



East Midlands
Development Centre

NHS
East Midlands

Children and Young People Services Commissioning

GP Information Pack

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1. Introduction

Commissioning services for children and young people

The aim of this document is to provide essential information, tips and signposting to assist in the commissioning of services for children and young people taking account of the recent changes in approach and infrastructure. It is not intended to be comprehensive or exhaustive but to simply act as an initial “aide memoire.”

2. What is different about children’s and young people’s services?

Not all aspects of the commissioning of Children and Young People (CYP) services are different from that of adults, in fact some children’s services are included in block contracts along with adult services e.g. hospitals. However, there are a number of issues/characteristics that add a level of complexity and require a significantly different approach. Issues which may impact on commissioning of CYP commissioning include the following:

Statutory Responsibilities

- The provision of education is a statutory responsibility of the Local Authority and all children up to the age of 16 have a right to education
- Safeguarding considerations, which are a statutory responsibility of many partners, including the NHS
- Legal status of child e.g. looked after status
- NHS Duty of co-operation with Local Authorities
- Fraser/Gillick competence for young people

Current issues

Demand in CYP services has increased as it has in adult services, however there are some specific issues for CYP services:

- There is a rise in the number of children with complex needs living to an age where they require transfer into adult services often with very expensive packages of care.
- Following a number of high profile child abuse cases there has been an increased number of children being placed in care (LAC)
- Increased demand in regard to disability, numbers of Looked after children etc result in large numbers of children requiring tailored packages of care that require individual negotiation.
- Funding – A number of children require joint packages of care, funding from a range of agencies need to be utilised to fund the packages e.g. children’s continuing care requires tripartite funding. Pooled budgets under section 10 and section 75 legislation are often used in CYP services e.g. CAMHS.
- An increasing number of different agencies and organisations can commission health services for CYP e.g. schools, special schools, children’s centres. It is therefore important that partners have a detailed understanding of each other’s cultures, approaches, targets and standards.
- Multi factorial causality in regard to a range of CYP issues e.g. teenage conception, offending etc.
- Maintenance of specialist expertise in regard to children in line with Royal College and NICE guidance – critical mass, patient flow etc.

3. Overarching principles for commissioning of children and young people services

(The principles involved in commissioning children's services have been developed at a national and regional level)

- Services commissioned will meet needs identified via needs assessment or via community/user consultation
- Services will be commissioned at the safest environment closest to home.
- Services commissioned will support identified outcomes, national policy and locally agreed priorities for children's services (local priorities will reflect a range of partners priorities and may be led by other agencies e.g. local authorities but will require health input)
- Services commissioned will reflect the policy direction towards preventative services, services within the community where possible and integrated provision and commissioning
- All services will be performance managed against outcome measures
- Children, young people and families will be actively involved in commissioning and service developments
- Commissioners will ensure providers involve children, young people and families in service planning, consultation and service delivery
- Commissioners will work in partnership with providers, other commissioners, children and their families to continually improve outcomes.
- Commissioning will enable users to have choice in services available to them
- Commissioners will take account of statutory responsibilities

The following gives a brief overview of how commissioning for CYP can be addressed and some of the issues that may be encountered. Account is taken of the new NHS commissioning infrastructure and identifies the partnerships and the relationships that either currently exist or will need to be forged.

4. Levels of commissioning

Services will be commissioned differently according to the type of service, needs of the user, local need and demographics and national issues. Each area will need to use a variety of commissioning levels and will consequently need the infrastructures and governance frameworks to enable this to happen.

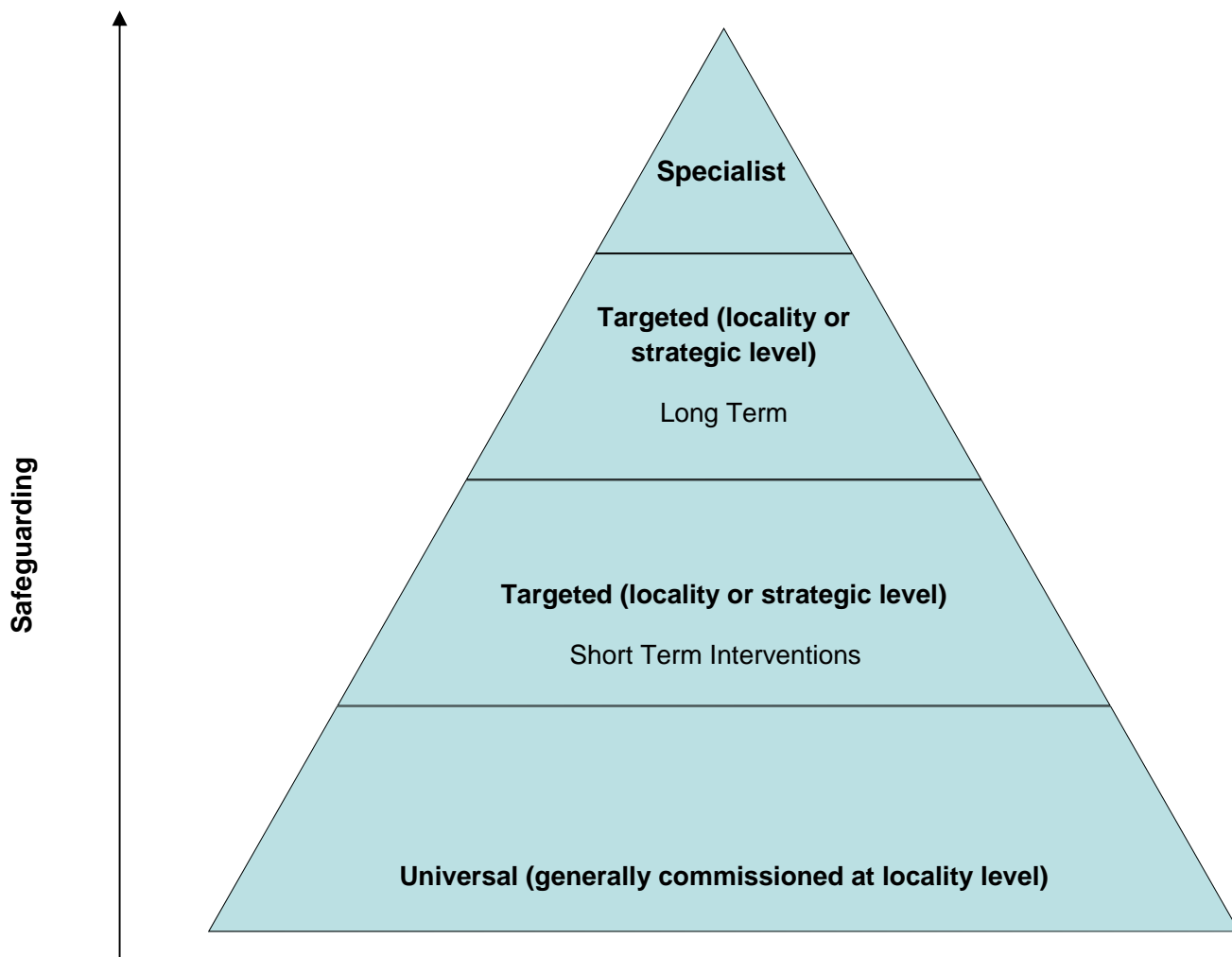
- Locality (consortia, children's centres, schools, other agencies/organisations)
- Strategic - groups of consortia, clusters of schools, Commissioning Board
- Specialist – Commissioning Board, Specialist Commissioning Group – High cost, low volume (regional and national commissioning)

Of particular note for children's services is the utilisation of personalisation agenda – direct payments, individual health budgets and joint commissioning (e.g. complex needs, CAMHS, LAC etc), which can be employed within any level.

All areas will therefore need to have a comprehensive understanding of the population profile and its needs to ensure an appropriate commissioning approach. To understand this a joint strategic needs assessment (JSNA) must be undertaken, this should include an agreed dataset, data from the Third Sector, views of users, equity audits and a gap analysis to identify services to be commissioned. This assessment should include minority groups and identify inequalities that can then be addressed via robust commissioning.

Generally the more specialised the situation the greater the size of the locality for commissioning, however, in CYP commissioning there are large numbers of children who require individual packages due to the complexity of their situation. (This includes children with a disability, looked after children, children in secure settings etc) There can be significant financial advantages from ensuring CYP services are commissioned at an appropriate level. This is a particularly significant issue in commissioning of children's services as commissioning individual packages of care can be extremely time consuming for commissioners. Joint commissioning can substantially reduce this burden. To enable this negotiation with partners is required and often the establishment of financial agreement, pooled budgets etc – although initial negotiations may be time consuming in terms of cost benefit this is cost effective in the medium and long term.

Commissioning Level



- Across the East Midlands there are approximately 4500 children in care at any one time.
- In a national study during 2009 of 15 areas across the country there were approximately 446 continuing care assessments undertaken of which 77% (345) were funded for continuing care
- Services for disabled children are commissioned across all tiers from universal to specialist, both in single agencies e.g. neuromuscular services in the NHS and across agencies short breaks
- A number of local areas have developed joint (NHS and Local Authority) commissioning arrangements for individualised packages of care for disabled children

5. Interactions between universal, targeted and specialist services

Universal services can be commissioned by a range of agencies e.g. GP consortia, Local Authorities, Schools, Children's centres etc – much potential exists for joint commissioning in this area which may lead to cost efficiencies, improved service quality and safety.

Universal services are currently provided to all irrespective of how they are commissioned or by whom e.g. Health Visiting, School Nursing, Children's centres, family support etc, however there is an increasing need to prioritise and potentially target such services in response to pressure on resources.

For local populations the provision of hospital care is a universal one. Services for acute and in-patient care for children and young people are often part of block contracts with Acute Trusts and it can be difficult to identify an exact pathway with regard to children's services spend. Not all children's services have tariffs but they are often higher than those for corresponding procedures in adults. Children may need to go to tertiary centres for treatment e.g. cancer which differs from the adult population who may receive treatment at the local hospital.

High cost, low volume services e.g. paediatric Intensive Care and Neonatal Intensive Care are commissioned at a specialist level and provided through managed clinical networks.

The interplay between commissioning of hospital care, community and preventative services is vital. Hospital care accounts for significantly greater financial outlay and currently we are seeing a year on year rise of admissions of children into hospital. (for greater detail see *Fundamentals of Commissioning of Health Services for Children – Kate Andrews*). If appropriate preventative and community services are not commissioned this can easily increase demand for acute services and increase cost to a prohibitive degree. The Department of Health Disease Management Information Tools (DMIT) can assist localities in developing care pathways and identify good practice by the commissioning of different providers. The potential for joint commissioning for preventative and community services provides an opportunity to enhance the overall children's services budget and reduce admissions.

Some paediatric acute services e.g. paediatric surgery, cancer, PICU require significant specialist skill in regard to anaesthesia etc and have national standards. This can result in appropriate competence levels being maintained in a limited number of settings due to critical mass. This need for specialisation can reduce choice for CYP, increase transport costs and affect patient flow.

Targeted services include services for Looked after Children, disability, CAMHS, young offenders, children in need and are often jointly commissioned using joint or aligned budgets; however, again many different agencies/organisations can commission these services.

A variety of tools/processes exist to identify and assess CYP in this category this may include **Common Assessment framework (CAF)** – an assessment that can be undertaken by a range of professionals (health, police, teachers, connexions, family support workers, social workers etc) to identify a CYP requiring additional support for any reason. This leads to a process where an individual plan is developed, delivered and monitored by a multi-agency team.

Case conferences – Multi-agency meetings in regard to an individual to develop care plans.

CYP with particular needs may need to be placed out of area.

The commissioner placing a child out of area still retains responsibility for funding of some aspects of health care. CYP placed in a commissioner's area from another area will require health care and the funding responsibility for universal services rests with the area of GP registration, funding of targeted and specialist services rest with the placing area, however services must be provided and then monies reclaimed from the placing area. Issues involving children placed from elsewhere can hold financial risk as some areas are significant net importers of CYP and this is fairly common with the East Midlands.

Issues that require joint commissioning approaches

Complex case – include multi-agency panels, individual negotiations in regard to a range of issues e.g. equipment, care plans, continuing care, placements etc. Complex case, case conferences etc all require input from commissioners to develop and negotiate tailored care plans and placements.

Youth Offending - Health commissioners have a duty to provide funding to youth offending teams etc.

Children in secure settings – Health have a responsibility to provide universal services to children in secure settings. The Responsible Commissioner details responsibilities for children placed out of county. There are three types of secure setting

- Secure Training Units (STC's) – only 4 exist in the country, one of which is Rainsbrook in Northamptonshire which caters for over 90 young people.
- Local Authority Homes – Two exist in the East Midlands one in Lincolnshire and one in Nottinghamshire.
- Young Offender Institute (YOI) – Plans to build a very large unit at Glen Parva in Leicestershire.

Rules vary in regard to secure settings commissioning dependent on the type of setting but they house an extremely vulnerable group. Commissioners need to be aware of the responsibilities for children in their area based in secure settings and also the responsibilities for any children placed out of area in such settings.

It is essential that complex cases and CYP in placements and secure units are included in JSNA's as risks in these areas can be great.

Specialist Services

35 services have identified as being most effectively commissioned by regional specialist commissioning groups for children and young people these include Tier 4 CAMHS, NICU, PICU and Children's Cancer Services. However, input is still required from local commissioners in regard to how and what is commissioned within these services to link into local universal provision for these children e.g. Community Nursing Support.

6. Delivery Processes

Whilst most of the delivery processes for children's services mirror those for adult services two are more widely used in children's services, care pathways and clinical networks

Care pathways are a useful tool in the commissioning of services. A number of national care pathways exist e.g. the ACT care pathway for children's palliative care. It may also be necessary to develop local pathways. Pathways may be developed via provider networks/managed clinical networks and this will also assist in the process of involving clinical expertise in advising the commissioning process.

Clinical Networks

Provider organisations can use networks to advise the commissioning process as they provide the ideal forum for clinicians and commissioners to meet and discuss future planning and developments. Models of networks currently used include:

- Overall children's network for geographical area
 - Advise the commissioning unit.
 - Provide a consultation route for e.g. reconfiguration, best practice etc
 - Provide a link with users and carers

- Specific conditions networks
 - Develop pathways- e.g. in the East Midlands the Children's Diabetes network
 - Contribute to service specifications
 - Identify and highlight resource impacts, workforce and other issues
 - Provide links to national bodies e.g. Council for Disability, BIBIC etc
 - Provide a link with users and carers

- Speciality / Client Group e.g. Looked After Children (role as specific condition network)

Managed clinical networks-The aim of managed clinical networks is to improve the quality of patient care.

They do this by

- focusing on the needs of patients
- Working across organisational boundaries
- Have designated funding
- Multi-professional membership
- Provide a link with users and carers.

Children's networks will be an integral component of the commissioning provider infrastructure. 'Lead' responsibility to develop the networks needs to be identified within the child 'lead' roles responsibility and therefore should be included in job descriptions. This responsibility could replace the need for network managers in some networks.

Networks that have a designated Network Manager the provider organisation(s) is responsible for employment and funding which could become a cost component within the contractual negotiations. Where multiple providers are benefiting from a managed network, shared / joint funding should be available for the employment of a network manager.

Networks would need to be multi-agency where appropriate and may need to pro-actively involve children and young people and families.

7. Inspection and Performance Management

GP Consortia have a central role in the inspection and performance management structure. GP Consortia will hold accountability in regard to performance management relating to contracts and service delivery for a whole range of providers and will be required to report to a range of groups/bodies. Health Watch, CQC and Monitor will perform the same regulatory function in CYP

services as in adults services, however, there is an additional regulatory body for CYP services in OFSTED - CQC work in conjunction with OFSTED in regard to children's services.

8. Financial issues

Cost Benefit information

The impact of environment, education, parenting and health status of CYP has a significant effect on adult health and in commissioning. Cost benefit issues need to be taken into account. Early intervention and preventative services can appear to be easy options in regard to reduction of overall cost, however such decisions need careful consideration. An example of relative costs in children's services is given below.

Costs per year

Family information from helpline	£33.86 per family
Family information – digital	£1.95 per family
Parenting course/support	£900-1000 per family
Family Nurse Partnership	£3k per family
Family Intervention Project	£8 – 20k per family
LAC Foster care	£25k per child
Multi-dimensional Treatment Foster care	£70k per child (increases as child gets older)
LAC in Children's Home	£125k per child (increases with age)
Secure Accommodation	£134 per child (increases with age)
Children's centres	£300 per 0 – 5 year old
School	£5k per child

- Continuing Care Costs for one year for PCTs range from 500k to £2.1million. Average spend is £1.2 million.
- Equipment costs for a child with cerebral palsy from birth to 18 years range from £39,000 to £62,000 added to this are the costs of special schools and additional nursing support at home. (An average cost of a walker is £2k, sleep system £2k etc).

Joint-cluster commissioning can reduce financial risk.

Financial opportunities

It is essential that services provide value for money, this will require benchmarking and in some cases cost benefit analysis (including outcomes).

Flexible opportunities now exist that enable partnerships in joint commissioning:

- Aligned budgets
- Pooled budgets – section 28a, section 31, section 75, section 10
- Individual and direct payments

- Children Act (CA) 2004 Section 10 and Health Care Act (HSCA 1999) Section 31
- Sub contracting
- Single management of multiple funding streams

In many cases it is helpful to look at whole resource across the partnership in order to ascertain the totality of resource for commissioning purposes. This may include:

- Allocated budgets from partners
- Grants and ring fenced funds
- Capital allowance
- Staff
- Buildings and capital estate
- Equipment
- Third and independent sector contributions
- Volunteers
- Expert patients

9. Safeguarding

The Children Act 1989 and the Children Act 2010 are the primary legislation. It is important that all organisations and practitioners working to safeguard children and young people understand fully their responsibilities and duties set out in primary legislation and associated regulations and guidance.

Local safeguarding Children Boards (LSCB) are the key statutory mechanism for agreeing how the relevant organisations in each local area will co-operate to safeguard and promote the welfare of children, and for ensuring effectiveness of what they do.

All organisations commissioning or providing health care should ensure there is a focus on the needs of children and that safeguarding is an integral part of their governance systems.

GP Consortia will be overall responsible for:

- Strategic Leadership
- Organisational and workforce development
- Ensuring local systems operate effectively and deliver improved performance.

GP Consortia will be statutory partners of the LSCB and will need to identify a senior member of staff who will be their representative on the LSCB who can speak for the organisation with authority, commit their organisation on policy and practice matters and hold their organisation to account. Each member organisation is expected to provide a financial contribution and the amount should be agreed locally.

GP Consortia as commissioners should have a designated doctor and nurse to take a strategic, professional lead on all aspects of the health service contribution to safeguarding children across their area. Across large areas a team approach can enhance the levels of support, so GP Consortia may choose to pool budgets/joint fund roles.

All NHS trusts, NHS Foundation trusts, and public, Third Sector, independent sector and social enterprises providing services for children should identify a named doctor and nurse - a named midwife where maternity services are provided and a named professional for NHS Direct, Ambulance trusts and independent providers.

All employers should ensure that all those in contact with children and young people and/ or with adults who are parents or carers are appropriately trained, competent and confident to safeguard and promote the welfare of children. There are a number of training packages available and GP Consortia as commissioners should ensure that any training enables staff to meet the competencies and learning outcomes set out in *Safeguarding Children and Young People: roles and competences for health care staff- Intercollegiate Document (2010)*.

Safeguarding Supervision should be available to ensure that practice is soundly based, that practitioners fully understand their roles, responsibilities and the scope of their professional discretion and authority and to help identify training and development needs. The arrangements for organising supervision will vary and a number of models exist such as 1:1, peer supervision, reflective practice and child protection networks.

Serious Case Reviews are commissioned by the LSCB and their prime purpose is for agencies and individuals to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of children. All agencies involved will produce an Individual Management Review to look openly and critically at individual and organisational practice.

Designated professionals will produce an integrated health chronology and a health overview report focussing on how health organisations have interacted together. This will be on behalf of the GP Consortia as commissioners. GP Consortia will have a responsibility to ensure that there are systems in place for implementing health action plans, learning lessons locally and supporting the LSCB with media enquiries.

GP Consortia through their commissioning and assurance role will need to ensure there are systems in place to monitor serious incidents, identify trends and monitor improvement action plans

10. Partnerships

Services require partnership approaches / integration across the care pathway. This is apparent in both commissioning and provision.

Partnerships with a range of agencies/organisations and bodies are essential to ensure effective commissioning. GP consortia have a duty of partnership with the local authority. Partners in regard to CYP commissioning include the following

- Local Authority – They are the overall statutory body for CYP. GP consortia have a duty to cooperate with their LA and lead children's partnerships through the Health and Well Being Board.
- LSCB's – statutory board of which GP consortia will be statutory members
- Schools – Health services for school age children are delivered through schools
- Other agencies commissioning the same services e.g's Youth Justice Boards – to avoid duplication, gaps in provision and financial and safeguarding consequences
- Districts Councils – as they have specific responsibility around housing, transport, licensing, leisure etc
- Providers including voluntary and private sector – to performance manage contracts and to develop the market
- National partners, including Commissioning board and Health Watch

- Community safety partnerships including Police, Probation, MARAC – public protection

Joint commissioning of services should be undertaken where it will improve / enhance outcomes. Responsibilities therein, of shared ownership and joint risk management should be explicit. Where joint commissioning is undertaken, integrated governance and accountability arrangements should be clear and laid out in the contract / agreement.

11. Engagement with CYP and parents/carers

Engagement should include children of all ages, young people and parents or carers. Specialist expertise may be required to effectively engage young children and engagement may need to be activity based. Many local authorities have systems in place to engage effectively with CYP and families and working in partnership can assist with effective engagement. Health Watch will have a specific role in regard to engaging children and their parents to ensure their views are fed into local commissioning.

12. Commissioners

There is additional complexity to CYP commissioning due to the number and range of potential children's health services commissioners. The number and variety of potential commissioners can increase the risk of duplication and inefficiency. Joint commissioning and pooled budgets are often a solution to this scenario however this takes time and effort. The number of potential commissioners also reflects the potential funding streams available to children's services. A range of funding streams exist e.g. area based grants, Local Authority funding, school funding etc however all funding streams are under pressure.

Examples of potential CYP services commissioners are as follows

- GP consortia
- Schools, special schools – e.g. can commission therapy, school health etc
- Prison services and secure settings – commission a whole range of health services
- Local Authority
- Private contractors
- Courts
- Police – commission health services for custody suites and sexual abuse referral centres (SARC)
- Individual users of the service - personalised budgets are becoming more popular and widespread

13. Workforce

There is a diverse range of staff supporting children and their families. Commissioners will need to consider professional standards, ensure provider workforce plans are in place, ensure commission of education and training places, ensure providers have appropriate HR processes in place etc. Should commissioners decide to retender or decommission a service TUPE and other factors e.g. risk must be taken into account.

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 January 2011

14. Legislation and policy specific to children and young people

Children Act 2004

The Act provides the legislative framework that sets out the arrangements for safeguarding and promoting the welfare of children. Its overall aim is to create clear accountability for children's services, enable more effective joint working and to secure a better focus on safeguarding. The Act places a duty on key people and bodies to make arrangements to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children; these include service development, staff training and competency, safer recruitment procedures, effective inter-agency working and effective information sharing. This covers the universal services which every child accesses, and more targeted services for those with additional needs.

The overall aim is to encourage integrated planning, commissioning and delivery of services

- Improved multi-disciplinary working
- Removal of duplication, increased accountability and improved coordination of individual and joint inspections in Local Authorities
- Local Authorities to be provided with a considerable amount of flexibility in the way they implement its provisions.

Health and Social Care Act 2001

Places a duty on NHS organisations (Inc Foundation Trusts) and Local Authorities to make arrangements to involve and consult patients and the public in service planning, in the development of proposals for changes in services, and in decisions affecting the operation of services. They are also required to consult the relevant overview and scrutiny committee on proposals that substantially vary or develop services. Where Foundation Trusts are planning and taking forward major service change, they should take into account the commissioning strategy of the PCT (s) as well as making their own regulatory requirements.

Working Together to Safeguard Children (DH 2010)

This document sets out how organisations and individuals should work together to safeguard and promote the welfare of children. It is addressed to practitioners, front line managers, senior and operational managers in:

- Organisations that are responsible for commissioning or providing services to children, young people, and adults who are parents or carers and
- Organisations that have a particular responsibility for safeguarding and promoting the welfare of children.

It reflects the Children Act 2004, Every Child Matters five outcomes, the National Service Framework for children, young people and maternity services and the principles contained within the United Nations convention on the Rights of the Child and the European Convention of Human Rights.

Financial flexibilities – Pooling of budgets can be based on:

- Section 28a of the NHS Act 1977
- Section 31 of the Health Act 1999
- Section 10 of the children Act 2004

It is also possible to align budgets to achieve a joint approach but without the use of legal agreements. If this approach is adopted; risk, governance and accountability need to be clear and transparent and demonstrate integration.

Responsible Commissioner

The 'placing' PCT or Local Authority is responsible for the funding of health and social care needs for children and young people that are placed out of county (April 2007).

Joint Strategic Needs Assessment

There is a statutory requirement for all PCT's to work with the Local Authority to produce a joint strategic needs assessment for the local population in order to inform effective commissioning (Commissioning for Health and Well being – DH 2007).

Safer recruitment of adults (including volunteers) who work with children

“To fulfil their commitment to safeguard and promote the welfare of children all organisations that provide services for, or work with children, need to have in place recruitment and human resources management procedures that take account of the need to safeguard and promote the welfare of children and young people including arrangements for appropriate checks on new staff and volunteers.”

Safeguarding Children and Safer Recruitment in Education 2007, 3.1-3.53

Provides statutory guidance for the education sector and contains best practice safer recruitment advice for all other organisations that provide services for or work with children.

Clinical Standards

Services must meet clinical standards as stated by NICE guidance, Royal Colleges, Safeguarding Boards, Schools standards, Directors of Public Health Annual Report.

Policy requirements

Children's NSF (2003)

The NSF is a ten-year, 11 module strategy, setting standards and the national direction for improving the delivery of social care and health services for children, young people, and maternity services. It addresses concerns raised in the Kennedy Report and the Laming Report and ensures that care is centred on the child, appropriate services can be accessed at the right time and that child and their families can take an active part in making decisions about their care. Agencies will need to work together to deliver services in partnership, based on what is known to be effective in meeting families' needs and take a holistic approach to addressing the diverse needs of all children, young people, pregnant women and their families in all care settings.

Key messages:

- Child-centred care
- Child-friendly hospitals
- Offering choices about care
- Professionals, children and parents in partnership
- Multi-agency team working
- Addressing the needs of the whole child and pregnant mother
- Tackling inequalities

Action on Health Visiting" (2009) A comprehensive review of Health Visiting Services has been undertaken, with health visiting now seen as a public health function and as such will be commissioned by each Local Authority in the long term. To build the workforce to expected levels (an extra 4,200 health visitors are planned) commissioning will be managed by current arrangements and then through the National Commissioning Board until 2013. Health Visitors are seen as key to implementing the Healthy Child Programme which alongside Surestart Children's Centres is seen as key to improving health and well being in the early years.

Statutory Guidance on Promoting the Health of Looked after Children 2010

This guidance sets out the responsibilities of the NHS and local Authorities to meet the needs of all children and young people looked after. The **aim** is to make sure that all looked after children and young people are physically, mentally, emotionally and sexually healthy, that they will not take illegal drugs and that they will enjoy healthy lifestyles. Looked after children and young people share many of the same health risks and problems as their peers but often to a greater degree. They often enter care with a worse level of health than their peers in part due to the impact of poverty, abuse and neglect. The NHS contributes to meet the health needs of looked after children by:

- commissioning effective services
- delivery through provider organisations
- Individual practitioners providing co-ordinated care for each child, young person and carer.

Poverty Act (2010)

The aim of the Act is to set targets for the eradication of child poverty. The Act also sets up a Child Poverty Commission.

The Act states that local areas must co-operate to reduce child poverty. The Local Authority must make arrangements to promote cooperation with partner agencies with a view to reducing, and mitigating the effects of child poverty in the area.

Each partner authority, including PCT's (this duty will pass to GP's), must co-operate with the Local Authority in the making of arrangements to achieve this.

Local areas must prepare and publish a local child poverty needs assessment which is regularly reviewed and a joint child poverty strategy.

The joint child poverty strategy must set out the measures that the Local Authority and each partner authority propose to take and must consult with children, parents and organisations working with or representing children.

Aiming High for Disabled Children

Published in 2008, Aiming High for Disabled Children: Better support for families, outlined the then government's commitment to improving services for disabled children and their families with 3 key priority areas.

- choice/access and empowerment
- Improving service quality and capacity
- Responsive services and timely support.

Both Local Authorities and NHS organisations received additional funding to address these areas focusing on improving short break provision, palliative care provision and community equipment for disabled children. Local Authority funding was ring fenced and will finish in March 2011, funding allocated by the DH to PCT's was not ring fenced.

SEN Green paper

We are currently awaiting a Green Paper for special educational needs, which will build on Aiming High for Disabled Children, one of the few programmes carried forward under this government.

Palliative Care "Better care better lives"

Published in 2008 this document sets the future direction for children's palliative care services. It called to action to all those engaged in providing palliative care to children, young people and their families and set eight priority action areas for service improvement.

Achieving Equity and Excellence for Children

This document published in October 2010 is a companion publication to Equity and Excellence: liberating the NHS and focuses specifically on the impact of the White Paper on children young people and their families. The document reiterates the government's belief that "strong and healthy families are the foundations of our society" and explores how the proposed changes to NHS commissioning and provision can best meet the needs of children, young people and their families. It specifically states the Government's commitment to ensure a focus on children and young people in the Outcomes Framework and the Public Health White Paper.

The document identifies the National Child Health responsibilities held by the Department of Health and outlines how the Secretary of State for Health will fulfil these responsibilities, by

- 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.
- Holding the NHS Commissioning Board to account for the delivery of improvements for children against the agreed outcome indicators.

- 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.
- Setting the legislative framework for the NHS including for the quality regulator (the care quality commission) and the economic regulator (Monitor).

Through the Public Health Service, the Secretary of State will also

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

Public Health white paper Healthy Lives, Healthy People: Our strategy for public health in England

The White Paper published in December 2010 outlines the creation of Public health England a dedicated and professional public health service which will work closely with but be independent of the National Health Service. Directors of Public Health will be employed by Local Authorities but will be expected to work closely with GP consortia and will have key roles in promoting integrated working. Acknowledging that the early years are key to establishing healthy lifestyles, health visiting, school nursing and the Child Health programmes they lead will be funded from the Public Health England budget.