From the President:
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Dear Sir or Madam

Liberating the NHS White Paper: RCPCH Response

The Royal College of Paediatrics and Child Health welcomes the opportunity to respond to this important White Paper, and we will also be providing more detailed responses to the four complementary consultation documents.

As a professional body seeking to ensure the best outcomes for children, we want to highlight the particular implications for children and young people of the proposals, as the healthcare needs of children are different from the adult population. Children are especially vulnerable, require information available in formats meaningful to them and cannot always make decisions by themselves. Furthermore, compared to other Western nations the health outcomes for children and young people are consistently poor. This results in a legacy of adult healthcare need, some of which could have been avoided by adequate investment in the health of children. We would like to work with the government to address these issues.

Choice and Competition

We strongly support the commitment to delivering high quality services which achieve the best outcomes for children and young people. For many aspects of healthcare, competition based on patient choice and competition can be an effective lever for quality improvement, however competition only works when genuine choice is offered to patients in way that means they can readily access a range of services. The reality for many people living in rural areas or without private transport is that choice isn’t an option. Competition undermines an integrated approach to care – this is particularly relevant for patients with long-term conditions, who often have multiple health needs which cross organisational and sector boundaries. We foresee significant problems with fragmentation of care if each of the specialists providing care for such children were employed by organisations whose inter-relationship is characterised by competition, when what is required is co-operation. Furthermore if providers are competing with each other, how will innovation be shared across the NHS? Instead of competition, we suggest that quality improvement could be delivered through the development of networks of care, with services commissioned along pathways.

There are specific considerations for children around how to ensure that choice is offered in a meaningful manner. What does choice mean for young people with learning disabilities or mental
health problems? Clarity will be required on how information will be provided in formats that make sense to children, young people and their families.

The proposal around choice of GP provider is positive, as it could be beneficial for children with long term conditions who move out of what was previously the practice boundary as they will be able to maintain their relationship with their existing GP.

**Quality and Outcomes**

We support the focus on clinical outcomes, linked to NICE quality standards and also greater use of patient reported experience measures (PREMs) and patient reported outcome measures (PROMs). It is positive to note the recognition that there will need to be child specific measures, however there will be some measures applicable to all ages and it is important to ensure that children’s outcomes are not lost within these particular measures.

The development of meaningful outcomes for many aspects of children’s health is likely to be challenging; there may be times when proxy measures (which use structure or process) may be the most appropriate measure. A balance needs to be achieved between outcomes that can easily be measured within existing information systems and outcomes that will provide the best indication of quality of care. Caution is needed in terms of how outcomes are utilised – factors such as case mix must be considered when making judgements about relative performance of services based on outcome measures. Furthermore PREMs and PROMs need to be able to reflect the views of children & young people and also their parents & carers. Both of these groups have needs which are different to those of adult patients. Engagement with health professionals is vital to ensure the development of relevant and meaningful outcome measures.

**Commissioning**

We welcome the increased focus on clinician-led commissioning, recognising the flaws with current commissioning models. Furthermore the emphasis on shared decision making across health professions is positive.

GP Consortia will have the freedom to decide which aspects of commissioning activity they undertake – it is not clear what happens to those services that they chose not to commission. What happens if commissioned funding and tariff are insufficient for provision of a quality service? There is a risk of a vicious spiral where inadequate funding reduces quality so a licence is revoked; who is then responsible for meeting the needs of the local population?

Further clarity is required on the future commissioning structure. Some services will require a more strategic view than can be offered by a GP consortium yet are not a specialised national service that might be overseen by the Commissioning Board. We would support the development of sub-national commissioning arrangements that enable either subgroups of the National Commissioning Board or clusters of GP consortia to collectively consider commissioning requirements. Clearly appropriate input from relevant specialists or services would be required depending on the service being commissioned. We could envisage services such as safeguarding, which require close working with local authorities to be commissioned by consortium clusters, whereas a subgroup of the National Commissioning Board would be well placed to consider commissioning of General Paediatric Surgery.

The idea of sub-national commissioning is pertinent for any service area that is best delivered through networks. For many aspects of children’s health services (such as neonatal services, general surgery) a network approach is seen as the most appropriate way in which to deliver a high quality and equitable service. The White Paper makes very limited mention of the role of networks of care and almost no reference to pathways of care. We urge the government to consider how networks will be commissioned in future.
Reform of PBR and the development of pathway tariffs offer potential to incentivise a joined up approach to care. However there is no detail on the scope and depth of the pathway tariffs. Furthermore will they be available in time for GP commissioners to utilise when commissioning services?

There does remain a question mark over who will hold providers to account for quality of care. The NHS Commissioning Board is too far removed from service delivery to account for quality, and the future role of Care Quality Commission (CQC) is unclear in terms of whether they will only regulate for minimum standards.

**Health and Wellbeing Boards**
The move of Public Health into Local Authorities is positive in terms of promoting some aspects of integrated working, and will enable the wider determinants of health to be linked in. While integration should be improved in Local Authorities, it may create new boundaries with the NHS and health services.

The development of Health and Wellbeing Boards could enable improved local input and scrutiny of health services. We envisage that these Boards offer the potential to help reduce health inequalities and also to help support and influence local GP commissioning consortia.

**Finance and Structure**
The White Paper attempts to reduce bureaucracy and minimise management costs, which is constructive so long as front line staff are not burdened with inappropriate administration.

There is increasing emphasis on the use of any willing provider. While this may encourage innovation and new ways of working, there are particular concerns about how such providers will work with existing providers. This includes ensuring that regulators can keep track of all relevant providers and also ensuring that responsibilities, such as safeguarding, are delivered appropriately regardless of provider. Third parties may manage contracts which may have a significant impact on services such as those for children which span local authority, primary and secondary care. The importance of each provider playing their part in safeguarding children and communicating effectively with partners is paramount. Expertise in design and management of contracts will be at a premium and it is not clear how licensing/ governance and contractual costs and management will interact.

The White Paper places considerable emphasis on the need for timely information to support commissioning and choice – as a principle this is positive. However there is a considerable gap between what is available now and is needed. A clear strategy for progress will be required which will need to detail how information will be made accessible to children and young people.

There are several organisations or programmes, whose role will be strengthened or revised, such as CQC, Healthwatch (from LINks) and CQUIN. These are broadly positive; however there is a lack detail around the proposed changes, which makes it difficult to assess how effective the proposals might be. We note that patient representation and advocacy has been somewhat weak since the abolition of Community Health Councils and will need to be radically strengthened with appropriate support, if patients’ (both parents’ and children’s) representation is to become at all meaningful.

The loss of national targets has mixed implications – clearly it removes the fixation and perverse outcomes of chasing specific time-based targets. However it would be a backwards step if progress in terms of offering patients timely access to care is reversed.

**Education and Training of Workforce**
Greater professional ownership of the quality of education and training is positive; however increased employer autonomy to plan and develop the workforce could result in a lack of strategic
planning. We appreciate that further detail will be published shortly however remain concerned that education is not given the centrality and importance required. As stated in the recent Temple Review ‘education is patient safety for the next 30 years’.

We recognise the potential benefits of education and training commissioning being aligned locally and nationally with the commissioning of patient care. Furthermore we welcome the statement that transparent funding flows for education and training will support the level playing field between providers. Concern remains that education and training will be less of a priority when in competition with other resource demands. This issue might be overcome if education and training were given a separate, autonomous role.

Research
The commitment to patient centred research as a core NHS role, and recognition of the benefits that research brings to health and wellbeing is welcomed. We are concerned by the continued poor representation of infants, children and young people in a range of biomedical, clinical and health services research. We urge Government to address this imbalance by improving patient and public understanding of research; ensuring research regulation and governance is compatible with and promotes child-specific issues; there are identifiable funding streams and wider and adequately flexible research training opportunities for paediatricians.

Implementation
We are concerned with how the transition from the current to the proposed structure will take place. This is particularly an issue for GP commissioning, given that no piloting of the proposed commissioner model has taken place. It is unclear how a potentially greater number of commissioning groups will be able to deliver the expected £20 billion costs savings and reduction in management costs. Furthermore it is unclear that sound financial governance processes will be in place to minimise any conflicts of interest such as GP consortia being able to commission new services from groups of their own practices. There is unease that the structural transition, together with the financial challenges for health, social care and education will significantly fragment services, to the detriment of children.

We hope you find these points useful as part of the consultation process, and we would be very happy to discuss any of them in further detail, if required.

Yours faithfully

[Signature]

Professor Terence Stephenson
RCPCH President