Royal College of Paediatric and Child Health

Some comments on the document "Delivering High Quality Hospital Health Services for the people of North East London".

RCPCH believes that local clinicians, managers, and commissioners are best placed to make recommendations about local services. We do, however, recognise how important it is that any reconfiguration of services should be to the benefit of children and we have produced generic guidance on this issue and your committee members may be interested to see the following documents:

a. Modelling the Future
b. The Role of the Paediatrician in Maintaining Faith and Sustainable Acute Services
c. Working Time Solutions
d. Reconfiguration Standards for Paediatric Services.

I shall restrict my comments to the implications for Children's Services.

The Child Health Strategy had a wide ranging remit with respect to children's services, both in the hospital and in the community, throughout the different stages of childhood. The majority of the strategy deals with the issue of promoting health and wellbeing and it is difficult to determine how many of these proposals will be addressed from the information provided in the document. There is a section in strategy on acute health services and I cannot find anything in your document which is at odds with the philosophy of the child health strategy in terms of urgent and emergency care.

From the documents that I have seen in relation to the NHS London Wide Vision for Children if your strategy for developing children's assessment and treatment units where children are treated by staff specifically trained in dealing with their particular illness it would appear to be in line with this strategy. It is recognised that there are currently considerable difficulties in providing general paediatric surgical services for children on the current number of inpatient sites in the UK. There are a number of reasons for this. Some units have to smaller case load and other units do not have surgeons and anaesthetists with appropriate skills available 24 hours per day. I would, therefore, fully support the proposals to reduce the number on inpatient sites where surgical procedures are performed but it is important to recognise the need for appropriate local protocols and transport arrangements for sites where children may be initially assessed. It is not always clear which children have surgical problems (only around 25% of children who have a surgical opinion will require an operation) and it is extremely important that there are network arrangements so that paediatricians are clear where to obtain both advice and a surgical opinion.

With regard to Workforce implications, it is clear from work that we have undertaken at RCPCH that there are currently insufficient consultant paediatricians to provide Working Time Directive (WTD) Compliant Rotas

across all sites in the United Kingdom that currently have in patient units. The problem has been compounded by the fact that the hours reduction under WTD 2009 has meant that many middle grade rotas are now supported by consultant paediatricians. The modelling would suggest that there are around 400 too few paediatricians for consultant rotas and there are around 200 Whole Time Equivalent (WTE) gaps on middle grade rotas. The RCPCH, therefore, would support the reduction in the number of inpatient units but we recognise that when the paediatric services are no longer provide an onsite that there are implications for other parts of the remaining service (for example maternity care or emergency departments). When service reconfiguration is proposed it is extremely important that these services are considered. We would support your proposals that there should be a paediatric assessment unit in hospitals that do not have inpatient services as it is quite clear that the majority of children who present to the hospital department can be treated quite appropriately either in an urgent care setting or an assessment unit. There would however have to be clear protocols drawn up with all relevant agencies to ensure that children with specific presenting features were transferred directly to the nearest inpatient service.

Without a detailed knowledge of your current services for acute children's health it is difficult to comment whether your proposals will improve their care but provided services are reconfigured appropriately the RCPCH has no evidence to suggest children's outcomes would deteriorate. I would refer you again to the College proposals for reconfiguration (listed above) which provide advice on developing safe and sustainable services. From the Modelling of work that we have undertaken and assuming that where there is to be closure of an inpatient facility but paediatric presence remains the reduction in the total requirement for the consultant workforce is relatively small. There may, however be the scope for reducing the number of tiers of doctors. Both of these factors could contribute to a cost saving which in the current economic climate is an important consideration when looking at totality of child health services.

With regard to your final comment on Child Protection and Social Care Wellbeing for Children under these proposals there are inadequate details within the document to make a specific comment. Safeguarding arrangements are extremely important in any child health services and it is very important that local protocols are designed and agreed between all relevant agencies when considering your future service configuration.

Dr David Shortland
Vice President (Health Services)
RCPCH