Direct telephone: +44 (0) 20 7772 6369
Direct facsimile: +44 (0) 20 7772 6232
Email: cdhillon@rcog.org.uk

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Royal College of Obstetricians and Gynaecologists

Setting standards to improve women's health

27 Sussex Place, Regent's Park, London, NW1 4RG
Telephone: +44 (0) 20 7772 6200
Facsimile: +44 (0) 20 7723 0575
Website: www.rcog.org.uk

EQUITY AND EXCELLENCE – LIBERATING THE NHS

Key Points

The Royal College of Obstetricians and Gynaecologists:

- Strongly endorses the concept of improving clinical quality by focusing on patient outcomes
- Believes that existing maternity and gynaecological standards, supported by all stakeholders, could form the basis of national commissioning
- Suggests that the introduction of such standards should be underpinned by quality metrics and clinical audit
- Supports the concept of informed patient choice, based on accurate and reliable information
- Believes that perinatal networks based on integration of maternity and neonatal services will improve safety, clinical effectiveness and patient experience
- Understands that standards of clinical care will only be achieved through the quality of staff training and clinical research
- Recommends a continuum in women's healthcare which may be significantly jeopardised by the potential fragmentation of commissioning
- Would welcome the opportunity to contribute to the leadership tasks inherent in the proposed reorganisation

The Royal College of Obstetricians and Gynaecologists (RCOG), an international organisation, which includes all UK-based specialists in the discipline, welcomes the White Paper: *Equity and Excellence – Liberating the NHS* and the opportunity to comment on the Government's strategy for the NHS. 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 focus on patient centred care, removal of bureaucracy and unnecessary targets is to be supported. In addition, recognising the shift in emphasis towards clinical, meaningful outcomes will be something the professions as well as the public will endorse and champion.

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. We shall provide more detailed feedback to the specific consultation C*ommissioning for patients.*

Further, the outcomes framework *Transparency in outcomes – a framework for the NHS,* although lacking detail is in line with the RCOG's focus upon auditable outcomes of agreed standards. A more comprehensive response will follow in response to the consultation document.

1. Liberating the NHS

The RCOG shares the Government's commitment to a comprehensive NHS service, available to all, free at the point of use and based on clinical need. We also welcome the principles set out in the White Paper on long-term transformation:

- putting patients and the public first
- focusing on improvement in quality and healthcare outcomes
- autonomy, accountability and democratic legitimacy
- cutting bureaucracy and improving efficiency.

2. Putting patients and the public first

The RCOG recognises the importance of information to enable patients to make informed choices about their care. We have been publishing patient information for many years.[3]

We agree that information generated by patients themselves could add value and may encourage a rise in standards, but it is important that systems and tools are in place to ensure the accuracy and quality of such information. There must be a uniform and standard message with additional local details of relevant service provision, choices available and expected outcomes. The RCOG supports the development of network,

[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]
[3] [http://www.rcog.org.uk/womens-health/patient-information]

hospital, team and, where relevant, individual outcomes data but recommends caution unless these data are accurate, case mix is included and attention is paid to specific clear denominators. Demography, geography and social factors such as deprivation must all be taken into account to provide meaningful risk adjusted information. Revalidation will ultimately support the aspirational aim of supporting patient choice in relation to consultant-led teams based on information about individual team members.

We strongly endorse national clinical audits to support clinicians and the RCOG is currently undertaking a National Audit of Heavy Menstrual Bleeding looking at patient reported outcomes, supported by the Healthcare Quality Improvement Partnership (HQIP).

The development of Patient Reported Outcome Measures (PROMs) is to be welcomed. This aspect of care is increasingly recognised as a valuable outcome measure and is more sophisticated in craft specialties such as gynaecology but surprisingly less so in maternity provision. The RCOG is supportive of this direction and is keen to be involved in a national solution.

The concept of patient-held records is common in maternity but the issue of uniformity remains. The concept of a national patient record identifying the patient by NHS number could be piloted in maternity with other specialties developing records from the pilot experience.

The RCOG supports patient choice as long as it is informed and safe. We would like to emphasise that choice must be governed by clinical need, which in maternity care ensures achievement of the optimum outcome of a healthy mother and baby. The care, opportunity for choice and service provision must be comprehensive and based on a (local) public health paradigm. This would need to take account of current public health concerns in women's health, e.g. rising levels of obesity, smoking and alcohol consumption during pregnancy, teenage pregnancies, delayed motherhood, social exclusion and postnatal depression.

The RCOG recognises that gynaecological care will encompass primary and secondary care services. GPs and consultants must work together to optimise appropriate commissioning and also appropriate provision of that care. The patient must be at the centre of care, not in the middle of competition to provide care. It should be stressed that certain models of care such as gynaecological cancer and infertility have lent themselves to network development with secondary unit and tertiary centre provision. This model has worked well.

The RCOG would like to see considerably more acknowledgment in the White Paper of the importance of the expertise of primary **and** secondary care professionals in achieving the optimum service provision. This would include setting standards and outcomes in both sectors; a level playing field for tariffs and equivalence of funding streams. In maternity there is still uncertainty about the structure of the tariff and consequently how services will function. Simply providing 24/7 care in every provider unit is likely to be unachievable. The development of maternity and ideally perinatal networks is to be welcomed with the benefits that will create.

We support the role of HealthWatch and its close proximity to the CQC. The involvement of patients and public are of paramount importance in any future commissioning structure to make sure that those communities and individuals who are less well educated, more deprived and less empowered have an equal voice. Care needs to be taken to ensure that the NHS is able to meet the high expectations of service users.

3. Improving healthcare outcomes

3.1 The NHS Outcomes Framework

The RCOG supports the NHS Outcomes Framework, including the three domains of quality:

- effectiveness of the treatment and care provided to patients
- safety of the treatment and care provided to patients
- broader experience of patients about their treatment and care.

We are also pleased to see the emphasis on consultant-delivered service and on clinical rather than process outcomes. The former is increasingly important as trusts comply with the European Working Time Directive and configure rotas with potentially fewer junior doctors in training. An appropriate workforce 24/7 is essential if we are to aspire to international outcomes. Standards have been recommended by the RCOG in *Safer Childbirth*[4] but additional resource will be needed to achieve these aims of consultant expansion and better midwifery ratios.

The RCOG will be responding separately to the *Transparency in outcomes – a framework for the NHS.*

3.2 Developing and implementing quality standards

We agree that NICE is the appropriate national body to develop quality standards, building on its current robust methodology and way of working with the Royal Colleges and professional bodies, utilising existing published evidence-based standards. The RCOG has published evidence-based standards across women's health (obstetrics and gynaecology), jointly with the Royal College of Midwives, Royal College of Anaesthetists, and Royal College of Paediatrics and Child Health. The relevant standards have been utilised for the Specialist Neonatal Care Quality Standards to be published by NICE jointly with the RCOG and the Royal College of Paediatrics and Child Health. The standards are in place and the RCOG has the expertise to continue joint working with NICE to develop these quality standards and auditable outcomes in other areas of women's health.

3.3 Research

We are delighted to note the Government's commitment to the promotion and conduct of research as a core NHS role particularly when financial resource is under greater scrutiny. Professor Kennedy's recent report *Getting it right for children and young people* stresses

[4] [http://www.rcog.org.uk/files/rcog-corp/uploaded-files/WPRSaferChildbirth Report2007.pdf]

the need for a cultural shift that is needed from the NHS to invest in the development of children from minus-nine-months to two or three years. The RCOG supports **start of life** as a clinical and research concept.

3.4 Incentives for quality improvement

The concept of incentivising for quality improvement is excellent but care will need to be taken to avoid perverse incentives. Until the fine details of commissioning and the level and structure of the tariff become clear it is difficult to comment, suffice to say that a neonatal tariff is welcomed. Excellent rather than average care will be the template, presumably by extending the CQUIN concept. It must include any pathway in its entirety, for example, as in cancer and maternity. The funding detail consequently will be important and the extension or creation of networks is the key to success.

4. Autonomy, accountability and democratic legitimacy

We note the Government's aim of reforming to liberate professionals and providers from top-down control and the intention for the DH to devolve power and responsibility for commissioning services. Whilst we welcome this in principle we have great anxiety about potential fragmentation - commissioning being split into three - GP consortia; National Commissioning Board 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 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. This element is unclear. We encourage the consultation with and involvement of secondary/tertiary care consultants in such circumstances. In addition, 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, see Figure 2, page 39.

Whilst accepting that public health services are an important element of social care, it is an equally important part of healthcare. Commissioning of healthcare must be based on the best available public health advice.

The delivery of the proposed changes will result in reorganisation of services, with the associated risks attached to any change. This together with the proposed efficiency reductions will need to be carefully managed so as not to have a negative impact on services. 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.

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.

Doctors providing obstetrics and gynaecology services will need common generic training programmes. Like other medical colleges, education and training is a major concern for this College and we await the consultation document with interest.

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 must 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.

5. Cutting bureaucracy and improving efficiency

We support the Government's moves to cut bureaucracy and waste and its commitment to increase the proportion of resource available for front-line services. It is important to remove duplication of roles. Care will need to be taken to minimise disruption and to mitigate risk in order to achieve the proposed ambitious reductions.

At the same time, we are also aware that efficiencies can be achieved through the existing Quality, Innovation, Productivity and Prevention (QIPP) initiative, e.g. the RCOG is currently undertaking research using existing HES data to demonstrate how reductions can be achieved in neonatal costs by delaying planned caesarean sections. We also appreciate the need for different ways of working and the provision of services seamlessly across different sectors; the focus being on care pathways rather than those providing the service. All this will need to be achieved through careful planning and negotiation.

A. D. Falconer

David Richmond

Dr Anthony Falconer FRCOG
President

Dr David Richmond FRCOG
Vice President Standards

AF/DR/IW/CD