wider delivery of health and social care.

Accountability

- They would continue to discharge their constituency responsibilities as now, raising any individual matters with the service management as appropriate, irrespective of the lead agency. It would be clear to elected members, and their constituents, who was responsible for services and how and where to get issues of concern addressed.

6.6 It is important that both services relate closely to local communities and will need to develop appropriate mechanisms to support this; without undue bureaucracy, but ensuring that there is effective engagement to facilitate service change. **This model will enable services to build on and improve existing local involvement and to ensure that local communities are meaningfully engaged.**

7. Single Lead agencies

7.1 If it is agreed that single lead agency arrangements are the most appropriate model to deliver the sought-for outcomes, and the above model framework is accepted, it makes sense to think about which agency is best placed to be the operational commissioning and delivery agency from operational and service user perspectives.

7.2 Whilst the bulk of Social Work Community Care Services have a clear joint application, several aspects of health primary care services are specialist, with little overlap with Council Services (e.g. Dentistry). On the basis then that GP and primary health care services are the common universal service providers for adults who need Community Care Services, it is suggested that the most appropriate lead agency for operational commissioning and service delivery for Adult Community Care Services is NHS Highland.

7.3 Whilst the NHS is the universal service provider for children under 5, education become the universal service provider for the rest of childhood. Schools are a hub around which Children's Services can and do orientate. It is suggested then that the most appropriate lead agency for operational commissioning and service delivery for children is The Highland Council.

8. The Recommended Model – Benefits for Service Users

8.1 Examples of the types of benefits of the recommended model of single lead agency delivery are set out below:

8.2 At present if an **elderly person** becomes ill or in need of emergency care out of office hours, the most likely scenario, depending on the problem, is admission to hospital. This is because, for the most part, the community health team do not have easy access to any other resource. It is widely recognised that unnecessary admission to hospital is detrimental to individuals and means the trauma of being taken out of their home at short notice with no time to put in place any emergency domestic arrangements that are needed. In addition, the evidence shows that one emergency admission is a predictor for future emergency admissions, leading in turn to longer lengths of stay in hospital including the possibility of delayed discharge. This can impact quite significantly on a person's confidence and feelings of being able to manage in their own home. It can also impact negatively on the older person's relatives' perceptions of the risk of discharge home.

8.3 Under the proposed model, the community health team would have at their disposal, with no need to consult with additional gatekeepers or budget managers, a range of options to provide the required support and care. The upheaval and trauma of emergency admission to hospital is prevented and the individual and their family have the reassurance of an appropriate package of care being put in place, within the home setting, at short notice. The evidence is clear that this type of provision helps maintain independence, a key aspiration older people have many times highlighted to us. This scenario is far less likely to result in the older person's loss of confidence and can reassure relatives about risk levels and risk management.

8.4 In summary the benefits to the older person and their carers in this example are –

- Prevention of admission to hospital
- Known care givers co-ordinating care
- Confidence of the older person and their carers in remaining independent is preserved
- The older person is able to stay in their own home and/or community
- Informal carers/family included in care planning
- Fewer professionals involved, streamlining communications for the older person and their families
- The older person is less likely to be admitted as an emergency in the future

8.5 Albeit the implementation of *Getting it right for every child* has achieved more seamless processes in **children's services**, the same benefits regarding early and effective intervention, with better outcomes, would also apply. At present, health staff should be able to access social work and other additional resources if they believe that a child has additional needs that require multi-agency involvement. However, there is an inevitable inhibition to make sufficiently prompt requests for such services when they are managed and budgeted for within a different organisation. Similarly, there can be inter-agency differences about the level of need, and the proportionality of response, that can take time to address between two different sets of managers. Accordingly, there is clear evidence that additional resources are not being used as soon and as often as they should be. This can be critical in the early years, when any developmental delay can have a long term impact, and when pressures on families can build and cause needs to escalate – requiring greater and more expensive interventions at a later stage.

8.6 At present if a **child with complex needs** requires specialist equipment, the lead professional will convene a meeting including professionals from both agencies and involving the child and their family. Agreement would be reached on the equipment needed. Following that, there would be discussion between professionals about which agency was responsible for funding, and a meeting of the relevant single agency resources group would be arranged. This could mean a significant delay between the first request for equipment support and the actual provision of such equipment. If there is any dispute between the agencies about the appropriate funding source for the equipment, the overall delay could increase significantly.

8.7 Under the proposed model, assessment and access to equipment would be provided from one source and thus more quickly and with less upheaval for the child and its parents or carers. The meeting at which the parent and child were in attendance would take the decision about allocation of the equipment, meaning that both parent and child would be able to contribute to and understand the basis of decision making. Should there be any need for the child or its parents to query anything, the routes into response and remedy would be more streamlined and there would be no need to approach two organisations or negotiate a complex system to have issues addressed.

8.8 In summary the benefits to the child and carers in this example are –

- Earlier and more effective responses
- Fewer Professionals to communicate with
- Improved communication
- Fewer unanticipated delays in the process
- Quicker access to required equipment
- Prompter means of resolving disagreements

8.9 The proposed model also benefits the child at a later age, at the time of transition into young adulthood. As a young person of 17 or 18 years, s/he may still be in the education system at a special school, and may have ongoing involvement from specialist health staff. Presently, the changeover point into adult services can vary between different groups of professionals in the adults' and children's systems. Moreover, there is not a seamless ongoing process into the different parts of the adult system, and there are new partners who need to become involved, for example careers and employment services, or further education. To too many young people and families, it feels that they are moving into a very confusing environment, with inadequate co-ordination at a critical life stage.

8.10 Under the proposed model, there would be a clarity of planning and service delivery responsibilities in the single Children's Service, and also a greater clarity in the adults' service, including for the additional partner agencies – who will understand and have easier access to the organisation with lead service responsibilities. Critically, there would be a co-ordinated and more seamless hand-over that can be agreed and achieved on a phased basis, taking account of the young person's particular needs, rather than on the basis of different and somewhat arbitrary service rules. While this will require flexibility and negotiation between the Council and NHS Highland, it is about one clear set of arrangements with the young person at the centre, rather than a multiplicity of bureaucratic arrangements.

8.11 In summary, the benefits to the young person and carers in this example are –

- Clearer planning from both children's and adults' services, and a more seamless handover of responsibilities.
- Simpler systems for other partner agencies to become involved in young adulthood
- Greater clarity and less stress and confusion for the young person and their family.

8.12 These few examples from a user perspective can be multiplied many times over to show the sort of impact that the new arrangements could have on the efficacy of the care systems. There will always be challenges in providing care, in particular for the most complex cases, but overall we believe this model is more likely to support improved outcomes.

9. Proposed Next Steps

9.1 This paper provides a high level description of a model of integration that it is felt will bring significant benefits to service users. There are many detail questions that need to be considered as a next stage.

9.2 Initial work should commence on the practical and technical aspects that will

emerge from the proposals. These will include HR issues, legal and professional issues, matters of finance and accounting, property related issues, IT and systems matters, etc. This work would need to consider those common aspects of the separate Adult and Children's components to the arrangements, as well as any distinct elements.

9.3 The HR issues particularly need careful consideration. The implication of these proposals is that relevant staff will be 'transferred' to the lead authority and that authority will be responsible for their direct line management and deployment. The implications on staff members contracts of employment need to be worked through and all options considered. Further, the issues concerning the professional and clinical accountability of staff need to be fully considered.

9.4 A change of this order would require a formal consultation process. Within the NHS, legislation and guidance relating to the staff governance principles would direct that staff and their trade unions should be formally engaged and involved in any changes that affect them. The same philosophy will apply within the Council. Other stakeholders and community interest groups will rightly expect to be formally consulted.

9.5 Whilst the approach should be kept as simple as possible without unnecessary bureaucracy, the complexity and challenge of the ambition should not be underestimated. Twelve months would seem a minimum period to put in place the new arrangements once agreement has been established and this timetable would only be achieved through focused and assertive effort on the part of all parties.

10. Interim Arrangements and Reporting back

10.1 Whilst it is clear that it will take some time to scope, address and implement new arrangements, and the Implementation Programme Plan will need to be a live document to ensure it picks up and addresses any new issues that emerge, it is suggested that the Highland Partnership be tasked with producing an initial implementation programme plan by May 2011.

10.2 At that time the report by the Highland Partnership should include any recommendations for initial first steps that can be implemented at that stage.

10.3 This will become a standing item at the Council and NHS Board as the work progresses. Local partnerships will also be kept fully briefed and engaged.

11. Resource Implications

11.1 In recognition of the pressures on the health and social care system in a challenging fiscal climate, the Scottish Government has allocated money in 2011/12 within the NHS budget to a Change Fund for NHS Boards and partner local authorities to redesign services to support the delivery of new approaches to improved quality and outcomes. Guidance on drawing up plans to back the spending is to be discussed at the next Ministerial Strategy Group. It is anticipated that this fund could be used to support any necessary time-limited financial pressures associated with implementing these new arrangements, and Government officials have further indicated that additional

support may be possible.

11.2 There will be aspects of detail of financial regulations that will require consideration.

12. Legal Implications

12.1 **Appendix 2** provides a brief overview of the legislation directly pertinent to this proposal. Whilst further detailed work is required to establish arrangements for some very specific functions such as services for the care of mothers and young children, and the precise position as it relates to nomination of Mental Health officers, it is clear that the Partnership could use the current legislative provisions for the delegation of functions to pursue arrangements as described above.

13. Equality Implications

13.1 The partners share identical core Equalities duties; although the Local Authority has additional duties in respect of it being an Education Authority, and these will be addressed as integral features of the development and implementation of strategic and operational plans and service design and delivery.

14. Climate Change Implications

14.1 No climate change implications have been identified

15. Risk Implications

15.1 A risk register and risk management plan will be developed as part of the implementation plan and will be included as an integral part of all future progress reports.

Recommendation

Members and NHS Directors are asked to agree in principle:

- To commit to a pathway for integration of health and social care services that would provide both Authorities with the joint responsibility for specifying the outcomes to be achieved for service users, and the totality of resources to be allocated to each of the two service areas, and would put in place single lead agency arrangements for Adult Community Care Services and for Children's Services.
- That the most appropriate single lead agency for the delivery of Adult Community Care Services is NHS Highland and that the most appropriate single lead agency for the provision of Children's Services is The Highland Council.
- A formal Implementation Programme Plan is developed to progress detailed planning and implementation with a view to the new arrangements being fully in place by April 2012.
- That this Plan is brought, by May 2011, to the Council and Health Board for formal endorsement and commitment to proceed.
- To receive and consider further reports on progress, and participate in a special workshop in the new year to explore the issues in depth with input from Partnerships elsewhere who have developed and implemented similar proposals.

Signatures:

Designation: Chief Executive Highland Council Chief Executive NHS Highland

Date: 8th December 2010

Authors: Chief Executive Highland Council & Chief Executive NHS Highland

Appendix 1

Values and Principles underpinning joint service delivery

- Services should be person centred, respecting individual need and circumstance; users must be involved as partners in the design and delivery of care
- Services should be enabling; designed and delivered to support people to achieve their own maximum potential, independence and attainment
- Improvements in service quality (user experience, effectiveness and efficacy) should be the priority, and achieving this will in turn improve efficiency and reduce cost
- Services need to be preventative and anticipatory, as well as reactive and responsive
- Those who deliver services, service users and their carers need to acknowledge that risks cannot be eliminated and that approaches to maximise a user's potential may require the acceptance of a higher level of risk
- The intention of a service intervention needs to be clear and understood; services need to be effective and deliver the outcomes intended

Criteria for assessing options for arrangements to support improved delivery, outcomes and efficiency

The arrangements must make sense to our Public and to Service Users

- It looks common sense from the public's view
- It is what our public and users would expect of us
- Services are received in a seamless, joined up way
- People don't fall through gaps
- It supports the transition from children's to adult services
- People don't have to give the same information multiple times
- Services aren't duplicated
- Users are not 'handed-off' by one part of the system to another
- Accountability is clear to the public

They will be Outcomes Focused

- They will achieve what we intend, be it independence, safety, learning and development, etc
- 'Upwards' accountability is for delivery of agreed outcomes
- There is a culture of delivery, and of performance management
- They will be information rich to support delivery

They must be Efficient and Cost Effective

- Reduced bureaucracy, reduced overheads, resources preserved for front line
- Fewer layers of management
- Reduced transactional costs – money and staff time
- Sustainable and affordable into future, i.e. cost less than at present
- Seamless joint resource

There must be sound Leadership, Governance and Accountability

- Governance will be in respect of delivery of outcomes
- Service models need to be designed to deliver the desired outcomes
- High trust, low maintenance accountability
- It is what Scottish Government would expect of us
- It will deliver the Scottish Government broad outcomes agenda
- Cultural barriers are removed
- Complements & doesn't compromise other partner arrangements
- Complements & doesn't compromise NHSH arrangements in Argyll and Bute.

Principles for Accountability and Governance in Single Lead Agency Model:

Strategic level

- Both organisations, in partnership with each other and engaging wider stakeholders, would be responsible for developing the 'strategic intent' for Adult Community Care and for Children's services. This would be captured in 'outcomes' terms and should define the quality standards to be delivered.
- Both organisations would be responsible for agreeing the totality of resources to be allocated to each of the two services areas
- These aspects would be agreed by the Council and the Health Board and would provide the 'commission' to the delivery partner for the period, say three years.

Delivery level

- The 'delivery organisation' would be responsible for arranging services (providing or commissioning) in order to meet the strategic intent. It would directly control all relevant staff and other assets. It would determine how to organise and manage delivery without referral back to the other partner. Internal governance mechanisms would apply; effectively it would be an operating division of the parent organisation, and would account for routine operations through appropriate internal governance mechanisms to the parent Board.

Accountability

- At the end of each year, the delivery partner would formally account for delivery against the strategic intent to both its parent Board and the partner Board. The Boards would satisfy themselves (or otherwise) that the intent was being delivered. In this way both organisations would discharge their legal accountabilities.

Appendix 2

A Brief Summary of the relevant legislative frameworks

Regulations related to delegation of functions – general

The Community Care (Joint Working, etc) (Scotland) Regulations 2002, which set out the functions which can be delegated between local authorities and NHS bodies, were drafted as part of the work to progress the Joint Future. They make provision for the delegation of various functions from NHS to Council and vice versa.

In terms of the proposed model, we are principally looking at a "two way" delegation - from The Highland Council to NHS Highland of a number of adult care functions, with the children's functions moving from the NHS to the Local Authority.

The Local Authority regulations relevant to a delegation of adult care functions are listed below:

1. Sections 4, 5A, 5B, 12A, 12AA, 12AB, 12B, 12C, 13, 13A, 13B, 14 and 59 of the Social Work (Scotland) Act 1968. These are general powers which principally relate to community care services eg making of community care plans, complaints procedures, duty to assess need, provision of residential accommodation with and without nursing care, and home help and laundry services.

2. Sections 1 and 2(1) Chronically Sick and Disabled Persons Act 1970. This relates to community care services and also includes the provision of welfare services to persons in need which includes adaptations to property.

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3. Section 8 Disabled Persons (Services, Consultation and Representation) Act 1986. This relates to community care services and in particular, the co-ordination of resources in relation to services for disabled people.

4. Sections 47 & 48 National Assistance Act 1948. This is community care orientated and covers removal of people in need of care and care of their property. It may have been superseded by the 2007 Act.

5. Section 3 Disabled Persons (Employment) Act 1958

6. Sections 25, 26, 27 and 32 of the Mental Health (Care and Treatment) (Scotland) Act 2003:-

- Section 25 Care and Support Services
- Section 26 Services designed to promote well being and social development
- Section 27 Assistance with travel.

7. Sections 1 to 8 of Part I, Part II and Part XIII Housing (Scotland) Act 1987. This relates to provision of housing and grant assistance and thereby links into the provision of housing adaptations and links with OT services

8. Part 1 of the Housing (Scotland) Act 2001. This relates to homelessness functions

9. Section 6 Community Care and Health (Scotland) Act 2002. This relates to the power to defer payments of accommodation costs.

The functions in the 1968 Act are the most broadly drafted but OT services are not specifically mentioned. We need to undertake further work to clarify the statute from which this duty originates or whether it is something that appears only generally – as a duty to provide assistance – rather than being specifically mentioned by name (for example the "cash or kind" Section 12 area of the 1968 legislation). Some aspects would appear to be provided for by the Chronically Sick and Disabled Persons Act 1970, which gives Local Authorities the power to make adaptations to properties. Funding through the grants process is dealt with by the Housing (Scotland) Act 1987.

The position in respect of the appointment of Mental Health Officers is governed by the Mental Health (Care and Treatment) (Scotland) Act 2003 and is not included as a function which can be transferred from a local authority to the NHS. It is however a service for which the NHS can make payment to a local authority. This distinction and its implications will require further exploration.

The NHS legislation relevant to a delegation of children and family service functions are listed below:

1. Sections 19(1); 25(1); 26(1); 27(1); 36, 37 & 45 of the NHS (Scotland) Act 1978. These refer to Arrangements and Regulation of general medical services; provision of dental services, ophthalmic services & pharmaceutical services; Accommodation (hospital provision); the prevention of illness and after care and the provision of ambulances. It specifically does not include surgery, radiotherapy, termination of pregnancies, endoscopy, laser treatment, any other invasive treatments or the provision of emergency ambulances.

2. Sections 12 A and 12 AA (a) Establishment and direction to delegate by NHS Bodies.

Regulations related to consultation

The regulations state that there should be a consultation 8 weeks prior to the commencement of the proposed arrangement. Such consultation should be with anyone likely to be affected by the arrangement and must include newspaper advertisements.

The regulations also provide that there should be consultation with affected employees although there does not appear to be any timescale for this and does not appear to be any bar to the consultations running concurrently.

There is legislative provision for the TUPE transfer of staff.

Conclusions

At this point, it is evident that the Partnership could use the provisions for delegation of functions to pursue arrangements as proposed in the main body of this report. Further detailed work is required to establish arrangements for functions such as services for the care of mothers and young children, and the precise position as it relates to the nomination of Mental Health officers, but the proposed direction of travel within the "two way" arrangement mean that the vast majority of non transferrable provision (eg. Local Authority statutory child care functions) are not being considered for delegation.