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Royal College of Obstetricians and Gynaecologists

Setting standards to improve women's health

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LIBERATING THE NHS: COMMISSIONING FOR PATIENTS

Key Points

The Royal College of Obstetricians and Gynaecologists:

- ***Believes that central commissioning for maternity care will accelerate the development of a service that is safe and accessible to all***
- ***Suggests that the incorporation of established standards and guidelines into the commissioning framework will accelerate improvements in service delivery***
- ***Recommends that such standards are underpinned by quality metrics and audit, thus providing quality assurance to the NHS Commissioning Board***
- ***Understands that new and flexible working practices, including the development of perinatal networks, will provide maximum safety for patients with greater economic benefit***
- ***Appreciates that separate commissioning models within the unified discipline of obstetrics and gynaecology may present significant challenges to patterns of clinical care and organisation***
- ***Feels that some areas of gynaecology, cancer care and assisted reproduction, would be enhanced by central commissioning***
- ***Would welcome the opportunity to contribute to the leadership tasks inherent in the proposed reorganisation, with a realisation of the need to embrace change***
- ***Believes that adequate financial provision must be made for multiprofessional education and training to ensure maintenance of clinical standards***

The Royal College of Obstetricians and Gynaecologists (RCOG), an international organisation, which includes all UK-based specialists in the discipline, welcomes *Liberating the NHS: Commissioning for patients* and the opportunity to comment. This response represents the views of the leadership of the RCOG and its UK-based membership, whose views were sought as part of this consultation process.

The RCOG's key objective is to set standards to improve women's health and as a College this encompasses both obstetrics **and** gynaecology. The majority of consultants continue to provide both aspects of care. Most hospitals and trusts employ consultants to provide the service in combination and the service is jointly configured and jointly commissioned. We have published standards across women's health: *Standards for* Gynaecology[1] cover 20 standards with commensurate auditable standards. *Standards for Maternity Care*[2] is a joint report from the Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, Royal College of Anaesthetists, and Royal College of Paediatrics and Child Health, covering standards from prepregnancy care to transition to parenthood. It contains 30 standards with auditable indicators. It is for reference and ideally implementation.

We are also very concerned with influencing healthcare policy to ensure that our patients receive safe and high quality care. Commissioning of that care is crucial and it will be essential to involve specialists in the new commissioning arrangements. The RCOG welcomes the initiative of national maternity commissioning and sees this as an exciting opportunity for development and genuine service change.

The RCOG has significant concerns about the potential difficulties resulting from split commissioning for specialties such as ours. Our members provide care across the whole spectrum of women's health, e.g. both obstetrics **and** gynaecology. Splitting commissioning for obstetrics and gynaecology will bring with it challenges that will need to be managed carefully. Women using these services will want and must receive continuity of care. For example, pregnancy management may start with infertility and if the pregnancy fails before four months of gestation all of this care will be gynaecological. The transition to obstetric care in most hospitals occurs at 16-20 weeks and care is then provided by midwives and obstetricians. The provision of postnatal care remains unclear. The boundaries of who provides care and how that is to be commissioned require further clarity. We believe the intention of the White Paper is to improve outcomes and provide holistic healthcare seamlessly throughout the patient journey. Although we support the proposal for patients and the public to be involved in GP commissioning we remain concerned that equality of access may be compromised and we return to postcode lottery for some services, such as assisted conception, unless there is a national mandate and guidance.

Furthermore, we have anxiety about potential fragmentation: commissioning being split into three: GP consortia, NHS Commissioning Board (NCB) and DH (public health). In addition, we are uncertain how specialist services will be commissioned at a local or network level unless the commissioning arm has a satellite configuration. Will this have purely an administrative function

[1] [http://www.rcog.org.uk/files/rcog-corp/uploaded-files/WPRGynStandards2008.pdf]
[2] [http://www.rcog.org.uk/files/rcog-corp/uploaded-files/WPRMaternityStandards2008.pdf]

or would there be a degree of autonomy for local or network implementation? The White Paper also describes GP consortia having influence and involvement in national and regional specialised services but this element is unclear. We encourage consultation with and involvement of secondary/tertiary care consultants in such circumstances. There is the added complexity with Monitor taking responsibility for defining regulated services that will be subject to special licence conditions and controls. We are concerned that there appears very little direct interaction between these organisations, for example, between Monitor, the Care Quality Commission, the NCB and GP consortia. There could also be conflict between the NCB and Monitor as the economic regulator where one is extending choice and the other is protecting it.

Whilst accepting that public health services are an important element of social care, it is an equally important part of healthcare.

Robust and transparent governance arrangements will also need to be in place to ensure fair play, e.g. GPs could potentially be commissioners and providers of some services.

Finally, we recommend that the current good practice and expertise in commissioning is retained as many of the consortia will not have existing expertise and will struggle during the initial phase. The emphasis throughout the White Paper is on GP led commissioning. There is a vast amount of enthusiasm and expertise in the secondary care sector which should be harnessed for the benefit of the NHS and above all patients. This should also ensure minimising cost of the NHS for implementing the changes, e.g redundancies, followed by employment of the same individuals for future services.

The RCOG has concerns about the size and pace of change during the transition between the abolition of PCTs/SHAs and the new structure which is yet to be established at a time of potential increased competition and financial constraints.

RESPONSES TO THE CONSULTATION QUESTIONS

RESPONSIBILITIES

1. ***In what practical ways can the NHS Commissioning Board most effectively engage GP consortia in influencing the commissioning of national and regional specialised services and the commissioning of maternity services (page 13)***

   The RCOG remains unclear about the structure of nationally commissioned services at a local level. If this is to include satellite administrative or commissioning offices then it would seem appropriate for engagement with GP consortia to be at that level. However, for this to work there would need to be some alignment between groups of GP consortia and the NCB with reference to specialised services, e.g. fetal and maternal medicine, within maternity services.

2. ***How can the NHS Commissioning Board and GP consortia best work together to ensure effective commissioning of low volume services?***

   Low volume services, such as those provided at supra-regional level may be best commissioned at the NCB level, e.g. laser fetoscopy in twin pregnancy, intrauterine fetal blood transfusion, urinary fistula surgery.

   We note that Monitor will be responsible for defining regulated services that will be subject to special licence conditions and controls. The RCOG must be involved in all aspects of these areas.

3. ***Are there any services currently commissioned as regional specialised services that could potentially be commissioned in the future by GP consortia?***

   We are aware of the *Specialised Services National Definition Set (SSNDS*) *Third edition 2010, Definition No 4* focusing on specialised services for women's health which includes fetal medicine services, maternal medicine services, complex urinary and faecal incontinence and genital prolapse, complex gynaecological reconstruction and complex minimal access gynaecological surgery. These should remain at national commissioning level until there is clarity between the NCB and local service provision. In addition the commissioning of gynaecological cancer and assisted reproduction nationally would ensure uniformity of service.

4. ***How can other primary care contractors most effectively be involved in commissioning services to which they refer patients, e.g. the role of primary care dentists in commissioning hospital and specialist dental services and the role of primary ophthalmic providers in commissioning hospital eye services?***

   No comment

5. ***How can GP consortia most effectively take responsibility for improving the quality of the primary care provided by their constituent practices (page 17)?***

   No comment

6. ***What arrangements will support the most effective relationship between the NHS Commissioning Board and GP consortia in relation to monitoring and managing primary care performance?***

   No comment

7. ***What safeguards are likely to be most effective in ensuring transparency and fairness in commissioning services from primary care and in promoting patient choice?***

   The answer to the question lies in performing against agreed clinical standards and auditable outcomes between the NCB and local providers of healthcare.

8. ***How can the NHS Commissioning Board develop effective relationship with GP consortia, so that the national framework of quality standards, model contracts, tariffs, and commissioning networks best supports local commissioning (page 20)?***

   Through performance against identified standards and clinical outcomes within a managed budget.

9. ***Are there other activities that could be undertaken by the NHS Commissioning Board to support efficient and effective local commissioning?***

   No comment

ESTABLISHMENT OF GP CONSORTIA

10. ***What features should be considered essential for the governance of GP consortia (page 21)?***

    The generally accepted principles of governance should be embedded into local quality frameworks. The RCOG believes that GP consortia should pass the tests of allowing patient choice, managing risk, commissioning effectively and providing value for money. The size will differ but essentially the framework of World Class Commissioning should still apply to demonstrate fitness for purpose.

11. ***How far should GP consortia have flexibility to include some practices that are not part of a geographically discrete area (page 22)?***

    No comment

12. ***Should there be a minimum and/or maximum population size for GP consortia?***

    No comment

FREEDOMS, CONTROLS AND ACCOUNTABILITIES

13. ***How can GP consortia best be supported in developing their own capacity and capability in commissioning (page 25)?***

    The expertise resting in secondary and tertiary care should be harnessed for the benefit of local services, clinical outcomes for the patients and the optimum patient experience.

14. ***What support will GP consortia need to access and evaluate external providers of commissioning support?***

    No comment

15. ***Are these the right criteria for an effective system of financial risk management? What support will GP consortia need to help them manage risk (page 26)?***

    No comment

16. ***What safeguards are likely to be most effective in demonstrating transparency and fairness in investment decisions and in promoting choice and competition (page 27)?***

    No comment

17. ***What are the key elements that you would expect to see reflected in a commissioning outcomes framework (page 28)?***

    Adherence to nationally agreed standards with mandatory outcome reporting as set out in the outcomes consultation document.

18. ***Should some part of GP practice income be linked to the outcomes that the practice achieves as part of its wider commissioning consortium?***

    Yes

19. ***What arrangements will best ensure that GP consortia operate in ways that are consistent with promoting equality and reducing avoidable inequalities in health?***

    All GP consortia will need to adhere to the nationally commissioned services, as well as responding to the local requirements of HealthWatch and the local authority.

PARTNERSHIP

20. ***How can GP consortia and the NHS Commissioning Board best involve patients in making commissioning decisions that are built on patient insight (page 31)?***

    Through nominated or elected representatives at a consortia level or locally devolved NCB commissioning (satellite) organisation. This would include HealthWatch, local voluntary organisations and community groups to ensure that the most disadvantaged and marginalised patients are represented.

21. ***How can GP consortia best work alongside community partners (including seldom heard groups) to ensure that commissioning decisions are equitable, and reflect public voice and local priorities?***

    See 19 above.

22. ***How can we build on and strengthen existing systems of engagement such as local HealthWatch and GP practices' Patient Participation Groups?***

    No comment

23. ***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 and, where appropriate, staff?***

    No comment

24. How can GP practices begin to make stronger links with local authorities and identify how best to prepare to work together on the issues identified above (page 32)?

No comment

25. Where can we learn from current best practice in relation to joint working and partnership, for instances in relation to Care Trusts, Children's Trusts and pooled budgets? What aspects of current practice will need to be preserved in the transition to the new arrangements?

No comment

26. How can multi-professional involvement in commissioning most effectively be promoted and sustained (page 33)?

By promoting integrated patient care pathways, incorporating health and social care.

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