Agenda No 2

AGENDA MANAGEMENT SHEET

Name of Committee	**Portfolio Holders (Health) Decision Making Session**
Date of Committee	**4 October 2010**
Report Title	**Consultation on White Paper: Liberating the NHS & Transition of Link to HealthWatch**
Summary	This report presents a joint response from Warwickshire County Council and NHS Warwickshire to the Government's consultation in respect of forthcoming health proposals.

For further information please contact:

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Would the recommended decision be contrary to the Budget and Policy Framework?	No.
Background papers	None

CONSULTATION ALREADY UNDERTAKEN:- Details to be specified

Other Committees	☐	.....
Local Member(s)	☒	All Members
Other Elected Members	☐	.....
Cabinet Member		
Chief Executive	☒	Jim Graham

Legal	☒	David Carter
Finance	☐	
Other Strategic Directors	☐	All including relevant senior officers from CYPF and ACHS directorates
District Councils	☐	.....
Health Authority	☐	Rachel Pearce.....
Police	☐	.....

FINAL DECISION YES

SUGGESTED NEXT STEPS: Details to be specified

Further consideration by this Committee	☐	.....
To Council	☐	
To Cabinet	☐	
To an O & S Committee	☐	.....
To an Area Committee	☐	.....
Other Bodies/Individuals	☐	

Agenda No 2

Portfolio Holder (Health) Decision Making Session

4 October 2010

Consultation on White Paper: Liberating the NHS & Transition of Links to HealthWatch

Report of the Assistant Chief Executive and Strategic Director of Customers, Workforce & Governance

Recommendation

That the Cabinet Portfolio Holder (Health) approves the attached responses (at appendices A and B) for submission to central government on 11th October 2010

1 Introduction

1.1 The Government's ambition is for health outcomes and quality health services that are as good as anywhere in the world. It is committed to the NHS' core values of a comprehensive service, available to all, free at the point of use, based on need and not on ability to pay. The White Paper *Equity and Excellence: Liberating the NHS* sets out proposals intended to make the NHS a truly world-class service that is:

- Easy to access;
- Treats people as individuals; and
- Offers care that is safe and of the highest quality.

1.2 The intention is to create a patient-centred NHS, which focuses on improving their experience and health outcomes, and that empowers professionals to take control of services. The proposals are ambitious, the proposed timetable tight and collectively amount to the most significant changes experienced by the Health Sector in the last 60 years.

1.3 In acknowledgement of the scale and pace of change the Government has invited comments upon its proposals. Attached as Appendix A is the draft consultation response to proposals relating to the White paper and the transition from the current Links Service to Healthwatch. Wide consultation has been undertaken and the proposed submission reflects the diverse range of comments that have been received.

1.4 This report seeks Portfolio Holder approval for submission of response to Government by the deadline of 11th October 2010.

MONICA FOGARTY
Assistant Chief Executive

DAVID CARTER
Strategic Director of Customers,Workforce & Governance

4 OCTOBER 2010

Item 2 - APPENDIX A

NHS Warwickshire and Warwickshire County Council

JOINT RESPONSE TO THE WHITE PAPER EQUITY AND EXCELLENCE: LIBERATING THE NHS

The response to the White Paper is presented as follows:-

- **General response in relation to the Government strategy for the future of the NHS, Social Care and Public Health**
- **Specific response to the questions posed by the Department of Health**
- **Response with a specific focus on the consultation regarding the proposed establishment of HealthWatch (Appendix 2)**

General Response

1. We welcome and support the Government's strategy as outlined in the White Paper, which upholds the values and founding principles of the NHS; namely comprehensive services, available to all, free at the point of use and based on clinical need, not the ability to pay. As public agencies, we are committed to taking the changes forward, together and in partnership between NHS Warwickshire and Warwickshire County Council.

2. We support the approach described in the White Paper to enable the user/patient and their carers to be more in control of their care through the drive to provide more personalised approaches to service provision and more information to facilitate patient choice. We also support the strengthening of the local patient and public voice through the new arrangements led by local authorities and the driving up of standards through revised regulatory and inspection arrangements of both acute and community based health and social care provision.

3. We strongly support the approach to strengthen democratic legitimacy at the local level and the role of local authorities in promoting the joining up of local NHS services, social care and health improvement. Similarly, the Council welcomes the proposals to lead the Public Health function and to ring-fence the Public Health budget as integral to underpinning the Local Authority's role in co-ordinating, joining up and integrating NHS and social care provision to provide more effective outcomes for the health and well-being of individuals and communities.

4. We appreciate that the White Paper describes a long-term plan for the NHS, not just for this parliamentary term. However, if the long-term goal is to provide for a NHS, which is coherent, stable, with sustainable service improvement, the initial early years implementation of this far reaching reform needs to be considered and supported by a national framework, proportionate, not bureaucratic, to enable the acceptable management of risks, both at a local and national level, during this huge transformation.

5. We welcome the consistent message throughout the White Paper that local authorities will have much greater autonomy to direct resources to meet agreed local priorities, whilst at the same time having greater transparency and accountability to the public in how it uses these resources to improve the quality of life, health and well-being of its citizens and communities. We see this enhanced role being explicit through the strengthened role in the JSNA.

Specific responses to the Department of Health consultation questions. (List of questions provided in Appendix 1; each paragraph has a reference number in Bold e.g. "Q1" which links it to the list of questions in Appendix 1)

6. Local HealthWatch should have a formal role in seeking patient and user views. We support the view that this is carried out through HealthWatch's membership of the Health and Well-being Board. This would enable public engagement and democratic scrutiny to become embedded in the local health and social care accountability framework. **(Q1)**

7. HealthWatch should take on the wider role with responsibility for complaints advocacy and supporting individuals to exercise choice and control. HealthWatch must have a key role in offering objective support to those who need it. Consequently, we would support reform of the current national NHS complaints service to be devolved to local authorities. Through the commissioning of HealthWatch, customised local support to people who want to make a complaint could be more easily achieved. **(Q2, Q3)**

8. We propose the development of a 'service specification' developed collaboratively with existing providers (LINks). This would provide an informed basis for local authorities to commission effectively Local HealthWatch. **(Q3)**

9. Within service specifications, we welcome a focus on clear **local** outcomes measures. The scrutiny role and reporting of such measures will enable elected members to exercise influence and accountability on the role and impact of local HealthWatch. **(Q4)**

10. The Local Authority must ensure that through contracting/commissioning arrangements, HealthWatch's independence from health and social care commissioners and providers is maintained. In addition, the Government could support the Local Authority's ability to commission effective outcomes through HealthWatch by ensuring HealthWatch has statutory rights as well as responsibilities. Whilst being accountable to the Health and Wellbeing Board, HealthWatch needs to have vested authority and power to require responses from all providers and commissioners of services. **(Q5, Q6)**

11. Effective commissioning by local authorities in respect of maximising the Local HealthWatch outcomes and impact for patients/users must not be undermined by HealthWatch England assuming authority and/or management responsibilities over Local HealthWatch. Therefore we welcome clear delineation of responsibilities at both the national and local level. **(Q3)**

12. Effective commissioning would be greatly strengthened by the local authority being proactive in holding HealthWatch to account in the event of under–performance. **(Q3)**

13. We support the proposals outlined within the White Paper for stronger institutional arrangements, within local authorities, led by elected Members to support partnership working across Health and Social Care and Public Health. In order to develop personalised health and social care, joint, integrated working is essential. The proposal of a statutory role within each upper tier local authority to support joint working on health and well-being is considered essential. **(Q7)**

14. We support proposals to create a statutory Health and Well-being Board and recommends that the Government allows freedom and flexibility as to how the Board would work in practice locally and set local priorities. **(Q7)**

15. We support the proposals for the Board's main functions as outlined in the White Paper. In addition to these the Board should also have as an explicit key function ensuring resources are directed towards identified priorities which address areas of deprivation and prevailing poor health outcomes. This could be achieved through giving the Board a lead role in determining strategies and allocation of placed-based health budgets. **(Q8)**

16. We recommend strongly that Children's Trusts have a duty to cooperate with the Health and Wellbeing Board. It is suggested that one of the key areas of business and scrutiny of the Board would be to maximise and ensure positive experiences of people with learning disabilities moving seamlessly from children to adult service provision. **(Q10)**

17. We anticipate that the Health and Well-being Board will be responsible for the citizens within the geographical area of Warwickshire (the County). In order to enable the Health and Well-being Board to have involvement and impact where it makes sense with other neighbouring Boards the provision of a framework within which to develop wider working would be welcomed. **(Q11)**

18. We consider that the Health and Well-being Board should have a small, tight membership in order to carry out its key strategic role, agree joint NHS and social care commissioning of specific services and agree allocation of place-based budges on cross cutting health issues. **(Q12)**

19. In principle we welcome the concept of scrutiny. We are unsure how this can be subsumed within the Health and Wellbeing Board. Potentially, it might be more efficient, avoid duplication of effort, be less confusing and enable clarity around democratic accountability. However, as currently described, the Health and Wellbeing Board is clearly an executive body and there would be an inherent conflict of interest in undertaking a scrutiny role in relation to its own function. We also believe that the Health and Wellbeing Board should be a high level body which focuses on strategy. The Department of Health needs to consider more rigorously how best to achieve democratic accountability and transparency within the Health and Wellbeing Board context. **(Q14)**

20. We recommend that the Health and Wellbeing Board produce an Annual Report, which is considered by local councils' executive bodies. The Annual Report would support accountability of the Board's performance, impact and activities. **(Q13, Q16)**

21. We recommend that GP Consortia be compelled to address the identified priorities with the JSNA. The GP consortia should be encouraged to work alongside community partners to ensure commissioning decisions/approaches reflect the public voice and local priorities. This can be delivered through patient participation groups, HealthWatch and voluntary groups. **(Q13, Q17)**

22. We extol the use of Equality and Health Impact assessments on major decisions affecting citizens and communities in respect of NHS, social care, public health, strategic planning, commissioning or provision. Similarly, as partners we would seek to engage Local Government Improvement and Development, to draw upon national best practice in improving the local NHS, Social Care and Public Health system. **(Q9, Q17)**

23. Finally, we are concerned that marginalised groups and communities with poorer health do not become further marginalised. Incentives to encourage actions based upon the findings of the Joint Strategic Need Assessment with outcome measures for the Board to be judged on what it achieves for these communities (as opposed to how it achieves outcomes) would be welcomed. **Q17)**

Item 2 APPENDIX A - Annex

Consultation Questions posed by Department of Health

Q1 Should local HealthWatch have a formal role in seeking patients' views on whether local providers and commissioners of NHS services are taking account of the NHS Constitution?

Q2 Should local HealthWatch take on the wider role with responsibility for complaints advocacy and supporting individuals to exercise choice and control?

Q3 What needs to be done to enable local authorities to be the most effective commissioners of local HealthWatch?

Q4 What more, if anything, could and should the Department do to free up the use of flexibilities to support integrated working?

Q5 What further freedoms and flexibilities would support and incentivise integrated working?

Q6 Should the responsibility for local authorities to support joint working on health and wellbeing be underpinned by statutory powers?

Q7 Do you agree with the proposal to create a statutory health and wellbeing board or should it be left to local authorities to decide how to take forward joint working arrangements?

Q8 Do you agree that the proposed health and wellbeing board should have the main functions described in the White Paper?

Q9 Is there a need for further support to the proposed health and wellbeing boards in carrying out aspects of these functions, for example information on best practice in undertaking joint strategic needs assessments?

Q10 If a health and wellbeing board was created, how do you see the proposals fitting with the current duty to cooperate through children's trusts?

Q11 How should local health and wellbeing boards operate where there are arrangements in place to work across local authority areas, for example building on the work done in Greater Manchester or in London with the link to the Mayor?

Q12 Do you agree with our proposals for membership requirements set out in the White Paper?

Q13 What support might commissioners and local authorities need to empower them to resolve disputes locally, when they arise?

Q14 Do you agree that the scrutiny and referral function of the current health OSC should be subsumed within the health and wellbeing board (if boards are created)?

Q15 How best can we ensure that arrangements for scrutiny and referral maximise local resolution of disputes and minimise escalation to the national level?

Q16 What arrangements should the local authority put in place to ensure that there is effective scrutiny of the health and wellbeing board's functions? To what extent should this be prescribed?

Q17 What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcome for all patients, the public and, where appropriate staff?

APPENDIX B

HealthWatch

1.1 What needs to happen for local HealthWatch to fulfil its new functions around health complaints advocacy? In particular to support people who do not have the means or capacity to make choices about their care?

The following factors should be taken fully into account:

a) Adequate levels of funding from central government – and if this could be ring-fenced for the purposes of Healthwatch, so much the better.

b) The advocacy service should be seen as a collaborative venture which brings together, under the coordination of the County Council, the range of existing advocacy services that to work towards collaboratively a common purpose. These organisations include a wide range of 3rd sector organisations, all of which should play a full part. We would also ensure that District/Borough Councils are involved in the development of local Healthwatch as they are providers of important services such as housing and council tax/housing benefit. Links should also be made with Coventry City Council as the local provider trust for mental health includes their area.

c) In short, local Healthwatch would best be seen as a coherent alliance of existing groups and organisations, funded to deliver the complaints advocacy service – with the County Council playing the key coordination role by ensuring that the service is of high quality, demonstrates value for money, and are accessible by all – especially the seldom heard.

d) The LINK experience offers many lessons and we should all learn from them. The good progress made by the LINk in the recent past should be seen as the foundation on which the advocacy service should be established.

e) The service should be free at the point of delivery, and steps should be taken via publicity and community networks to promote the service in particular to those who may not have the means, confidence, or capacity to make choices about their care.

f) Government should enable the establishment of local Healthwatch (including the complaints advocacy service) to take place and for providers to be selected by the County Council through a process of collaborative commissioning rather that insisting on rigid procurement rules. By doing so, a service specification could be developed collaboratively with existing providers taking fully into account their knowledge, experience, track record, and, most importantly their community knowledge and existing links with patients and service users.

g) Local Healthwatch will need to link well with existing patients advocacy consortia – the PALS Service in Warwickshire is a significant service (NHS Warwickshire has already dealt with 700 queries from them so far this year)

h) We have concerns that local Healthwatch may be expected to be all things to all people and there is a risk involved in attributing too many responsibilities to it too

soon – this would not only damage its development but would also adversely affect the progress made by the Warwickshire LINk over the past twelve months

1.2 What needs to happen for local HealthWatch to support people making choices, in particular to support people who do not have the means or capacity to make choices about their care?

We repeat the points made under 1.1 above

2 Healthwatch role

2.1 What should be done to embed local HealthWatch as the local consumer voice, and HealthWatch England as the national voice for health and social care consumers?

The following factors are relevant in addition to the points raised under 1.1 (above):

In relation to local Healthwatch:

a) Helpful locally relevant publicity and promotional activities

b) The use of community development techniques to the promotion, and marketing of local Healthwatch

c) Ensuring the independence of local Healthwatch from service providers and commissioners

d) Embedding local Healthwatch within the democratic framework of local government and ensuring that elected representatives play a full part in the development and monitoring of the service via local scrutiny arrangements (in Warwickshire the Adult Social Care and Health Overiview & Scrutiny Committee) and the forthcoming statutorily based Health & Well Being Board (there will be a need to ensure that duplication / confusion is avoided)

e) Ensuring that local Healthwatch is linked well with the wide range of existing advocacy and engagement opportunities available to Warwickshire citizens

f) Ensuring that local Healthwatch has statutory rights as well as responsibilities – especially in relation to Enter View and a right to make representations and demand responses from all service deliverers, service commissioners and the local Health and Well Being Board

In relation Healthwatch England:

a) Ensuring that it does not assume authority and management responsibilities over local Healthwatch

b) Ensuring its independence from the Department of Health, the Quality Care Commission and all other aspects of the regulatory regime

c) Embedding accountability for Healthwatch England activities to local Healthwatch organisations

d) Ensuring that the public is fully aware of the activities and responsibilities of local Heathwatch

Additionally (unlike with the LINks') there should be no requirement on the part of the local authority to establish by contract a hosting arrangement. Independence can be secured in more effective, subtler and cheaper ways.

The responsibility should be given to local authorities to demonstrate the independence of local Healthwatch and NOT for a central government driven model to be imposed on them.

2.2 How should HealthWatch England and local HealthWatch relate to and work with other patient and community groups and structures, and what principles should underpin this relationship?

a) In so far as Healthwatch England is concerned, its governance arrangements should ensure that it is distanced from the authority of central government and that it has three way accountability to central government, local government and the local Healthwatch.

b) Its governance arrangements should include obligatory involvement of national 3rd sector organisations and national coalitions of patient and community groups.

c) Regarding local Healthwatch, it should be a membership organisation, with its governing body being drawn from and elected by its membership. The local authority should have the right to nominate a councillor to champion the role of Healthwatch within local democratic arrangements.

d) Healthwatch England should assume the key role of facilitating the transfer of good practice and mutual support between 'branches' of local Healthwatch.

e) The over-riding principle that should apply is that of subsidiarity with decision making being made at the level closest to patients, service users and communities

2.3 How should local HealthWatch work with the local authority and GP consortia to influence commissioning decisions?

a) Local Healthwatch should work in a collaborative and inclusive way. It should forge positive relationships with the consortia based on an assumption of equal value and mutual respect.

b) The same principles should apply to all commissioning bodies which should be given a statutory duty to ensure that they co-operate with local Healthwatch.

c) To give further strength to its position, local Healthwatch should be given the legal rights set out in 2.1 f) above.

d) As a matter of good practice, local commissioners should be required to establish an annual commissioning programme which would be shard with local Healthwatch thus giving it at the earliest possible stage the opportunity to shape and determining a relevant and manageable annual work programme.

2.4 What needs to happen for local HealthWatch to support the needs of vulnerable people –such older or very frail people? What needs to happen for HealthWatch to champion the rights of people who lack capacity to make decisions about their care?

a) Within the alliance of advice / advocacy organisations referred to in paragraph 2.1 above, the local authority should ensure that carers and local organisations representing these groups are actively involved.

b) Adequate levels of resourcing is again a key to success

c) The local authority should be put under a legal responsibility to ensure that the rights of these individuals and groups are championed

d) It may be necessary to ensure that appropriate statutory linkages are made with regard to the Mental Capacity Act for those individuals who cannot:

- understand the information relevant to decisions
- retain that information,
- use or weigh that information as part of the process of making the decision, or
- communicate the decision.

3 Governance Arrangements and Funding

3.1 What governance arrangements need to be put in place to ensure that accountabilities are clear for all parties?

The following points are made:

a) In relation to all governance issues – form should follow function. Hence, governance arrangements should be considered in detail when the precise shape / form of Healthwatch England and local Healthwatch have been established.

b) Government is advised against imposing a strict governance model for local Heathwatch. This should be a matter for local determination within the context of a broad statutory framework

c) There should be no legal requirement for the local authority to contract out hosting services to external bodies (see 2.1 above).

d) Healthwatch England should come under the umbrella of the Centre for Public Scrutiny (CfPS)

e) The governance arrangements for Healthwatch England should ensure that representatives of local Healthwatch 'branches' are actively involved in its management

3.2 How should HealthWatch England be constituted within the CQC structure?

It should be independent of the legal structure of CQC but accountable to it for performance

3.3 What role, if any, should HealthWatch England play in holding local authorities to account for how local HealthWatch is operated?

a) This is a matter for local determination, and local Healthwatch should primarily be accountable to its membership and locally elected representatives

b) The local authority should be under a legal responsibility to ensure that an Annual report of local Healthwatch activities and performance is produced and published.

3.4 What role should HealthWatch England and local authorities play in assessing the effectiveness of local HealthWatch?

See 3.3 above

3.5 What needs to happen to ensure transparency over how HealthWatch funding is spent by local HealthWatch and by local authorities?

The following should apply:

a) Financial support from central government for the local Healthwatch funding should be hypothecated ./ ring-fenced

b) The local authority should be under a responsibility to prepare an annual set of accounts in line with sound accounting practice

c) The Annual Report and Accounts should be published and formally signed off by the senior financial officer at the local authority in consultation with the Chair of the Health and Well being Board

4 Breadth of the role and balancing competing interests

4.1 How will local HealthWatch cover both health and social care services?

The following points are made:

a) Local Healthwatch should be held to account by the local authority and its broader membership to ensure an appropriate balance

b) Those managing and supporting local Healthwatch should ensure that it has access to and animates community organisations and networks representing both health and social care

c) It should be recognised that the dividing line between health and social care is often unclear and occasionally illusory – especially from the patient / service user and care perspective. It is the service that counts – not its classification

4.2 'What role should local HealthWatch play in seeking patients' views on whether local providers and commissioners are taking account 'of the NHS Constitution?

a) Local Healthwatch should be a statutory consultee in relation to the establishment of the constitution

b) Health commissioners should be under a responsibility to produce an annual report demonstrating, amongst other matters, its adherence to the constitution – and local Healthwatch should be a statutory consultee and with the formal legal right to publically respond and comment

4.3 What needs to happen to ensure an effective balance is achieved between HealthWatch England and local HealthWatch?

We have already responded.

4.4 What role should HealthWatch England play in achieving this balance?

We have already responded.

5 Relationships

5.1 HealthWatch England will need to develop working arrangements with the NHS Commissioning Board, Monitor, Department of Health and CQC. What principles should underpin these relationships?

a) The major principle that should apply is the right to independently and publically challenge the activities and performance of these bodies

b) Coupled with this, both Healthwatch England and this group of bodies should seek to establish positive and collaborative relationships based on mutual trust and respect

5.2 What needs to happen to build relationships between local HealthWatch and other local partners, such as local authorities or GP Commissioning Consortia?

See paragraph 2.3 above.

6. Transition during 2011/12

6.1 What do we need to take into account for the transition of LINks into local HealthWatch?

The following apply:

a) Ensure an ongoing dialogue between Department of Health, local government, community organisations, Primary Care Trusts and all other stakeholders to ensure that the transition is capably managed and that the model for local Healthwatch is built on:

- Collaboration and
- Takes fully into account the lessons learned from the LINKs

b) Responsibility for securing the transition should rest with the local authority

c) The local authority should be empowered to take the management of the LINk in house for a minimum period of 12 months and should be released from the

existing statutory responsibility to secure the hosting of the LINk by an independent organisation (on terms)

d) Guidance to local authorities that any under-spend on the LINk accounts should be ring-fenced and carried forward to 2011/12 to support work on the transition.

6.2 What support will LINks need during this period?

The following apply:

a) Adequate levels of funding - if possible ring-fenced to the purposes of the LINk

b) Access to independent advice and support

c) The establishment of a positive can do organisational culture within the LINk, the local authority and with all key stakeholders

d) Sufficient support / resource to ensure that the LINk continues to deliver its functions notwithstanding its imminent demise

6.3 What additional skills will staff and volunteers require to deliver the expanded functions, and how can they be developed?

a) It may be inappropriate to view the introduction of local Healthwatch as a mere 'expansion of functions'. We suggest that it would be preferable to regard this as a new development building on the experiences and successes of the LINk and its forerunners

b) Additional skills may not always be required – it will be more important to secure a positive approach coupled with gaining a clear understanding of the individual advocacy role, including an awareness of existing organisations and groups that already deliver the function locally

c) A training and development programme should be developed and delivered locally which is geared to managing the transition and participants acquiring the necessary skills and knowledge to deliver local Healthwatch by March 2012

d) Some additional resources may be required to achieve the transition but it is suggested that these could be found from savings that would result from taking the management of the transition in-house within the local authority

6.4 What are the organisational and resource implications of expanding LINks' functions?

a) Organisational implications have already been addressed through this response.

b) It is at this stage difficult to predict whether and if so to what extent additional resources would need to be invested by central government.

c) In relation to the **management and support** of local Healthwatch our instinct is that the current level of funding (Area Based Grant 2010/11) may be sufficient so long as the local authority is released from the requirement of contracting with an independent host organisation

d) Additional resources will be required to enable the delivery of the complaints / advocacy service – although the requirement will be limited so long as existing local organisations and networks are empowered to deliver.

Portfolio Holder Health Decision Making 4.10.10

Your ref:
My ref: AF/JI
Date: 29th September 2010

Cllr. Alan Farnell
Leader of the Council

County Councillor Alan Farnell
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White Paper Team
Room 601
Department of Health
79 Whitehall
LONDON SW1A 2NS

Dear White Paper Team,

LIBERATING THE NHS - RESPONSE

On behalf of Warwickshire County Council, I am pleased to respond to the proposed changes to the NHS and to the new roles for local authorities.

Warwickshire County Council is supportive of the changes proposed. We provide a commentary and a range of key questions and concerns in the enclosed papers.

Overall, we welcome the opportunity for local government to play an enhanced role in both the commissioning and provision of health services locally. We particularly welcome the transfer of the Public Health Service into our leadership and see this as an opportunity to consolidate our growing influence in the shaping of multi-agency services at a local level. The role of GPs in this aspiration cannot be overstated and we welcome the opening to forge new, stronger relationships between local government and the GP community.

If we have a key concern, it is the need to achieve transparency and clarity on the role of decision-making bodies such as the Health and Wellbeing Board. It is absolutely right that such a partnership vehicle should shape and oversee the provision of healthcare services, but roles, responsibilities and duties must be transparent.

This Council welcomes and supports the Government's strategy as outlined in the White Paper, which upholds the values and founding principles of the NHS. As a council, we are committed to taking the changes forward, working closely in partnership with NHS Warwickshire. In that spirit I offer the comments of Warwickshire County Council and hope they will be given serious reflection and consideration.

Yours sincerely

Cllr Alan Farnell
Leader of the Council

Working for Warwickshire

JOINT RESPONSE TO THE WHITE PAPER EQUITY AND EXCELLENCE: LIBERATING THE NHS

The response to the White Paper is presented as follows:-

- **General response in relation to the Government's strategy for the future of the NHS, Social Care and Public Health**
- **Specific response to the consultation questions posed by the Department of Health from the document Liberating the NHS; Local democratic legitimacy in health**
- **Response with a specific focus on the consultation regarding the proposed establishment of HealthWatch (Annex 1)**
- **Response with specific focus on the consultation regarding Achieving Equity and Excellence for Children (Annex 2)**

General Response

1. This Council welcomes and supports the Government's strategy as outlined in the White Paper, which upholds the values and founding principles of the NHS; namely comprehensive services, available to all, free at the point of use and based on clinical need, not the ability to pay. As a public agency, we are committed to taking the changes forward, together and in partnership with NHS Warwickshire.

2. We support the approach described in the White Paper to enable the user/patient and their carers to be more in control of their care through the drive to provide more personalised approaches to service provision and more information to facilitate patient choice. We also support the strengthening of the local patient and public voice through the new arrangements led by local authorities and the driving up of standards through revised regulatory and inspection arrangements of both acute and community based health and social care provision.

3. We strongly support the approach to strengthen democratic legitimacy at the local level and the role of local authorities in promoting the joining up of local NHS services, social care and health improvement. Similarly, the Council welcomes the proposals to lead the Public Health function and to ring-fence the Public Health budget as integral to underpinning the Local Authority's role in co-ordinating, joining up and integrating NHS and social care provision to provide more effective outcomes for the health and well-being of individuals and communities.

4. We appreciate that the White Paper describes a long-term plan for the NHS, not just for this parliamentary term. However, if the long-term goal is to provide for a NHS, which is coherent, stable, with sustainable service improvement, the initial early years implementation of this far reaching reform needs to be considered and supported by a national framework, proportionate, not bureaucratic, to enable the acceptable management of risks, both at a local and national level, during this huge transformation.

5. We welcome the consistent message throughout the White Paper that local authorities will have much greater autonomy to direct resources to meet agreed local priorities, whilst at the same time having greater transparency and accountability to the public in how it uses these resources to improve the quality of life, health and well-being of its citizens and communities. We see this enhanced role being explicit through the strengthened role in the JSNA, including quality and provision of housing and its impact upon health and well-being.

Specific responses to the Department of Health questions [posed in the consultation document Liberating the NHS; Local and democracy in health. (Each paragraph has a reference number in Bold e.g. "Q1" which links it back to the relevant question as numbered within the consultation document.

6. Local HealthWatch should have a formal role in seeking patient and user views. We support the view that this is carried out through HealthWatch's membership of the Health and Well-being Board. This would enable public engagement and democratic scrutiny to become embedded in the local health and social care accountability framework. **(Q1)**

7. HealthWatch should take on the wider role with responsibility for complaints advocacy and supporting individuals to exercise choice and control. HealthWatch must have a key role in offering objective support to those who need it. Consequently, we would support reform of the current national NHS complaints service and its devolution to local authorities. Through the commissioning of HealthWatch, customised local support to people who want to make a complaint could be more easily achieved. **(Q2, Q3)**

8. We propose the development of a 'service specification' developed collaboratively with existing providers (LINks). This would provide an informed basis for local authorities to commission effectively Local HealthWatch. **(Q3)**

9. Within service specifications, we welcome a focus on clear **local** outcome measures. The scrutiny role and reporting of such measures will enable elected members to exercise influence and accountability on the role and impact of local HealthWatch. **(Q4)**

10. The Local Authority must ensure that through contracting/commissioning arrangements, HealthWatch's independence from health and social care commissioners and providers is maintained. In addition, the Government could support the Local Authority's ability to commission effective outcomes through HealthWatch by ensuring HealthWatch has statutory rights as well as responsibilities. Whilst being accountable to the Health and Wellbeing Board, HealthWatch needs to have vested authority and power to require responses from all providers and commissioners of services. **(Q5, Q6)**

11. Effective commissioning by local authorities in respect of maximising the Local HealthWatch outcomes and impact for patients/users must not be undermined by HealthWatch England assuming authority and/or management responsibilities over Local HealthWatch. Therefore we welcome clear delineation of responsibilities at both the national and local level. **(Q3)**

12. Effective commissioning would be greatly strengthened by the local authority being proactive in holding HealthWatch to account in the event of under–performance. **(Q3)**

13. We support the proposals outlined within the White Paper for stronger institutional arrangements, within local authorities, led by elected Members to support partnership working across Health and Social Care and Public Health. In order to develop personalised health and social care, joint, integrated working is essential. The proposal of a statutory role within each upper tier local authority to support joint working on health and well-being is considered essential. **(Q7)**

14. We support proposals to create a statutory Health and Well-being Board and recommend that the Government allows freedom and flexibility as to how the Board would work in practice locally and set local priorities. **(Q7)**

15. We support the proposals for the Board's main functions as outlined in the White Paper. In addition to these the Board should also have as an explicit key function ensuring resources are commissioned towards identified priorities which address areas of deprivation and prevailing poor health outcomes. This could be achieved through giving the Board a lead role in determining strategies and allocation of placed-based health budgets. **(Q8)**

16. We recommend strongly that Children's Trusts have a duty to cooperate with the Health and Wellbeing Board. It is suggested that one of the key areas of business of the Board would be to maximise and ensure positive experiences of people with learning disabilities moving seamlessly from children to adult service provision. **(Q10)**

17. We anticipate that the Health and Well-being Board will be responsible for the citizens within the geographical area of Warwickshire (the County). In order to enable the Health and Well-being Board to have involvement and impact where it makes sense with other neighbouring Boards the provision of a framework within which to develop wider working would be welcomed. **(Q11)**

18. We consider that the Health and Well-being Board should have a small, tight membership in order to carry out its key strategic role, agree joint NHS and social care commissioning of specific services and agree allocation of place-based budges on cross cutting health issues. **(Q12)**

19. We are unsure how the scrutiny role can be subsumed within the Health and Wellbeing Board. Potentially, it might be more efficient, avoid duplication of effort, be less confusing and enable clarity around democratic accountability. However, as currently described, the Health and Wellbeing Board is clearly an

executive body and there would be an inherent conflict of interest in undertaking a scrutiny role in relation to its own function. We also believe that the Health and Wellbeing Board should be a high level body which focuses on strategy. The Department of Health needs to consider more rigorously how best to achieve democratic accountability and transparency within the Health and Wellbeing Board context. **(Q14)**

20. We would expect the Health and Wellbeing Board to undertake a strategic role, for example managing the interface between hospital discharges and social care provision.

21. We recommend that the Health and Wellbeing Board produce an Annual Report, which is considered by local executive bodies, including GP consortia. The Annual Report would support accountability of the Board's performance, impact and activities. **(Q13, Q16)** and should also be submitted to the National Commissioning Board.

22. We recommend that all partners (including adult social care and GP Consortia) should be compelled to address the identified priorities with the JSNA. The GP consortia should be encouraged to work alongside community partners to ensure commissioning decisions/approaches reflect the public voice and local priorities. This can be delivered through patient participation groups, HealthWatch and voluntary groups. **(Q13, Q17)**

23. We extol the use of Equality and Health Impact assessments on major decisions affecting citizens and communities in respect of NHS, social care, public health, strategic planning, commissioning or provision. Similarly, as partners we would seek to engage Local Government Improvement and Development, to draw upon national best practice in improving the local NHS, Social Care and Public Health system. **(Q9, Q17)**

24. Finally, we are concerned that marginalised groups and communities with poorer health do not become further marginalised. Incentives to encourage actions based upon the findings of the Joint Strategic Need Assessment with outcome measures for the Board to be judged on what it achieves for these communities (as opposed to how it achieves outcomes) would be welcomed. **Q17)**

Appendix – Annex 1

HealthWatch

1.1 What needs to happen for local HealthWatch to fulfil its new functions around health complaints advocacy? In particular to support people who do not have the means or capacity to make choices about their care?

The following factors should be taken fully into account:

a) Adequate levels of funding from central government – and if this could be ring-fenced for the purposes of Healthwatch, so much the better.

b) The advocacy service should be seen as a collaborative venture which brings together, under the coordination of the County Council, the range of existing advocacy services which work towards collaboratively a common purpose. These organisations include a wide range of 3rd sector organisations, all of which should play a full part. We would also ensure that District/Borough Councils are involved in the development of local Healthwatch as they are providers of important services such as housing and council tax/housing benefit. Links should also be made with Coventry City Council as the local provider trust for mental health includes their area.

c) In short, local Healthwatch would best be seen as a coherent alliance of existing groups and organisations, funded to deliver the complaints advocacy service – with the County Council playing the key coordination role by ensuring that the service is of high quality, demonstrates value for money, and are accessible by all – especially the seldom heard.

d) The LINK experience offers many lessons and we should all learn from them. The good progress made by the LINk in the recent past should be seen as the foundation on which the advocacy service should be established.

e) The service should be free at the point of delivery, and steps should be taken via publicity and community networks to promote the service in particular to those who may not have the means, confidence, or capacity to make choices about their care.

f) Government should enable the establishment of local Healthwatch (including the complaints advocacy service) to take place and for providers to be selected by the County Council through a process of collaborative commissioning rather that insisting on rigid procurement rules. By doing so, a service specification could be developed collaboratively with existing providers taking fully into account their knowledge, experience, track record, and, most importantly their community knowledge and existing links with patients and service users.

g) Local Healthwatch will need to link well with existing patients advocacy consortia – the PALS Service in Warwickshire is a significant service (NHS Warwickshire has already dealt with 700 queries from them so far this year)

h) We have concerns that local Healthwatch may be expected to be all things to all people and there is a risk involved in attributing too many responsibilities to it too

soon – this would not only damage its development but would also adversely affect the progress made by the Warwickshire LINk over the past twelve months

1.2 What needs to happen for local HealthWatch to support people making choices, in particular to support people who do not have the means or capacity to make choices about their care?

We repeat the points made under 1.1 above

2 Healthwatch role

2.1 What should be done to embed local HealthWatch as the local consumer voice, and HealthWatch England as the national voice for health and social care consumers?

The following factors are relevant in addition to the points raised under 1.1 (above):

In relation to local Healthwatch:

a) Helpful locally relevant publicity and promotional activities

b) The use of community development techniques to the promotion, and marketing of local Healthwatch

c) Ensuring the independence of local Healthwatch from service providers and commissioners

d) Embedding local Healthwatch within the democratic framework of local government and ensuring that elected representatives play a full part in the development and monitoring of the service via local scrutiny arrangements (in Warwickshire the Adult Social Care and Health Overiview & Scrutiny Committee) and the forthcoming statutorily based Health & Well Being Board (there will be a need to ensure that duplication / confusion is avoided)

e) Ensuring that local Healthwatch is linked well with the wide range of existing advocacy and engagement opportunities available to Warwickshire citizens

f) Ensuring that local Healthwatch has statutory rights as well as responsibilities – especially in relation to Enter View and a right to make representations and demand responses from all service deliverers, service commissioners and the local Health and Well Being Board

In relation Healthwatch England:

a) Ensuring that it does not assume authority and management responsibilities over local Healthwatch

b) Ensuring its independence from the Department of Health, the Quality Care Commission and all other aspects of the regulatory regime

c) Embedding accountability for Healthwatch England activities to local Healthwatch organisations

d) Ensuring that the public is fully aware of the activities and responsibilities of local Heathwatch

Additionally (unlike with the LINks') there should be no requirement on the part of the local authority to establish by contract a hosting arrangement. Independence can be secured in more effective, subtler and cheaper ways.

The responsibility should be given to local authorities to demonstrate the independence of local Healthwatch and NOT for a central government driven model to be imposed on them.

2.2 How should HealthWatch England and local HealthWatch relate to and work with other patient and community groups and structures, and what principles should underpin this relationship?

a) In so far as Healthwatch England is concerned, its governance arrangements should ensure that it is distanced from the authority of central government and that it has three way accountability to central government, local government and the local Healthwatch.

b) Its governance arrangements should include obligatory involvement of national 3rd sector organisations and national coalitions of patient and community groups.

c) Regarding local Healthwatch, it should be a membership organisation, with its governing body being drawn from and elected by its membership. The local authority should have the right to nominate a councillor to champion the role of Healthwatch within local democratic arrangements.

d) Healthwatch England should assume the key role of facilitating the transfer of good practice and mutual support between 'branches' of local Healthwatch.

e) The over-riding principle that should apply is that of subsidiarity with decision making being made at the level closest to patients, service users and communities

2.3 How should local HealthWatch work with the local authority and GP consortia to influence commissioning decisions?

a) Local Healthwatch should work in a collaborative and inclusive way. It should forge positive relationships with the consortia based on an assumption of equal value and mutual respect.

b) The same principles should apply to all commissioning bodies which should be given a statutory duty to ensure that they co-operate with local Healthwatch.

c) To give further strength to its position, local Healthwatch should be given the legal rights set out in 2.1 f) above.

d) As a matter of good practice, local commissioners should be required to establish an annual commissioning programme which would be shard with local Healthwatch thus giving it at the earliest possible stage the opportunity to shape and determining a relevant and manageable annual work programme.

2.4 What needs to happen for local HealthWatch to support the needs of vulnerable people –such older or very frail people? What needs to happen for HealthWatch to champion the rights of people who lack capacity to make decisions about their care?

a) Within the alliance of advice / advocacy organisations referred to in paragraph 2.1 above, the local authority should ensure that carers and local organisations representing these groups are actively involved.

b) Adequate levels of resourcing is again a key to success

c) The local authority should be put under a legal responsibility to ensure that the rights of these individuals and groups are championed

d) It may be necessary to ensure that appropriate statutory linkages are made with regard to the Mental Capacity Act for those individuals who cannot:

- understand the information relevant to decisions
- retain that information,
- use or weigh that information as part of the process of making the decision, or
- communicate the decision.

3 Governance Arrangements and Funding

3.1 What governance arrangements need to be put in place to ensure that accountabilities are clear for all parties?

The following points are made:

a) In relation to all governance issues – form should follow function. Hence, governance arrangements should be considered in detail when the precise shape / form of Healthwatch England and local Healthwatch have been established.

b) Government is advised against imposing a strict governance model for local Heathwatch. This should be a matter for local determination within the context of a broad statutory framework

c) There should be no legal requirement for the local authority to contract out hosting services to external bodies (see 2.1 above).

d) Healthwatch England should come under the umbrella of the Centre for Public Scrutiny (CfPS)

e) The governance arrangements for Healthwatch England should ensure that representatives of local Healthwatch 'branches' are actively involved in its management

3.2 How should HealthWatch England be constituted within the CQC structure?

It should be independent of the legal structure of CQC but accountable to it for performance

3.3 What role, if any, should HealthWatch England play in holding local authorities to account for how local HealthWatch is operated?

a) This is a matter for local determination, and local Healthwatch should primarily be accountable to its membership and locally elected representatives

b) The local authority should be under a legal responsibility to ensure that an Annual report of local Healthwatch activities and performance is produced and published.

3.4 What role should HealthWatch England and local authorities play in assessing the effectiveness of local HealthWatch?

See 3.3 above

3.5 What needs to happen to ensure transparency over how HealthWatch funding is spent by local HealthWatch and by local authorities?

The following should apply:

a) Financial support from central government for the local Healthwatch funding should be hypothecated ./ ring-fenced

b) The local authority should be under a responsibility to prepare an annual set of accounts in line with sound accounting practice

c) The Annual Report and Accounts should be published and formally signed off by the senior financial officer at the local authority in consultation with the Chair of the Health and Well being Board

4 Breadth of the role and balancing competing interests

4.1 How will local HealthWatch cover both health and social care services?

The following points are made:

a) Local Healthwatch should be held to account by the local authority and its broader membership to ensure an appropriate balance

b) Those managing and supporting local Healthwatch should ensure that it has access to and animates community organisations and networks representing both health and social care

c) It should be recognised that the dividing line between health and social care is often unclear and occasionally illusory – especially from the patient / service user and care perspective. It is the service that counts – not its classification

4.2 'What role should local HealthWatch play in seeking patients' views on whether local providers and commissioners are taking account 'of the NHS Constitution?

a) Local Healthwatch should be a statutory consultee in relation to the establishment of the constitution

b) Health commissioners should be under a responsibility to produce an annual report demonstrating, amongst other matters, its adherence to the constitution – and local Healthwatch should be a statutory consultee and with the formal legal right to publically respond and comment

4.3 What needs to happen to ensure an effective balance is achieved between HealthWatch England and local HealthWatch?

We have already responded.

4.4 What role should HealthWatch England play in achieving this balance?

We have already responded.

5 Relationships

5.1 HealthWatch England will need to develop working arrangements with the NHS Commissioning Board, Monitor, Department of Health and CQC. What principles should underpin these relationships?

a) The major principle that should apply is the right to independently and publically challenge the activities and performance of these bodies

b) Coupled with this, both Healthwatch England and this group of bodies should seek to establish positive and collaborative relationships based on mutual trust and respect

5.2 What needs to happen to build relationships between local HealthWatch and other local partners, such as local authorities or GP Commissioning Consortia?

See paragraph 2.3 above.

6. Transition during 2011/12

6.1 What do we need to take into account for the transition of LINks into local HealthWatch?

The following apply:

a) Ensure an ongoing dialogue between Department of Health, local government, community organisations, Primary Care Trusts and all other stakeholders to ensure that the transition is capably managed and that the model for local Healthwatch is built on:

   - Collaboration and
   - Takes fully into account the lessons learned from the LINKs

b) Responsibility for securing the transition should rest with the local authority

c) The local authority should be empowered to take the management of the LINk in house for a minimum period of 12 months and should be released from the existing statutory responsibility to secure the hosting of the LINk by an independent organisation (on terms)

d) Guidance to local authorities that any under-spend on the LINk accounts should be ring-fenced and carried forward to 2011/12 to support work on the transition.

6.2 What support will LINks need during this period?

The following apply:

a) Adequate levels of funding - if possible ring-fenced to the purposes of the LINk

b) Access to independent advice and support

c) The establishment of a positive can do organisational culture within the LINk, the local authority and with all key stakeholders

d) Sufficient support / resource to ensure that the LINk continues to deliver its functions notwithstanding its imminent demise

6.3 What additional skills will staff and volunteers require to deliver the expanded functions, and how can they be developed?

a) It may be inappropriate to view the introduction of local Healthwatch as a mere 'expansion of functions'. We suggest that it would be preferable to regard this as a new development building on the experiences and successes of the LINk and its forerunners

b) Additional skills may not always be required – it will be more important to secure a positive approach coupled with gaining a clear understanding of the individual advocacy role, including an awareness of existing organisations and groups that already deliver the function locally

c) A training and development programme should be developed and delivered locally which is geared to managing the transition and participants acquiring the necessary skills and knowledge to deliver local Healthwatch by March 2012

d) Some additional resources may be required to achieve the transition but it is suggested that these could be found from savings that would result from taking the management of the transition in-house within the local authority

6.4 What are the organisational and resource implications of expanding LINks' functions?

a) Organisational implications have already been addressed through this response.

b) It is at this stage difficult to predict whether and if so to what extent additional resources would need to be invested by central government.

c) In relation to the **management and support** of local Healthwatch our instinct is that the current level of funding (Area Based Grant 2010/11) may be sufficient so long as the local authority is released from the requirement of contracting with an independent host organisation

d) Additional resources will be required to enable the delivery of the complaints / advocacy service – although the requirement will be limited so long as existing local organisations and networks are empowered to deliver.

Annex 2

Achieving equity and excellence for children

Department of Health – September 2010

Engagement topics

The responses below are on behalf of NHS Warwickshire and Warwickshire County Council.

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

1. *Are there examples of good local best practice from LINks or other groups or organisations in engaging with children, young people and their families?*

   In Warwickshire, Vox (Youth Council) have taken a keen interest in issues of sexual health, substance misuse and obesity. This has led to young people directing and leading campaigns on these issues. The WACY Forum leads on disability issues for young people.

   NHS Warwickshire and Warwickshire County Council have worked together on how to involve young people in the development of programmes in these areas both in response to demand from young people and to ensure a single efficient approach. Young people are routinely involved in the interview panels for senior appointments.

2. *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?*

   We welcome the role of HealthWatch in collecting evidence on how best to engage children, young people and families in services. How this is achieved is a matter for the agencies involved. The *You're Welcome* standards currently provide challenge and evaluation on the ability of some public health services to engage with young people.

Choice and personalisation

3. *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?*

   In order to involve children, young people and families in the choice of their care it will be important to have local services with local flexibility. For this reason it is suggested that commissioning functions for children's services should move into the public health remit that local authorities are expected to undertake. This will allow, for example, better understanding of how the provision of health services integrates with local school arrangements (including extended schools). These pathways of care should be agreed locally rather than nationally.

4. *How might GP practices best demonstrate particular expertise and knowledge in caring for children and young people?*

   At least initially, it is suggested that GP practices delegate commissioning for children's services to the expected local authority public health function. This will allow the best use of current expertise in children's commissioning. As GP consortia develop, the relationship between consortia and the local authority can develop and change in accordance with the need for high quality health services at the most efficient cost.

Support to navigate the system

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

   The role of the NHS should be to identify needs and commission outcomes-based services accordingly, with third sector, private sector and public sector organisations demonstrating innovative, low-cost, effective approaches through the tender process.

The NHS Outcomes Framework

6. *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.*

   The proposed outcomes framework requires a stronger focus on the prevention of ill health in young people. Therefore, the following outcomes are suggested:

   - Reduce number of teenage conceptions
   - Reduce number of sexually transmitted infections
   - Reduce the number of young people drinking alcohol and the number of young people getting drunk
   - Reduce the number of young people using illicit substances
   - Increase the number of young people reporting good emotional well-being
   - Reduce levels of obesity in children and young people
   - Reduce the number of accidents involving children and young people
   - Increase the number of children with disabilities attending mainstream school
   - Reduce hospital admissions and readmissions for children and young people with life limiting conditions
   - Ensure children and young people are immunised in accordance with national standards

   There are clearly some health conditions where a crude aggregate outcome is inappropriate and outcomes will be determined on an individual basis.

Quality standards

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

   There is already NICE guidance on health issues affecting children and young people. We welcome a continuation of this programme in order to have clear national clinical guidelines on health interventions for children and young people.

Clarity over local budgets

8. *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?*

   The vast majority of health care for children and young people is in primary care. Further to this a number of prevention and early intervention programmes will take place in the community. Taking this into account, and anticipating that funding for prevention and early intervention will be limited, payment by results is considered to be a costly and inappropriate tool for improving health outcomes for children and young people.

Additional incentives for quality improvement

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

   There is already considerable integration in the provision of children's services between health and local authority services. This takes the form of joint/aligned working with schools, colleges and youth services. In terms of effectiveness, it is considered beneficial to continue to address public health issues through this joint working by placing public health functions within the local authority.

Local commissioning

10. *How can GP consortia pool risk and expertise for the purposes of commissioning children's services?*

    (As question 4) At least initially, it is suggested that GP practices delegate commissioning for children's services to the expected local authority public health function. This will allow the best use of current expertise in children's commissioning. As GP consortia develop, the relationship between consortia and the local authority can develop and change in accordance with the need for high quality health services at the most efficient cost.

Local partnership

11. *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?*

    It will be important for local commissioning plans to have local political support. We welcome the proposal of Health and Wellbeing Boards and it will be imperative for these boards to have consistent elected member representation from services from children young people and families.

    The change of direction in terms of putting fewer requirements on schools to tackle health issues is likely to become a barrier to effective prevention. Where schools neglect the health and wellbeing of their young people, the lack of requirement is likely to lead to health inequalities.

12. *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?*

    (As question 11) We welcome the proposal of Health and Wellbeing Boards and it will be imperative for these boards to have elected member representation from services from children young people and families.

Children's Trusts

13. *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.*

    The key stakeholders involved in Children's Trusts (e.g. schools, colleges, police, probation, youth services) should be included in Health and Wellbeing Board arrangements.

Safeguarding

14. *How can GP consortia best be supported and enabled to play their part in local arrangements to safeguard children and young people?*

    GP consortia should continue to work to the multi-agency safeguarding procedures agreed by the local safeguarding children's board. GP consortia should undertake a programme of training from the local safeguarding board in order to quickly develop expertise and confidence in safeguarding. Section 11 (Children Act 2004) Statutory legal requirements should be transferred to the GP consortia which would enable them to have an identified executive lead at 'Board' level and a requirement for appointing a Designated Nurse & Doctor. Each consortium should have a nominated safeguarding lead.

    Training would certainly be crucial and there is a potential for joint training with the LSCB Members training as outlined in Working Together 2010.
    The 'executive lead' from the Consortia should have a place on the LSCB. Where there are several consortia within one LSCB area then one person can represent all consortia and ensure communication is spread across all consortia.

    There need to be links with the proposed Health & Wellbeing Boards and perhaps they could have the operational agenda for Safeguarding Children and the LSCB the Quality & Scrutiny as is starting to merge now
    Very Clear roles and responsibilities need to be enforced as already in Working Together to Safeguard Children 2010-10-06
    Consortia will also need to recognise that there is a funding issue for the LSCB's (currently paid by NHS Warwickshire)

15. *What specific safeguarding and child protection responsibilities should be taken into account as part of local partnerships?*

    All responsibilities should be covered under local safeguarding children's board child protection procedures.
    LSCB's and Local partnerships will need to work together but one may need to be strategic/overview/quality & Safety e.g. LSCB and the Local partnership would be operational and implementation.

Most importantly that in the Transition period Safeguarding vulnerable children must remain a priority and not slip below the radar as there are no high profile cases such as Baby Peter.

Much of Current practice should be transferred across. However with the Munro Review which could result in more clarity of the statutory guidance for professionals, more focus on risk assessment and the change of terminology e.g. safeguarding Children to Child Protection (therefore focussing on the most vulnerable children, young people and families)