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 its response to the second phase of the Future Forum

The RCOG welcomes the opportunity to submit its views on the themes in the second phase of the Future Forum.

Its briefing on the Government's response to the Future Forum report, published on 2 August 2011, can be found here.

Its views on its concerns as the Bill goes through the House of Lords can be found here.

The RCOG would like the Future Forum to consider the following points within the four themes:

A. Information

The RCOG supports the Coalition Government's aspirations to provide open and transparent information on the NHS. This will empower patients and encourages higher standards in hospitals. However, the RCOG has also signalled its unease over the unintended consequences of such action.

Experience has shown that patients will travel to the unit which they think will offer a better service. This may result in the destabilisation of services – the unit that is perceived to be better performing may find itself inundated with patients. Subsequently, training and morale in the less popular unit will be affected. These experiences have been witnessed in maternity services within London in response to CQC publications of hospital ratings.

The other issues are to do with data interpretation and perception. Information gathered and presented must be meaningful and tailored to a lay audience.

Currently, the Hospital Episode system of data collection is incomplete and the areas lacking in reliable data include national rates of caesarean section and planned home delivery [1].

The RCOG has argued for data to be collected electronically and the Department of Health must ensure that this information is standardised and linked in order for meaningful comparisons to be made. The Department must work closely with the RCOG to improve maternity data collection and audit. The national maternity data system, although approved in principle, needs to be live.

What good data is important in O&G

Maternity is a high-risk specialty, as recognised by the NHS Litigation Authority's (NHSLA) Clinical Negligence Scheme for Trusts (CNST). Each NHS maternity unit has its own risk management strategy and CNST assessment. The Chief Medical Officer in 2007 recognised the challenges in maternity services in his annual report, *Intrapartum-related deaths: 500 missed opportunities*.

The RCOG works closely with the Department of Health to ensure quality and safety are maintained in the NHS. This commitment was further strengthened by the formation of the RCOG Safety and Quality Committee in 2009.

With the disbanding of the National Patient Safety Agency (NPSA), the RCOG is working with the National Quality Board to devise reliable and meaningful outcome measures for maternity and gynaecology. We are embarking on an exercise to develop specific measures that will help assess safety in maternity and gynaecological units.

The RCOG's Maternity Dashboard enabled each maternity unit to have in place a system of process and clinical outcome indicators that was as accurate as possible. This planning tool was a success but it is costly to implement and favours units with a strong electronic infrastructure.

The RCOG would like to develop with the Department of Health outcome indicators that are nationally mandated. This is especially important with the current restructuring of the NHS. ***These outcome measures should be devised to measure the safety of a unit on a weekly or monthly basis and need to be collected electronically. The problem however, there are currently units in the country that do not have a standard maternity data package. The RCOG emphasises that all UK maternity units should work to a system in place where the information collected is uniform and consistent.***

Finally, the UK's maternal mortality audit, the Confidential Enquiries, is regarded as the gold standard around the world. This work has come to a halt over the last year and it is crucial for the Coalition Government to ensure that this work recommences as soon as possible.

A. Education and training

The RCOG welcomes the introduction of Health Education England (HEE) and its place in the NHS but there is anxiety over its undefined role, the current pace of change and the burden of expectation on such a significant new organisation, especially at the same time as existing structures are being dismantled. We are also unclear about its relationship to the NHS Commissioning Board and the new Local Education Training Boards (LETBs). The accountabilities between the various different organisations, new and existing, need to be much better defined.

The RCOG has formed strong links with postgraduate deaneries, through appointment of educational leads whose role it is to co-ordinate postgraduate medical education and training. The RCOG believes that these close relationships must be maintained and indeed strengthened. ***We are concerned about the potential loss of expertise and knowledge within existing structures and the destabilisation to the system if the deaneries are to go. It is not obvious which bodies would undertake the essential tasks they currently carry out.***

What the deanery system works

The important role of the deaneries is demonstrated in the RCOG's educational progress matrix[2]. The RCOG is able to set standards for every aspect of training for every training year. The process to develop the matrix was through consensus between all the Heads of School.

The standards in the matrix can be made more stringent each year thus increasing training standards nationally. In addition, with future additions, newly developing aspects of the speciality can be added progressively. This will ultimately be a process of not having to have major (expensive) reviews of the curriculum every few years.

This model will be difficult to replicate and achieved by groups of commissioners based on PCT sized populations.

Other considerations in education and training

The RCOG believes that the competencies of all doctors in training can be improved by offering O&G modules at Foundation level for every trainee. This will ensure that our future doctors, including GPs, have basic training in women's health. The RCOG has long emphasised that the NHS needs to end its reliance on trainees delivering the majority of emergency services out-of-hours in hospitals to improve safety and to make training comply with the European Working Time Regulations (EWTD)[3]. Likewise, teaching and training time needs to be protected for trainees and trainers.

The RCOG would like to see more recognition for consultants involved in the education and training of junior doctors. These individuals should be accredited and offered faculty development based on the level of their commitment. This arrangement adds value to the consultant's own CPD and assists in their revalidation. The RCOG is presently developing and offering more training to enhance the knowledge and skills for those interested in medical education. The RCOG would be happy to work with HEE and the GMC on this important issue.

The issue of academic research is of particular concern to the College because of the dwindling numbers of doctors actively engaged in O&G research. The formation of academic science networks through the existing medical schools will enable closer working between the different specialities.

Much has already been said about the entrance of any qualified providers (AQPs) into the NHS. The RCOG reiterates its belief that sound provision in educating and training is integral to a functioning NHS. The move to open the NHS to private providers will improve patient choice and while the RCOG is not against competition, the Coalition Government must be cognizant that the majority of these commercial providers will not have the experience or the ability to provide education to a standard that we or our partners would find acceptable. ***It is therefore critical for AQPs to take the advice of the royal colleges in the development of education and training programmes which must be appropriately quality managed by the deaneries.***

Workforce planning is integral to meeting service demands. Within O&G, there is an on-going challenge to balance the number of trainees entering the specialty with the future numbers of consultants required. The RCOG is working closely with the Centre for Workforce Intelligence (CfWI) on aligning service requirements with the available posts. ***We***

believe that better long-term planning is needed by employers. Central monitoring and planning of workforce requirements are needed to enable the service to be responsive to the external changes which may add pressure to the system.

Finally, the RCOG is concerned about the viability of the Medical Training Initiative if the Home Office reduces its length of appointment to a year of attachment in the UK. International Medical Graduates play a crucial role in the NHS and in O&G service provision. They plug the gaps unfilled by local doctors. The UK has a long and respected tradition of training overseas doctors and gains much from the contribution of these professionals. These doctors will pursue other opportunities elsewhere if the MTI process is unattractive to them.

B. Integrated care

Women's health services are currently configured across the specialties of general practice, sexual health, community women's' health services and hospital-based gynaecology. After GP referral, a woman may have to attend several hospital visits for specialist care.

With advances in diagnosis and treatment, many elements of gynaecological care currently managed in acute settings could be delivered in the community.

The RCOG and Faculty of Sexual and Reproductive Healthcare (FSRH) believe many gynaecological conditions can be managed in community settings with closer links between the GP and the gynaecologist. These conditions include:

- Menstrual dysfunction
- Polycystic ovarian syndrome
- Menopause
- Vulval dermatology
- Urinary incontinence
- Some types of pelvic pain
- Complex contraception

Of the above, the menopause, urinary incontinence and complex contraception are often associated with co-morbidities which make integrated care essential.

While a patient journey may appear simple, in some instances, it can be cumbersome and inconvenient. Referral pathways may result in the woman seeing several specialists across different locations (eg. for consultations or diagnostics) before receiving treatment.

The RCOG and FSRH believe that community gynaecology services can provide a one-stop service meeting the needs of patients. This requires cooperation and joined-up working between primary, intermediate and secondary care with agreed clinical pathways and clear inclusion and exclusion criteria for referral. ***Pathways should be designed so that the number of visits is kept to a minimum and relevant clinical information should follow the patient to avoid the duplication of investigations or the absence of relevant clinical information at a particular point of the pathway.***

A user engagement exercise[4] showed that patients value:

- ∞ Quicker access to investigations and results
- ∞ Improved services from local GPs
- ∞ Drop-in centres for advice and investigations and care where they have access a multidisciplinary team in one single location
- ∞ More community-based services.

Patients welcomed the increase in the number of service access points and the improved patient journey. This approach resulted in a fall in the number of visits to GPs and consultants for diagnostics and tests, thereby improving the patient experience.

An example of how better joint-working within a community can work[5]

A scoping exercise prior to piloting a community gynaecology service in North London suggested that 63% of gynaecology referrals could have potentially been managed in the community and over 25% of these referrals were premenopausal women with abnormal bleeding. Average waiting time was eight weeks. On the basis of this, a redesigned community-based service was established.

Local GPs were questioned regarding their views on current gynaecology service provision in secondary care and how it could be improved. Recurrent issues were: seeing an expert in gynaecology was deemed important; GPs said their patients were waiting too long to be seen, correspondence from secondary care was taking too long to come to them and was often inadequate; GPs thought their patients were making questionable repeat visits to the hospital.

The pilot was designed and run by Community Sexual & Reproductive Healthcare Consultants and operated as a one-stop shop with the following services available if required: pelvic ultrasound, STI testing, endometrial biopsy and phlebotomy.

Results: GPs praised the pilot for clear referral criteria, seamless clinical pathways across primary, intermediate and secondary care, prompt appointments and timely detailed explanation of appointment outcome and management plans. Patient satisfaction was excellent with 85% patients who had previously been seen in secondary care saying they preferred the community gynaecology service and patients praised the “one-stop” nature of the service.

Workforce considerations

Any service redesign has implications for workforce planning and careers advice. In 2010, the new medical speciality of Community Sexual & Reproductive Healthcare was established by the government, the RCOG and the FSRH to provide community-based specialists in women’s health. However, as the services develop, GPs and nurses working closely with specialist medical colleagues are likely to have an important role in these emerging community services.

As demonstrated in the RCOG’s High Quality Women’s Health Care report, care closer to home is now possible with the gradual shift towards hospital-based gynaecologists running specialist clinics in the community. This approach should be supported to enable greater integrated care.

C. The public's health

The RCOG supports the Government's plans to make public health a core element in their NHS reforms. This dovetails with the recommendations in the RCOG's *High Quality Women's Health Care* report, which made the case for the life-course approach, as advocated by Sir Michael Marmont[6], with the focus on health promotion and preventive medicine in women's health rather than disease intervention.

We have identified the several key contact points during a woman's life when a woman is more receptive to receiving information. This maximises the opportunities to spread public health messages about her sexual and reproductive health and to encourage healthy lifestyle behaviours. ***The desired outcome is to have a healthier population and to tackle health inequalities through a structured programme of health education.***

The increase in life expectancy means we need to ensure that our population is healthy so that we can go on to enjoy a good quality of life in old age. This requires forward planning so that women make good lifestyle choices early in life to prevent problems from occurring later. Maternal obesity is an example of a medical condition that needs serious attention. Likewise, as a woman gets older, she will require support from the NHS to address conditions associated with age such as osteoporosis and incontinence.

The life-course approach in women's health can only occur if services are organised in managed clinical networks. Such linkages, between different specialties, across different care settings and working closely with social services, would result in integrated care being provided on the NHS. Within such a system, care will be women-centred and patients should receive the timely interventions, support and treatment that they want and need.

<u>A pertinent issue for the Future Forum to consider</u>

An area not covered within the scope of this phase of the Future Forum's work is the issue of the involvement of clinicians in work for the wider NHS. The RCOG feels this needs to be brought to the attention of the Future Forum since it has some bearing on the other strands of the Forum's work, including education and training. It also has an impact on some of the proposed reforms in the Health and Social Care Bill.

Many clinicians, besides working for the NHS, are engaged in a range of professional activities outside of their employing Trust such as involvement in NICE, the Royal Colleges and specialist societies. They devote much time and effort in an advisory capacity for the good of medicine, science and research and their contribution to the NHS cannot be under-estimated.

This work, the majority of which is done on a voluntary basis, is of benefit to the NHS. Not only does such involvement play a role in the individual's continuing professional development, but its intrinsic value is in improving patient safety and encouraging clinical leadership.

Constraints on healthcare professionals' involvement would disadvantage the NHS in the long-term and the RCOG would like to see due recognition for such work and believes that flexibility is needed to allow doctors to share their expertise, for the greater good.

RCOG

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Notes

[1] Drife JO, 'Assessing the consequences of changing childbirth', *BMJ* 310 : 144 (Published 21 January 1995)

[2] RCOG ST1–ST7 educational progress matrix (2011-2012), 'Annual expectation of educational progression from ST1 to ST7 in O&G' http://www.rcog.org.uk/files/rcog-corp/Training-matrix-ST1-7.pdf

[3] RCOG/RCPCH/NHS Workforce Projects, *Children's and Maternity Services in 2009: Working time solutions* (July 2008) http://www.rcog.org.uk/files/rcog-corp/uploaded-files/WPRChildrensandMaternityServicesWTD2008.pdf

[4] NHS Wales, North Wales, Maternity, Gynaecology and Neonatal Service Review User Engagement Feedback (Second Stakeholder Event - 2010)

[5] Camden Provider Services Community Gynaecology Pilot for Islington PCT 2011

[6] *Fair Society, Healthy Lives. The Marmont Review* (February 2010) http://www.marmotreview.org/

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