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Royal College of Obstetricians and Gynaecologists

Setting standards to improve women's health

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LIBERATING THE NHS: GREATER CHOICE AND CONTROL

Key Points

The Royal College of Obstetricians and Gynaecologists:

- ***Believes that choice should be inclusive of all people, independent of their background and relative advantage/disadvantage***
- ***Believes that clinically appropriate choice and shared decision-making should be the rule and not the exception***
- ***Believes that choices should be clinically safe and sustainable***
- ***Believes that choice needs to be framed in the context of service capacity in a safe and sustainable environment***
- ***Believes that clinically meaningful choice must be linked to unambiguous information***
- ***Believes that information, support for patients and infrastructure need to be in place to achieve the vision of informed and empowered patients***
- ***Remains concerned that the general practitioners' role as gatekeepers, providers and commissioners may have a negative impact on choice***
- ***Is concerned that choice may disadvantage vulnerable groups***
- ***Believes that choice will facilitate a culture change to ensure healthcare is a partnership between the professional and the patient, resulting in the opportunity to enhance the education and training curricula for future professionals.***

The Royal College of Obstetricians and Gynaecologists (RCOG), an international organisation, which includes all UK-based specialists in the discipline, welcomes *Liberating the NHS: Greater choice and control.* 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.

Q1. How should people have greater choice and control over their care? How can we make this as personalised as possible?

The RCOG supports choice as long as it is clinically appropriate and deliverable within available resources and capacity.

The RCOG believes that careful thought needs to be given at the outset to manage patient expectation as failure to do this may have a negative impact on the health and experience of patients.

The RCOG has serious concern that the choice agenda may assist the privileged and be detrimental to those large number of young mothers who feel excluded from society-eg asylum seekers, drug addicts.

Q2. Which healthcare services should be our priorities for introducing choice of any willing provider?

The prioritisation for introducing choice of any willing provider must take into account services that can be delivered safely within existing premises, e.g. GP surgeries, or those that can be adapted easily, e.g. diagnostic services.

To ensure effective implementation, careful thought needs to be given to service providers' existing contractual arrangements, e.g. different terms and conditions of primary and secondary care providers.

Q3. How can we offer greater choice of provider in unplanned care?

To offer greater choice of provider in unplanned care there needs to be a better definition of "unplanned care" (we have assumed this to be "emergency care"). At present, availability of choice for unplanned care is greater than that for elective care as the patient chooses their provider. However, there is emerging evidence that choice is creating confusion for the patient and a rapidly expanding out of hours attendance at secondary care level. In addition, currently there appears to be a paradox between the choice available between planned and unplanned care such that patient choice out of hours appears to be overwhelming emergency services in secondary care unnecessarily.

Q4. What would help more people to have more choice over where they are referred?

To help people to have more choice over where they are referred, they must have access to information which is unambiguous and describes available resources and the optimal outcome.

Q5. Which choices would you like to see in maternity services and which are the most important?

The RCOG supports choice for maternity services encompassing pre-conceptual care; antenatal care; labour and birth; and postnatal care.

Choices may be made at any stage of the pregnancy, but it is vital that that primary care services are involved at an early stage together with midwives and obstetricians if indicated. Pre-pregnancy care may involve general practitioners, obstetricians and other specialists in cases of complexity.

Complications in early pregnancy may involve imaging services with gynaecological input in some cases of unsuccessful pregnancy. Historically, choice in maternity services has created some tensions between different provider groups and expectant women in the choice of place of confinement. For the conduct of delivery the choice of carer and place of birth should be determined by defining accurately a risk analysis for each mother. Confinement in the home or in midwifery-led units is entirely appropriate for many women, but there must be immediate transport infra structure and ready access to major obstetric services when unforeseen complications arise.

The period of greatest risk and uncertainty in pregnancy is labour, as supported by the NHS LA data on litigation for maternity services.

The provision of post natal services are perceived to be in need of improvement to increase the breast feeding rates and to detect at an earlier stage the significant stigmata of serious psychiatric illness. These services need the input of midwives, health visitors, obstetricians, the primary care team and the mental health services.

Women must be supported in their desire for choice in maternity care by appropriate design of perinatal networks, based on appropriate population size, which would guarantee the continuity of care by a Multidisciplinary Team in cases of rapidly changing complexity. A hub and spoke model incorporating all levels of pregnancy care would provide safety combined with choice. Independent care outside such quality assured services within the NHS should not be encouraged.
The development of the choice agenda and perinatal networks would be more apparent within a central commissioning framework. Small consortia would be unable to provide and afford the appropriate clinical services and therefore negate the choice agenda. In addition perinatal networks are likely to develop on significant population bases, far in excess of those envisaged for commissioning.

All professional providers of maternity care feel that the services need to be more appropriate and sensitive to the needs of those that are disadvantaged and excluded; this population is increasing in number. Choice is fine for those with an intellectual framework to exert such opinion but for the substantial number of disadvantaged women it is not an option and they need access to local safe services. It must be clinically appropriate, safe and does not de-stabilise service provision and further disadvantage the vulnerable communities.

Q6. Are these the right choices for users of mental health services, and if not why not?

Within the context of maternity, perinatal mental health service provision is important.

Q7. When people are referred for healthcare, there are a number of stages when they might be offered a choice of where they want to go to have their diagnostic tests, measurements or samples taken. At the following stages, and provided it is clinically appropriate, should people be given a choice about where to go to have their tests or their measurements and samples taken:
- At their initial appointment - for example, with a GP, dentist, optometrist or practice nurse?
- Following an outpatient appointment with a hospital consultant?
- Whilst in hospital receiving treatment?
- After being discharged from hospital but whilst still under the care of a hospital consultant?

Yes, as long as the results of tests or measurements are immediately and readily available across the range of service providers, and systems are in place for appropriate action.

Q8. Are there any circumstances where choice of where to go for diagnostic testing would not be appropriate, and if so what are they?

We are not aware of any. Also see answer to Q7 above.

Q9. Would you like the opportunity to choose your healthcare provider and named consultant-led team after you have been diagnosed with an illness or other condition?

Yes.

Q10. What information and/or support would help you to make your choice in this situation and are there any barriers or obstacles that would need to be overcome to make this happen?

See answer to Q4 above.

Q11. Is there anything that might discourage you from changing your healthcare provider or named consultant-led team - for example, if you had to repeat tests, wait longer or travel further?

No comment.

Q12. What else needs to happen so that personalised care planning can best help people living with long term conditions have more choice and control over their healthcare?

The providers and users of these services are better placed than the RCOG to respond to this question.

Q13. What choices are most important to people as they approach the end of their lives? What would best help to meet these?

The important choices for people as they approach the end of their lives should include the place to die and the right to be treated with respect and dignity. There should be adequate service provision in a range of settings from hospice to home.

Q14. We need to strengthen and widen the range of end of life care services from which patients and carers can choose. How can we best enable this?

See answer to Q13 above

Q15. Carers may sometimes feel that they themselves have no choice when the person they care for chooses to die at home. How should the respective needs and wishes of patients and carers be balanced?

No comment.

Q16. What sort of choices would you like to see about the NHS treatment that you have? Treatment could mean therapy, support for self management, medication or a procedure like surgery.

No additional comment, see above.

Q17. How can we encourage people to take more responsibility for their health and treatment choices?

People can be encouraged to take more responsibility for their health and treatment choices by the provision of information which is accessible and unambiguous that describes the available resources and optimal outcomes.

Section 3: Shared healthcare decisions
Our answers to Qs1-17 address the issues raised in Section 3, e.g. Qs18-35.

Q36. How should people be told about relevant research and how should their preferences be recorded?

If an organisation is undertaking research in a given area, this should be publicised through their premises, website and any related national organisations. The publicity should provide information on how patients can participate.

Q37. How can we encourage more healthcare professionals to use Choose and Book when they make a referral?

The Choose and Book system must have appropriate flexibility for the patient and their GP to facilitate patient choice.

Q38. How can we encourage more healthcare providers to list their services on Choose and Book?

More healthcare providers would list their services on Choose and Book if this was possible without having a negative impact on their other local services and central targets.

Q39. How else can we make sure that Choose and Book supports the choice commitments in chapter 2?

We have responded to Q2 and we have nothing further to add.

Q40. Do you agree with the proposed approach to implementing choice of named consultant-led team? What else would you suggest needs to be done?

We agree in principle with the proposal to implement choice of named consultant-led team. However, there needs to be further clarity of the team that is explicit both to the user and the provider. The RCOG advocates a consultant-based service, particularly in maternity.

Q41. Do you agree with the proposed approach to establishing a provider's fitness to provide NHS services? What other criteria would you suggest?
Q42. Should this approach apply uniformly to all providers, no matter what size, sector and healthcare services that they provide? For example, should a small charity providing only one healthcare service to a very localised group of patients be subject to the same degree of rigour as a large acute hospital that delivers a range of services to a regional catchment of patients?
Q43. Do you agree that an "any willing provider" directory should be established to make it easier for commissioners to identify providers that are licensed and have agreed to the NHS standard contract terms and conditions?

The RCOG supports the concept of any willing provider, subject to rigorous quality and financial licensing as long as it does not de-stabilise local services, particularly urgent care. Equally, within any local service provision, each service is accountable and responsible for the services they provide, e.g. complications and adverse outcomes are managed within the local governance framework.

Q44. The White Paper indicates that the Government will explore the potential for introducing a right to a personal health budget in discrete areas. Which conditions or services should be included in this right?

The right to a personal health budget may be more relevant to community/home services. Care needs to be taken not to disadvantage or de-stabilise other health/social services.

Q45. How can we make sure that any limits on choice are fair, and do not have an unequal effect on some groups or communities?

The RCOG is concerned with the assumption that everyone would be able to make choices about their healthcare. The most vulnerable members of the society are least likely to exercise this choice for various reasons.

Furthermore, the question itself is contradictory by asking how to limit choice! The RCOG believes that true choice can only be made within the confines of available resources and deliverability.

Q46. What do you consider to be the main challenges to ensuring that people receive joined-up services whatever choices they make, and how should we tackle these challenges?

To ensure people are receiving joined-up services, there must be clear inter- and intra-service boundaries, and arrangements must be in place to ensure seamless transfer in and out of each service. See answer to Question 5.

Q47. What do you consider to be the main risks to the affordability of choice and how should we mitigate these risks?

The main risks to the affordability of choice are when choice is promoted without boundaries and limitations as this raises expectations to a level which is undeliverable.

Q48. How far should we extend entitlements to choice in legislation and hold organisations to account against these?

The RCOG believes that there is no need for additional bureaucracy.

Q49.Where no specific right to choice applies, how can the Board best encourage GP consortia to maintain and extend the choice offer?

No comment.

Q50. What is the right mix of measures to encourage GP consortia to offer appropriate choices to their populations?

No comment.

Q51. What is the best way to gather patient feedback about the extent to which commissioners have put in place choices?

No comment.

Q52. Are the responsibilities of organisations as outlined enough to:
- ensure that choices are offered to all patients and service users where choices are safe, appropriate and affordable?
- ensure that no-one is disadvantaged by the way choice is offered or by the choices they make?

The responsibilities of organisations, as outlined, will probably be sufficient to offer choice without disadvantage if implemented appropriately.

Q53. If you do not get a choice you are entitled to, what should you be able to do about it?

No comment

Q54. What are the main risks associated with choice and how should we best mitigate these risks?
The main risks associated with choice are:

- unachievable expectation
- destabilisation of services
- lack of capacity to accommodate choice
- disadvantage to the most vulnerable
- longer waiting times
- if the aspirations of choice and information revolution are not synchronised.

The above risks can be mitigated to an extent by limiting choice to "clinically appropriate choice" and defining boundaries.

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