RCOG policy briefing

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Royal College of Obstetricians and Gynaecologists

Bringing to life the best in women's health care

RCOG briefing on the Health and Social Care Bill (HoL, Second reading 11 October 2011)

The Royal College of Obstetricians and Gynaecologists (RCOG) welcomes the opportunity to brief Peers on its views about the Health and Social Care Bill.

The RCOG's position on the Government's response to the Future Forum report can be found here.

As the Bill enters the House of Lords, the RCOG would like to focus on some very specific areas of concern.

A. Clinical leadership

The RCOG has argued for the establishment of women's health networks to provide better, more joined-up care. These recommendations are contained within the report *High Quality Women's Health Care: A proposal for change*.

The RCOG believes that managed clinical networks will improve women's health services as these focus on the entirety of women's healthcare and bring together obstetricians, gynaecologists, community consultants in sexual and reproductive healthcare, midwives, nurses, GPs, physicians and other specialists to ensure that timely advice and treatment can be provided to the patient throughout key stages in a woman's lifetime.

However, for the concept of the managed network to be a reality, a national lead to oversee the development and running of women's health networks is required in a similar manner as the way cancer networks are headed by a cancer tsar.

The RCOG expects this women's health network lead to have a pivotal role reporting through the Chief Nurse and Medical Director to the National Commissioning Board.

B. Configuration of services

As outlined in *High Quality Women's Health Care*, in order to meet the demands of the Nicholson challenge and ensure high quality services continue to be provided in our hospitals, there is a need to reorganise women's health services. In some cases, this will mean care is concentrated in areas where they are needed most. This may result in services at smaller units moving over to bigger units where better facilities and access to expertise is available.

Other organisations such as the King's Fund, NHS Confederation, the Royal College of Nursing and the Royal College of Paediatrics and Child Health have put forward very persuasive arguments for the reorganisation of services, in the interests of patients and the NHS.

The RCOG believes that if women's healthcare is arranged in the network model, services will be linked and women should have access to the services they need. Care provided will be comprehensive, 'integrated' and as close to home as practical.

C. Integrated care

There is much talk about offering 'integrated' health and social care within the Bill. However, there is a lack of definition of what this integration entails.

The RCOG's model of integration encompasses community-based services, primary and secondary care providers working closely with social services and the voluntary sector. For this to occur, it is essential to follow the life-course approach as described by Sir Michael Marmot[1] and as contained in the public health White Paper[2]. This approach focuses on disease prevention rather than disease intervention within a public health context. Services which focus on reducing alcohol consumption, smoking cessation and weight control and those which tackle health inequalities must be a core part in the provision of integrated care.

The RCOG is pleased to note that sexual health is a key policy area in the Department of Health's public health strategy. There are concerns that the lack of a requirement for local authorities to recognise payment by results tariffs could reduce access and the ability of sexual health services to respond to the needs of the population. Sexual health programmes prevent STIs and unwanted pregnancies. There are other knock-on effects that are long-term.

The RCOG would like to urge Peers that apart from tackling modern-day lifestyle diseases such as obesity, diabetes and heart disease, there is also the need to focus on the nation's (and by implication, the individual's) sexual and reproductive health needs. Integrated healthcare commissioned by local authorities, as advised by the Health and Wellbeing Boards, must be impartial, evidence-based and include an educational element targeting secondary schools.

D. Clinical quality and health inequalities

While the RCOG appreciates that competition can be a force for good, there is also the risk that competition may benefit the more privileged in our society. This approach could have a detrimental effect on efforts to reverse health inequalities.

Health inequalities can be tackled by ensuring that good quality care is provided on the NHS. Defining quality around recognised clinical guidelines, standards and outcomes developed by expert medical groups must be encouraged. The RCOG asserts that these should include a range of publications produced by organisations other than the National Institute for Health and Clinical Excellence (NICE).

E. Patient choice

The RCOG supports the concept of clinically appropriate choice for all women and choice to use open access sexual and reproductive healthcare services. However, popularity and

media misinformation can destabilise NHS services. The Government must protect core services located in areas that are perceived to be less desirable to patients.

F. Workforce planning

Current workforce planning in O&G is undertaken nationally by the Centre for Workforce Intelligence (CfWI), supported by data gathered from the RCOG's annual workforce census. The prediction of workforce needs is difficult and accuracy is almost impossible. The CfWI's projections of workforce numbers include doctors working part-time or in a less than full-time capacity.

With the increasing numbers of female doctors in senior posts, as mirrored in other specialties such as surgery, there are a growing number of doctors going on maternity leave throughout the year. These will result in rota gaps which require filling. These developments add pressure to the system which operates generally on 24/7 basis. Greater flexibility could involve the use of visiting specialists through the Medical Training Initiative (MTI) scheme.

The RCOG believes that workforce planning needs to be conducted at a national level with national supervision so that the service meets demand. The RCOG, through its annual census and local knowledge, welcomes closer working with CfWI.

G. Education and training

The RCOG is not opposed to competition in the health service. However, a criticism of the development of alternative providers has been the disastrous impact on the education and training of doctors. In many instances, private companies providing services did not have the same responsibilities as the NHS. Hospitals committed by contract to the training of all clinical staff should receive commensurate financial support for such duties.

There has been some movement in the Health and Social Care Bill with the suggestion of an educational levy on any qualified providers (AQP) but only when they are capable of fulfilling these requirements. The Government must reassure the royal colleges that AQPs are subject to the same requirements as NHS organisations. The RCOG is pleased to see that Monitor must have regard to the education and training of healthcare professionals.

The RCOG urges all Peers debating during second reading to ensure that any qualified providers have the statutory duty to provide for the educational and training needs of all doctors working for them. They must also adhere to the same high educational and training standards as the NHS when providing these services.

H. Medical research

In order for UK medicine and science to compete on the global stage, there must be an emphasis on research. The RCOG is pleased to see that it will be the duty of the Secretary of State, the NCB and clinical commissioning groups to promote research in the health service, to ensure that medical practice is evidence-based and the promise of incentives to promote innovation in research. Within the Bill, it is also stated that local authorities are involved in enabling research carried out in relation to the health service. The RCOG is pleased to see that Monitor must have regard to promoting research that is relevant to the NHS, conducted by health service providers.

However, there is concern that the abolition of the Health Protection Agency, National Patient Safety Agency, Human Tissue Authority and Human Fertilisation and Embryology Authority will result in a vacuum in regulation and research within these fields. There is

therefore the urgent need to ensure the transfer of knowledge and expertise before these organisations are dissolved.

Only the HPA and NPSA are mentioned in the Bill and there is uncertainty over the future of the HFEA and HTA. ***The RCOG urges Peers to pressure the government to review the decision to abolish these two bodies as there is currently no indication of whether the functions carried out by the HFEA and HTA will be carried out elsewhere.***

Notes

[1] *Fair Society, Healthy Lives: The Marmot Review* (February 2010)
http://www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLives.pdf

[2] Department of Health (November 2010), *Healthy lives, healthy people: our strategy for public health in England*
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121941

To view the latest edition of the Bill, please click here
http://www.publications.parliament.uk/pa/bills/lbill/2010-2012/0092/2012092.pdf

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