High Quality Women’s Healthcare: What should the service look like?
The Royal College of Obstetricians and Gynaecologists
Written Evidence: 17th December 2010 – 31st January 2011

i. Background

Following recent publication of the government’s White Paper, a large scale change is planned for the UK health services, including the way in which commissioning is organised. In order to respond to these changes, the Royal College of Obstetricians and Gynaecologists intends to publish a report entitled High Quality Women’s Healthcare: What the service should look like. The purpose of the report will be to support commissioners to effectively translate service planning into commissioning decisions which will set the standards of care for women’s services. To facilitate this, the College has convened an Expert Advisory Group to lead a review on the configuration and delivery of women’s services in the UK. The review’s terms of reference include consideration of the following:

- the key principles of service configuration
- the evidence base to support clinically appropriate choice
- the evidence on the appropriate size of maternity units to deliver a safe service
- issues relating to the establishment of perinatal networks and multidisciplinary working
- the delivery of gynaecological services in the context of new service redesign
- the impact of the recommended model on training

We are using a number of sources of evidence to ensure the review is comprehensive. Currently we are conducting a literature review of the available research and evidence. This will be supported by evidence gathering from relevant parties in oral and written formats. The evidence will be collated to form the draft report and recommendations.

Drawing on a range of evidence, the purpose of the report will be to make recommendations to the Secretary of State, Ministers and Department of Health and other stakeholders, such as commissioners and providers, about what high quality women’s health services look like and how they will need to be configured to operate in the future. The focus must therefore remain on producing a consultant and trainee workforce which continues to deliver a high quality service to all patients. Evidence will be drawn from a range of stakeholders, spanning across specialties, sub-specialties and geographical settings. The review will build on and complement reports previously published by the Royal College of Obstetricians and Gynaecologists.

ii. Guidance for submission

Please respond to the questions below, using as much space as required. You may wish to attach source documents if applicable to your submission (see section 3). Where possible it would be helpful if you could summarise the main points of the article in your written response, and please be aware that we may not be able to review and summarise all appended documents. Please give evidence/examples where possible and identify whether your comments are general or linked to a particular profession or specialty within that profession. If you are returning your response by email, please keep it in an unlocked and malleable format (No PDF documents please).

iii. How to submit a response

All responses should be submitted electronically to kcheung@rcog.org.uk under the heading ‘RCOG Women’s Services Review - Written Evidence’. If you are unable to submit by email, responses should be sent to:

Karen Cheung
The Royal College of Obstetricians and Gynaecologists
27 Sussex Place
Regent’s Park
London
NW1 4RG

Responses received after 31st of January, either hard copy or electronic, will not be considered. If you have any queries please contact Karen Cheung on kcheung@rcog.org.uk or on 020 7772 6345.

iv. Report

The review team will consider all evidence submitted, and will produce a final report in May 2011.
1. Details of your response

About you
Mandatory questions are marked with an *

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Confidentiality – If you are responding as an individual

| *Do you consent for your name to appear in the index of responses in the group’s final report? Please delete as applicable: | YES/ |
| *Do you consent for your response to be quoted in the group’s final report? Please delete as applicable: | Yes/ |

Confidentiality – If you are responding on behalf of an organisation

| *Do you consent for your name to appear in the index of responses in the group’s final report? Please delete as applicable: | Yes/ |
| *Do you consent for your response to be quoted in the group’s final report? Please delete as applicable: | Yes/ |
2. Consultation questions

1. **What do high quality women’s healthcare services look like?**

The respondents may wish to consider:
- What are the right outcomes?
- What are the drivers?
- What might this mean for each involved specialty?

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<th>A woman centred service provided by skilled, updated, motivated clinicians who keep safety at the heart of their practice.</th>
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<td>Drivers for high quality women’s healthcare should be the desire to deliver optimum outcomes with low mortality and morbidity.</td>
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<td>Women should be able to access excellent services from the highest quality reproductive service, maternity care and gynaecological medical and surgical techniques</td>
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<td>Gynaecologists should continue to develop specialities in parallel with highly trained specialist and consultant nurses to complement and enhance the service provided for women.</td>
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<td>Community gynaecology and reducing theatre operating time by continuing to develop day case and outpatient gynaecology will enhance the service for women.</td>
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<td>Screening services should continually be developed to maximise early detection of cancers so that gynaecology oncology can continue to be detected early to ensure successful treatment.</td>
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<td>Reproductive medicine is a vital part of women’s healthcare; specialist centres should be supported and developed with research driving new techniques and procedures. The importance of reproductive medicine for women should be high in the agenda for commissioners and providers.</td>
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<td>Reducing the Perinatal mortality and morbidity rates by high quality antenatal care, obstetricians and midwives working closely in partnership should be a key driver for maternity services. The continued development of fetal medicine with experts delivering the service in specialist centres working alongside well established universities focusing on research is key for high risk maternity care.</td>
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<td>Keeping low risk women midwifery led and avoiding intervention (Maternity Matters 2007) Midwifery led units (MLU) should continue to be promoted with constant and vigilant risk assessment being an ongoing theme. Reconfiguration of services and development of MLU’s will ensure care remains close to home.</td>
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<td>There should be a drive to ensure that obstetricians and midwives with an interest in Intrapartum care is nurtured and that staffing levels on labour wards are reviewed constantly and labour wards are appropriately staffed in line with Safer Childbirth and LSA standards. One to One care in labour should be a key aim for midwifery to promote safety and continuity of care. This is also key to facilitate and increase normal birth.</td>
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<td>In order to ensure the right outcomes all specialties for women’s health should have robust governance structures, ongoing in depth training, be subject to peer review and should be reflective services.</td>
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<td>In delivering these key services it is essential to offer choice to our women and allow educated decision making by providing written, oral and on line access to information.</td>
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Availability of best evidence to enable clinicians to offer most up to date relevant care, ensuring that guidelines are currently reviewed and updated based on best evidence and practice.

In order to support maternity services appropriately sized neonatal units need to be in place. There is an urgent need to ensure that numbers of neonatal unit intensive care cots (NICU) are commissioned to enable care to be delivered within designated neonatal networks and reduce transfer outside the local network.

Maternity services urgently need a national IT system so that data can be captured and reported in a systematic, cohesive way across the country. This would enhance information sharing and deliver more accurate, informative data. Integration into the documentation required for CNST and Clinical record keeping would allow this system to be far more efficient than the current way information is recorded.
2. What should women’s services look like in the different settings we have in the UK?

The respondents may wish to consider their response in the following context:
- Population based
- Geography
- Activity based (e.g. birth cohorts, cancer numbers)

In giving your response, you may also wish to consider:
- What does this mean for the workforce?
- What does this mean for the training of the future workforce?
- What does this mean for commissioners?
- What implications does this have for service design?

Women’s Services differ across the UK depending upon the population, deprivation, geography and activity.

The United Kingdom has seen a change in population over the last 10 years with the migration of people from the Sub African Sahara, Asia, Eastern Europe and the European Union. Services have seen an increase in women with altered health issues. There has been research from Birmingham University in collaboration with the Department of Health looking at Migrant Friendly Maternity services (DOH 2010) in order to approve the accessibility and appropriateness of services for the local migrant population. In Coventry in 2008 29.33%of live births were to mothers born outside of the United Kingdom. The research demonstrated that the needs of vulnerable women are not being met and women are becoming lost in the system leading them to be disempowered and frightened throughout their pregnancy. Maternity services should review existing maternity care pathways to ensure that they are adequately addressing the issues and migrant women are at the heart of maternity care.

In order to meet the needs of vulnerable women training programmes for health professional in maternity services need to be developed alongside mandatory training.

The population is seeing an increase in women with raised BMI. The NHSLA standards suggest that women with a BMI of 30 are cared for by the multidisciplinary team. Adequate information (delivered in a non judgemental way) regarding obesity in pregnancy and weight loss strategies in the post natal period are delivered both orally and in written format. In our geographical area, increasing BMI has become a significant problem and further work (preferably between geographical areas) is required in order to develop strategies for optimizing Intrapartum and particularly surgical care of these women.

Some strategies have caused a significant impact on our funding and workload, a case in point being the introduction of Oral Glucose Tolerance Tests in all Asians and in those women with a raised BMI.

Reconfiguration of services is currently being considered and implemented in many areas. Midwifery 2020 focuses on the future of services based on the ability to attract people to the profession. Reconfiguration may need further exploration where recruitment, training and experience for medical, midwifery and nursing staff is limited in some areas. Maintaining skills and training for Junior doctors and Consultants, particularly in caring for the sick child has led to reconfiguration of paediatric services which ultimately impacts on maternity and newborn services.

Developing new roles and models of delivering care (such as Low Risk Midwifery Led Units) may go some substantial way to improving access to care for all women (but especially those vulnerable women discussed above)
Gynaecology services are increasingly under training pressure as surgical procedures (e.g. hysterectomy) become increasingly rare. Centralized surgical training centres may alleviate this gap in training. Alternatively, Out of Programme Training in countries where surgery is still a primary treatment regime may allow those trainees to become competent in what is often a life saving procedure in the Maternity Unit.

Of major importance is the significant problem with doctor/midwife/Nurse recruitment and retention within the specialty. This is increasingly becoming an issue as a large tranche of senior consultants/midwives approach retirement leaving a significant gap in experience.

As far as commissioners are concerned, the increase in overall birth rate coupled to a relative decrease in numbers a)able and b) prepared to take care of them means that funding for units will require expansion rather than “hold steady” which is the current strategy. Moreover, the increasing complexity of our patients, with an increased range of treatment options means that each patient requires more time (in a counselling as well as clinical input).

For service design the following would go some way to alleviating stress on already hard pressed service providers

1. Introduction of no-fault compensation
2. Devolve a number of clinical roles currently undertaken by both medical/midwifery in order to utilize their expertise most time efficiently
3. A programme of patient education to inform them that the NHS is free but not a free private care system
4. Commissioners to support organisations to limit non-urgent self referrals (perhaps by increasing the roles of GPs)
5. Simplification of the CNST/NHSLA/Record Keeping system so that staff are not answering to three masters
6. Developing the role of the maternity support worker further to take on non essential midwifery duties.
7. The West Midlands Perinatal Network is currently under development and this should be supported.
3. How well does the current system satisfy clinically appropriate choice?

Respondents may wish to consider:

- What data is there from patients to assess their satisfaction with the service available?
- How can these data be effectively interpreted?
- What choices are available to patients and how are they delivered?
- What information is made available to patients to support effective choice?

The CQC questionnaires, local patient surveys, complaints and general patient feedback allow us to assess patient satisfaction with the service, however, only to a certain degree. Feedback from Maternity Services Liaison Committee and local groups such as MAMTA inform the service and user views.

A lack of investment in this area means we are unable to correlate clinical outcomes with patient satisfaction (i.e. the patient is alive after a caesarean hysterectomy but feels that the car parking is too expensive).

Interpretation of data is currently performed without the ability to perform this important correlation, but that notwithstanding, our satisfaction surveys indicate that the majority of women feel we deliver a high quality service.

Whilst clinicians are keen to offer choice, some choices made will put added pressures on the service. Currently home birth is a choice which is supported within the service, however this is resource intense. There is a growing number of women who choose to birth at home outside normal guidance this puts a strain on the service. It may be pertinent for commissioners to consider supporting the development of home birth teams to increase this option as a true choice for women. Women are supported in their choice of hospital birth with collaborative care from the multi professional team. The role of statutory supervision of midwifery should continue to support midwives and mothers to protect and support the safety and well being of women.

Choice of place of antenatal and post natal care and choice of pace of birth is discussed but this could be further developed in all maternity services. The NCT survey in 2010 identified that postnatal care remains the Cinderella of the service and is not as well supported as in other countries such as Holland. There is a need to review post natal services for the future.
4. **What lessons can we learn from national and international experience?**

Respondents may wish to consider:
- How have other countries/part of the country managed service delivery effectively?
- Where are the examples of best practice both nationally and internationally?
- What pitfalls do we need to be aware of?

In both obstetrics and gynaecology in the developed world, significant inroads into service delivery have been made by introduction of charging for services associated with healthcare rather than healthcare per se. Examples include, provision of milk for newborns, provision of single rooms, ultrasound scan as a choice rather than clinical need, antenatal aqua classes, preparation for parenthood sessions.

These corollary benefits to patients are largely unappreciated and divert funds from frontline healthcare.

Best practice nationally as evidenced by NICE, internationally as provided by nations such as the Netherlands, Sweden and Norway. Management of gynaecological cancers is significantly better in these nations (with better outcomes) than the UK, moreover, the management of pregnancy and in particular postnatal management is significantly better in these countries as there is an interest in the long term health of the mother and her baby not merely for the pregnancy and immediate post natal period.

The pitfalls to some of this is the risk of not providing free healthcare from cradle to grave but a selected free service.
5. **What more can be done to ensure delivery of high quality women’s services in the future?**

Respondents should consider:
- What further actions need to be taken locally and nationally?
- What does this mean for commissioners?
- What future outcome based metrics should be developed?

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Improve recruitment and retention of high quality staff

Invest in smarter information storage and retrieval systems

Decrease litigation by introduction of a no-fault scheme

Move forward with Reconfiguration locally and develop midwifery led units to offer further choice.

Need to ensure adequate level 3 neonatal cots in the neonatal networks

Commissioners to ensure that women are aware of the services that have been commissioned and those which have not to ensure realistic expectation.

Improve audit and measurement of pregnancy outcomes and link these outcomes to patient satisfaction

Improve audit and measurement of gynaecological and reproductive service outcomes and link these outcomes to patient satisfaction

Commissioners have a difficult task of purchasing appropriate services and providers are challenged with delivering services and expectation, the challenge will be intensified as the commissioner role moves to clusters until this becomes embedded.

Contribute to the Perinatal Network. The West Midlands has approximately 72,000 births each year. The Perinatal Network will support the challenges that maternity and newborn services face, particularly poor neonatal and maternal outcomes. The area has increased vulnerable groups and deprivation. The increased activity and complexity leads to the West Midlands having one of the highest Perinatal and infant mortality rates in England and Wales. The Perinatal network should address some of the challenges highlighted earlier in this document.
3. Publications to be considered as evidence

Please list any published articles or research papers that you would like the group to consider as evidence. Wherever possible, when appending documents please can you summarise relevant key points in your answer to one of the five questions above. Please note that where the referenced article appears on a password-protected site, a copy should be submitted alongside your response. Given the limited timeframe of this consultation, if you are unable to provide a valid web-link, electronic or hard copy for all other articles/papers, your suggestion may not be considered.

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<th>Article/paper title</th>
<th>Author(s)</th>
<th>Source journal</th>
<th>Web-link</th>
<th>Have you submitted a hard copy? (Applicable only where web-link is not provided)</th>
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<tr>
<td>Migrant Friendly Maternity Services</td>
<td>Sharpe H November 2010</td>
<td>West Midlands Strategic Migration Partnership</td>
<td>E mail link <a href="mailto:d.newall@wmcouncils.gov.uk">d.newall@wmcouncils.gov.uk</a></td>
<td>Electronic copy available via <a href="mailto:d.newall@wmcouncils.gov.uk">d.newall@wmcouncils.gov.uk</a></td>
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<td>Delivering in an age of super Diversity</td>
<td>Phillimore, Thornhill et al November 2010</td>
<td>University of Birmingham</td>
<td>E mail Link J.A <a href="mailto:Phillimore@bham.ac.uk">Phillimore@bham.ac.uk</a></td>
<td>Electronic copy available via J.A <a href="mailto:Phillimore@bham.ac.uk">Phillimore@bham.ac.uk</a></td>
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<td>DOH 2007 Maternity Matters</td>
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<td><a href="http://www.doh.gov.uk">www.doh.gov.uk</a></td>
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<td>NCT 2010 Survey of Postnatal care</td>
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4. Confidentiality of information

The Royal College of Obstetricians and Gynaecologists adheres to UK Data Protection legislation which governs the collection and management of personal information. The personal information you provide as part of your response will be used only to facilitate the consultation process. Unless you have agreed to your name being used in the published document (see above), your response will be anonymous. With the exception of these published results, no personal data will be disclosed to third parties.