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Scrutiny Panel A

Educational Attainment for Children with Special Needs Inquiry

Wednesday, 19th January,
2011 at 6.00 pm

PLEASE NOTE TIME OF MEETING
Council Chamber – Civic Centre

This meeting is open to the public

Members

Councillor Fitzgerald (Chair)
Councillor Kolker (Vice-Chair)
Councillor Mrs Damani
Councillor Morrell
Councillor Odgers
Councillor Turner
Councillor Willacy

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PUBLIC INFORMATION

Role of Scrutiny Panel A

The Panel has responsibility for:-

- providing an independent assurance to the Standards and Governance Committee on the adequacy of the risk management framework and the internal control and reporting environment including (but not limited to) the reliability of the financial reporting process and the statement of internal control;
- satisfying and providing assurance to the Standards and Governance Committee that appropriate action is being taken on risk and internal control related issues identified by the internal and external auditors and other review and inspection bodies; and
- specifically, the oversight of, and provision of assurance to the Standards and Governance Committee on, the following functions:-
 - ensuring that Council assets are safeguarded;
 - maintaining proper accounting records;
 - ensuring the independence, objectivity and effectiveness of internal and external audit;
 - the arrangements made for co-operation between internal and external audit and other review bodies;
 - considering the reports of internal and external audit and other review and inspection bodies;
 - the scope and effectiveness of the internal control systems established by management to identify, assess, manage and monitor financial and non-financial risks (including measures to protect against, detect and respond to fraud).

Southampton City Council's Six Priorities

- Providing good value, high quality services
- Getting the City working
- Investing in education and training
- Keeping people safe
- Keeping the City clean and green
- Looking after people

Public Representations

At the discretion of the Chair, members of the public may address the meeting about any report on the agenda for the meeting in which they have a relevant interest.

Smoking policy – the Council operates a no-smoking policy in all civic buildings.

Mobile Telephones – please turn off your mobile telephone whilst in the meeting.

Fire Procedure – in the event of a fire or other emergency a continuous alarm will sound and you will be advised by Council officers what action to take.

Access – access is available for the disabled. Please contact the Democratic Support Officer who will help to make any necessary arrangements.

Dates of Meetings: Municipal Year

2010	2011
3 June	19 January
8 July	3 February
2 September	3 March
7 October	7 April
4 November	

CONDUCT OF MEETING

Terms of Reference

The terms of reference of the Audit Committee are contained in Article 8 and Part 3 (Schedule 2) of the Council's Constitution.

Business to be discussed

Only those items listed on the attached agenda may be considered at this meeting.

Rules of Procedure

The meeting is governed by the Council Procedure Rules as set out in Part 4 of the Constitution.

Quorum

The minimum number of appointed Members required to be in attendance to hold the meeting is 3.

Disclosure of Interests

Members are required to disclose, in accordance with the Members' Code of Conduct, **both** the existence **and** nature of any "personal" or "prejudicial" interests they may have in relation to matters for consideration on this Agenda.

Personal Interests

A Member must regard himself or herself as having a personal interest in any matter

- (i) if the matter relates to an interest in the Member's register of interests; or
- (ii) if a decision upon a matter might reasonably be regarded as affecting to a greater extent than other Council Tax payers, ratepayers and inhabitants of the District, the wellbeing or financial position of himself or herself, a relative or a friend or:-
 - (a) any employment or business carried on by such person;
 - (b) any person who employs or has appointed such a person, any firm in which such a person is a partner, or any company of which such a person is a director;
 - (c) any corporate body in which such a person has a beneficial interest in a class of securities exceeding the nominal value of £5,000; or
 - (d) any body listed in Article 14(a) to (e) in which such a person holds a position of general control or management.

A Member must disclose a personal interest.

Continued/.....

Prejudicial Interests

Having identified a personal interest, a Member must consider whether a member of the public with knowledge of the relevant facts would reasonably think that the interest was so significant and particular that it could prejudice that Member's judgement of the public interest. If that is the case, the interest must be regarded as "prejudicial" and the Member must disclose the interest and withdraw from the meeting room during discussion on the item.

It should be noted that a prejudicial interest may apply to part or the whole of an item.

Where there are a series of inter-related financial or resource matters, with a limited resource available, under consideration a prejudicial interest in one matter relating to that resource may lead to a member being excluded from considering the other matters relating to that same limited resource.

There are some limited exceptions.

Note: Members are encouraged to seek advice from the Monitoring Officer or his staff in Democratic Services if they have any problems or concerns in relation to the above.

Principles of Decision Making

All decisions of the Council will be made in accordance with the following principles:-

- proportionality (i.e. the action must be proportionate to the desired outcome);
- due consultation and the taking of professional advice from officers;
- respect for human rights;
- a presumption in favour of openness, accountability and transparency;
- setting out what options have been considered;
- setting out reasons for the decision; and
- clarity of aims and desired outcomes.

In exercising discretion, the decision maker must:

- understand the law that regulates the decision making power and gives effect to it. The decision-maker must direct itself properly in law;
- take into account all relevant matters (those matters which the law requires the authority as a matter of legal obligation to take into account);
- leave out of account irrelevant considerations;
- act for a proper purpose, exercising its powers for the public good;
- not reach a decision which no authority acting reasonably could reach, (also known as the "rationality" or "taking leave of your senses" principle);
- comply with the rule that local government finance is to be conducted on an annual basis. Save to the extent authorised by Parliament, 'live now, pay later' and forward funding are unlawful; and
- act with procedural propriety in accordance with the rules of fairness.

AGENDA

Agendas and papers are now available via the City Council's website

1 APOLOGIES AND CHANGES IN PANEL MEMBERSHIP (IF ANY)

To note any changes in membership of the Panel made in accordance with Council Procedure Rule 4.3.

2 DISCLOSURE OF PERSONAL AND PREJUDICIAL INTERESTS

In accordance with the Local Government Act, 2000, and the Council's Code of Conduct adopted on 16th May, 2007, Members to disclose any personal or prejudicial interests in any matter included on the agenda for this meeting.

NOTE: Members are reminded that, where applicable, they must complete the appropriate form recording details of any such interests and hand it to the Panel Administrator prior to the commencement of this meeting.

3 DECLARATIONS OF SCRUTINY INTEREST

Members are invited to declare any prior participation in any decision taken by a Committee, Sub-Committee, or Panel of the Council on the agenda and being scrutinised at this meeting.

4 DECLARATION OF PARTY POLITICAL WHIP

Members are invited to declare the application of any party political whip on any matter on the agenda and being scrutinised at this meeting.

5 STATEMENT FROM THE CHAIR

6 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the Minutes of the Inquiry Meeting held on 4th November 2010 and to deal with any matters arising, attached.

7 3RD MEETING OF THE PRIMARY SCHOOL EDUCATIONAL ATTAINMENT FOR CHILDREN WITH SPECIAL NEEDS INQUIRY

Report of the Head of Corporate Policy and Performance, providing feedback from members on their school visits to see specialist units in action and detailing information outlining the future, nationally and locally, for SEN, disability and emerging issues from Government, attached.

TUESDAY, 11 JANUARY 2011

SOLICITOR TO THE COUNCIL

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Agenda Item 6

SCRUTINY PANEL A **EDUCATIONAL ATTAINMENT FOR CHILDREN WITH SPECIAL NEEDS INQUIRY** **MINUTES OF THE MEETING HELD ON 4th NOVEMBER 2010**

Present:

Councillors Fitzgerald (Chair), Kolker (Vice-Chair), Damani, Morrell, Osmond, Turner and Willacy

Also in attendance:

Liz Filer – Headteacher, Bassett Green Primary School

Jackie Partridge – Headteacher, Springwell School

Lisa Osborn – Southampton ADHD Support Group

Alex Isles – Parent Partnership (Mencap)

Gwen Harrison – Parent Partnership (Mencap)

Lesley Hobbs – Strategic Lead for Special Educational Needs (SEN), SCC

Paul Nugent – Head of Standards

Julie Wharton – SEN Inspector

18. APOLOGIES AND CHANGES IN PANEL MEMBERSHIP

Apologies were received from Councillor Odgers and the Panel noted that in accordance with the provisions of Procedure Rules 4.3 and 4.4, Councillor Osmond replaced Councillor Odgers, for the purposes of this meeting.

19. DISCLOSURE OF PERSONAL AND PREJUDICIAL INTERESTS

Councillors Osmond, Morrell, Turner and Willacy declared non-prejudicial interests in relation to the scrutiny inquiry in view of their relationships with members of their family who were in receipt of or provided special educational needs. Councillor Damani declared a non-prejudicial interest in relation to the scrutiny inquiry in view of her working relationship with the witnesses.

20. MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

RESOLVED that the minutes of the meeting held on 7th October 2010 be approved and signed as a correct record. (Copy of the minutes circulated with the agenda and appended to the signed minutes).

21. 2nd MEETING OF THE PRIMARY SCHOOL EDUCATIONAL ATTAINMENT FOR CHILDREN WITH SPECIAL NEEDS INQUIRY

The Panel considered the report of the Head of Policy and Performance, introducing the 2nd meeting which would be separated into two main sections detailing the school's perspective of special needs and the parent's and child's perspective of support for children with special education needs, attached.

The Panel received the following presentations:

- (i) **Liz Filer - Headteacher, Bassett Green Primary School – managing SEN in a mainstream primary school**

The Panel noted that:-

- there were two distinct groups of pupils at the school ,45% who were eligible for free school meals and 45% who were from ethnic minority backgrounds;
- the school enjoyed a diversity of 26 languages with 41% of pupils having English as an additional language and it was important that when a child joined the school there was a settling in period in order to ascertain whether the child had difficulties because of the language barrier or special educational needs;
- 30% of the children had special educational needs (SEN) as well as 13 children having statements with 1:1 support;
- at least half of the children had chaotic home lives and each child was welcomed into school everyday which often included breakfast, in an attempt to provide security and enabling them to have time to share their feelings and thus meet their emotional needs;
- each child had an individual learning plan, an IEP (Individual Education Plan), an IBP (Individual Behaviour Plan) or a Statement of Special Educational Needs, so that individual learning needs could met and these plans were shared with the children and the teachers;
- the school had a Whole School Behaviour policy written with the children based on the belief that they were all responsible members of the school community rather than complying because the rules said so;
- the school worked very closely with outside agencies;
- a lot of psychological problems were as a result of the environment outside of the school, over which the school had no control; and
- the inclusive approach has seen a significant drop in the absence rates

(ii) **Jackie Partridge – Headteacher, Springwell School – best practice in special schools and via Outreach**

The Panel noted that:-

- there was a greater complexity of needs at Springwell than at a maintained school and all the pupils were statemented;
- the school had 64 children in 8 classes of 8 and each class had 1 teacher with 3 learning support assistants;
- the children had personalised learning programmes which covered all aspects of learning, social skills and developing confidence and self esteem;
- the curriculum was based on the national curriculum but rewritten to specific levels for each child with specialist teaching techniques;
- the school environment was totally communicative and children used a range of spoken language, Makaton (sign language) and PECS (picture exchange card system);
- children were supported and encouraged to work independently without adult intervention by means of independent work systems and tasks;
- the school had close partnership working with parents, professional partners and the community and 5 members of staff provided outreach services;
- the school had applied to be a National Leader in Education – a National Support School; and
- all the staff provided training and support at mainstream schools and this training was in the process of being extended;

(iii) **Lisa Osborn – Chair , Southampton ADHD Support Group – an overview of their activities**

The Panel noted that:-

- the service was run by a group of volunteers and was part of SVS;
- ADHD had recently been diagnosed as a genetic condition;
- the statistics on ADHD were grossly incorrect and many parents of children diagnosed with ADHD were unaware that they also had this condition which further complicated their situation; and
- parents quite often had to stop work or change their work pattern if their child had been excluded from school because of severe behavioural problems as it was very difficult to find childcare to cope with their child's behavioural problems;

(iv) **Alex Isles and Gwen Harrison – Southampton Parent Partnership Service (SPPS) - the parental perspective**

The Panel noted that:-

- SPPS was a voluntary organisation who delivered an independent service to families with children and young people with SEN and at present had a caseload of approximately 200 parents;
- The main services provided were:-
 - * how special educational needs were identified and assessed by schools and the local authority;
 - * who parents could talk to in a school or LA about their concerns;
 - * the SEN Code of Practice, the statutory assessment process and statements;
 - * parents/carers rights and responsibilities;
 - * meetings and reviews about a child's needs;
 - * how progress was monitored and reviewed; and
 - * what parents could do if they were not happy with a decision made about their child's SEN.

RESOLVED

- (i) that the following requests and comments from officers be noted :-
- that more recognition be given to those schools who worked hard to enable children with SEN to be successful;
 - that all schools be encouraged to be more inclusive and if expertise in SEN was lacking, that training be provided;
 - that financial support be provided so that children with SEN did not suffer as a result of the economy;
 - that volunteers from the ADHD Support Group and SPPS were better linked with schools; and

- that services needed to be more joined up and if possible one point of contact be available for all services and support related to SEN/disability issues.
- (ii) that the report of the Head of Policy and Improvement and the comments and presentations received from the Headteachers of Bassett Green Primary School and Springwell School, Southampton ADHD Support Group and Southampton Parent Partnership, along with the ideas and suggestions contributed by Members of the Panel , be placed in the register of evidence of the Inquiry into Educational Attainment for Children with Special Needs.

Agenda Item 7

DECISION-MAKER:	SCRUTINY PANEL A		
SUBJECT:	3rd MEETING OF THE PRIMARY SCHOOL EDUCATIONAL ATTAINMENT FOR CHILDREN WITH SPECIAL NEEDS INQUIRY		
DATE OF DECISION:	19 JANUARY 2011		
REPORT OF:	HEAD OF CORPORATE POLICY AND PERFORMANCE		
AUTHOR:	Name:	Dorota Goble	Tel: 023 8083 3317
	E-mail:	dorota.goble@southampton.gov.uk	

STATEMENT OF CONFIDENTIALITY

None

SUMMARY

The third meeting of the Primary School Educational Attainment for Children with Special Educational Needs (SEN) Inquiry will include feedback from members on their school visits to see specialist units in action followed by three presentations outlining the future, nationally and locally, for SEN, disability and emerging issues from Government.

RECOMMENDATIONS:

- (i) The panel is recommended to consider the discussions at the meeting and use the information provided as evidence in the inquiry.

REASONS FOR REPORT RECOMMENDATIONS

1. To enable the panel to compile a file of evidence in order to formulate findings and recommendations at the end of the inquiry process.

CONSULTATION

2. Stakeholders are being consulted throughout the inquiry process. The Head of Standards, the Principal Officer for Prevention and Inclusion, the NHS Commissioner for Children's Healthcare and Associate Director for Children and Families, Solent Healthcare were involved in developing the agenda for this meeting.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3. None

DETAIL

4. Members will be visiting Bassett Green Primary School, Hardmoor Early Years Centre, Highfield CE Primary School, Mason Moor Primary School and Springwell School between 11-18 January to see the schools in action, with a particular focus on their specialist units or provision for special educational needs.

5. At the beginning of the third meeting members will be invited to give a verbal feedback of their observations and views following the visits.
6. This will be followed by first presentation from Julie Wharton and Julia Katherine which will outline the emerging national picture for special educational needs. This will also highlight issues around child poverty and the new pupil premium. The presentation will draw on the expected direction of the delayed white paper. The consultation document from the Green Paper: Children And Young People With Special Educational Needs And Disabilities - Call For Views is attached as **Appendices 1 and 2**.
7. **Appendices 3 and 4** provide a breakdown of Southampton City School pupils with and without special needs against children receiving free school meals.
8. The second presentation from Donna Chapman and Liz Taylor will outline the future model of delivery and developments from the health perspective. This will cover emerging issues from the disability review and how the Health White Paper will impact on service delivery for children with special needs. It will draw out the key messages for joint working and decision making. The engagement paper for children and young people has been included as **Appendix 5: Achieving Equity and Excellence for Children**.
9. Finally, there will be an outline of the expected changes and context from Southampton City Council's perspective by Lesley Hobbs.

FINANCIAL/RESOURCE IMPLICATIONS

Capital

8. Not applicable

Revenue

9. Not applicable

Property

10. Not applicable

Other

11. Not applicable

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

12. The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007.

Other Legal Implications:

13. None

POLICY FRAMEWORK IMPLICATIONS

14. None

SUPPORTING DOCUMENTATION

Appendices

1 2	The consultation document from the Green Paper: Children And Young People With Special Educational Needs And Disabilities - Call For Views
3 4	Breakdown of Southampton City School pupils with and without special needs against children receiving free school meals.
5	Engagement paper for children and young people: Achieving Equity and Excellence for Children.

Documents In Members' Rooms

	None
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Background Documents

None

Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)

	None	
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Background documents available for inspection at:

FORWARD PLAN No: Not applicable **KEY DECISION?** No

WARDS/COMMUNITIES AFFECTED:	Not applicable
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Overview from the Department of Education

SEN AND DISABILITY GREEN PAPER: Government calls for Views

Date: 10 September 2010

Ministers are considering how to ensure parents can send their child with special educational needs (SEN) or disabilities to their preferred educational setting – whether that is a mainstream school, special school or an academy.

The plans were outlined today as Children's Minister Sarah Teather called on parents, charities, teachers and LAs to contribute to the Government's SEN Green Paper.

The paper, to be published in the autumn, aims to improve radically the entire SEN system and will cover issues including school choice, early identification and assessment, funding and family support.

Ministers are considering a range of options, including how to

- give parents a choice of educational settings that can meet their child's needs
- transform funding for children with SEN and disabilities and their families, making the system more transparent and cost-effective while maintaining a high quality of service
- prevent the unnecessary closure of special schools and involve parents in any decisions about the future of special schools
- support young people with SEN and disabilities post-16 to help them succeed after education
- improve diagnosis and assessment to identify children with additional needs earlier.

Sarah Teather said:

Children with special educational needs and disabilities should have the same opportunities as other children, but the current system is so adversarial that too often this doesn't happen. I want parents, teachers, charities, teaching unions and local authorities to come forward with the changes they think are needed to make the system better for children with SEN and their families.

Parents should be in control of their child's education and future. Importantly, they must be involved in discussions and decisions about the support they need rather than feel they have to battle the system. I want to make it easier for parents to choose where their child is educated.

I want to look at every aspect of SEN – from assessment and identification to funding and education. We need to strip away the

cumbersome bureaucracy but ensure there is a better, more comprehensive service for families.

To support fundamental changes to the SEN and disability system, ministers are looking at how to identify children's needs earlier, develop fairer and more transparent funding arrangements, and streamline assessments to make life easier for parents and families.

Ministers are seeking a wide range of views to help them develop proposals for consultation that are practical to implement, reduce bureaucracy and build on current effective practice as well as make the most of the available funds.

Alongside the launch of the Call for Views, the Children's Minister today confirmed the end of the national disabled children's services parental survey. Only a limited number of parents could respond to the survey and ministers want all parents to have the opportunity to get involved in how local services are designed and delivered. The Government welcomes views on how to strengthen the process for ensuring parents' views affect the services their family receives locally.

Green Paper: Children And Young People With Special Educational Needs And Disabilities - Call For Views

Response Form

The closing date for this Call For Views is:
15 October 2010

Your comments must reach us by that date.



THIS FORM IS NOT INTERACTIVE. If you wish to respond electronically please use the online or offline response facility available on the Department for Education e-consultation website (<http://www.education.gov.uk/consultations>).

Information provided in response to this consultation, including personal information, may be subject to publication or disclosure in accordance with the

access to information regimes, primarily the Freedom of Information Act 2000 and the Data Protection Act 1998.

If you want all, or any part, of your response to be treated as confidential, please explain why you consider it to be confidential.

If a request for disclosure of the information you have provided is received, your explanation about why you consider it to be confidential will be taken into account, but no assurance can be given that confidentiality can be maintained. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data (name and address and any other identifying material) in accordance with the Data Protection Act 1998, and in the majority of circumstances, this will mean that your personal data will not be disclosed to third parties.

Please tick if you want us to keep your response confidential.x

Reason for confidentiality:

Name

Organisation (if applicable)

Address:

If your enquiry is related to the policy content of the consultation you can contact Shane Samarasinghe Telephone: 020 7783 8602

e-mail: shane.samarasinghe@education.gsi.gov.uk

If you have a query relating to the consultation process you can contact the Consultation Unit on:

Telephone: 01928 794888

Fax: 01928 794 311

e-mail: consultation.unit@education.gsi.gov.uk

Please mark an X in the box below that best describes you as a respondent.

<input type="checkbox"/> Parent/Carer	<input type="checkbox"/> Child/Young Person	<input type="checkbox"/> National Voluntary Organisation
<input type="checkbox"/> Children's Service	<input type="checkbox"/> Local voluntary Organisation	<input type="checkbox"/> School/College
<input type="checkbox"/> Local Authority	<input type="checkbox"/> Headteacher/Teacher	<input type="checkbox"/> SENCO
<input type="checkbox"/> Governor	Other (please specify)	

Please Specify:

Q1) Are the SEN and Disability statutory frameworks - including the SEN statementing process - helping children and young people to get what they need? If not, what changes could help?

Yes

No

Not Sure

Comments:

Q2) How can we identify children's special educational needs earlier, and make sure that they get the support they need as quickly as possible?

Comments:

Q3) How can we improve the processes for special educational needs and disability - in schools, in assessments, and across all services - so that professionals can spend more of their time with children and their families?

Comments:

Q4) How can we ensure all schools and colleges have high expectations for children and young people with special educational needs and disabilities, including their future potential and contribution to society?

Comments:

Q5) How can we improve the choices of schools and services available to parents and improve opportunities for them to be involved in decisions that affect their family?

Comments:

Q6) How can we improve the transition from school to adult life for young people with special educational needs and disabilities and the support provided for their families throughout?

Comments:

Q7) Ideas and examples of what's working well

We would like to include ideas and examples of what's working well. If you have an example we could include please respond setting out your response as detailed below.

Summary: 150 words

Examples:150 words

- *Where is it?*
- *What was done, by whom, how and when?*
- *What resources were required?*
- *How was the work funded?*

By the TDA

A bit about you: 100 words

Permission to use:

Comments:

Q8) Please use this space for any other comments you would like to make.

Comments:

Q9) Please let us have your views on responding to this consultation (e.g. the number and type of questions, was it easy to find, understand, complete etc.)

Comments:

Thank you for taking the time to let us have your views. We do not intend to acknowledge individual responses unless you place an 'X' in the box below.

Please acknowledge this reply

Here at the Department for Education we carry out our research on many different topics and consultations. As your views are valuable to us, would it be alright if we were to contact you again from time to time either for research or to send through consultation documents?

Yes No

All DfE public consultations are required to conform to the following criteria within the Government Code of Practice on Consultation:

Criterion 1: Formal consultation should take place at a stage when there is scope to influence the policy outcome.

Criterion 2: Consultations should normally last for at least 12 weeks with consideration given to longer timescales where feasible and sensible.

Criterion 3: Consultation documents should be clear about the consultation process, what is being proposed, the scope to influence and the expected costs and benefits of the proposals.

Criterion 4: Consultation exercises should be designed to be accessible to, and clearly targeted at, those people the exercise is intended to reach.

Criterion 5: Keeping the burden of consultation to a minimum is essential if consultations are to be effective and if consultees' buy-in to the process is to be obtained.

Criterion 6: Consultation responses should be analysed carefully and clear feedback should be provided to participants following the consultation.

Criterion 7: Officials running consultations should seek guidance in how to run an effective consultation exercise and share what they have learned from the experience.

If you have any comments on how DfE consultations are conducted, please contact Donna Harrison, DfE Consultation Co-ordinator, tel: 01928 794304 / email: donna.harrison@education.gsi.gov.uk

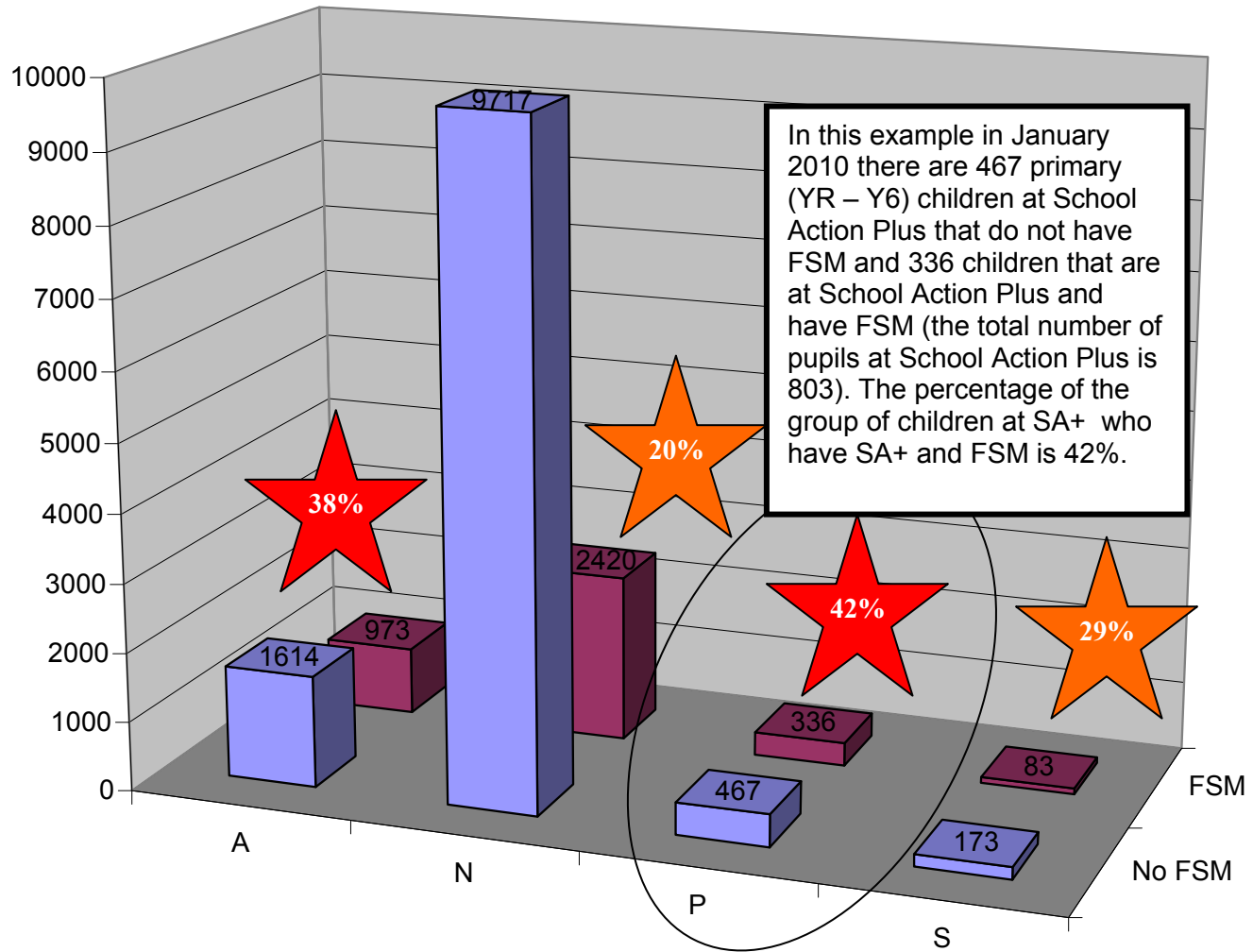
Thank you for taking time to respond to this consultation.

Completed questionnaires and other responses should be sent to the address shown below by 15 October 2010

Send by post to:

SEN and Disability Frameworks Team
Special Educational Needs and Disability Division
Department for Education
Sanctuary Buildings
Great Smith Street
London
SW1P 3BT

Send by e-mail to: send.callforviews@education.gsi.gov.uk



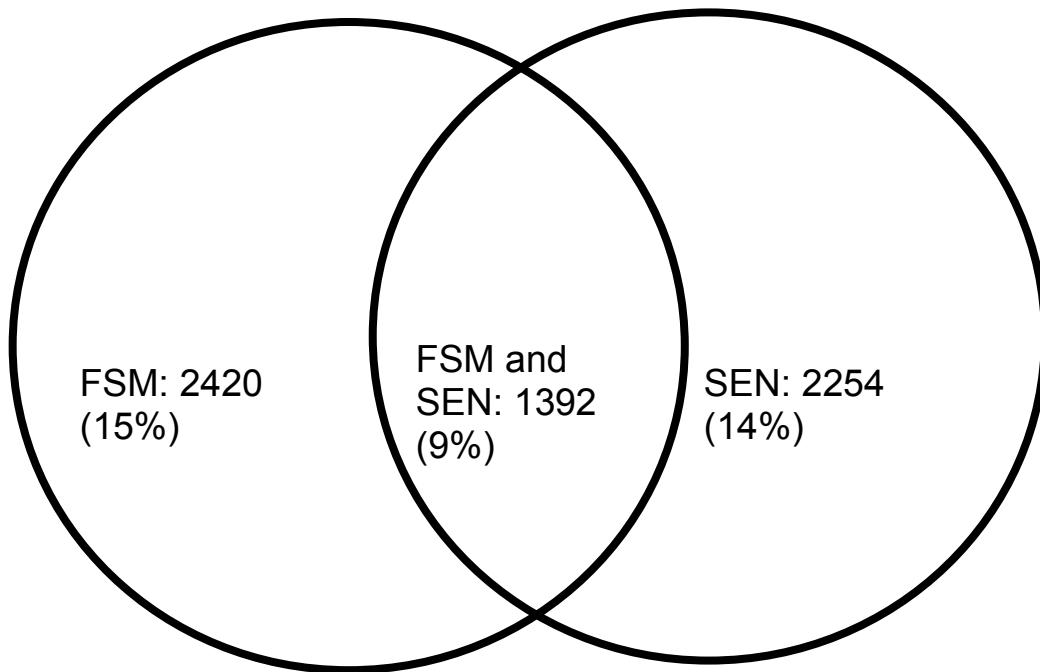
Total number of primary pupils (YR – Y6) with and without FSM (January 2010) at (A) School Action, (N) No SEN, (P) School Action Plus and with a (S) Statement

■ No FSM
■ FSM

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January 2010: Primary School SEN:Free School Meal break down

No Special Needs (SEN) or Free School Meals (FSM):
9717 pupils (62%)



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Achieving equity and excellence for children

How liberating the NHS will help us meet the needs of children and young people

DH INFORMATION READER BOX

Policy HR/Workforce Management Planning Clinical	Estates Commissioning IM&T Finance Social Care/Partnership Working
Document purpose	Policy
Gateway reference	14788
Title	Achieving equity and excellence for children
Author	DH/Children, Families and Maternity
Publication date	16 September 2010
Target audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, PCT Chairs, NHS Trust Board Chairs, Special HA CEs, Directors of HR, Directors of Finance, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's SSs, Voluntary Organisations
Circulation list	Directors of Adult SSs
Description	This paper sets out what the NHS White Paper will mean for children, young people and families and seeks your views on how we can make the most of these important opportunities. Any responses can be sent back through the White Paper consultation process.
Cross reference	<i>Equity and excellence: Liberating the NHS</i> (July 2010); <i>Getting it right for children and young people: Overcoming cultural barriers in the NHS</i> (September 2010)
Superseded docs	
Action required	
Timing	Consultation on <i>Equity and excellence: Liberating the NHS</i> and supporting documents closes on 11 October 2010
Contact details	Ralph Mold Children, Families and Maternity Wellington House 133–155 Waterloo Road SE1 8UG 020 7972 4329
For recipient's use	

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Ministerial foreword

The Government believes that strong and healthy families are the foundations of our society. We know that our ability to create a healthy and prosperous nation for the future depends upon the care we take of our children and young people today. That is why it is imperative that our great national institutions such as the NHS work well for children, young people and their families.

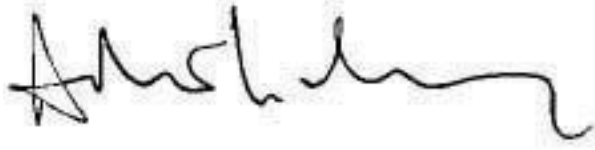
In 2009, Sir David Nicholson, the Chief Executive of the NHS, asked Professor Sir Ian Kennedy to review the cultural barriers to improvement in the way the NHS provides services to children and young people. This reflected concerns raised in a number of inspectorate reports, but also more fundamentally in response to concerns from young people and parents, the public and professionals that, despite a wealth of government publications and targets, things were simply not as good as they could and should be.

Sir Ian has produced a compelling report, *Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs*. He has highlighted areas of good practice, and we know that there are many dedicated professionals who work very hard in the NHS and beyond to do their best for children and young people. We are all grateful for their continued efforts.

But Sir Ian's review has also highlighted issues which will sadly be only too familiar to many families, young people and professionals. Some aspects of the previous system were simply not well designed to meet the needs of children and young people. Sir Ian poses some important challenges. We know that we can and should do better. That is why in our new vision for the NHS, set out in the White Paper *Equity and excellence: Liberating the NHS*, and in preparing for our public health White Paper later this year, we are determined to design children and young people into our proposals from the outset.

We want all patients, including children and young people and their families, to be at the heart of everything that we do. We want families and young people to share fully in decision making, to have real choices and to be empowered and enabled to make decisions about their own care. We know that the previous focus on process targets did not, in many instances, produce benefits for children and young people and, at worst, meant that they lost out to other, 'higher' priorities. We want the focus on outcomes in the system to include children and young people clearly and explicitly. We want professionals who are expert in working with children and young people to be empowered to do so in the way which works best for them and their families.

This paper sets out what our proposals will mean for children, young people and families and seeks your views on how we can make the most of these important opportunities. We look forward to hearing from you.

A handwritten signature in black ink, appearing to read 'A. Lansley', with a long horizontal flourish extending to the right.

Rt Hon Andrew Lansley CBE MP
Secretary of State for Health

1. Introduction

- 1.1 In the past, the NHS was not always set up to put the needs of patients and the public first. Too often patients were expected to fit around services rather than services around patients. Nowhere was this more the case than for children, young people and their families, as Sir Ian Kennedy has shown in his report *Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs*.¹
- 1.2 Nothing can be more important than getting it right for children and young people. We know the importance of health services and healthy behaviours in childhood and teenage years in setting patterns for later life. Recent advances in research have increased our understanding of how what happens in pregnancy and early childhood affects physical and mental health and future development and wellbeing. The NHS is in close contact with families through this vital period, with crucial opportunities to help children get off to the best possible start. This point was made clearly by Sir Michael Marmot in his report on the wider determinants of health.² Young people can also fall through the gap between the arrangements for children's and adult services, with neither fully meeting young people's needs in areas such as confidentiality, privacy and communication skills.
- 1.3 Children and young people are mostly healthy and therefore, thankfully, will never feature highly where decisions are taken based on the burden of disease or on cases of premature death. But illness and injury can have a long-lasting impact on a young person's life and ultimately on their life chances and therefore on our economy and society. In turn this can impact significantly on their family's life. So this matters for all of us.

Purpose

- 1.4 This document forms part of the process of engagement with the NHS White Paper, *Equity and excellence: Liberating the NHS* and applies to England only. It is not a policy statement or an additional consultation. It draws together information from the White Paper and the associated consultation documents to create a vision of how the proposed new arrangements for the NHS could improve services for children and young people. We hope that this will stimulate thinking in this important area.

1 *Getting it right for children and young people*, Kennedy Review, Sep 2010: para 4.64.

2 *Fair Society, Healthy Lives*, The Marmot Review, Feb 2010: pp60–62.

Any views on the implementation of the NHS White Paper or the previously published consultation documents should be sent, by 5 October 2010 in the case of the White Paper or by 11 October in the case of the supporting consultations, to NHSWhitePaper@dh.gsi.gov.uk or White Paper Team, Room 601, Department of Health, 79 Whitehall, London SW1A 2NS.

- 1.5 This document begins an ongoing dialogue on how to ensure high-quality services for children and young people. As we develop our vision for the NHS, we will continue to welcome views on how to achieve the best outcomes for children, young people and families.³

³ At the same time the Government is keen to hear your views on improving the wellbeing and achievement of children and young people with special educational needs and disabilities, as well as the support for families. The Department of Education has published a 'call for views', available at www.education.gov.uk/consultations/, in advance of a Green Paper on special educational needs and disability that is due to be published in the autumn.

2. Putting children, young people and their families first

2.1 If we are to meet the needs of children, young people, families and carers, it is vital that we listen to them in designing services, gather information on their experiences and priorities, provide them with the accessible information that they need to make choices about their care, and involve them in decision making. In *Equity and excellence: Liberating the NHS*, we set out how, subject to consultation and Parliamentary approval, we will put patients at the heart of the NHS, through an information revolution and greater choice and control:

- Shared decision making will become the norm: *no decision about me without me*.
- Patients will have access to the information they want, to make choices about their care. They will have increased control over their own care records.
- Patients will have choice of any provider, choice of consultant-led team, choice of GP practice and choice of treatment. We will extend choice in maternity through new maternity networks.
- The Government will enable patients to rate hospitals and clinical departments according to the quality of care they receive, and we will require hospitals to be open about mistakes and always tell patients if something has gone wrong.
- The system will focus on personalised care that reflects individuals' health and care needs, supports carers and encourages strong joint arrangements and local partnerships.
- We will strengthen the collective voice of patients and the public through arrangements led by local authorities and, at national level, through a powerful new consumer champion, HealthWatch England, located in the Care Quality Commission (CQC).
- We will seek to ensure that everyone, whatever their need or background, benefits from these arrangements.

2.2 Many dedicated professionals go to great lengths to deliver the best possible clinical care to children and young people, and to support them

through difficult times. Yet there is some way to go before services are truly child-centred. Children and young people too often have to miss more school than necessary in order to attend separate appointments on different days, are treated in inappropriate environments or find it hard to understand easily what is being said about their care. This impacts not just on them but also on their families.

- 2.3 For example, we know that families with children, particularly in their children's first years of life, are frequent users of urgent and emergency care – around 26% of those attending A&E are children and around half of children under one year old will attend A&E in a year.⁴ Although sometimes A&E is the right place for families to go, often high-quality services in the community would be a better option. Current 'out-of-hours' and urgent care arrangements are often not clear or convenient for families.⁵ So, in *Equity and excellence: Liberating the NHS*, we committed to developing in every area of England a coherent 24/7 urgent care service which will make sense to families.⁶

Listening to the voice of children, young people and their families

- 2.4 Families and carers can be the most powerful individual advocates for their children and young people, but there is also a need to strengthen their voice in the system. Children and young people must also be offered opportunities to speak of their experiences and to say what in their view has and has not made a difference to their lives.
- 2.5 Subject to Parliamentary approval, local HealthWatch would evolve from current Local Involvement Networks (LINKs) arrangements and would play a key role in collecting views and feedback from local patients, young people, families and the public to feed into commissioning. Local HealthWatch could be represented on Health and Wellbeing Boards and will be key in ensuring that the voice of children, young people and families is heard through the commissioning cycle. Local authorities would have flexibility in commissioning local HealthWatch, enabling them to best reflect the needs of their entire communities rather than those of particular interest groups.
- 2.6 HealthWatch England would provide a vehicle for ensuring that families' and young people's voices are fed into local commissioning so that the design and impact of services can take full account of the needs and experiences of children and young people.

4 Hospital Episode Statistics, Emergency admissions by age, 2008–09.

5 *Getting it right for children and young people*, Kennedy Review, Sep 2010: para 4.65.

6 *Equity and excellence: Liberating the NHS*, DH, Jul 2010: p18.

- 2.7 Engaging parents who are balancing caring and other responsibilities will require innovative approaches, such as employing technology and using people's natural neighbourhoods and communities of interest to engage with them. For example, parents with childcare responsibilities may find meetings difficult, but many parents are active in internet-based groups. Specific, evidence-based tools and techniques for gathering the views of children and young people are also very important. We know there is good practice on this already in many local authorities. Local authorities would be responsible for ensuring that local HealthWatch are operating effectively, so there is real scope for drawing on their expertise and experience in engaging children and young people.
- 2.8 It is important to consider the needs of vulnerable children and young people, including, for example, those who are looked after by the local authority. Children and young people may have particular needs, such as complex disability, a mental health condition or speech, language and communication difficulties, and their families may find dealing with services particularly challenging. It would be possible for local authorities to commission local HealthWatch to provide advocacy and support to help people with particular needs to access services.

Engagement Topic: Are there examples of good local best practice from LINKs or other groups or organisations in engaging with children, young people and their families?

- 2.9 HealthWatch England would provide leadership and support for local HealthWatch but would also collect and feed in intelligence to the CQC. HealthWatch England would be able to pull together a national picture. This is potentially very important for groups where an individual local HealthWatch may not engage with large numbers of, for example, children and young people with more serious mental health conditions or disabled children. In these cases, HealthWatch England can build a series of local issues and encounters into a national picture for the CQC. It would also be able to pick up issues that span services, such as the transition between young people's and adult services. If an issue is raised by HealthWatch, there should be a response from the body with which the issue has been raised – for example, Monitor, the NHS Commissioning Board, the Secretary of State or the CQC itself.

Engagement Topic: How can HealthWatch England and the CQC best collect evidence from local HealthWatch on the issues facing children, young people and their families, and engage them in influencing the quality of those services?

Information

- 2.10 Better information and shared decision making will ensure that children, young people and families have real choices in the system, so that it works for them and is set up to be responsive to their views and experiences.
- 2.11 Information generated by children, young people and their families about the quality of their treatment, care and service experience will be important in the new system. We set out in the consultation document *Transparency in outcomes* the need to improve experiences and outcomes for children and young people.⁷ In the past, patient experience surveys and other quality measures were limited and often covered only adult services. Over time, we will ensure that the experiences and priorities of children and their families are captured in consistent and comprehensive ways – for example, through national clinical audit, expanding the use of Patient Reported Outcome Measures (PROMs), and developing a range of appropriately focused ways of capturing feedback from children and their parents (such as through surveys, feedback at or near the point of care and internet-based approaches). Through the steps we are taking in our information strategy, we will make this information available so that patients, families and members of the public can scrutinise the quality of their local services.

Choice and personalisation

- 2.12 The vision in *Equity and excellence: Liberating the NHS* is of shared decision making, a fundamental cultural change putting patients and the public at the heart of the NHS. Choice is fundamentally about the circumstances of treatment and care, and this is just as relevant for children and young people as for adults. This includes being treated in age-appropriate settings, having care that enables children and young people to be at home with their families as much as possible, and treatment that enables children and young people to lead as normal a life as possible, at school and with their friends. As well as extending maternity choice, choice in palliative care, end-of-life care and urgent care will be of particular importance to families.
- 2.13 Subject to Parliamentary approval of its establishment, the NHS Commissioning Board would be tasked with developing an implementation plan for promoting and extending choice and control. This will explicitly include responsibility for applying this appropriately to children, young people and families. In the autumn, we will publish a further consultation document on patient choice.

⁷ *Liberating the NHS: Transparency in outcomes – a framework for the NHS*, DH, Jul 2010: p34.

- 2.14 The right to register with any GP practice could also make an important difference to families. In many countries, parents are able to directly access doctors who have greater expertise with children and young people. While it is important that all GPs provide a good service to children, young people and families, some GP practices may wish to develop particular expertise and knowledge in caring for children and young people and we know that some practices are already looking into this idea, which could provide a more effective primary care service for children and young people. The new system would enable families with children and young people to register with such a practice, regardless of previous practice boundaries.
- 2.15 Personal health budgets are currently being piloted in the NHS as one way of giving people more choice and control over how their health needs are met. This could include choosing non-NHS providers or having greater control of when and where traditional NHS services are delivered. A number of the Department of Health's pilot sites are developing plans to include people in transition from children's to adult services in their pilot programme. As part of the Department for Education's Aiming High for Disabled Children programme, a pilot of individual budgets for disabled children and their families is also being developed. We are working to ensure that we share learning and, if possible, join up some pilots locally. This could mean that a child who was part of the Aiming High pilot could include their funding from the NHS in their plans to personalise their care and support. We will continue to explore the potential that personal health budgets offer for young people and families, in the context of the forthcoming Green Paper on special educational needs and disability due in the autumn.

Engagement Topic: What might the NHS Commissioning Board need to consider when developing a plan for promoting and extending choice and how might it best include children and families?

Engagement Topic: How might GP practices best demonstrate particular expertise and knowledge in caring for children and young people?

Shared decision making

- 2.16 It is vital that children and young people are involved in decisions about their care. As we make clear in *Equity and excellence: Liberating the NHS*, there should be *no decision about me without me*. Shared decision making relies on good information and a culture that enables patients and carers to make use of it. Choice, control, personalised care, collective voice and ensuring equity all depend on children, young people and families having reliable, salient information available to them. Third parties will be encouraged to provide information on services. Web-based support groups and charities could have an important role to play in sharing information about services with families and young people.
- 2.17 Information should be tailored to the needs and preferences of different audiences, for example ensuring that it is age appropriate. If children, young people and families have easy access to convenient health advice and support that are tailored to their needs, across key life stages, their needs are more likely to be met. While younger children may access health advice and support with their parents' help, as they mature and develop greater independence they should have independent access to information about the health and support services available, including those offered in settings that young people use.
- 2.18 Services should also consider the possibility that Gillick competent children and young people may not wish their parents to know that they are receiving health care or be involved in decisions about the health care they receive. This should ensure that they do not inadvertently breach a child's or young person's confidentiality by sharing information with their parents without consent.⁸
- 2.19 Specific, tailored, age-appropriate methods are needed to communicate with children and young people so that they can understand their illness and the choices facing them. This can include evidence-based techniques designed around communicating through play.

8 The Department of Health's *You're Welcome* quality criteria (3 – confidentiality and consent) provide more information on these issues, along with details of where to find further information and guidance on competence and consent for children and young people.

- 2.20 The Department of Health's *You're Welcome* quality criteria⁹ for making health services young people friendly are being used to improve NHS and public health services. *You're Welcome* is demonstrating the potential and benefits of delivering better age-appropriate and responsive health information and support that help to reduce the escalation of problems. *You're Welcome* also encourages services to involve young people in shared decision making about their care and how services could continue to be improved.

Support to navigate the system

- 2.21 We know that navigating the NHS can be challenging, particularly for the families of children with multiple needs. In a context of far more openness and transparency about local health services, families will have access to a much greater range of information, which will help them to make the most of the services available. This will include better information on patient experiences.
- 2.22 Information alone may not be enough. Health visitors are well placed to help families to link to local communities and, where needed, to specialist care. Professionals such as health visitors can also help to connect families with others with similar needs with whom they can share experiences, suggest links to appropriate local services and community groups, and help to mobilise wider community engagement in support of children and families. We are also considering what role outreach services in Children's Centres can continue to play alongside health visitors.
- 2.23 Community groups and charities have an important part to play. For example, groups such as the National Childbirth Trust (NCT), National Children's Bureau (NCB) and YoungMinds are exploring the scope to support communities of interest in sharing information about NHS services and in helping children and families to understand their clinical records. There is even scope to help people to share their records if they want to do so.
- 2.24 Other imaginative uses of technology include a Netmums project, currently funded by the Department for Education, to engage parent support advisers (health visitors and other specialists) to provide online advice to its users on a range of family-related topics. Emerging evidence from approaches such as these demonstrates the potential for technology to complement face-to-face service delivery and, in some instances, to provide an alternative, and illustrates the important contribution that voluntary and community groups can make.

⁹ *You're Welcome quality criteria: Making health services young people friendly*, DH, Mar 2007.

Engagement Topic: How can we best encourage and enable third parties including community groups, charities and the private sector to provide information or support to families?

Information sharing

- 2.25 Where staff from different services and settings need to work together to provide the right support for a child, young person or family, good arrangements to share information are essential. There is good local practice – set out in guidance – on information sharing between staff in different agencies.¹⁰ We will continue to look to remove any inappropriate bureaucratic burdens that inhibit the appropriate sharing of information in the interests of the child.
- 2.26 Sharing information is especially important in the case of vulnerable children, including those at risk of harm. The Government has taken the decision to decommission the former ContactPoint database because, while we believe that information sharing is very important for safeguarding children and young people, it was disproportionate and unjustifiable to hold records on every child in the country, making them accessible to large numbers of people. The Government is exploring the practicality of a new national signposting service which would focus on helping practitioners to find out whether another practitioner is working, or has previously worked, in another authority area with the same vulnerable child.

Next steps

- 2.27 As promised in *Equity and excellence: Liberating the NHS*, a document to launch a consultation on an 'NHS information revolution' will be published in the autumn.
- 2.28 The Government is keen to hear your views on improving the wellbeing and achievement of children and young people with special educational needs and disabilities, as well as the support for families. The Department of Education has published a 'call for views', available at www.education.gov.uk/consultations/, in advance of a Green Paper on special educational needs and disability that is due to be published in the autumn.

¹⁰ *Information Sharing: Guidance for practitioners and managers*, HM Government, Oct 2008; *Information Sharing: Further guidance on legal issues*, HM Government, Feb 2009; *Information Sharing: Case examples*, HM Government, Oct 2009; *NHS Services and Children's Centres – how to share information appropriately with children's centre staff*, DCSF and DH, Mar 2010.

3. Improving outcomes for children and young people

3.1 In order to improve services for children and young people we need a system which works to achieve the outcomes that are important for their health and wellbeing. This must be supported by funding systems that provide the right financial incentives, and training and education that produce a workforce with the right skills. In *Equity and excellence: Liberating the NHS* we set out how, to achieve our ambition for world-class health care outcomes, the service must be focused on outcomes and the quality standards that deliver them. The Government's objectives are to reduce mortality and morbidity, increase safety, and improve patient experience and outcomes for all. Subject to consultation and Parliamentary approval:

- The NHS will be held to account against clinically credible and evidence-based outcome measures, not process targets. We will remove targets with no clinical justification.
- A culture of open information, active responsibility and challenge will ensure that patient safety is put above all else, and that failings such as those in Mid-Staffordshire¹¹ cannot go undetected.
- Quality standards, developed by the National Institute for Health and Clinical Excellence (NICE), will inform the commissioning of all NHS care and payment systems. Inspection will be against essential quality standards.
- Money will follow the patient through transparent, comprehensive and stable payment systems across the NHS to promote high-quality care, drive efficiency and support patient choice.
- Providers will be paid according to their performance. Payment should reflect outcomes, not just activity, and provide an incentive for better quality.

3.2 We know that child health services have been of variable quality.¹² Sir Ian Kennedy's report¹³ identifies a number of challenges concerning the quality of services alongside examples of areas of excellence, and suggests that child health services have received "disproportionately low priority".

11 *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009*, Robert Francis QC, Feb 2010.

12 *Improving services for children in hospital*, Healthcare Commission, Feb 2007.

13 *Getting it right for children and young people*, Kennedy Review, Sep 2010.

3.3 International comparisons of outcomes suggest that the NHS in England does not do as well as it should for children and young people.¹⁴ The importance attached previously to top-down targets did not work well for children and young people. Process targets with no or little clinical relevance, such as those focused on waiting times, which dominated the system, were of very limited relevance to children and young people's health care. They did little to help children and young people with health needs such as long-term conditions or to improve the experience of the NHS for children, young people and their families, particularly for groups with complex needs, such as disabled children and young people, and those with mental health conditions.

The NHS Outcomes Framework

3.4 A new NHS Outcomes Framework will provide a clear direction for the NHS.¹⁵ It will include a focused set of national outcome goals determined by the Secretary of State, against which the NHS Commissioning Board would be held to account, alongside overall improvements in the NHS. In turn, the NHS Outcomes Framework would be translated into a commissioning outcomes framework for GP consortia, to create powerful incentives for effective commissioning.

3.5 The consultation document *Transparency in outcomes* proposes that the NHS Outcomes Framework should be developed around a set of five outcome domains:

- Preventing people from dying prematurely.
- Enhancing quality of life for people with long-term conditions.
- Helping people to recover from episodes of ill health or following injury.
- Ensuring people have a positive experience of care.
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

For each domain, the consultation document gives examples of what outcome measures for children could look like, and invites views.

3.6 We are committed to ensuring that outcomes for children and young people are fully reflected and we are keen to gather views through the consultation process on how this can best be achieved. We know that focusing entirely

¹⁴ *Getting it right for children and young people*, Kennedy Review, Sep 2010: p26; Are health services in England failing our children? Alan Craft, *BMJ* 2007; 335: p268.

¹⁵ *Liberating the NHS: Transparency in outcomes – a framework for the NHS*, DH, Jul 2010.

on burden of disease or mortality risks excluding children and young people, so we are looking at including outcomes that are relevant to them. We will also explore how the framework can take account of safeguarding needs, taking into account in due course any recommendations on this from the Munro review of child protection.¹⁶ How the NHS Outcomes Framework is translated into the proposed commissioning framework for GP consortia will be very important and we will work to ensure that this contains the right incentives for commissioning services for children and young people.

- 3.7 We are also committed to ensuring that relevant outcomes for children and young people are reflected appropriately in the Public Health Service Outcomes Framework¹⁷ and the public health White Paper later this year, emphasising the opportunity to improve outcomes across the lifecourse. Given the evidence showing that development in the early years of life and lifestyles developed in adolescence and young adulthood are strongly associated with better physical and mental health and later educational success, the value and potential of support in childhood and the teenage years will be an important consideration for the Public Health Service and the Public Health Service Outcomes Framework.

Engagement Topic: We would welcome thoughts on appropriate outcome measures for children both for the NHS, as part of the NHS Outcomes Framework consultation, and in relation to public health for children, young people and families.

Quality standards

- 3.8 The NHS Outcomes Framework will be underpinned by a comprehensive and authoritative set of quality standards, developed by NICE. For every quality standard formulated by NICE, any specific considerations relating to children and young people should be an automatic ingredient of the standard, where appropriate. In some instances, it would be most appropriate for children and young people's services to be included in quality standards that cover all ages. In other areas, the services and quality standards might differ so considerably that it would be better to have separate children's and adults' standards. We would welcome thoughts or proposals for any specific quality standards relating to children and young people's health which reflect the key outcomes for children and young people, the burden of disease and the potential for quality improvement. We would also welcome thoughts on how these frameworks could take

¹⁶ See para 3.19.

¹⁷ *Equity and excellence: Liberating the NHS*, DH, Jul 2010: para 3.8.

account of safeguarding needs and the part that the NHS and local partnerships could play in this.

- 3.9 We are also considering how quality standards might reflect some of the overarching quality and experience themes which relate to children and young people's health services and public health, such as:
- transition between children's and adult services;
 - arrangements for and responses to children and young people who are not safe or who are at risk of significant harm;
 - how to pick up on and respond to children's, young people's and their families' experiences of care, particularly young children, severely disabled children and those in need of additional support and protection;
 - arrangements for looked-after children in the care of local authorities, particularly those with mental health needs; and
 - the impact of the health of parents on the health of their children.

Engagement Topic: We would welcome thoughts on appropriate areas for quality standards and the balance between inclusion within adult standards and child-specific standards.

Clarity over local budgets

- 3.10 There is also a need to ensure that funding arrangements are clear and support effective outcomes for children, young people and families. The Payment by Results funding system currently provides transparency in the funding of acute health services, including maternity and paediatrics. Under Payment by Results, commissioners pay providers a tariff or price for the number and complexity of patients treated or seen. The unit of payment for a tariff is known as the currency. Payment by Results means that funding follows the patient. Together with patient choice, it offers a real incentive for trusts to provide high-quality services which meet the needs and expectations of children and young people and their families.
- 3.11 The Department of Health is working on the expansion of the scope of Payment by Results in a number of areas which will be of benefit to children and young people, for example by accelerating the development of currencies for community services, neonatal critical care and child and adolescent mental health services, which could underpin future mandatory tariffs.

- 3.12 As well as looking to expand the scope of the tariff, changes are being made to the way in which tariffs are set for services currently within the scope. For example, a number of 'best practice tariffs', which are determined by best clinical practice rather than average cost, were introduced in 2010/11. By reflecting and rewarding recognised best practice models of care, these tariffs are designed to incentivise care that will lead to better outcomes for patients. The Department of Health is committed to expanding the number of services covered by best practice tariffs.
- 3.13 In addition, we will explore the potential for using the Commissioning for Quality and Innovation (CQUIN) payment framework to support local quality improvement goals for child health services, linked to NICE quality standards and the NHS Outcomes Framework.
- 3.14 In future, the structure of payment systems will be the responsibility of the NHS Commissioning Board, and the economic regulator¹⁸ will be responsible for pricing. This will increase transparency in the system at a national level.

Engagement Topic: How might we continue to expand and develop Payment by Results to benefit children and young people, including any potential areas for best practice tariffs?

Additional incentives for quality improvement

- 3.15 The Department for Education is exploring how to implement the Coalition commitment to investigate systems of payment by results for Children's Centre providers,¹⁹ including the scope to take account of health outcomes for young children that Children's Centres can help to improve.
- 3.16 The new dentistry contract will include an additional focus on the oral health of school children.

Engagement Topic: We would welcome thoughts on aligning outcomes for children and young people across the NHS, public health systems and other services.

¹⁸ *Liberating the NHS: Regulating healthcare providers*, DH, July 2010

¹⁹ *The Coalition: our programme for government*, HM Government, May 2010: p19.

Training and education

- 3.17 Children, young people and their families need access to appropriately trained and qualified professionals in all services, including primary care. Many non-specialist services and professionals will see far fewer children and young people than adults, and some illnesses in children, particularly very young children, can be challenging to identify or diagnose. So training and education in dealing with children and young people are particularly important.
- 3.18 In the future, there will be greater professional ownership of the structure and content of training and quality standards. We will engage with the Royal Colleges on education and training issues relating to children. The Department of Health will publish a consultation document on provider-led education and training by the end of 2010.
- 3.19 Department for Education Ministers have commissioned Professor Eileen Munro to carry out a review of child protection. The review includes within its remit a commitment to consider the ways in which non-social work professionals can support improved front-line practice in child protection. GPs, health visitors and staff in urgent care settings have a central role in the identification of children whose needs are not being met or are at risk of harm, while professionals in adult mental health services and working with substance misusers also have an important role in identifying families who may need support. We will explore these issues further with the professions in the light of Professor Munro's work.

4. Clear accountability, local autonomy and cutting bureaucracy

4.1 Children and young people need professionals who are supported by systems that give them the freedom they need to do what is best, and hold them to account for the outcomes they achieve. They need organisations and professionals that work in partnership to produce the best services for children and young people. In *Equity and Excellence: Liberating the NHS* we set out how, subject to consultation and Parliamentary approval, the Government's reforms will empower professionals and providers, giving them more autonomy and, in return, making them more accountable for the results they achieve, accountable to patients through choice and accountable to the public at local level.

- The forthcoming Health Bill will give the NHS greater freedoms and help to prevent political micromanagement.
- The Government will devolve power and responsibility for commissioning services to the health care professionals closest to patients: GPs and their practice teams working in consortia.
- To strengthen democratic legitimacy at local level, local authorities will promote the joining up of local NHS services, social care and health improvement.
- We will establish an independent and accountable NHS Commissioning Board. The Board will lead on the achievement of health outcomes, allocate and account for NHS resources, and lead on quality improvement and promoting patient involvement and choice. The Board will have an explicit duty to promote equality and tackle inequalities in access to health care. We will limit the powers of Ministers over day-to-day NHS decisions.
- We aim to create the largest social enterprise sector in the world by increasing the freedoms of foundation trusts and giving NHS staff the opportunity to have a greater say in the future of their organisations, including as employee-led social enterprises. All NHS trusts will become or be part of a foundation trust.

- Monitor will become an economic regulator, to promote effective and efficient providers of health and care, to promote competition, regulate prices and safeguard the continuity of services.
 - We will strengthen the role of the CQC as an effective quality inspectorate across both health and social care.
 - We will ring-fence the public health budget, allocated to reflect relative population health outcomes, with a new health premium to promote action to reduce health inequalities.
- 4.2 We know that there are excellent examples of organisations working in partnership to support children and young people, but often these are driven by committed individuals, in spite of the system rather than because of it. The Government understands that a lack of effective joint working has hindered the development of high-quality services for children and young people. However, we do not feel that the solution lies, either nationally or locally, in creating a single organisation with responsibility for all of the public services that support children and young people. This risks looking at children and young people in isolation from their family and the rest of society, creating new divisions between services for children and the other services and sources of support that are so important for families.
- 4.3 Problems with joint working locally are not solved in Whitehall but by individuals, professionals and organisations taking responsibility for devising solutions and achieving the right outcomes for children and families locally. This works best within a clear framework of responsibilities.
- 4.4 To lay down firm foundations for joint working we are setting out the key responsibilities for the organisations that will be responsible for child health following the reforms outlined in *Equity and excellence: Liberating the NHS*. This will provide a framework of responsibilities within which different professionals, agencies and organisations will work together to use their understanding of wider services to produce the best results for children and families.
- 4.5 Local services providing care and support for children and young people have struggled in recent years with confusion about roles and accountability and mixed messages from Government. The complex system of strategic health authorities (SHAs), primary care trusts (PCTs), Government Offices and local authorities, the difference between the structure of NHS Vital Signs and the National Indicator Set for local authorities, and the lack of distinction within the NHS Vital Signs over NHS, public health and social care accountability in the system sometimes created confusion and

inconsistent messages. The focus in the new system will be on clear and unambiguous accountability for outcomes, coupled with freedom for front-line professionals.

National responsibility

- 4.6 The Coalition Agreement made clear the importance the Government attaches to strong and stable families. A number of arrangements are in place to consider the overall impact of government policy on children and families. The Government has established an Inter-ministerial Taskforce on Childhood and Families to identify policies which will make a big difference to children and families and has commissioned reviews to inform cross-government approaches to issues such as childhood poverty and life chances, and early intervention. The Department of Health and the Department for Education are contributing to this work.
- 4.7 The Cabinet Sub-committee on Public Health, chaired by the Secretary of State for Health, will consider the impact of new policies on public health, including the health of children and young people.
- 4.8 While it is important to ensure that government departments work together effectively for children, young people and families, it is equally important to be clear about the distinctive contribution that each department will make. We have scrapped the bureaucracy of Public Service Agreements introduced by the previous Government. We know that, at times, the previous division of roles caused confusion locally about who was responsible for child health – especially between the Department of Health and the former Department for Children, Schools and Families. This led to two streams of bureaucracy for local staff to deal with, and a lack of clear accountability for child health at national level. The Department for Education replaced the Department for Children, Schools and Families, with a focused remit on teaching and learning, the early years, safeguarding and support for children, young people and families. We have also set out the new Department of Health and NHS national responsibilities on child health (see Appendix A) and have no plans for further changes to machinery of government at the national level.
- 4.9 Within this framework, we will offer freedom and flexibility for front-line professionals and providers to enable them to join up services around children, young people and families. They are closest to families, they know them best and they are best placed to meet their needs. To achieve this, the Department of Health will continue to work closely with the Department for Education on services for children, to ensure that NHS and public health reform supports the ability of local health, education and social care services to work together for children, young people and families.

Simplifying the system

- 4.10 In the future, there will be much simpler and clearer accountability structures. Within three years, all NHS trusts will be supported to become foundation trusts and providers will no longer be part of a top-down management system, with the abolition of SHAs as statutory bodies during 2012/13.
- 4.11 The Government has also announced its intention in principle to abolish the Government Offices. Rather than a mechanism for joining up messages from central government, they had become agents of central government to intervene in local areas which impeded local innovation and accountability.²⁰
- 4.12 As Sir Ian Kennedy suggested in his report, the previous arrangements meant that commissioners and providers “looked towards the centre of the system to be told what to do or to check that what was envisaged was alright, rather than feeling free to act for themselves within acknowledged boundaries”.²¹
- 4.13 Subject to Parliamentary approval, a comprehensive network of GP consortia will be set up which will commission most NHS services, in partnership with other health and care professionals. PCTs’ health improvement functions will be transferred to local authorities and PCTs abolished. This transfer of health improvement functions will provide greater opportunities for joined-up working, particularly for complicated issues like tackling childhood obesity where many agencies and groups have a role to play to deliver change, and in supporting preventative child social care.
- 4.14 These principles of clarity of accountability and freedom to act will underpin thinking about the part that every organisation has to play. Schools will continue to support children and young people’s health and wellbeing – not because they are required to do so, but because good headteachers know that pupils cannot learn if they are unwell, unhappy or struggling with what’s going on in their family life. Further education colleges will also continue to promote and develop their public health role through the sector-led Healthy Further Education initiative. This absolute clarity of purpose between schools and the NHS will better enable providers and

20 Hansard, Vol 514, Part 37, House of Commons Written Ministerial Statements 22 July 2010, Communities and Local Government (<http://services.parliament.uk/hansard/Commons/bydate/20100722/writtenministerialstatements/contents.html>).

21 *Getting it right for children and young people*, Kennedy Review, Sep 2010: para 4.92.

commissioners to work together where these outcomes interrelate, for example in the provision of both treatment and education which enable children with health needs to attend schools and colleges and achieve.

- 4.15 The emerging strong strategic role for local authorities, as champions for greater equality, fairness and opportunities for all pupils, will allow them to focus on supporting the progress and achievement of disadvantaged and vulnerable children and breaking down barriers to achievement for all children. They will continue to have a particular role in co-ordinating provision for excluded and high-cost special educational needs pupils in particular, as well as co-ordinating wider health and welfare services for all vulnerable children so that roles and responsibilities are clear and there is a continuing focus on intervening early to prevent deeper problems. These ways of working will vary according to the local configuration of schools and services and the needs of the children and parents that they serve.

Local commissioning

- 4.16 GP practices will continue to be at the heart of the new health system. On average, children under two years old visit their GP practice six times a year. They provide a critical role in areas such as immunisation as well as managing illness. Children and young people constitute an estimated 40% of the GP's workload and, historically, GPs and practice staff have provided family health services. So as commissioners who are closer to their local community, GP consortia would be best placed to ensure provision of appropriate, high-quality care for children, young people and their families, particularly urgent care and services for children and young people with minor injuries and illnesses with which they are very familiar. They would do this in partnership with other health and care professionals, supported by evidence-based NICE quality standards and the commissioning outcomes framework for GP consortia. We will work to ensure that these are all underpinned by a good understanding of the evidence around children and young people and by feedback from young people themselves to ensure that commissioned services are in the right settings, age appropriate and responsive.²²

²² For example, in line with the Department of Health *You're Welcome* quality criteria.

- 4.17 As Sir Ian Kennedy suggests in his report, GP practices are the obvious point of contact at the centre of child health services.²³ They are ideally placed to make the connection between the range of services around children, young people and their families and ensure that those services are sustainable over time.
- 4.18 This pivotal role on children and young people's health may pose challenges for some GP consortia and their partners locally, both culturally and in terms of historic relationships in the wider children's system. Systems and processes have often not been designed to make it easy for GP practices to be active participants, for example by not taking into account the GP practice's working patterns and other demands. It has also been a challenge for local partners to engage with a large number of GP practices individually. The consortium arrangements would offer a new opportunity to engage with GP practices collectively, particularly through the proposed Health and Wellbeing Boards. Subject to Parliamentary approval, GP consortia would have statutory duties to co-operate and would be fully part of the system, enabling them to deliver for their patients with others and providing a better mechanism for other partners to engage with GP practices locally.

Engagement Topic: How can we support and enable GP consortia and their partners to overcome these challenges during the transition to the new system?

- 4.19 Of course, an individual GP practice or even a consortium or lead consortium arrangement may not deal with very large numbers of children with more complex needs, such as disabilities, mental health conditions or even long-term health conditions. In such circumstances, GP consortia will wish to consider ways in which they can pool expertise and financial risk.
- 4.20 It is proposed that the NHS Commissioning Board will take responsibility for commissioning national and regional specialised services, and may also host some clinical commissioning networks to pool expertise in the commissioning of other services, with the support of GP consortia. Other routes through which expertise and risk might be pooled include multi-consortia commissioning, delegating commissioning of children's services to local authorities or securing external, specialist expertise.

Engagement Topic: How can GP consortia pool risk and expertise for the purposes of commissioning children's services?

²³ *Getting it right for children and young people*, Kennedy Review, Sep 2010: para 4.65 onwards.

Local democratic accountability

- 4.21 The NHS White Paper *Equity and excellence: Liberating the NHS* and the consultation document *Local democratic legitimacy in health* set out proposals for an enhanced role for local authorities in health. Subject to consultation, the Government intends that local authorities will have greater responsibility, including for leading the local Joint Strategic Needs Assessment and for promoting joined-up commissioning of local NHS services, social care and health improvement. With the local authority in a convening role, there will be opportunities to further integrate health with children's services, including education, with scope to build on previous local partnership working, drawing on experience of joint commissioning and the work of Children's Trusts.
- 4.22 Local NHS commissioners and local authorities will continue to conduct Joint Strategic Needs Assessments to inform the planning and commissioning of services for children and young people, including health services. The reduction in central prescription over local partnership means that they will be able to determine locally how to conduct these activities. This will include deciding which settings are best placed to meet local needs, for example by making use of Children's Centres. The responsibility for commissioning child health services would sit clearly with GP commissioning consortia but removing central prescription will better enable local bodies to work together in a way that suits them to commission joined-up services.
- 4.23 Local authorities' enhanced responsibilities will include leading on health improvement and prevention activity. The Department of Health plans to create a ring-fenced public health budget and, within this, local Directors of Public Health, employed by local authorities and jointly appointed by local authorities and the Public Health Service, will be responsible for health improvement funds allocated according to relative population health needs. The allocation formula for those funds will include a new 'health premium' designed to promote action to improve population-wide health and reduce health inequalities. As action plans for the Coalition Agreement commitments on health visiting and Sure Start Children's Centres are firmed up, the Government will set out further detail on how these can be taken forward through the evolving NHS and public health arrangements.

Local partnership

- 4.24 We are consulting on ways to support co-ordination of commissioning between local authorities and GP consortia,²⁴ with one option being the

²⁴ *Liberating the NHS: Local democratic legitimacy in health*, Department for Communities and Local Government and Department of Health, Jul 2010.

establishment of statutory Health and Wellbeing Boards within local authorities.

- 4.25 The key functions proposed for the Health and Wellbeing Boards are to assess the needs of the local population, promote integration and partnership, support, where this makes sense, joint commissioning and pooled budget arrangements, and undertake a scrutiny role in relation to major service redesign.
- 4.26 Some local partnerships have successfully utilised existing enabling legislation (section 75 of the Health Act 2006) to establish lead commissioning arrangements, pooled budgets and delegated functions. Others highlight that these flexibilities are complex to put into place and require significant partnership energy to achieve results.

Engagement Topic: What practical steps need to be taken to enable local partners to realise their joint commissioning plans? Are there unnecessary central bureaucratic barriers that can be removed to facilitate this?

- 4.27 Subject to Parliamentary approval, GP consortia would have a statutory duty to co-operate and work in partnership with local authorities and it is proposed that they should be members of joint Health and Wellbeing Boards along with local HealthWatch. This would be a significant change to local accountability. These boards would allow local commissioners across the NHS and local authorities to take a strategic approach and promote integration across children's services. The intention is that new duties for GP commissioning consortia and the Health and Wellbeing Boards would fully replicate those that currently apply to PCTs and SHAs under the Children Act 2004.
- 4.28 Experience to date suggests that successful partnerships to secure the joined-up services people want are built at local level. We do not propose to be prescriptive, but to enable local partners to build partnerships that respond effectively to local needs.

Engagement Topic: How should existing local authority leadership responsibilities for children and young people and health duties to co-operate fit with the proposed Health and Wellbeing Board?

Children's Trusts

- 4.29 The Department for Education has announced its intention to remove much of the bureaucracy around Children's Trusts in order to free local partnerships to address local issues with innovative solutions. It plans to keep the basic duty to co-operate on local authorities and other local strategic partners, which currently include PCTs and SHAs (following the NHS reforms these duties will be transferred to appropriate bodies), but to:
- remove the duty to co-operate on schools and colleges via the forthcoming Education Bill;
 - remove the requirement for local authorities to set up Children's Trust Boards and the requirement for those boards to prepare and publish a joint Children and Young People's Plan, at the first available legislative opportunity; and
 - revoke the regulations underpinning the Children and Young People's Plan and withdraw the statutory guidance on Children's Trusts, in the autumn.
- 4.30 We do not intend to set out centrally how local Children's Trusts and Health and Wellbeing Boards would work together or to be prescriptive about the total membership of the proposed Health and Wellbeing Boards. This will be up to local partners to decide.
- 4.31 If we pursue the alternative to Health and Wellbeing Boards and leave local partners to design their own arrangements for partnership working on health, they would still be required to meet any statutory requirements in relation to Children's Trusts, including the duties which currently apply to PCTs and SHAs and which would then be transferred to appropriate new bodies.

Engagement Topic: We would welcome views on this and what central government should and should not do with regard to Children's Trusts and potential Health and Wellbeing Board arrangements.

Safeguarding

- 4.32 It is especially important that local organisations work together to safeguard children and young people and protect them from harm. Every organisation must also be clear about its own responsibilities in this field. PCTs and SHAs have responsibilities for safeguarding set out in statute. We propose that these should pass to GP consortia and the NHS Commissioning Board,

adapted as necessary to reflect the wider roles of those bodies. We are also considering the links which would be necessary between Local Safeguarding Children Boards (LSCBs) and the proposed Health and Wellbeing Boards.

- 4.33 Professor Eileen Munro's review of child protection is to include consideration of the future arrangements for LSCBs, the clarity of statutory guidance for professionals working together to safeguard and protect children, and Serious Case Reviews. Professor Munro's final report is due in April 2011. Detailed development of future arrangements for joint working between the NHS, local authorities and other partners to safeguard children will need to take account of Professor Munro's conclusions.
- 4.34 In the meantime, the Government is considering providing for the following core accountability framework through the Health Bill.
- A clear statutory responsibility for every NHS commissioning body and licensing requirement for every NHS provider to make arrangements to safeguard children and to work with partners to that end.
 - GP consortia would become members of LSCBs.
 - If there were concerns about partnership working between health and other bodies that the LSCB was unable to resolve, it could (subject to consultation) raise these with the proposed local Health and Wellbeing Board, which could have the responsibility for promoting and supporting partnership working. Subject to consultation, the Health and Wellbeing Board could, in turn, escalate unresolved concerns over NHS commissioners to the NHS Commissioning Board.
- 4.35 This will be an important new role for GP consortia and one which will go beyond the experience of most existing GP commissioning groups.

Engagement Topic: How can GP consortia best be supported and enabled to play their part in local arrangements to safeguard children and young people?

Engagement Topic: What specific safeguarding and child protection responsibilities should be taken into account as part of local partnerships?

5. Conclusion

- 5.1 This document draws together information from *Equity and excellence: Liberating the NHS* and the associated consultation documents to create a vision of how the proposed new arrangements for the NHS could improve services for children and young people. Any views on the implementation of the NHS White Paper or the associated consultation papers should be sent, by 5 October 2010 in the case of the White Paper or by 11 October in the case of the supporting consultations, to NHSWhitePaper@dh.gsi.gov.uk or White Paper Team, Room 601, Department of Health, 79 Whitehall, London SW1A 2NS.
- 5.2 This document forms the opening part of an ongoing dialogue on how to ensure high-quality services for children and young people. As we develop our vision for the NHS, we will continue to welcome views on how to achieve the best outcomes for children, young people and families.

Appendix A

National Child Health Responsibilities

The Department of Health and Secretary of State for Health

The Department of Health is currently responsible for securing improvements in the physical and mental health of children and young people in England and for promoting a comprehensive health service for the prevention, diagnosis and treatment of illness among children and young people.

Subject to Parliamentary approval, in the future the Secretary of State would fulfil this responsibility by:

1. Setting a formal mandate for the NHS Commissioning Board, including the NHS Outcomes Framework. This would include outcomes for children and an explicit consideration of children and families in its implementation plan for choice.
2. Holding the NHS Commissioning Board to account for the delivery of improvements for children against the agreed outcome indicators.
3. Publishing national outcome statements where necessary, to enable the roles of the NHS and public health services to be better co-ordinated. This would include children and young people as a key area which runs across the boundary of the NHS and public health.
4. Setting the legislative framework for the NHS, including for the quality regulator (the Care Quality Commission) and the economic regulator (Monitor).

In addition, through the Public Health Service, the Secretary of State would:

5. Conduct and co-ordinate national campaigns to protect public health and support health improvement.
6. Agree with local authorities the local application of national health improvement outcomes, including outcomes for children and young people.

NHS Commissioning Board

Subject to Parliamentary approval, the NHS Commissioning Board would be responsible for overseeing the commissioning of NHS services for children and young people. It would fulfil this responsibility by:

7. Allocating resources to GP consortia on the basis of seeking to secure equivalent access to NHS services for all, relative to the prospective burden of disease. This will also reflect demographic pressures such as the birth rate.
8. Designing model contracts (for example, including potential provider responsibilities on safeguarding or on information sharing).
9. Setting commissioning guidelines for GP consortia on the basis of clinical approved quality standards developed with advice from NICE. These standards would include standards for certain child health services.
10. Developing the NHS Outcomes Framework into a more comprehensive set of indicators for NHS care, including indicators on child health and experience.
11. Setting appropriate structures for tariffs, for example for acute paediatrics, child and adolescent mental health services and children's palliative care.
12. Where appropriate, and by agreement with consortia, hosting some clinical commissioning networks to pool specialist expertise, for example for targeted health services for ill and disabled children.
13. Tackling inequalities in outcomes of health care which will be of particular relevance to many vulnerable children.
14. Promoting and extending public and patient involvement and choice – including explicit consideration of children and families in its implementation plan for choice.
15. Commissioning some health services that it would be less appropriate for consortia to commission, including primary care services, maternity services and national and regional specialised services.

Appendix B

List of Engagement Topics

- A. Are there examples of good local best practice from LINks or other groups or organisations in engaging with children, young people and their families?
- B. How can HealthWatch England and the CQC best collect evidence from local HealthWatch on the issues facing children, young people and their families, and engage them in influencing the quality of those services?
- C. What might the NHS Commissioning Board need to consider when developing a plan for promoting and extending choice and how might it best include children and families?
- D. How might GP practices best demonstrate particular expertise and knowledge in caring for children and young people?
- E. How can we best encourage and enable third parties including community groups, charities and the private sector to provide information or support to families?
- F. We would welcome thoughts on appropriate outcome measures for children both for the NHS, as part of the NHS Outcomes Framework consultation, and in relation to public health for children, young people and families.
- G. We would welcome thoughts on appropriate areas for quality standards and the balance between inclusion within adult standards and child-specific standards.
- H. How might we continue to expand and develop Payment by Results to benefit children and young people, including any potential areas for best practice tariffs?
- I. We would welcome thoughts on aligning outcomes for children and young people across the NHS, public health systems and other services.
- J. How can we support and enable GP consortia and their partners to overcome these challenges during the transition to the new system?
- K. How can GP consortia pool risk and expertise for the purposes of commissioning children's services?
- L. What practical steps need to be taken to enable local partners to realise their joint commissioning plans? Are there unnecessary central bureaucratic barriers that can be removed to facilitate this?

- M. How should existing local authority leadership responsibilities for children and young people and health duties to co-operate fit with the proposed Health and Wellbeing Board?
- N. We would welcome views on this and what central government should and should not do with regard to Children's Trusts and potential Health and Wellbeing Board arrangements.
- O. How can GP consortia best be supported and enabled to play their part in local arrangements to safeguard children and young people?
- P. What specific safeguarding and child protection responsibilities should be taken into account as part of local partnerships?



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