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8 October 2010

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LIBERATING THE NHS: TRANSPARENCY IN OUTCOMES
A FRAMEWORK FOR THE NHS

Key Points

The Royal College of Obstetricians and Gynaecologists:

- ***Strongly endorses the concept of improving clinical quality by focusing on patient outcome***
- ***Understands the requirement to develop patient reported outcome measures (PROMs) and more sensitive indicators of maternity quality provision***
- ***Believes that existing maternity and gynaecological standards, supported by all stakeholders, could form the backbone of such a structure***
- ***Suggests that collecting unified maternity data will improve information for patients and quality assurance bodies***
- ***Strongly underlines the urgent need to maintain excellence of gynaecological care in the management of conditions that profoundly impact on the quality of life***
- ***Believes that quality of care and outcomes are intimately related to the quality of staff training and research***
- ***Would welcome the opportunity to contribute to the leadership tasks inherent in the proposed reorganisation, with a realisation of the need to embrace change***

The Royal College of Obstetricians and Gynaecologists (RCOG), an international organisation, which includes all UK-based specialists in the discipline, welcomes *Liberating the NHS: Transparency in outcomes – a framework for 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.

This response is restricted to the specialty of obstetrics and gynaecology and follows the structure of the White Paper:

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*[3] but additional resource will be needed to achieve these aims of consultant expansion and better midwifery ratios.

[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/files/rcog-corp/uploaded-files/WPRSaferChildbirth Report2007.pdf]

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 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 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, e.g. as in cancer and maternity. The funding detail consequently will be important and the extension or creation of networks is the key to success.

RESPONSES TO THE CONSULTATION QUESTIONS

PRINCIPLES

1. ***Do you agree with the key principles which will underpin the development of the NHS Outcomes Framework (page 10)?***

   Yes

2. ***Are there any other principles which should be considered?***

   The RCOG accepts that public health services are an important element of social care but they are an equally important part of healthcare. We feel they should be reflected in the key principles to address issues around the maintenance of good physical health as NHS services have a major role to play in preventing ill health, e.g. onward transmission of sexually transmitted diseases and effective choices of contraception.

3. How can we ensure that the NHS Outcomes Framework will deliver more equitable outcomes and contribute to a reduction in health inequalities?

By ensuring nationally and locally commissioned services are held accountable. A nationally commissioned service will accelerate uniformity of service provision through national standard setting and thereby facilitate accountability.

4. How can we ensure that where outcomes require integrated care across the NHS, public health and/or social care services, this happens?

By ensuring that patient outcomes of integrated care are reported and those responsible are held accountable. The synergy between the outcomes framework and the outcomes in public health is essential to encourage joint goals and the provision of effective services.

FIVE DOMAINS

5. Do you agree with the five domains that are proposed in Figure 1 (page 14) as making up the NHS Outcomes Framework?

Yes. In addition, the RCOG believes that there should be a domain for preventing people from acquiring ill-health to cover sexual and reproductive health needs. This will ensure more holistic care.

6. Do they appropriately cover the range of healthcare outcomes that the NHS is responsible for delivering to patients?

Yes, except for the fact the NHS is responsible for not only maintaining good health but also for preventing ill health (see 2 above).

STRUCTURE

7. Does the proposed structure of the NHS Outcomes Framework under each domain seem sensible?

Yes.

DOMAIN 1 – PREVENTING PEOPLE FROM DYING PREMATURELY

8. Is 'mortality amenable to healthcare' an appropriate overarching outcome indicator to use for this domain? Are there any others that should be considered?

Yes. The RCOG proposes that public health and social care may contribute to preventable mortality, e.g. in urban areas with high prematurity and associated perinatal mortality. Consequently, social and public health interventions may also need to be considered.

In addition, opportunities are being missed currently to identify antenatal fetal and maternal conditions which may have a profound effect on health in later life and which may impact on life expectancy. Please see also our response to Question 22.

Care needs to be taken with language to ensure a common understanding, e.g. *mortality amendable to healthcare* could be described as *preventable mortality.*

9 Do you think the method proposed at paras 3.7-3.9 (page 20) is an appropriate way to select improvement areas in this domain?

Yes

10. Does the NHS Outcomes Framework take sufficient account of avoidable mortality in older people as proposed in para 3.11 (page 21)?

Yes

11. If not, what would be a suitable outcome indicator to address this issue?

Not applicable

12. Are either of the suggestions at para 3.13 (pages 21) appropriate areas of focus for mortality in children? Should anything else be considered?

Yes. The RCOG supports perinatal mortality as an appropriate indicator as long as precise denominators are included; ideally at the level of perinatal networks.

DOMAIN 2 – ENHANCING THE QUALITY OF LIFE FOR PEOPLE WITH LONG-TERM CONDITIONS

13. Are either of the suggestions at para 3.19 (page 24) appropriate overarching outcome indicators for this domain? Are there any other outcome indicators that should be considered?

Yes
No comment

14. Would indicators such as those suggested at para 3.20 (page 24) be good measures of NHS progress in this domain? Is it feasible to develop and implement them? Are there any other indicators that should be considered for the future?

Yes
Yes. The RCOG has expertise of validated PROMs, particularly in benign gynaecology. We are currently undertaking an audit of Heavy Menstrual Bleeding: patient reported outcomes. We would be happy to collaborate with those responsible for the development of PROMs.

15. As well as developing Quality Standards for specific long-term conditions, are there any cross-cutting topics relevant to long-term conditions that should be considered?

In maternity, there will be aspects of maternal pre-existing long-term conditions, such as diabetes, cardiac or respiratory disease, which might impact upon the outcome of the pregnancy and delivery.

In gynaecological oncology, there may be associated urological or colorectal disease which may need to be considered.

DOMAIN 3 – HELPING PEOPLE TO RECOVER FROM EPISODES OF ILL HEALTH OR FOLLOWING SURGERY

16. Are the suggestions at para 3.28 (page 27) appropriate overarching outcome indicators for this domain? Are there any other indicators that should be considered?

Yes. Some elements of timely and effective healthcare intervention may also occur in secondary care, e.g. antenatal screening, breast mammography, unless there is reconfiguration of appropriate services and commensurate responsibility.

We are uncertain where community care lies within this context, e.g. postnatal care and the discipline of sexual and reproductive health.

17. What overarching outcome indicators could be developed for this domain in the longer term?

No comment

18. Is the proposal at paras 3.30-3.33 (page 28-29) a suitable approach for selecting some improvement areas for this domain? Would another method be appropriate?

No comment

19. What might suitable outcome indicators be in these areas?

No comment

DOMAIN 4 – ENSURING PEOPLE HAVE A POSITIVE EXPERIENCE OF CARE

20 Do you agree with the proposed interim option for an overarching outcome indicator set out at para 3.43 (page 32)?

We agree with the interim option and agree with the five themes.

21. Do you agree with the proposed long term approach for the development of an overarching outcome indicator set out at para 3.44 (page 32-33)?

Yes, but this would be dependent on the implementation and analysis of the interim option.

22. Do you agree with the proposed improvement areas and the reasons for choosing those areas set out at para 3.45 (pages 33-34)?

The RCOG agrees with the proposed improvement areas but wishes to emphasise that maternity care must include the care of **the mother and the baby.** Although perinatal mortality is used as a denominator, maternal and neonatal morbidity are of equal importance and must be recognised as areas for outcome development.

Because maternity services relate to the **start of life** in contrast with the end of life focus, this should be considered as an additional improvement area. The social and financial consequences of ignoring the **start of life** are immeasurable as they will span the life of the individual concerned and their families.

We are already aware from the NHS Litigation Authority (NHS LA) data that whilst obstetric claims currently represent 20% of all claims dealt with by the UK NHS LA, 60% of payments relate to claims arising out of birth.[4] Legal claims in cases of cerebral palsy arising from negligent intrapartum care account for most of the NHS annual litigation bill.

23. Would there be benefit in developing dedicated patient experience Quality Standards for certain services or client groups? If yes, which areas should be considered?

No. We must take a holistic approach to the patient journey. Separating patient experience from their treatment may have unintended consequences.

24. Do you agree with the proposed future approach for this domain, set out at paras 3.52-3.54 (pages 36-37)?

Yes

DOMAIN 5 – TREATING AND CARING FOR PEOPLE IN A SAFE ENVIRONMENT AND PROTECTING THEM FROM AVOIDABLE HARM

25. Do you agree with the proposed overarching outcome indicator set out at para 3.58 (page 38)?

Yes

26. Do you agree with the proposed improvement areas proposed at para 3.63 (page 39-40) and the reasons for choosing those areas?

Yes but we cannot understand the rationale for including maternity amongst the vulnerable group.

GENERAL CONSULTATION QUESTIONS

27. 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 outcomes for all patients and, where appropriate, NHS staff?
No comment

28. Is there any way in which the proposed approach to the NHS Outcome Framework might impact upon sustainable development?
No comment

29. Is the approach to assessing and analysing the likely impacts of potential outcomes and indicators set out in the Impact Assessment appropriate?
No comment

30. How can the NHS Outcomes Framework best support the NHS to deliver best value for money?
No comment

31. Is there any other issue you feel has been missed on which you would like to express a view?
No thank you

[4] NHS Litigation Authority, Factsheet 5: (2008/09) Accessed 10 May 2010 [www.nhsla.com/claims]

ANNEX A: Identifying Potential Outcome Indicators

POTENTIAL INDICATORS

32. What are the strengths and weaknesses of any of the potential outcome indicators listed in Annex A with which you are familiar?

The RCOG cannot understand the rationale for including maternity amongst the vulnerable group. Furthermore, of the three outcome indicators listed under "Safety Culture: vulnerable groups" on page 61, the RCOG strongly supports the *unexpected or unplanned admission of term baby (>37 weeks) to neonatal care*. However, the RCOG has reservations about the accuracy and validity of *haemorrhage* as an indicator. In addition, we consider that *medical errors (epidural)* should be classified as a never event.

33. Are other practical and valid outcome indicators available which would better support the five domains?

No comment

34. How might we estimate and attribute the relative contributions of the NHS, Public Health and Social Care to these potential outcome indicators?

No comment

PRINCIPLES FOR SELECTING INDICATORS

35. Are the principles set out on pages 48 and 49 on which to select outcome indicators appropriate? Should any other principles be considered?

The RCOG believes that more thought needs to be given to the selection of meaningful clinical indicators. The rationale for continuing to use existing indicators should be revisited. For obstetrics and gynaecology, we have already developed *Standards for Gynaecology* and *Standards for Maternity Care*. The latter 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.

The RCOG, in partnership with others providing these services, would welcome the opportunity to develop meaningful outcome indicators for the future.

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