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Royal College of  
Obstetricians and Gynaecologists

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Bringing to life the best in women's health care

Expert Advisory Group Report

July 2011

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# High Quality Women's Health Care:

A proposal for change





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## Foreword

Women deserve a medical service which focuses around their needs, is safe and effective and meets their expectations. In addition, the service must be efficient, local and one in which the woman's informed choice is respected, where practical.

I believe there is a window of opportunity to change the face of women's health care very significantly. Some of the drivers for this opportunity include the proposed changes in the health system, the ramifications of the Working Time Regulations and the variation in clinical services and outcomes in all parts of the UK.

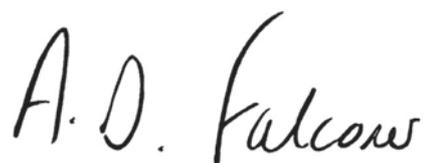
In the UK, the majority of out-of-hours acute health care is still provided by doctors in training, yet in maternity care, which is truly an emergency specialty, the need for a consultant presence 24/7 has never been more relevant. The present position is not acceptable, nor sustainable.

The model we are proposing focuses on the needs of the woman and her baby by providing the right care, at the right time, in the right place, provided by the right person and which enhances the woman's experience. The network approach proposed in this report will provide consistent care, removing variation, using the standards which have already been set by the Royal College of Obstetricians and Gynaecologists and the National Institute for Health and Clinical Excellence. Running in parallel is the concept of a structured life-course approach to health promotion and disease prevention.

Too much care is provided within secondary and tertiary care settings, including emergency and diagnostic gynaecology, and too many babies are born in the traditional 'hospital' setting. We need to drive this care back into the community, with appropriate provision of facilities and professionals with the appropriate skills. This will mean more midwife-led deliveries, the expansion of nursing roles and a reduction in the number of hospital units and services. However, there is also an urgent need to focus complicated care, including complex pelvic surgery, within fewer units, thereby guaranteeing the very best multiprofessional and multidisciplinary care possible within the most cost-effective environment.

I want to see all professionals within the National Health Service, including public health, coming together to think of health promotion as a priority and to develop new integrated roles and training packages for the provision of women's health care.

Finally, women themselves need the support and encouragement of society, including the professionals, to take responsibility for their own health.



**Dr Anthony Falconer FRCOG**  
*President, RCOG*

# Key messages

## Ministers and policy makers

- The combined force of the National Health Service (NHS) reforms and workforce and financial pressures, against a backdrop of rising demand, increasing complexity and changes in demographics, means that the delivery of women's health care in the current configuration cannot be sustained. (Chapter 2)
- At present, the service tends to fire-fight as a reactive response to disease rather than be proactive in preventing ill health. Now we have the chance to reconfigure services using every opportunity to improve health gain in light of the unsustainable nature of the current arrangements. (Chapter 3)
- The proposed women's health network will facilitate a shift from the traditional model to a life-course view of women's health services. This shift will maximise every opportunity that the health service has with a woman to improve her lifestyle and her general health, ultimately to improve her outcomes irrespective of her situation in society. Adopting such an approach to delivering health care will provide women with consistent information from a young age, enabling them to make better decisions about their own health. (Chapter 4)
- The Expert Advisory Group recommends the appointment of a National Women's Health Clinical Director to champion implementation and provide leadership. (Chapter 5)
- With the implications of the Working Time Regulations (WTR) and the likely reduction in trainee numbers within obstetrics, gynaecology and neonatology, careful consideration will need to be given to the need for the current number and configuration of delivery units, the majority of which remain within a hospital setting. It is likely that there will be an increase in the number of midwife-led units, which women will be able to use after validated risk assessment, ensuring choice where appropriate. (Chapters 2 and 5)
- While choice is supported in principle, there is a need to be mindful that choice has to be delivered in a realistic manner, balancing wants and needs with what is clinically safe and affordable and what resources can be made available without destabilising other services. (Chapter 2)
- Information and communications technology solutions are urgently required so that different providers and policy makers can have access to information to improve services for populations as a whole. (Chapter 4)

## Commissioners

- A radical re-think of the current organisation and configuration of women's health care is required to ensure that the required efficiency savings can be achieved without compromising quality. This will require different ways of working and different configurations of multiprofessional teams to ensure appropriate use of skills and competencies. (Chapter 2)
- Commissioning women's health care through a managed women's health network will facilitate better coordination of care, standardisation of delivery and improved clinical outcomes, be more cost-effective, support more multiprofessional working and improve access and women's experience. (Chapter 3)
- The women's health network will include all aspects of obstetrics and gynaecology, to incorporate sexual and reproductive health and primary care. Neonatal care and other co-dependent specialties, such as anaesthesia and emergency medicine, will have to be considered. (Chapter 4)
- Care must be evidence based and services must be commissioned using the Royal College of Obstetricians and Gynaecologists (RCOG) multiprofessional standards across women's health: *Standards for Maternity Care* and *Standards for Gynaecology*. It is imperative that the Care Quality Commission monitors against these national standards. (Chapters 2 and 5)
- Different approaches to networks have all worked well in the UK, as long as the underpinning principles are followed and local needs are taken into account in designing the service. An essential component is appropriate governance, including the establishment of a network management board. The membership of the board must include women using the service and commissioners. (Chapter 3)
- The network concept aims to encourage the transition of activity from secondary to community settings and will therefore have an impact on the configuration of all current health service settings. (Chapter 4)
- For a women's health network to be successfully implemented and to deliver truly integrated women's services, the commissioners will need to address the size of the network, the life-course approach to women's health care and the 'any qualified provider' concept. (Chapter 5)
- All women around the time of their 50th birthday should be invited to attend an NHS health and lifestyle consultation to discuss a personal health plan for the menopause and beyond. (Chapter 4)

## Workforce and training

- Given the current workforce pressures, there is a need to think laterally about how services can be provided and by whom, as well as the input, role and training of the wider multiprofessional team. (Chapter 2)
- It is likely that the medical workforce will need to be more flexible in the settings in which they work to facilitate this improvement in care for women. (Chapter 4)
- Careful planning needs to start now to match training numbers with future consultant opportunities. This process should be undertaken on a national basis. (Chapter 5)
- A proactive approach is required by all the multiprofessional groups to develop new training programmes to ensure that skills and competencies are appropriate for potentially different roles in the future. (Chapter 5)

## Future actions

Ministers, policy makers, commissioners and providers must embrace the life-course approach to women's health care. The RCOG, in partnership with the sister colleges, has set out a framework for a managed women's health network. This is the beginning and not the end of a journey to realise the vision of a life-course approach. Further actions are required by other stakeholders and the RCOG would wish to be involved in further developments.

**The relevant stakeholders are invited to work with the RCOG to progress the following key areas:**

- **Configuration of services:** to discuss future models of care based on the evidence provided.
- **Commissioning and delivery of women's health services:** to explore working practices across different healthcare settings.
- **Quality of care:** to introduce accurate and effective metrics which will reflect accurately the pattern of care to facilitate improvements where indicated.
- **Medical workforce planning:** to discuss professional configuration and future numbers to deliver high quality and safe services.
- **Training (medical, midwifery, nursing and others):** to explore future training programmes that match future service needs.

# 1. Introduction

The Royal College of Obstetricians and Gynaecologists (RCOG) views the proposed changes to the health system as an opportunity to review women's health services. The RCOG:

- strongly endorses a life-course concept for women's health care
- believes that every child can be given the best start in life only by reducing health and social inequalities
- believes that wellbeing can be achieved only by delivering health and wellbeing education from the preschool years onwards in an incremental fashion
- recognises that sexual health education and disease prevention strategies are prerequisites to improving the health of boys and girls in preparation for adulthood
- believes that preconception care can improve maternal and newborn health by providing the foundation for a good pregnancy and birth experience
- is of the opinion that pregnancy is the optimum time to help promote a healthy lifestyle and introduce preventative measures for reducing ill health in the mother and baby
- believes in an evidence-based health service for all providers and consumers of care
- understands that optimal standards of clinical care will be achieved only by following national guidelines and through the quality of staff training and clinical research
- believes that preventative strategies need greater emphasis in health planning.

The RCOG established this expert review under a lay Chair, Dame Joan Higgins, to produce a vision of patient-centred high quality women's health care focusing on a holistic life-course approach. The services should not only improve women's experience by including them more in decision making ('no decisions about me without me') but also improve services for all, based on some already excellent good practice. Services must also be cost-effective.

The proposals to be underpinned by the following principles and values:

- women should be at the centre of their own care
- healthcare standards must be consistent, evidence based and applicable to all providers
- care must be the right care, at the right time, in the right place and provided by the right person
- care should be provided closer to home (accepting this principle may require women to travel to access very specialist care)
- care should cause minimal disruption for the woman
- care should be personalised, ensuring risk assessment, continuity of care and choice (this may be influenced by safety and availability of services)
- the quality of care should be uniform within the UK despite different political and healthcare systems.

“Women and families talking about women's health care in Greater Manchester, when asked about their priorities, said:  
*'health care should be relevant, equitable, safe, accessible and well-resourced services'*  
*'specialist care should be available when needed, however this is best provided'*  
*'getting the best services available for the needs at the time'*

The review defines 'women's healthcare services' as those restricted to the reproductive system.

This report puts forward a proposal for change in the way women's health care is provided. The framework set out in this document is an essential tool for policy makers and commissioners to begin the transformation needed to provide a holistic high quality woman-centred service. The framework will also meet the needs of those providing the services to achieve their goal of providing excellent care to the women they look after. It is acknowledged that implementation will need to be incremental to bring to life this vision to which we all aspire.

The purpose and membership of the Expert Advisory Group can be found in Appendix A. A list of the organisations that participated in the review can be found in Appendix B. Appendix C contains details of the review methodology.

## 2. The status quo: is it acceptable and sustainable?

There is much to celebrate about the current quality and delivery of women's healthcare services in the UK. The UK has declining infant, neonatal and maternal mortality rates, with similar levels to other countries that are at a comparable stage of development. However, there is scope for significant improvement and an urgent need to elevate the standards of care in all parts of the UK to the quality delivered by the very best providers. A powerful example is the creation of gynaecological oncology and neonatal networks, which has impacted positively on the organisation and delivery of care by improving coordination of services and communication between providers, and by driving consistency of care through standards and protocols and through improved sharing of information and data on performance.

**For ovarian cancer, with the development of networks and centralised specialist care, the overall improvement in 5-year survival has been 10–15%.<sup>2,3</sup>**

**Since reorganisation into managed clinical networks, the proportion of births at 27–28 weeks of gestation taking place in the most experienced neonatal units has risen from 18.5% to 50.1%. During the same period, survival has risen from 88% to 94%.<sup>4</sup>**

However, the demands on women's services are increasing. There has been a year-on-year rise in new referrals for outpatient obstetrics and gynaecology,<sup>5</sup> which now account for the highest volume of outpatient attendances at 11.4% of total annual referrals. In obstetric care, the number of births has increased by 19% overall since 2000.<sup>6</sup> However, this is not uniform throughout the UK (in Scotland, total births registered in 2009 showed a drop of 1.7% compared with 2008<sup>7</sup>). This has been coupled with an increasing case complexity (Table 2.1) caused by changing demographic factors such as the increasing age of first-time mothers, obesity, multiple pregnancy and an increase in the number of women with existing comorbidities.<sup>6</sup> This shift has added to the pressure on women's services in terms of both the volume of demand and the intensity and types of care required.

**Table 2.1 Delivery outcome data 1998/99 and 2009/10 by finished consultant episodes (England)**

	Finished consultant episodes 1998/99	Finished consultant episodes 2009/10	% change
Normal delivery with complications	17 211 (3.1%)	24 973 (3.8%)	+0.7
Normal delivery without complications	363 955 (66.0%)	385 765 (596.0%)	-7.0
Assisted delivery with complications	5 403 (1.0%)	9 968 (1.5%)	+0.5
Assisted delivery without complications	60 679 (11.0%)	74 917 (11.4%)	+0.4
Caesarean section with complications	15 788 (2.8%)	29 830 (4.6%)	+1.8
Caesarean section without complications	91 956 (16.6%)	129 170 (19.7%)	+3.1
<b>Total</b>	<b>554 992</b>	<b>654 623</b>	

Source: Hospital Episode Statistics.

Furthermore, there are still specific areas where the UK's performance lags behind that of its European counterparts and where more needs to be done to improve outcomes for women, notably the UK's rates for teenage pregnancy,<sup>8</sup> abortions<sup>9</sup> and perinatal mortality.<sup>10</sup>

In addition, there are three further major challenges that will impact upon planning and provision of women's services: the Health and Social Care Bill 2011 (England), the Working Time Regulations (WTR) and related legislation and financial constraints.

- **Major changes are being proposed to the structure of the National Health Service (NHS)**, with the transfer of commissioning responsibilities to general practitioner (GP) commissioning consortia and local authorities (for public health commissioning), the development of a national commissioning board and the associated abolition of primary care trusts (PCTs) and strategic health authorities (SHAs). Therefore, different elements of women's health care will be commissioned at different levels and by different agencies.
- **Workforce pressures:** Changes to the working hours of both consultants and doctors in training, particularly since the introduction of the WTR, have required different approaches to staffing the acute 24/7 service in obstetrics and gynaecology. This issue has also had to be considered in neonatology, anaesthesia, midwifery and nursing.

There is also a planned reduction in trainee numbers by the Centre for Workforce Intelligence, which potentially will act as a major driver for change.

While the WTR provided a driver for further consultant expansion with more consultants directly delivering front-line care in obstetrics, most units are still reliant on doctors in training for the majority of out-of-hours cover. However, the Temple review of the impact of the European Working Time Directive on the quality of training states that where there is good planning and management, high quality training and service can still be delivered.<sup>11</sup>

- **Financial pressures:** the NHS is facing a significant financial challenge, with an estimated funding gap of £15–20 billion that needs to be resolved by 2014. The impact of this will be felt across all specialties. New ways of working and service redesign will be essential if the efficiency aims of the Quality, Innovation, Productivity and Prevention agenda are to be realised while improving the quality of care delivered.

## 2.1 Variation in healthcare provision

### 2.1.1 Service provision

Evidence suggests that there are regional variations in the quality of care provision and clinical outcomes within England. The Healthcare Commission found that London in particular compared unfavourably with other regions on a range of aspects of maternity care, including early booking, choice and midwife contact details.<sup>12</sup>

A range of maternal inequalities currently exists. Surveys into experiences of care demonstrate significant variations in the way maternity care is accessed by different black and minority ethnic groups,<sup>13</sup> such as being less likely to be aware of all of the possible options for birth and more likely to receive fewer postnatal visits and to say that they were not treated with respect by postnatal staff.

Evidence suggests that there is a correlation between socioeconomic status and antenatal risk factors, which then results in inequitable distribution of infant health outcomes. Young and single mothers, multiparous mothers and women from black and minority ethnic groups are typical poor antenatal attendees. Teenage mothers frequently have lower birthweight babies, higher infant mortality rates and a higher risk of having a baby with congenital abnormalities, and are less likely to breastfeed.<sup>14</sup>

**In London in 2008, 4% of births (4857 babies) were to mothers aged 11–19 years. The most recent perinatal mortality report shows that babies born to women aged under 20 years have a higher rate of stillbirth (5.6/1000 deliveries), a higher rate of perinatal death (8.9/1000 deliveries) and a higher rate of neonatal death (4.4/1000 births) compared with women aged 20–34 years.<sup>15</sup>**

Responding to these inequalities, the National Service Framework for Children, Young People and Maternity Services recommended targeted interventions to provide support to those women who tend to experience the poorest outcomes, specifically by improving take-up of antenatal and

postnatal care.<sup>16</sup> There are also inter-generational effects associated with poor maternal outcomes: for example, children born of diabetic pregnancies are more likely to develop diabetes and have higher body mass index than their siblings born of non-diabetic pregnancies; teenage pregnancy repeats across generations; and there is a direct correlation between a grandparent's socio-economic status and their grandchild's birthweight.<sup>17</sup>

There is also evidence that a woman's ability to exercise meaningful choice in maternity care is affected by her socioeconomic status and/or ethnicity. Data suggest that women of lower socioeconomic status are more likely to be dissatisfied with the care they receive<sup>18</sup> and that older, better educated women are likely to be more assertive and to expect a greater share in decision making.<sup>19</sup>

“The King's Fund in its evidence stated:

*Tackling inequalities in outcomes and access to key services should be a priority, particularly those in more rural areas, where access has historically been a challenge.*

The British Society for Urogynaecology in its evidence stated:

*The National Institute for Health and Clinical Excellence (NICE) guideline on urogynaecology has not been fully implemented in many areas, including standards relating to the need for women to have access to conservative management and at least 3 months of specialist physiotherapy.*

Services are currently fragmented, partially as a result of the way they are commissioned. This may be to the detriment of offering women an integrated model of care and enabling opportunities to maximise women's health and the associated outcomes. For example, there is a clear benefit to providing and commissioning contraception and termination of pregnancy services within the same envelope; this would provide an important opportunity to offer women counselling and advice on appropriate forms of contraception at the time of a termination, thus minimising the potential for any subsequent terminations of pregnancy.

“The Faculty of Sexual & Reproductive Healthcare in its evidence stated:

- *It is estimated that every £1 spent on contraception saves £11 in health care.<sup>20</sup>*
- *Use of long-acting reversible contraception in a PCT with a population of 400 000 could save up to £790,000 by reducing the number of unintended pregnancies.<sup>21</sup>*
- *NHS England could save £100 million each year by increasing the use of long-acting reversible contraception.<sup>22</sup>*
- *Every teenage birth costs the NHS around £1,500.<sup>23</sup>*
- *Every abortion costs the NHS £650.<sup>21</sup>*

The journal *Midwifery*, reporting on a state-wide review of postnatal care in Victoria, Australia, noted:

*Women's satisfaction with postnatal care increases when they have received postnatal care in a model that allows continuity of carer.*

The Expert Advisory Group, while strongly supporting the Australian model mentioned in the box above, appreciates that this is rarely achieved in the UK, where the prime focus is on antenatal and intrapartum care. This must be addressed. It is appreciated that an ideal model in one population may not be the ideal for all, such as rural and island communities. Risk assessment is the key, and women may have to acknowledge that risk may vary in certain parts of the UK and that this may impact on choice.

“The National Clinical Advisory Team member cited the following example of a solution in Cumbria:

**Cumbria:** two hospitals.

- *Cumberland Infirmary, Carlisle (80 000 population; five obstetrics and gynaecology consultants; 1700 deliveries/year): cannot achieve 98-hour consultant cover, so consultant-delivered service would be impossible.*
- *West Cumberland Hospital, Whitehaven (60 000 population; four obstetrics and gynaecology consultants; 1400 deliveries/year).*

*The two hospitals are 1.45 hours apart. The trust has to use all of its resource to create a safe and sustainable service.*

**Solution:** *quality risk assessment; provide information for women about their risk status.*

**The Scottish Executive report stated:**<sup>24</sup>

*Women must be given information in a suitable format to allow them to understand that equal access to services cannot always be guaranteed because geographical factors can impact on the services available in their locality. Women must have information to allow them to make informed decisions by balancing risks.*

**The King's Fund in its evidence stated:**

*Coordination of care is also important, as well as continuity. How professionals support women to make decisions about their own care is important as more information is not always the answer; women need 'summative' measures to help them make decisions.*

**The National Perinatal Epidemiology Unit in its evidence stated:**

*Certain women were less likely to have seen a health professional by week 12 of their pregnancy. These included:*

- *those who left education at 16 years of age*
- *women living in the most deprived areas*
- *women from black and minority ethnic communities.*

## 2.1.2 Clinical outcomes

There is evidence of variation in some clinical outcomes internationally and within the UK.

### Perinatal mortality

The UK perinatal mortality rate has shown a gradual improvement between 2000 and 2009 to a level of 7.6/1000 total births. This decrease is attributable to a reduction both in the stillbirth rate and in the early neonatal mortality rate. The overall adjusted perinatal mortality rate (excluding notified terminations of pregnancy and babies born at less than 22 weeks of gestation) was 6.8/1000 total births.<sup>15</sup> This compares with European mortality rates of: Belgium 7.4, France 6.9, Netherlands 6, Spain 4.7 and Austria 3.2/1000 total births.<sup>10</sup> In England, adjusted perinatal mortality rates by neonatal network in 2009 ranged from 4.8 to 8.6/1000 total births.<sup>15</sup>

### Cervical cancer

In England, between 2006 and 2008, the age-standardised incidence rate for cervical cancer/100 000 women/year ranged between 5.48 and 13.69 (average 8.2). In England, between 2000 and 2004, the 5-year relative survival rate for cervical cancer by cancer network ranged between 58.7% and 80.6% (average 68.0%).

### Ovarian cancer

In England, between 2000 and 2004, the 5-year relative survival rate for ovarian cancer by network ranged between 28.5% and 48.0% (average 41.0%).

NB: The above cancer figures demonstrate variation. Careful scrutiny is needed to establish uniformity of case mix, staging and other such variations [source of data: National Cancer Intelligence Network].

### Caesarean section

Caesarean section rates in the UK continue to rise. There also remains significant variation in rate, even when adjusted for patient populations, between 14.9% and 32.1%. The rates of emergency caesarean section vary between trusts to a greater degree than the rates of elective caesarean section.<sup>25</sup>

### Stress incontinence surgery

In the UK, in a multicentre randomised controlled trial of tension-free vaginal tape compared with colposuspension, there was wide variation in objective cure rates within the 14 participating centres, ranging from 0% to 92%.<sup>26</sup>

## 2.1.3 Clinical practice

There are multiprofessional national standards across the specialty of obstetrics and gynaecology (the RCOG's *Standards for Maternity Care*<sup>27</sup> and *Standards for Gynaecology*<sup>28</sup>) as well as national clinical guidelines produced by NICE, the Scottish Intercollegiate Guidelines Network (SIGN) and others. Despite this, there is considerable variation in practice.

“The Healthcare Commission review *Towards Better Births* concluded:<sup>12</sup>

*Many of the accepted clinical standards for high quality maternity care have been variably applied across England, specifically inconsistent compliance with NICE guidance on antenatal care and postnatal care.*

The Association of Early Pregnancy Units in its evidence stated:

*Despite the availability of standards in early pregnancy care set by the RCOG/Association of Early Pregnancy Units, early pregnancy care suffers from a 'Cinderella' image and is the poor relation to obstetrics and cancer as far as investment is concerned.*

*The top ten standards for early pregnancy care are beacons for practice and are easily achieved. Their adoption would vastly improve women's experience and harmonise care so that all women with early pregnancy problems would have an equal chance of excellent care.*

The NHS *Atlas of Variation in Healthcare*<sup>29</sup> presents data on two specific surgical interventions relevant to women's health: caesarean section (without complications) and abdominal and vaginal hysterectomy (inpatient admission expenditure). In both cases, there is evidence of significant variation in expenditure across PCTs, with related variation in terms of clinical practice and thresholds for surgical intervention. (It should be noted that these data are collated from NHS Hospital Episode Statistics and do not include data from private providers.)

- Rate of expenditure on caesarean section (without complications): expenditure (per 1000 population) across the 152 PCTs in England varies by a factor of nearly 3; even when the five PCTs with the highest and lowest levels of spend are excluded, expenditure still varies by a factor of 2. Approximately 40% of caesareans are planned (elective caesareans) and 60% are emergency procedures. In about 70% of cases, caesareans can be attributed to one of four indications: failure to progress in labour, fetal distress, breech presentation and repeat caesarean section. It is unlikely that the rising caesarean section rate is attributable to an increasing rate of self-elected caesarean sections (NICE guidelines found evidence that only 6–8% of women surveyed during pregnancy expressed a preference for caesarean section). The *Atlas of Variation in Healthcare* suggests that 'variation is most probably related to differences in the thresholds for intervention at institutional and practitioner levels and variations in the preferred models of care'.<sup>29</sup> This is confirmed by Bragg et al.<sup>25</sup>

- Abdominal and vaginal hysterectomy inpatient admissions expenditure per 1000 population by PCT: expenditure across PCTs varies by a factor of 4, or 3 when the five PCTs with the highest and lowest expenditure rates are excluded. Some of the variation may be explained by the clinical indication for hysterectomy (a common indication is cancer of the uterus, but other indications exist). Other factors contributing to variation include the culture of the gynaecological service, the views of women themselves and technological innovation (new technologies are now available for some of the indications for hysterectomy, such as uterine artery embolisation and endometrial ablation techniques).

“The RCOG organisational survey, part of the RCOG National Heavy Menstrual Bleeding Audit, reported:

- *Only 30% of units followed the RCOG recommendation regarding heavy menstrual bleeding protocol.*<sup>30</sup>
- *Women living in the most deprived areas were more likely to have a hysterectomy, while women in the least deprived areas were more likely to have endometrial ablation.*<sup>30</sup>

Infertility Network UK in its evidence stated:

- *A large proportion of the PCTs did not fund a full cycle of in vitro fertilisation/ intracytoplasmic sperm injection, nor understood the definition of a full cycle.*
- *Ten PCTs have completely disinvested in the in vitro fertilisation service since September 2010.*

The variation must be addressed. The Care Quality Commission has an extremely important role to play. It is imperative that it monitors against national standards, such as the RCOG multi-professional standards across women’s health.<sup>27,28</sup>

The commissioners must play an equally important role in minimising variation by building into contracts the requirement to deliver services and manage performance against national standards.

## 2.2 Workforce

The service vision of the right care, at the right time, in the right place, by the right person can be delivered only by multidisciplinary teams. Workforce pressures are being felt by most professional groups involved in the delivery of women’s health care. The major pressures are summarised below.

### 2.2.1 Obstetrics and gynaecology

Across women’s health care, workforce pressures are being felt which may require different ways of working. First, it is anticipated that there will be a significant bulge in the number of retirements among senior and experienced consultant obstetricians and gynaecologists because of changes in established practice, the potential for residence on call and alterations to the NHS pension scheme. Second, a key issue for the current workforce in women’s health care is the impact of the WTR, notably the introduction of the 48-hour week, which formally came into effect in August 2009. As outlined in the Temple report,<sup>11</sup> the impact of the WTR is summarised below:

- there has been an impact on rotas and the ability to staff services safely 24 hours a day, 365 days a year
- many units still rely on doctors in training to provide the majority of out-of-hours care
- the reduced working week has had an impact on the quality and comprehensiveness of medical training
- there has been an impact on recruitment and retention of clinical staff.

Against this context of resource pressure, a high quality women’s service is one that should be compliant with professional standards. As outlined in *The Future Role of the Consultant*,<sup>31</sup> there should be 24-hour consultant cover on labour wards to meet the needs caused by the growing complexity of the case mix, the increase in operative birth rates and the reduction in trainee

numbers, hours and experience. *Safer Childbirth*<sup>32</sup> and *The Future Workforce in Obstetrics and Gynaecology*<sup>33</sup> set out the standards for delivery suite presence, signalling the consultant cover required at all levels and the additional direct clinical care activity which must be included. In addition, the age profile of the consultant workforce must be considered. It is unrealistic to expect a senior consultant aged, say, over 55 years to function out of hours, potentially with resident duties, after 8 p.m. at the same level and regularity as a junior, newly appointed colleague.

There will need to be expansion to achieve these standards for delivery suite presence. The Healthcare Commission review *Towards Better Births*<sup>12</sup> concluded that maternity units in England have below average staffing levels and that consultant obstetricians are not spending the recommended time on labour wards. Trusts will face significant challenges to achieve the required increase in consultant numbers in terms of both the economic implications and the availability of specialists. However, RCOG census data show that in the UK between 2007 and 2009, there was a 7.7% increase in consultant numbers (from 2029 to 2186). This clearly demonstrates the trusts' recognition of the need to increase consultant numbers to support implementation of a consultant-delivered service. However, despite the expansion in numbers, consultant presence on the labour ward still falls woefully short of the recommendations made in multiprofessional standards.<sup>32</sup>

Given that the majority of obstetrics and gynaecology is carried out by consultants who practise both specialties and the pressures on workforce demands for obstetric services, it was recommended in *The Future Workforce in Obstetrics and Gynaecology*<sup>33</sup> that the majority of consultants, including subspecialists where relevant, should be expected to undertake some obstetric duties for the foreseeable future. This was purely a pragmatic solution. However, the restrictions of the WTR and delivery suite out-of-hours care mean that a gynaecology subspecialist providing obstetric services would require such a level of compensatory rest that their primary clinical focus would be diminished.

Changing practice in gynaecology is impacting on the gynaecological workforce. Therapeutic options for many conditions no longer require surgery and therefore there has been a decrease in the number of inpatient episodes and length of stay. While the number of major surgical procedures is decreasing, those that remain are often complex.<sup>34</sup> With the devolution of some aspects of gynaecology to primary and community care settings, and with the recognition of sexual reproductive health as a specialty, there may also be a decline in referrals to secondary care. Therefore, the number of consultants and trainees needs to be kept under review.

The King's Fund in its report *Staffing in Maternity Units*<sup>6</sup> states that the reforms to the postgraduate medical training programme have led to some concern that newly qualified specialists today are less experienced than under the previous system, having worked for fewer hours. A mentoring system for new consultants is to be supported.

Any workforce plan needs to take into account the increasing feminisation of the medical workforce (Table 2.2). Although there is some concern about an increase in less than full-time working patterns, there is emerging evidence that a full-time contract of 10 programmed activities (PAs) involving resident consultant on call may not be unattractive because of the compensatory rest.

	Consultants (n)	Trainees (n)	Other (n)
England	1794	1708	–
Wales	98	64	–
Scotland	221	190	–
Northern Ireland	73	67	–
<b>Total</b>	<b>2186<sup>a</sup></b>	<b>2029<sup>b</sup></b>	<b>771</b>

<sup>a</sup>41% female, 59% male. <sup>b</sup>73% female, 27% male. Source: RCOG Medical Workforce Census 2010 [<http://www.rcog.org.uk/our-profession/good-practice/medical-workforce-census>].

Paternity/maternity leave is another factor that needs to be considered within workforce calculations.

### 2.2.2 Midwifery

In *Safer Childbirth*,<sup>32</sup> the recommended ratio of midwives to assure a safe level of service is one whole-time equivalent (WTE) midwife per 28 births for hospital births and per 35 births for home births. Other, more specific recommendations are summarised in Table 2.3.

	<b>Recommended ratio</b>
Midwifery-led birthing unit	35:1 A separate assessment is required when providing intrapartum care for women requiring transfer to hospital care or when providing antenatal or postnatal care on an inpatient basis.
Caseload midwifery practice	35:1 Calculated on the assumption of midwives providing all antenatal, intrapartum and postnatal care to low-risk women. This figure should be reviewed in the case of women who have high levels of social complexity.
Labour ward	There should be 1:1 care for women in established labour.

“The Royal College of Midwives (RCM) in its evidence stated:

*There is a need to develop a workforce strategy to recruit and retain sufficient staff to be able to respond to demand for maternity care.*

The configuration of the midwifery workforce may also have a negating influence on the availability of options available to a woman when she is deciding on her preferred place of birth. There are three main categories of care provided by a midwife, each accounting for approximately one-third of the workforce:

- community-based midwives providing antenatal and postnatal care
- hospital-based midwives providing antenatal and postnatal care
- hospital-based midwives providing care during labour and birth.

The Healthcare Commission<sup>12</sup> reported that some trusts economise on community midwives to preserve the number of hospital midwives. The effect of this may be a reduction in the availability of community midwives, with the consequent effect of limiting women’s ability to give birth at home as well as an impact in terms of provision of effective antenatal and postnatal care.

### 2.2.3 Neonatology

The specialty of paediatrics is under similar pressures to obstetrics and gynaecology, with difficulty in providing a safe and sustainable workforce environment for all of the inpatient paediatric rotas that currently exist. In addition, the WTR are another driver for change and the specialty wishes to move towards a consultant-delivered service with closer alignment of trainee numbers and consultant opportunities in the future.<sup>35</sup>

The 2009 UK paediatrics workforce census showed that there are 3264 consultants in the specialty (3084 WTE). The number of doctors, including trainees and nurse practitioners, participating on tier 1 rotas is 2478 while the number participating on tier 2 rotas is 2230; both of these figures are approximately 300 lower than the predicted number required to comply with the standards recommended by the Royal College of Paediatrics and Child Health (RCPCH).

Neonatology is the largest subspecialty of paediatrics. In its 2009 Medical Workforce Census, the RCPCH recorded 369 (358.1 WTE) neonatal consultants. Although there has been growth in the subspecialty over the last decade, there are on average fewer than six consultants for each of the 63 British Association of Perinatal Medicine (BAPM) level 3 neonatal intensive care units. This contrasts with the recommendation of the 2010 BAPM *Service Standards for Hospitals Providing Neonatal Care*<sup>36</sup> for a minimum of seven consultants on the on-call rota. Furthermore, the census identified eight BAPM level 3 units where a separate tier of consultant cover was not present. The RCPCH supports the BAPM guidance that there should be a separate consultant rota for these units.

The National Audit Office report on value for money, *Caring for Vulnerable Babies*,<sup>37</sup> identified that there is a shortage of nursing staff across neonatal units which is impacting adversely on capacity. This shortage was identified across England, with wide regional variations and inconsistent attainment of workforce standards:

- 100% met the guideline for special care (one nurse to four babies)
- 50% met the guideline for high dependency care (one nurse to two babies)
- 24% met the standard for intensive care (one nurse to one baby).

According to the Healthcare Commission's review into maternity services in England,<sup>12</sup> variable use is being made of neonatal nurse practitioners, with reports that they attended delivery in 42% of obstetric units and postnatal wards in 40% of units. The report emphasises that underuse of this role is significant since a large proportion of neonatal nurse practitioners' work involves checking the newborn, thus allowing the neonatologists/paediatricians to carry out more demanding tasks and preventing unnecessary delays to transfer.

#### 2.2.4 Anaesthesia

All consultant-led obstetric units require the provision of anaesthesia services. The Royal College of Anaesthetists (RCOA) guidance on the provision of obstetric anaesthesia services<sup>38</sup> recommends that each obstetric unit should have a nominated consultant in charge of obstetric anaesthesia services, with PAs allocated for this in addition to those for clinical 'sessions'. As a basic minimum for any consultant-led obstetric unit, there should be 10 consultant anaesthesia PAs per week; where elective lists are run daily, this would mean at least 15 PAs. There should be a named consultant with responsibility for each caesarean section list. Mothers requiring anaesthesia have the right to the same standards of perioperative care as other surgical patients. Therefore, skilled anaesthesia assistants and postoperative recovery staff are also required.

Where an epidural service is provided, a duty anaesthetist should be immediately available for the obstetric unit 24 hours a day. In busier units (those with over 5000 deliveries/year), it may be necessary to have two duty anaesthetists in addition to a supervising consultant. If the duty anaesthetist has other responsibilities, they must be able to be interrupted should the obstetric unit require them. The RCoA strongly recommends that the duty anaesthetist should not be solely responsible for the intensive care unit or cardiac arrest calls in addition to the labour ward.

#### 2.2.5 What needs to change?

Given these workforce pressures, there is a need to think laterally about how services can be provided and by whom, as well as the input and role of the wider multidisciplinary team. There are already examples where roles have been developed to support caseload and to ensure that professionals with more specialised skills are freed up to deliver the appropriate level of care. The development of midwifery support workers who undertake nonessential midwifery duties is a notable example.<sup>6</sup> Similarly, some evidence has suggested that services for benign gynaecology could also be provided by others, such as nurse hysteroscopists and GPs with a special interest in this area.

“The Care Quality Commission in its written evidence stated:

*There is perhaps a need to think laterally about how services can be provided and by whom and the input of the multidisciplinary team.*

“The Mid Staffordshire NHS Foundation Trust in its evidence stated:

*Some evidence has suggested the need for a review of the role of advanced practitioners, specialist nurses, community nurses and support workers, and to consider the role this group could play in providing community care, with support from the wider multidisciplinary team.*

## 2.3 Resources

The workforce pressures described above require a radical rethink of the current organisation and configuration of women’s health care to ensure that the required efficiency savings can be achieved without compromising quality. This will require different ways of working and different configurations of multiprofessional teams to optimise the volume of professionals, skills mix and competencies in a manner that is pragmatic, safe and clinically appropriate. Reorganisation of care will require consideration of both the professionals delivering the care and the settings in which care is delivered: consultants could support GPs in primary care or community settings, bringing patients to secondary care only for specialist expertise or technical support which can only be provided in hospitals because of the required skills mix, experience and facilities.

There has been a year-on-year increase in referrals to secondary care. However, we are aware that some referrals could have been more effectively dealt with in the primary care or community setting.

“Despite the NICE guideline stating that all patients should receive some treatment in primary care, the National Heavy Menstrual Bleeding Audit found:<sup>30</sup>

*Thirty-seven hospitals (17.0%) reported that most or almost all of their patients did not receive any treatment in primary care.*

### 2.3.1 Hospital delivery units

In view of the difficulties experienced across all specialties, careful consideration should be given to the need for the current number and configuration of delivery units, the majority of which remain within a hospital setting.

The range of delivery unit size is illustrated in Table 2.4. There are 56 units delivering fewer than 2500 babies/year and 17 units delivering more than 6000 babies/year. The need for some of the small units will be determined by geography (Figure 2.1).<sup>39</sup> The larger units will often have co-located midwife-led units. Experience suggests that units delivering more than 8000 babies/year will require a significant increase in staffing and facilities. This is predicated upon a co-located midwife-led unit delivering 25–30% of the total number of babies.

## 2.4 Choice

The way in which women’s services are configured should support choice as a principle. Choice includes:

- choice over whether, where and when to seek care
- choice of care or treatment offered
- choice of appointment (date and time)
- choice of hospital and/or doctor.

There is some evidence that women are not always offered the full range of options available to them.

**Table 2.4 Size of hospital delivery units, 2010**

Deliveries (n)	Units (n)				
	England	Wales	Northern Ireland	Scotland	UK
<500	3	1	1	–	5
501–1000	1	1	–	–	2
1001–1500	4	3	4	2	13
1501–2000	10	2	–	1	13
2001–2500	17	4	1	1	23
2501–3000	28	–	2	1	31
3001–3500	24	1	1	1	27
3501–4000	24	1	1	3	28
4001–4500	17	–	–	1	18
4501–5000	13	–	–	2	15
5001–5500	10	1	–	–	11
5501–6000	16	–	1	–	17
6501–7000	4	–	–	3	7
>7001	9	–	–	1	10
<b>Total</b>	<b>179</b>	<b>14</b>	<b>11</b>	<b>16</b>	<b>220</b>

In addition, there are approximately 90 stand-alone midwifery units in the UK. Source: RCOG Medical Workforce Census 2010 [<http://www.rcog.org.uk/our-profession/good-practice/medical-workforce-census>]

Healthcare for London's consultation of women clearly supported co-location of different types of units.

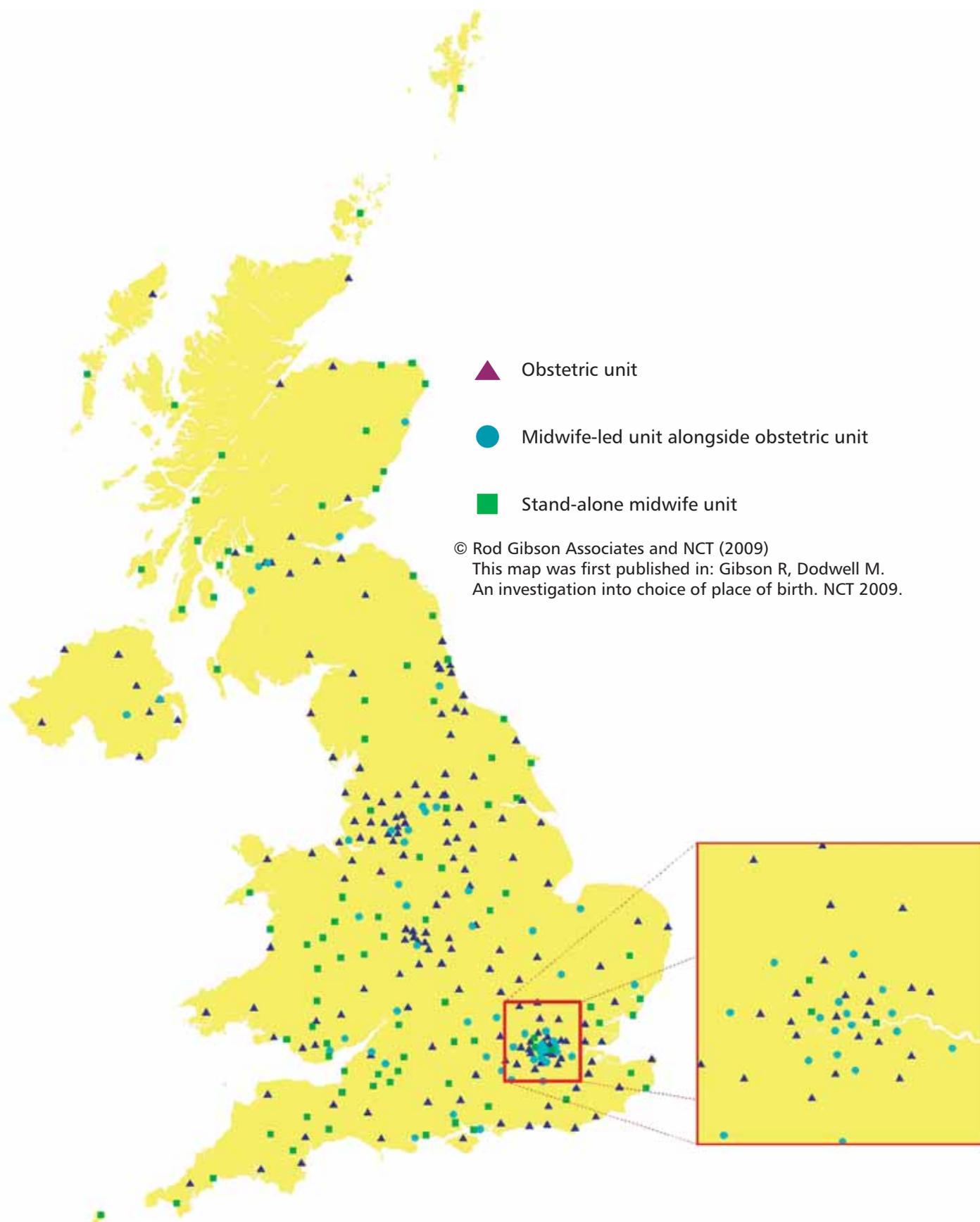
“*Maternity Matters* sets out the following national choice guarantee that should be available to all women:<sup>40</sup>

- Choice of how to access maternity care.
- Choice of type of antenatal care.
- Choice of place of birth. Depending on their circumstances, women and their partners will be able to choose between three different options: These are:
  - home birth
  - birth in a local facility, including a hospital, under the care of a midwife
  - birth in a hospital supported by a local maternity care team including midwives, anaesthetists and consultant obstetricians; for some women, this will be the safest option.
- Choice of place of postnatal care.

*As well as the choice of local options, a woman may choose to access maternity services outside her area with a provider that has available capacity. In addition, every woman will be supported by a midwife she knows and trusts throughout her pregnancy and after birth.*

*Delivered with Care* reported variations in the exercise of choice in relation to antenatal care. Geographical differences also exist, with women in certain areas more likely to be offered antenatal classes, ranging from 73% in the North East of England to 62% in the East Midlands.<sup>13</sup>

Figure 2.1 Location of maternity units in the UK, 2009



However, based on the evidence presented to them, the Expert Advisory Group concluded that, within current resources (financial, workforce, facilities), choice may have to be influenced by the availability of services. Choice needs to be aligned to the level of complexity and risk. Women will be expected to make informed choice based on the best care available: for example, in neonatal networks the family may need to travel further to a level 3 intensive care unit because that is the designated unit with the specialist resource, expertise and facilities.

There is also a need to ensure that the choices offered to women allow an appropriate use of resource. For example, women may choose to be treated further from home in an acute hospital rather than in the local unit because the public transport system makes it more convenient. However, it would not be possible to access the highest levels of subspecialist care without clinical need as these subspecialist centres would be for women requiring subspecialist care only. It is essential to balance choice against adequate service provision.

Clear signposting is crucial at all stages of a woman's life. Integrated women's healthcare models should support the range of choices available to women, including public health services such as smoking cessation. Such care models should also support improved information sharing across different health providers, thus allowing for appropriate risk assessment and subsequent care planning.

**“The Care Quality Commission in its evidence stated:**

*There will be a need to be mindful that choice needs to be realistic, balancing wants (and sometimes needs) with what is affordable and what resources can be made available.*

**Bliss reflected:**

- *It's not just about extending choice; it's about ensuring that services are in place to deliver the best possible outcomes for women with high-risk pregnancies and babies admitted to neonatal care.*
- *Networks need to ensure that, when extending choice, there is sufficient capacity available at the appropriate centre for women experiencing complications and delivering their babies early and unexpectedly.*
- *Choice is not appropriate in the case of specialist care (such as neonatology), where people need to go to the appropriate specialist centre; the same principle must apply to the totality of women's services.*

**The BAPM in its evidence stated:**

*Neonatal care is organised through networks which aim to meet the clinical needs of their local population. This is achieved, but on fairly regular occasions it involves the transport of women and/or their babies away from the local base to find a cot in a unit that is able to provide the appropriate level of care. Essentially, there is no patient choice with regard to this element of service.*



## 3. New model: considerations

The pressures highlighted in the previous chapter beg the question of whether the service is currently configured in the most effective way from the point of view of both service delivery and cost-effectiveness.

Currently, many interventions occur for all women (adolescence to old age) but the provision of these services is fragmented. The life course starts with examination of the newborn/neonatal screening and moves through to rubella screening, human papillomavirus immunisation, chlamydia screening, contraception services, pre-pregnancy care, cervical screening, pregnancy care, gynaecological care and prevention of ill health in the older woman. These episodes illustrate times of contact between a woman and health services when more comprehensive interventions could be made.

At present, the service tends to fire-fight as a reactive response to disease rather than be proactive in preventing ill health. Now we have the chance to reconfigure services, using every opportunity to improve health gain in light of the unsustainable nature of the current arrangements.

The Expert Advisory Group was given the challenge by the RCOG to review evidence and consider models of integrated care underpinned by the following principles and values:

- women should be at the centre of their own care
- healthcare standards must be consistent, evidence based and applicable to all providers
- care must be the right care, at the right time, in the right place and provided by the right person
- care should be provided closer to home (accepting this principle may require women to travel to access very specialist care)
- care should cause minimal disruption for the woman
- care should be personalised, ensuring risk assessment, continuity of care and choice (this may be influenced by safety and availability of services)
- the quality of care should be uniform within the UK despite different political and healthcare systems.

Drawing on data gathered as part of the review process, the Expert Advisory Group drew up generic principles of high quality women's health care, grouped under the headings quality, innovation, productivity and prevention. These principles can be found in Appendix D.

The Expert Advisory Group considered the following key components:

- current models which are safe, clinically effective, efficient and patient centred and which enhance women's experience
- the key components of an effective model
- what will bring together multiple providers to deliver high quality women's health care.

### 3.1 Current network models

There is some evidence that integrated care can be provided through clinical networks. Networks can be focused on a specific disease, a specialty or a specific function. Fundamentally, the purpose of networks is to enable services to be linked across organisational boundaries, where these would have hitherto restricted the coordination of services to ensure high quality, effective, equitable care. The emphasis shifts from buildings and organisations towards patients and services.

Within the UK, managed clinical networks were first set up in cancer care following the publication of the Calman Hine report.<sup>41</sup> Subsequently, similar network models have been established in neonatology, diabetes, stroke and cardiology services; in each case, the intention was to ensure appropriate access to the range and level of specialist care.

### Case study 3.1

NHS Diabetes recognised that midwives did not have a clear perspective on the requirements in terms of knowledge, skills and competencies to meet the challenging role of managing women with diabetes in pregnancy. NHS Diabetes therefore identified an opportunity, in partnership with the RCM, to undertake an important project in developing national standards for the role and associated skills and competencies for a diabetic midwife specialist.

The objectives of the project were:

- Map the number of midwives nationally who have a role specifically targeting the care and support of women with diabetes in pregnancy.
- Develop an agreed role specification for midwives whose role targets the care and support of women with diabetes in pregnancy.
- Develop and agree standards and competency frameworks for the role of midwife diabetic specialists.

In mapping the number of midwives, the need for a network became very apparent. NHS Diabetes moved from 50 identified midwives to a network of over 160, representing a named midwife in over 83% of English trusts with a maternity unit. This was initially managed using a contact database, but in the latter part of 2010 the network moved onto the NHS Networks site (<http://www.networks.nhs.uk/nhs-networks/diabetes-midwives>).

“Bliss reported on an audit of neonatal networks (February 2011):

*In their current form, neonatal networks play a key role in bridging provider and commissioning organisations. They have a dual role: advising commissioners and supporting coordination and benchmarking/audit through the patient pathway (thus the network has a role akin to a consultancy). There should be joint working between commissioners and providers, including having commissioning representatives on networks.*

## 3.2 Learning from networks

### 3.2.1 Neonatal managed networks

The National Audit Office in its report identified the following key factors that should be considered when setting up a managed clinical network:<sup>37</sup>

- **Capacity constraints:** capacity is a key challenge, as shown in the case of neonatal networks. The National Audit Office concluded that capacity constraints continue to undermine the efficiency and effectiveness of neonatal networks.

Although the reorganisation of neonatal services into networks has led to greater transfer and survival of babies born at 27–28 weeks of gestation, the proportion undergoing an acute postnatal transfer within 24 hours of birth has risen from 6.8% to 12.7%, suggesting that capacity continues to be an issue and that neonatal and maternity services are not functioning efficiently to coordinate and facilitate in utero transfers to appropriate centres before delivery.<sup>4</sup>

- **Current commissioning arrangements:** again in relation to evidence on neonatal networks, a second barrier identified in the literature lies in the current commissioning arrangements. Special care is currently commissioned by PCTs, while high dependency and intensive care are commissioned separately by specialised commissioning groups. Since babies can frequently transfer across units of care, the current commissioning arrangements act as a barrier to integrated care. On this basis, the National Audit Office concluded that neonatal services should be commissioned as part of a continuum of care which starts with maternity care.
- **Network delivery of care in isolation will not be sufficient; a preventative focus will also be required:** reducing disparities in neonatal outcomes cannot be achieved through neonatal networks in isolation. There is a need for neonatal services to be considered within a wider framework of public health across services more generally. A range of coordinated public health and cross-government initiatives are required to reduce the prevalence of premature and low-birthweight babies.

The RCPCH in its report *Modelling the Future III*<sup>42</sup> set out a series of solutions on how networks can be better developed and aligned to promote quality outcomes in services for infants, children and young people. While specific to paediatrics and child health, these solutions are transferrable to women's health care. The key recommendations include:

- Systems alignment around defined patient pathways.
  - Future services should be designed around patient journeys, grouped together into the pathways that women take.
  - Teams working in networks rather than across organisational boundaries.
- A 'one size fits all' approach will not suffice: networks must be matched to local need and characteristics.
  - Networks will span different sized units and they must work cooperatively to deliver better outcomes.
- Medical workforce planning.
  - Acute care should be a consultant-delivered service, particularly in smaller services which are close to larger inpatient units.
  - To ensure that the future medical workforce is competent and sustainable, the roles of other practitioners should be taken into account.

### 3.2.2 Gynaecological cancer networks

The key drivers in the success of the gynaecological cancer networks include:

- national clinical leadership
- subspecialisation
- financial support for network administration and review
- political priority to succeed and implementation of targeted national policy (waiting times)
- continuous focus on quality, particularly through the peer review process
- high quality data.

### 3.2.3 Diabetes networks

The following are the key drivers in the success of the diabetes networks:

- diabetes services were explicitly mentioned and defined in the NHS operating framework
- strong clinical leadership
- the commissioning model for diabetes services was developed by a multiprofessional group
- the simple audit process, which is cheap yet highly effective in comparison with many other networks, driven by enthusiastic diabetes champions
- champions meet regularly to share good practice
- the needs assessment can be populated from data from National Diabetes Information Services.

### 3.3 Key components of an effective network

#### 3.3.1 Coordination of care and standardisation of delivery

The National Audit Office report on the effectiveness of neonatal networks<sup>37</sup> identified that a key success of neonatal networks has been the improvement in care coordination through the development of standardised care pathways, referral guidelines and clinical protocols. An evaluation of the impact of managed clinical networks in Scotland also draws this conclusion.<sup>43</sup> There are clear benefits to having standardised clinical protocols and referral guidelines,<sup>44</sup> as they:

- minimise duplication or gaps in care and ensure that patients have access to the same quality of services wherever they live
- improve the quality of care, since everyone is working to the same standards
- enable continuity of care.

The following improvements in gynaecological cancer outcomes have been attributed to the development of service configuration through the establishment of cancer networks:<sup>45</sup>

- survival of women with ovarian cancer improved when they were managed by gynaecologists subspecialising in cancer within a multiprofessional team
- audits of cervical cancer have shown that nonspecialists may be less likely to use appropriate investigations, may underestimate the stage of the cancer and may provide suboptimal treatment.

In neonatology, the declining rates of neonatal mortality may point to the positive impact of neonatal networks.<sup>46</sup> There is also an implied relationship between the establishment of regional stroke networks and improvements in clinical outcomes (owing to patients' increased access to acute stroke therapies).<sup>47</sup>

Commissioning Support for London has produced a case for change for the reorganisation of cardiovascular services in London.<sup>48</sup>

However, the above findings need to be viewed with a degree of caution as it is difficult to claim that, in all of these cases, it is the network organisational form in isolation that has led to improved outcomes. It is for this reason that some of the literature reviewed emphasised the paucity of evidence on clinical outcomes associated with managed clinical networks.<sup>49,50</sup>

#### 3.3.2 Cost-effective management of care

The RCOG reports *The Future Role of the Consultant*<sup>31</sup> and *The Future Workforce in Obstetrics and Gynaecology*<sup>33</sup> set out a case for delivering services through a network approach similar to that used for gynaecological oncology, ensuring that resources are centralised for the infrequent but complex high-risk cases and localised where possible. These reports state that service reconfiguration across sites and working practices may be necessary to ensure the delivery of optimum care, since not all hospitals will be able to provide the full range of obstetric and gynaecological services required.

Managed clinical networks are able to make more efficient use of staff,<sup>44,50,51</sup> but evidence on the financial impact is both scarce and inconclusive. The primary source of evidence on the effectiveness of neonatal networks is the National Audit Office report,<sup>37</sup> which states that it is very difficult to conclude whether neonatal networks have improved value for money.

#### 3.3.3 Multiprofessional working

There is evidence to show that managed clinical networks support and improve multiprofessional working by sharing good practice and learning and dismantling institutional and organisational boundaries.<sup>43,44,49,51</sup> One study demonstrated that referral to a multiprofessional team improved ovarian cancer survival rates since the majority of women with the disease required a combination of surgery and chemotherapy as initial therapy.<sup>52</sup> These women should not be managed by surgeons working in isolation.

### 3.3.4 Effective network enablers

The Expert Advisory Group recommends the following enablers (derived from Goodwin et al.<sup>50</sup>) that must be considered when setting up a network:

- Each network should have sufficient capacity to meet the demands of the service.
- Commissioning must be integrated to overcome fragmentation of services.
- Each network should have appropriate links with public health to engender a culture of preventative care.
- Each network must establish a network management board, the membership of which must include women using the services and commissioners.
- Each network should have clarity about management arrangements, including the appointment of a designated operational lead (managerial or clinical).
- Each network should have a defined structure that sets out the points at which the service is to be delivered and the connections between those points.
- Each network should have a clear statement of the specific clinical and service improvements which women should expect.
- Each network should have documented evidence and be committed to expansion of the evidence base through appropriate research and development.
- Each network should be truly multiprofessional, with representation from patient organisations in the management arrangements.
- Each network should have a clear policy on the dissemination of information to women.
- Each network should have a quality assurance programme.
- Each network should use their education and training potential to the full through exchanges among primary, community and secondary care.
- All health professionals within the network must produce audit data to the required standards.

## 3.4 Bringing together multiple providers

Women's healthcare services will need to be woman-centred and configured in a way that enables integration across different levels of care, delivered by different local healthcare, social care and voluntary sectors. This network of providers should ensure that women experience a seamless pathway of care with minimal fragmentation and duplication. This will require delivery of services beyond traditional organisational boundaries and providers. The role of commissioners will be crucial in coordinating services across networks, ensuring that the totality of care provision is taken into account and that women with multiple conditions, spanning networks, do not have a poor experience or poor outcomes.

A high quality service will be based on what is best for the woman at a specific point in time, regardless of old referral patterns. This will enable much of the core care to be provided locally, keeping disruption to women's lives and that of their children and families to a minimum. Specifically, services should be more integrated rather than defining women's health care into specialties and subspecialties (as is commonly the case at present). A more helpful approach would be to define services as either 'core' community services (such as sexual health, contraception, community gynaecology, screening) or specialist hospital-based services (such as reproductive medicine, gynaecological cancer). This will ensure a seamless transition of care from community (core) to secondary (specialist) care and will minimise fragmentation.

The above model should be defined as a women's health network. This model will offer the opportunity for all providers to work collaboratively. It will also make best use of declining resources, enable expertise to be shared and disinvest in ineffective clinical practice.



## 4 Preferred model: the women's health network

### 4.1 Life-course approach

The women's health network concept is about a woman-centred life-course approach based on the principle of the right care, at the right time, in the right place and provided by the right person. The network would:

- focus on health promotion as well as disease prevention
- use current contact opportunities (such as rubella screening, human papillomavirus vaccination, cervical cytology, pregnancy, menopause or 50 years of age) to promote a healthy lifestyle and potential interventions
- incentivise the public and professionals to embrace the public health agenda
- create opportunities for the public to be educated from an early age to stay healthy from birth and throughout their lives.

This thinking resonates with the Marmot Review<sup>17</sup> and the public health white paper *Healthy Lives, Healthy People*.<sup>53</sup>

“Sir Michael Marmot in his report stated:<sup>17</sup>

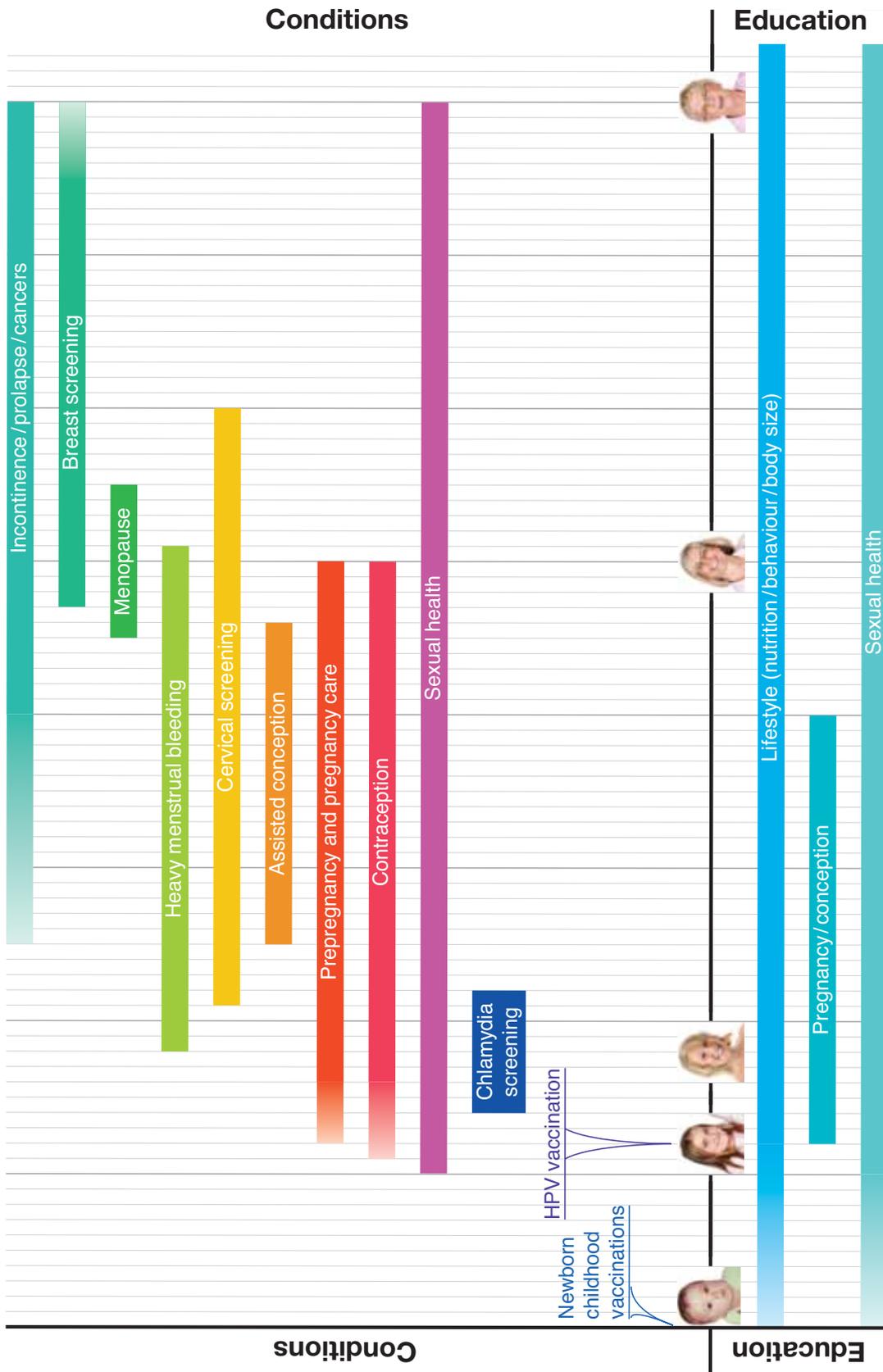
- *Only 4% of NHS funding is spent on prevention, yet the evidence shows that ... targeted preventative intervention can bring important benefits.*
- *Health inequalities are not inevitable and can be significantly reduced. They stem from avoidable inequalities in society: of income, education, employment and neighbourhood circumstances. Inequalities present before birth set the scene for poorer health and other outcomes accumulating throughout the life course.*

The life-course approach sets out to maximise every opportunity that the health service has with a woman to improve her lifestyle and her general health, ultimately to improve her outcomes irrespective of her situation in society. Adopting such an approach to delivering health care will provide women with consistent information from a young age, enabling them to make better decisions about their health. A further opportunity arises at the time of the menopause as this is a significant life event for women and, historically, has been taken as the threshold of old age. However, with the continued increase in life expectancy, menopause should perhaps now be considered as a new beginning. A key recommendation of the British Menopause Society is that all women around the time of their 50th birthday should be invited to attend a health and lifestyle consultation to discuss a personal health plan for the menopause and beyond.<sup>54</sup> The British Menopause Society recommendations can be found in Appendix E.

The life-course approach centres on the relationship between biological behaviours and social exposures during gestation, childhood, adolescence and young adulthood and health outcomes in later life. Predictable women's healthcare needs are depicted in Figure 4.1. The benefits of this approach to women's health care are that:

- reproductive and sexual health are relevant to almost all women and unfold across the life course; by default, healthcare needs are more predictable over a woman's life compared with, for example, sporadic disease episodes
- pregnancy is an optimum time to help promote a healthy lifestyle and introduce preventative measures for reducing ill health in the mother and baby.

Figure 4.1 Predictable women’s healthcare needs



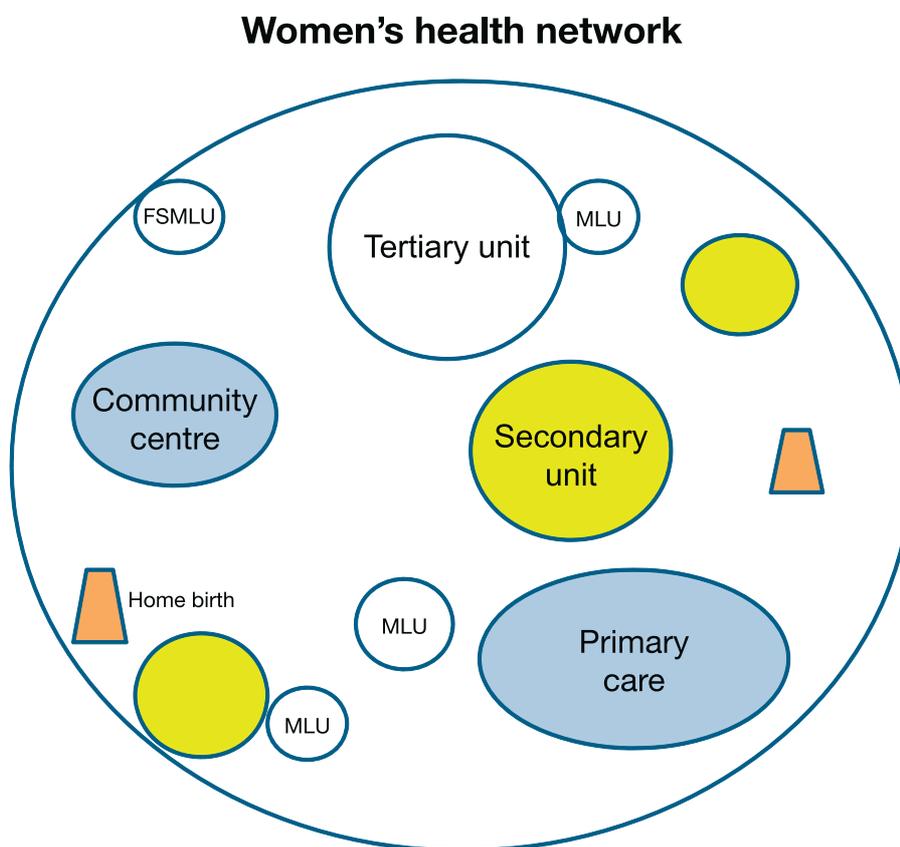
## 4.2 Managed women's health network

The managed women's health network would improve the care of women by bringing together a group of providers working in collaboration in a defined geography within agreed principles and guidelines with respect to settings and standards of care. It would:

- raise the standard of services provided to women
- reduce the fragmented approach to the current provision of services
- encourage healthcare professionals to consider a life-course approach to treatment and the promotion of better women's health, using every interaction with a woman as an opportunity to identify future potential healthcare needs and signposting women to other services
- support multiprofessional working (facilitating standard evidence-based care for all)
- promote care closer to home (more services to be provided in the community)
- locate the appropriate skills mix of staff in the correct facility to maximise outcome, efficiency and cost-effectiveness
- concentrate the clinical workload for complex cases, allowing the teams looking after such cases to maintain and improve their skills
- improve the training of tomorrow's specialists, who will be able to train and learn within networks as opposed to in isolation
- facilitate a shift from the traditional model to a life-course view of a women's health service.

Figure 4.2 shows the potential service settings that may constitute a women's health network with the flexibility of working across different healthcare settings, while Figure 4.3 illustrates links between healthcare settings and activity.

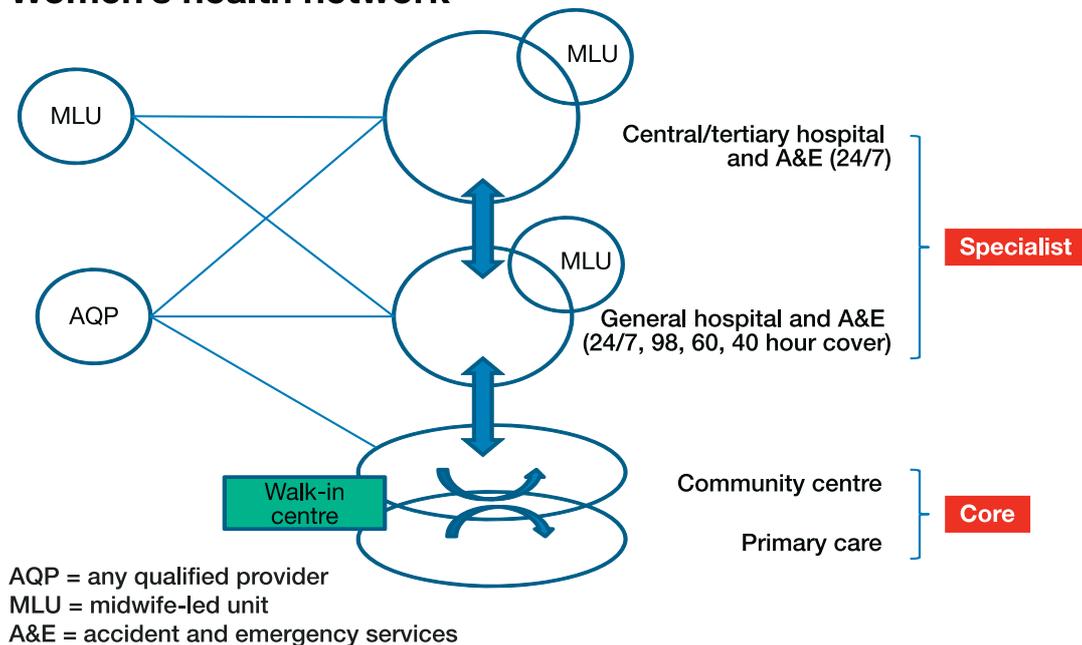
Figure 4.2 Potential service settings in a women's health network



FSMLU = freestanding midwife-led unit; MLU = midwife-led unit

**Figure 4.3 Links between healthcare settings and activity in the women’s health network**

**Women’s health network**



The same levels of service will continue to exist in the network model. However, the network will outline the standards. It will also outline the expected workforce skills and competencies required. Flexibility of the workforce will be needed for the structure to meet the different demands.

The women’s health network will include all aspects of obstetrics and gynaecology, to incorporate sexual and reproductive health. Neonatal care and other co-dependent specialties, such as anaesthesia and emergency medicine, will have to be considered. In addition, there are other clinical services such as those in medicine, haematology, surgery, radiology and pathology which will have to be commissioned where there is an important interface with any aspect of women’s health.

It is accepted that the configuration of general units and specialist centres already exists to some degree and can be built upon to create women’s health networks. Some trusts will provide both general units and specialist centres, but this ideal is not feasible throughout the UK. This model is already embedded in the area of gynaecological oncology.

The women’s health network will facilitate the movement of women according to need and will lead to a more dynamic referral system. The incentive to transfer in the interests of the woman will then be satisfied and will cut across the foundation trust barrier which exists at present. The flow of women across different levels of care will ensure that women are referred to specialist centres when the need arises, but will also allow less complex care and follow-up to be delivered in community and primary care settings.

Risk assessment and stratification will be crucial at every interface; pathway algorithms should be adopted to ensure better direction of care. The competing choice element will have to be articulated over time. There is a need to be mindful that choice needs to be offered in a realistic manner, balancing wants and needs with what is clinically safe and affordable and what resource can be made available without destabilising other services.

**4.3 Network configuration**

There are many types of network – neonatal (22), gynaecological oncology (28) and stroke (28) – but all have different boundaries. **Uniformity of the boundary map to facilitate commissioning**

**and identity would be essential.** The present health board structure in Northern Ireland and Scotland may be the appropriate size to configure such networks. However, in England the dissolution of PCTs and SHAs will complicate the commissioning process. Some sort of regional structure is essential, perhaps using one of the current networks. NHS Wales reorganised its health services in 2009, creating seven local health boards which now plan, commission and deliver healthcare services in their areas.<sup>55</sup>

Another concept may be to develop networks based on a population size of one to two million; alternatively, activity burden (such as, in maternity care, 10 000–30 000 deliveries) may be considered.

Determining the configuration of women's health networks will also require detailed consideration of how changes will impact on other clinical services closely linked to any aspect of obstetrics or gynaecology. The important factors to consider include:

- the woman's comorbidity
- the complexity of surgery
- the availability of co-dependent services (such as appropriate level of neonatal care, emergency medicine)
- the availability of support services (such as interventional radiology, trained cell salvage theatre teams for major haemorrhage)
- out-of-hours service provision
- transfer times to ensure a safe service
- the availability of trained and experienced paramedics as members of the maternity team.<sup>14</sup>

The clinical adjacencies described above largely affect the services delivered at a secondary or tertiary level. For the network concept to be successful, there needs to be a redefinition of the services that are aligned to women's health care in the community. The greatest change required at this level will be access to diagnostic facilities. The network concept encourages the transition of activity from secondary to community settings. However, if access to simple diagnostics is not commissioned for community practitioners, the longer-term viability of care in this setting will be threatened.

It is noted that in England, the revised operating framework for the NHS 2011/12<sup>56</sup> mandates that any service change must comply with four criteria before being given authority to proceed:

- support from GP commissioners
- strengthened public and patient engagement
- clarity on the clinical evidence base
- consistency with current and prospective patient choice.

Once local commissioners are satisfied that their service change proposals meet the four tests, the scheme may then be subject to a National Clinical Advisory Team review, followed by public consultation.

The purpose of the above approach is to ensure public involvement and engagement. The Expert Advisory Group strongly supports this concept to ensure that services are designed by the local population to ensure patient-centred care. This good practice is applicable to all four countries in the UK. In Wales, the structures are already linked: the NHS trusts cover primary and secondary care plus social services. The Welsh structure is designed to promote collaborative care planning. There is a strong emphasis on public health and long-term planning.<sup>55</sup>

## 4.4 Other considerations

### 4.4.1 Resources

The development of a network must be appropriately led and managed. Consequently, this will need to be carefully considered and funded at the outset. Any savings will materialise only in the fullness of time but have the potential to reduce NHS Litigation Authority settlements.

The ramifications of network development will result in changes to the skills mix and clinical competencies at different levels. This has the potential to reduce costs by realigning care at appropriate levels and, consequently, reducing reference costs.

Training and education opportunities will also have to be reconsidered for all professionals involved in women's health care.

#### **4.4.2 Information and communications technology**

Information and communications technology is an essential tool to deliver high quality services. Sharing of information across networks will be crucial to ensure that different providers can work together in an integrated way and that there can be coordinated care planning across the whole system. In the area of maternity care, the woman-held medical record has been a success but probably because it relates to a single event, albeit over a period of nearly a year. It is unclear whether a similar approach will work in other areas.

Data are also essential to measure outcomes and for benchmarking, as well as to provide meaningful information to women and commissioners. These data will also be essential for research so that services can be improved further. At present, simply accessing basic, meaningful clinical information on a national basis for benchmarking of outcomes is impossible. This must change.

The Expert Advisory Group believes that to deliver integrated services, a single information technology system with the following key features is essential:

- an electronic health record
- patient access to the record
- picture archiving and communications
- electronic prescribing
- electronic booking
- telemedicine.

It is appreciated that some components already exist, but uniform electronic platforms need development and coordination.

In terms of the quality of data, we advocate that clinicians take an active role in ensuring that their local information is accurate.

#### **4.4.3 Culture change**

The impact of developing a woman's health network will result in more services being delivered in a primary and community-based setting. Women will still have ready access to hospital-based care but this will be when clinical need dictates or the woman chooses to have her care delivered in this setting (if clinically appropriate). Specialist services are likely to be strengthened by pooling the subspecialist consultant resource into fewer localities, allowing for more focused delivery of care.

It is likely that the medical workforce will be required to be more flexible in the settings in which they work to facilitate improvement in care. This will require contractual negotiations across foundation trusts. However, such an excellent model exists within midwifery, with midwives working across different levels of service. This also facilitates continuity of care for the woman.

Such a major change needs a culture change among professionals (particularly primary and secondary care physicians), commissioners and women. A concerted effort will be required to educate all stakeholders.

## 4.5 Changes to current settings

### 4.5.1 Primary care

Primary care must remain the first point of access for the majority of services for women, similar to the way in which services are delivered now. Access and availability are key. The professional at this level will be the GP. Women will also be able to access services within the primary care setting which will be delivered by other professional groups such as nurses, midwives, physiotherapists and occupational therapists.

The aim of the network at this level will be to promote best practice, assess risk and standardise quality with respect to the delivery of women's health services. The service will offer some treatments, screening diagnostic facilities, information and education. The ways in which this setting of care will change to support the network will be:

- more referrals to community services, resulting in a reduction of referrals to secondary and tertiary care (we know that approximately 50% of emergency medical admissions have not encountered a primary care professional on their journey from home to admission; 45% of these people are discharged within 24 hours and a further 20% have a very short stay only)
- multiprofessional teams located in, and providing care in, the community
- facilitation of regular health promotion (this may maximise the most appropriate resource to take a holistic and long-term view of that individual and her particular requirements).

### 4.5.2 Community care

The services delivered at community level will be based on core services, which all or the significant majority of women may require access to during the course of their lifetime. Many of these services are already provided by colleagues in sexual and reproductive health. Certain elements of more specialist care can also be provided at this level, depending on the technical equipment and facilities required. Clinical work at this level will be multiprofessional, with the team being led by a clinician with the appropriate skill and training. This will most likely be a GP with appropriate specialist knowledge and competencies, a sexual reproductive health consultant or a general obstetrics and gynaecology consultant.

Services at this level will manage women at low risk who require diagnostic support as well as medical management in the community. Local commissioning groups will also be able to determine the scope for provision of other services, such as elements of surgical activity based on skills mix, resource requirements and cost-effectiveness. While support services may be geographically centralised, GPs and community care professionals will require contractual access to those services.

It is expected that there will be a high degree of obstetrics and gynaecology consultant support at this level. Consultants will act as specialist advisors to primary and community care practitioners with clinics in the locality. These consultants will either be employed directly in the community (for example, by a community foundation trust), by the acute trusts or by the network, or will have agreed sessions to support community delivery of services as part of the women's health network. These arrangements will be determined locally, the important consideration being to ensure that appropriate clinical supervision and governance are in place.

### 4.5.3 Secondary care

At the secondary care level, services will be delivered by consultants, with the expectation that the majority of roles will be focused on general obstetrics and gynaecology, excluding subspecialty and tertiary care. Consultants at this level may be expected to work in more than one setting depending on their interests. This may be in the community, supporting the development and management of the community women's health team. Consultants may have a particular interest in one aspect of obstetrics and gynaecology although not as subspecialists. Local activity and configuration may require the consultant to see more women in this area, but it should not be developed as a subspecialist service that is in conflict with other tertiary services.

At this level, women will be seen because of a clear clinical requirement for hospital-based services. Commissioners must ensure the management of women in a clinically appropriate setting through contractual arrangements. However, the woman's choice will remain an important principle and reason for providing care at this level. If a woman wants to attend hospital for her treatment or care, it will be encouraged so long as there is a clear clinical requirement.

There will need to be local consideration of the need and extent of out-of-hours cover depending on service requirement and resource available. Due consideration of delivery suite activity and emergency gynaecological provision should be taken into account.

#### **Case study 4.1: Community-based one-to-one caseload group practice programme in areas of high deprivation, Guy's and St Thomas'**

The caseload group practice programme at Guy's and St Thomas' commenced services in July 2005. Three community-based teams of six midwives are based in areas of deprivation. Each woman has a named midwife. Midwives have a personal caseload size of 36 births/year and caseloads are mixed in terms of their level of risk. The midwives work in partnership to provide out-of-hours cover. This group structure and philosophy supports continuity of carer and care.

##### **Outcomes:**

- Sixty-two percent of women were attended to during birth by their named midwife/partner, and 90% by one of the practice midwives.
- Compared with women receiving standard care (i.e. not caseload care), women receiving caseload care had a higher vaginal birth rate (62% compared with 58%), higher breastfeeding rates (82% compared with 77%), lower caesarean section rates (27% compared with 29%) and lower epidural anaesthesia rates (27% compared with 33%).
- The antenatal missed appointment rate was lower in women receiving caseload care than in those receiving standard care (1.6% compared with 18%), as was the preterm birth rate (5.6% compared with 8%), with Apgar scores less than 7 at 5 minutes remaining at the same level as in the rest of the trust at 3%.

The increase in the home birth rate was influenced by positive home birth stories and early labour assessments in the home (39% of women were assessed at home). Early labour assessment in the home can reduce anxiety while encouraging and supporting women to stay at home longer during early labour. The benefits of home birth include lower costs to midwifery and hospital resources and more 'normalised' childbirth for women.

Missed appointments or 'did not attends' are expensive in terms of wasted clinic time and are a patient safety issue as they reduce women's access to care. The caseload group practices were successful in reducing 'did not attends' by: providing women with the option of home bookings and follow-up care where appropriate and desired; making personalised contact with women to organise place and time of appointments, including booking; and tailoring the location of care to women's needs.

##### **This model of caseload care comprises:**

- personalised contact with women to organise appointments, including bookings
- home bookings and antenatal appointments when appropriate and desired
- early labour assessment in the home
- delayed choice of place of birth until early labour for low-risk women
- continuity throughout antenatal, intrapartum and postnatal periods
- partnership caseloading providing labour cover 24 hours a day, 7 days a week using a week-on, week-off on-call model.

(Source: Florence Nightingale School of Nursing & Midwifery at King's College London.)

#### 4.5.4 Tertiary care

Consultants operating at the tertiary level will typically be subspecialty accredited or at least have a high degree of experience of practising in an area requiring subspecialty skills and training. The majority of consultant time at this level is expected to be spent managing women requiring complex specialist-level care. In addition, consultants will have to manage their local population at a secondary level.

The distribution of these subspecialty services is currently widespread. The network concept will bring many of these services together to strengthen the provision and delivery of these specialties.

From a clinical perspective, the centralisation of specialist services is not a new concept and has been successfully shown to enhance patient outcomes in the management of a number of conditions.

Only a small number of units providing specialist services will be required within each network. The precise number will be based on the total population of the area, influenced by local demographics and geography. Proximity of certain services to others is also an important consideration for non-elective services such as maternity. In these cases, travel times for transfer of care should be considered as part of the configuration dialogue.

From an efficiency perspective, the pooling of subspecialist resources will help reduce duplication of high-cost services on numerous sites. These units are usually coexistent with large secondary care providers.



## 5 Implementing a managed women's health network

It is accepted that the concept of a life-course approach is visionary and will require major changes, which in turn will need a cultural shift by commissioners, providers and the public alike.

The vision cannot be achieved immediately. A planned incremental approach over the next decade will be required. With regard to efficiencies, some will be realised immediately and will be easily measurable. The focus of the life-course approach is health promotion as well as disease prevention. Some savings will take time to come to fruition, while the benefits will be cross-generational and will have a wider impact than just health and social care.

While there are identifiable benefits to setting up women's health networks, there will also be challenges, such as foundation trust autonomy and the lack of a central mandate to develop women's health networks. Those with experience of networks who gave evidence to the Expert Advisory Group were unanimous that success was attributable to national policies and strong national leadership.

*“The National Clinical Director for Diabetes advised during her evidence that one of the key drivers for the success of the diabetes networks was the national service framework, including the appointment of a national clinical leader.*

The Expert Advisory Group therefore recommends the appointment of a National Women's Health Clinical Director to champion implementation and provide leadership. The group explored the key areas that will be challenging and need particular attention in setting up a women's health network. These include:

- the quality agenda, encompassing documented standards underpinned by evidence-based guidance
- service configuration
- workforce
- commissioning.

### 5.1 Quality standards

It is imperative that care is evidence based. There is a plethora of national clinical guidelines produced by organisations such as NICE, SIGN and medical royal colleges, including the RCOG. However, variation in outcomes persists, so it is essential that commissioners build into contracts the requirements to deliver services to national standards and to manage performance against these. It is also important that the Care Quality Commission monitors against national standards such as, within women's health, the RCOG multiprofessional standards *Standards for Maternity Care*<sup>27</sup> and *Standards for Gynaecology*.<sup>28</sup>

NICE has recently been given the responsibility of developing quality standards to be used by the National Commissioning Board to set outcome measures against which to monitor commissioners' performance. Quality standards for women's health must be developed taking into account existing guidelines and RCOG standards.

## 5.2 Service configuration

### 5.2.1 Anticipated changes to service design

It is anticipated that implementation of the women's health network will result in the delivery of more care in a community setting. There are some services which could easily transfer because of the lack of dependence on equipment or other services. An alternative in such cases will be for professionals to work in different settings from those used at present. It is important that services are cost-effective, whatever the model.

**“The King's Fund in its evidence stated:**

*Outreach midwifery workers working in socially deprived communities provided enhanced, targeted support for 'at risk women' who typically experience poor maternal (and other health) outcomes.*

**Two RCOG Council members reflected:**

*Within urogynaecology, basic clinical assessment and initial management of most pelvic floor conditions should be at a primary care level.*

**The British Society for Gynaecological Endoscopy in its evidence stated:**

*Many investigational procedures such as hysteroscopy can be provided in an outpatient/community setting, which improves access for women, increases efficiency and reduces cost.*

#### Case study 5.1

In 1998, a Charter Mark was awarded to sexual health services in Luton. Key to this achievement was the development of community gynaecology services, including colposcopy and cervical treatment, and a menopause service which had a dual-energy X-ray absorptiometry (DEXA) scanner and ultrasound facilities. Initially, acute gynaecologists expressed concern about logistics, quality and governance. Dr X, a consultant in reproductive and sexual health, used all national standards to ensure quality care and invited acute colleagues to advise and assist in the project. Over time, it became clear that the work in the community had a positive effect on quality and the number of referrals to the acute trust. Acute and community services worked with primary care to streamline care pathways. Dr X left in 2003, when provision of hysteroscopy by acute colleagues in the community was the next stage in development.

### 5.2.2 Obstetrics and gynaecology units

Given the scale of the challenge, changes to service configuration will be necessary to ensure delivery of optimum care. It will not be possible for all hospitals to continue to provide the full range of obstetric and gynaecological care in the present configuration.

At present, deliveries occur at home, within a stand-alone midwifery unit, in a co-adjacent midwifery unit (alongside a consultant obstetric unit) or in a consultant-led unit within a hospital setting.

Obstetric care from a consultant perspective is provided in 220 medically staffed units throughout the UK (Table 5.1). There are fewer than 2500 births in 25% of these units. The basic 40-hour consultant delivery suite presence occurs in 136 (64%) of hospitals in England and Wales.

### Case study 5.2

South East London has high referral rates from primary to secondary care in gynaecology. Dr X (the same consultant as in case study 5.1) conducted a health needs assessment around gynaecology in 2005. Demand management work continued thereafter. In 2010, the North Southwark Practice Based Commissioning Group commissioned a community gynaecology pilot run by Dr X in the community sexual reproductive health service. Conditions suitable for referral were defined, the same IT system that GPs use (EMIS) was put in place and the service was put on Choose and Book, the national electronic referral service.

An hour of consultant time was allocated to assess referrals and to speak with GPs about these or to offer advice. This pilot is currently being fully evaluated. It has had excellent patient feedback. Seeing women, discussing referrals and providing advice gave considerable insight into the difficulties and educational needs of primary care. Furthermore, it provided an educational opportunity and enabled the most effective referral patterns. All women seen would have otherwise gone to the acute trust and all but a few were managed in the community.

Engagement of acute colleagues is key to enable the development of such patient pathways. Guy's and St Thomas' and King's are now working with community colleagues to see how the lessons learned from the pilot could be used to introduce effective referral management and use of consistent guidelines throughout the health system. In the longer term, working with primary care to enhance knowledge and skills is the key to improving referral standards. Currently, acute and community services are approaching commissioners together. The door has been opened for all in gynaecology to consider how care can be delivered by involving innovative ways of working while maintaining quality and cost-effectiveness.

**Table 5.1 Obstetrics and gynaecology units, 2010**

Country	Units (n)	Deliveries (n)	Consultants (n)	Units with <2500 deliveries (n)
Scotland	16	64483	221	4
Northern Ireland	11	25935	73	6
Wales	14	34876	98	11
England	179	673711	1794	35
<b>Total</b>	<b>220</b>	<b>799005</b>	<b>2186</b>	<b>56</b>

Source: RCOG Medical Workforce Census 2010 [<http://www.rcog.org.uk/our-profession/good-practice/medical-workforce-census>].

With the implications of the WTR and the likely reduction in trainee numbers within obstetrics, gynaecology and neonatology, the present number of units providing obstetrics and gynaecology is likely to reduce.

As discussed earlier, there is a need to redesign the configuration and delivery of women's services to provide safe and high quality care within existing resource constraints. The configuration of services within networks will provide a solution to the current situation and maximise the choice agenda by facilitating the full range of delivery options.

Maternity services will be provided from all settings, with high-risk obstetric services being positioned within a network and some units providing a degree of specialist services but referring on to other trusts within the network for more specialist care.<sup>14</sup>

Within gynaecology, there will be different implications for each subspecialty. In the UK, for example, there has been an emerging shift in gynaecological care, separating medical and diagnostic gynaecology (which can be provided in non-hospital settings) from surgical gynaecology.<sup>33</sup> Surgical procedures will be performed in secondary and tertiary hospitals, depending on the complexity of the procedure and local expertise, as is the case in the current gynaecological cancer care model. Lessons from the ‘care closer to home’ pilots in gynaecology<sup>34</sup> have suggested that it is possible to stratify gynaecological care and devolve provision for some aspects of care to non-hospital settings, as summarised in Table 5.2.

**Careful consideration will need to be given to the provision of emergency gynaecology which can be facilitated within a women’s health network, with appropriate flexibility of the consultant workforce. This will be particularly relevant for out-of-hours care.**

Primary care	The development of the GP with a specialist interest might lead to a significant percentage of gynaecological services being dealt with in-house. Accreditation processes would ensure quality control.
Community care	<p>The following conditions are potentially amenable to community management with referral to secondary care only at the appropriate stage, when specialist intervention is required:</p> <ul style="list-style-type: none"> <li>● heavy menstrual bleeding</li> <li>● incontinence</li> <li>● infertility</li> <li>● menopausal symptoms</li> <li>● premenstrual symptoms</li> <li>● pelvic pain</li> <li>● contraception and medical termination of pregnancy.</li> </ul> <p>Access to ultrasound is essential to enable provision of a wider range of gynaecological care in the community.</p> <p>Delivering gynaecology in the community should not represent a shift from specialist to generalist care. Rather, it presents an opportunity for integrated care; therefore, care pathways need to be in place, clearly showing the transition from simple to complex care.</p>
Specialist care	Delivered in specialist centres; for example, major pelvic surgery.
Subspecialist care	Gynaecology subspecialists will continue to provide an essential hospital-based service. Since the majority of this work is elective, the geographical location is less important than for obstetrics care.

### 5.2.3 Paediatric units

The RCPCH has recently proposed that to staff all of the UK inpatient paediatric units (218) with appropriate numbers of doctors at each tier of service in a safe and sustainable way, comply with the WTR and relate trainee numbers to consultant opportunities, significant change will be required in a structured manner.<sup>35</sup> The RCPCH report sets out ten standards which the RCPCH considers to be a minimum for all acute general paediatric services. Two scenarios for this change are suggested. The first describes a moderate reconfiguration converting 48 small and very small inpatient units (based upon annual emergency paediatric admissions) to 32 short-stay paediatric assessment units, closing the other 16 units. The more radical scenario converts 76 small and very small units to 50 short-stay paediatric assessment units, closing the remaining 26 units. The majority of the closures involve units that are within a 30-minute normal drive of other inpatient facilities. This may have ramifications for hospital maternity unit configuration and needs careful collaboration.

## 5.3 Workforce

The provision of safe and high quality care requires an appropriately skilled and competent well-trained workforce. This will require:

- recognition that **childbirth is an emergency service** requiring 24/7 provision
- developing **standards and planning for workforce** (numbers and training)
- understanding and responding to **capacity**
- defining and implementing an appropriate **skills mix**
- having sufficient **supervision** in place
- **improving job satisfaction**
- **career planning**: maximising the potential of the workforce, especially concentrating on retaining staff with expertise and developing career progression to ensure the best use of skills and competencies, especially in view of the rise in the retirement rate.

The proposals in this report will have an impact on workforce generally, including midwifery, anaesthesia, neonatology, general practice and nursing, which are not examined to the same extent as obstetrics and gynaecology. A more detailed appraisal will be needed.

The current UK obstetrics and gynaecology consultant workforce totals 2186. In current consultant practice, 1471 (67%) practise both obstetrics and gynaecology, 416 (19%) practise gynaecology only and 241 (11%) practise obstetrics only. The remaining 58 (3%) are unknown. In the majority of units, out-of-hours care (i.e. between 8 p.m. and 8 a.m. Monday to Friday and all weekend) is provided by doctors in training with consultant supervision from home and within 30 minutes of the hospital. The proposals are to increase consultant on-site presence depending upon unit size, but the ideal of consultant presence 24/7 will take time to materialise.

Careful planning needs to start now to match training numbers with future consultant opportunities. In obstetrics and gynaecology, a target of 3000–3300 consultants was proposed in the *Future Workforce in Obstetrics and Gynaecology* report,<sup>33</sup> based upon the present configuration of hospital units and standards for consultant delivery suite presence. However, if training numbers reduce, as is being considered by the Centre for Workforce Intelligence, the service will be unable to staff the current number of middle-grade rotas and, consequently, the number of hospital units will have to be reduced to allow delivery of a safe service. Any reduction in the number of trainees must be implemented in conjunction with appropriate consultant expansion, depending on future reconfigurations, but certainly not before.

In *The Future Role of the Consultant*,<sup>31</sup> the RCOG outlines how gynaecologists might work within managed clinical networks, providing a potential framework for the different role of gynaecologists. This is summarised in Table 5.3.

Medical and diagnostic gynaecologist	Minor surgery Will need to refer to trained surgical gynaecologist for advanced pelvic or subspecialist surgery
Community gynaecologist	Trained in medical gynaecology with appropriate advanced skills Hospital-based consultant providing community services
Surgical gynaecologist	Spends a substantial amount of their time providing a service to women who require major gynaecological surgery, maintaining their competence Must have sufficient access to beds and operating time to maintain competencies Depending on size and need of unit, some will also need to provide an obstetric service Should work as part of a managed clinical network
Gynaecological subspecialist	Working within a tertiary referral unit with a regional or subregional referral practice

### 5.3.1 Obstetrics and gynaecology subspecialist consultants

Consultants at subspecialist level will be either subspecialty trained, having completed a Certificate of Completion of Training (CCT) in the subspecialty, or an individual who spends 50% (or more) of their time working in the subspecialty. These roles would be centralised into a smaller number of tertiary units to ensure high enough levels of activity to maintain the relevant skills and knowledge. Table 5.4 shows the current number of subspecialists in obstetrics and gynaecology.

**Table 5.4 Number of subspecialists holding Certificate of Completion of Training (CCT) and number in subspecialty posts, 2010**

Subspecialty	Consultants (practising)	CCT holders
Fetal and maternal medicine	134	152
Gynaecological oncology	161	135
Reproductive medicine	100	103
Sexual reproductive health	22	31
Urogynaecology	82	40

Source: RCOG Medical Workforce Census 2010 [<http://www.rcog.org.uk/our-profession/good-practice/medical-workforce-census>].

### 5.3.2 Obstetrics and gynaecology consultants (generalist)

The obstetrics and gynaecology consultant (generalist) provides a broader range of services than a subspecialist consultant. The range of special interests within a network will dictate the nature of the service and where it will be best delivered to allow maximum flexibility within which the consultants practise.

Within the new configuration, many consultants will continue to practise exclusively in a hospital setting. However, an increasing number will be expected to develop a specialist service in the community in partnership with GPs. In this role, the consultant will lead a multiprofessional team, acting as an advisor to clinical colleagues.

#### **Case study 5.3: General gynaecology clinics and routine antenatal care for women at low risk in GP surgeries or community hospitals**

- Provides care nearer home for women.
- Provides opportunities for primary care education and involvement of GPs with a special interest in women's health to work alongside consultants.
- Provides a one-stop service for most women where supporting services such as ultrasound are co-located.

Mr A, a consultant obstetrician and gynaecologist, is based in a major teaching hospital in Bristol. Once a fortnight he provides a clinic in Clevedon, a small town 15 miles from the base hospital. The clinic takes place in the outpatient department of a community hospital, which has co-located radiology and physiotherapy and also provides clinics in medicine of the elderly, general medicine and surgery.

Mr A has an ultrasound scanner available for his clinic and is supported by nursing and clerical staff. If surgery is needed, women are admitted to the base hospital in Bristol, but otherwise all women from Clevedon have their outpatient appointments in Clevedon.

The community hospital is also used for weekly community-based antenatal clinics for low-risk pregnant women. The care is midwife led and the routine ultrasound scans are performed by sonographers who divide their time between the base hospital and community clinic.

### 5.3.3 Obstetrics and gynaecology trainees

If the number of hospital units is reduced, as recommended in this report, there is the potential to maximise the training opportunities throughout more of the working week (168 hours) than is the case at present. Indirectly, this will enhance the training experience with an extension of out-of-hours training by consultants.

The requirement for consultants to practise across secondary care and in the community will need to be reflected in the training model. Commissioners of education and training will need to ensure educational providers are aware of local geographical services.

The RCOG has responsibility for setting the curricula for training and is willing to work collaboratively with other professional bodies, particularly the Royal College of General Practitioners (RCGP), to develop education standards.

### 5.3.4 Midwifery

The RCM workforce data for England suggest that the current birth rate demands approximately 25 000 WTE midwives while there are only just over 20 000, a shortfall of almost 5 000 (a more detailed analysis of the regional shortfall is presented in Appendix F). This leads to heavy workloads, stress and demoralisation among the existing workforce. Such a shortage, which has existed for many years, encourages exit from the profession and has led to high and rising litigation costs. This situation must improve.

### 5.3.5 Anaesthesia

Challenges to anaesthesia workforce planning are similar to those experienced in obstetrics and gynaecology, with the possibility that changes in consultant working patterns may not only increase the incidence of early retirements but may also discourage women from entering the specialty.

Evidence suggests that the anaesthesia workforce is already stretched. Not all consultant-led obstetric units have the recommended number of consultant sessions and there are a number of unfilled staff and associate specialist posts and consultant vacancies that have not been advertised. Additionally, an effect of the WTR is that an increasing number of hospitals have reduced tiers on call with the result that the obstetric duty anaesthetists have to cover intensive care or general theatres as well as the labour ward; that is, there has been a reduction in the number of hospitals meeting the RCoA recommended standards.

The potential mismatch of CCT holders to available consultant posts in the near future requires consideration of a reduction in trainee numbers. However, if numbers are reduced, there will be difficulties in providing the service. From the latest RCoA census, it is known that staff and associate specialist doctors provide 24% of the service, but there is good evidence that attempts to expand this grade have exhausted the pool of potential candidates within the UK. It is likely that consultant expansion will need to be increased from the current 4% per annum to meet the demands of the service. If all current non-advertised consultant vacancies were filled and consultant expansion increased to meet the service gap, even the predicted number of CCT holders in the next few years will be inadequate to meet the demand in the short term, although a reduction in trainee numbers in the future will be inevitable. In the current financial climate, any expansion in consultant numbers is likely to require a significant change to consultants' working patterns.

### 5.3.6 Neonatology

The 2011 RCPCH workforce report<sup>35</sup> concluded that to deliver a safe and sustainable service, the current UK consultant workforce in paediatrics needs to expand from 3084 WTE posts to between 4500 and 4900 WTEs, depending upon which scenario is adopted. In addition, working practices will also need to change, with increased use of resident consultants, an expansion of the number of advanced nurse practitioners and an increase in the number of GPs trained in paediatrics. It is recommended that the number of specialty trainees be reduced from 3000 to 1720 WTEs.

### 5.3.7 Nursing

Nursing has an increasing and important role in delivering care in obstetric and gynaecological services. This is particularly relevant in colposcopy, hysteroscopy, fertility and urogynaecology, for example. These advanced nursing roles will need to be developed further to provide a solution to some of the workforce pressures. Appropriate curricula need to be developed and the roles formalised to assist with an integrated workforce plan.

In neonatology, a survey conducted in 2010 showed that 67 of 96 units did not meet nursing staffing standards.<sup>57</sup> The report estimated a shortfall of approximately 1150 nurses to provide direct hands-on care to babies across England. This shortfall was particularly marked in neonatal intensive care.

### 5.3.8 Emergency medicine

Emergency medicine is available 24 hours a day, treating all patients, at all times, with all illnesses and all injuries, including women presenting with obstetric and gynaecological conditions. The particular skills of emergency medicine clinicians are the diagnosis and management of an unselected patient caseload, including the resuscitation of the critically ill and injured pregnant and non-pregnant woman and all conditions related to pregnancy or gynaecological disease. Some women access early pregnancy assessment units directly. Women requiring immediate resuscitation or with trauma-related conditions attend emergency departments, as this is where the concentration of resuscitation skills lies.

There is a tension between the requirement for specialised care and the need for immediate availability of clinicians 24/7. Until all services are available at all times, it is likely that the emergency departments will continue to be the place where many women present with obstetric and gynaecological emergencies, particularly out of core hours.

Emergency medicine is moving towards a consultant-delivered service, with consultant expansion allowing consultant presence in emergency departments in the evenings and at weekends.

The College of Emergency Medicine's training curriculum includes six domains relating to pregnancy and gynaecology: pregnancy, vaginal bleeding, pelvic pain, ectopic pregnancy, sexually transmitted disease and sexual assault.

### 5.3.9 General practitioners

Although the number of GPs increased in the 12 months to September 2010, the WTE decreased by 2.4%. Similarly, the number of practice nurses decreased by 3.1% WTE and health visitors by 4.6% WTE. Table 5.5 shows the number of GPs in December 2010.

Country	Number of GPs
England	47 225
Scotland	6060
Wales	3001
Northern Ireland	1772
Channel Island	208
Non-UK	1438
Unspecified	35
<b>Total</b>	<b>59 769</b>

Source: General Medical Council, December 2010.

Although the Centre for Workforce Intelligence has sanctioned a modest increase in GP training numbers for the next period,<sup>58</sup> there is significant concern that some GP training posts remain unfilled. This is worrying because of the need for added capacity in areas of deprivation and the likely impacts of part-time working and new managerial demands on available GP clinical time.

The involvement of GPs in maternity care has rapidly declined in recent years. This has led to a consensus statement, developed and approved by the RCGP, RCM and RCOG. As a minimum, the Colleges believe that GPs should be able to:

- provide preconception care, especially for women with complex medical or social needs, in collaboration with other specialists
- provide counselling and health promotion in early pregnancy. This would include competence in management and appropriate referral for conditions such as bleeding and hyperemesis, obesity and smoking cessation management
- provide information about screening in pregnancy, as determined by the UK National Screening Committee, and initiate or refer promptly for the tests
- provide an early pregnancy consultation to check the woman's general health, including a review of her medical history from the medical records and an examination of the heart. The GP should then formally communicate, with the woman and members of the maternity team, any issues of medical, psychiatric or social significance for the pregnancy
- signpost childbearing women with emergency conditions directly to hospital. For less urgent conditions, face-to-face assessment by the GP may be appropriate. GPs need to be competent to recognise, manage and refer conditions such as pre-eclampsia, sepsis, headache and breathlessness in pregnancy
- provide postnatal care, including contraception advice and a postnatal examination
- provide follow-up care for diabetes, hypertension, anaemia, sepsis, mental health or conditions which may have complicated pregnancy.

Strategic policy should encourage GPs to maintain skills and competencies around the impact of pregnancy and childbirth on women's general medical and social health. It should reinforce the value of retaining relationships with GPs during pregnancy and the crucial role of GPs in continuing care for women with underlying medical conditions. Policy should reiterate the importance of GPs and midwives sharing information as partners in care to facilitate optimum specialist maternity care provision for women. In remote and rural areas, the GP's role in maternity care may be enhanced to ensure appropriate medical input, through GPs retaining a range of obstetric skills which facilitate safe provision of antenatal, intrapartum and postnatal care for women.

This can happen only if skills are acquired in training and maintained in practice, through continuing education. The RCGP needs to ensure that all GPs in training receive training to equip them for this role. The messages from the Confidential Enquiry into Maternal Deaths need to be adopted and disseminated by the RCGP, which should also develop educational material and activities to ensure that GPs can maintain and update their skills in maternity care.

## 5.4 Training

A change in configuration of the service will result in a change to the workforce requirement. There is therefore a need to map service requirements with appropriate skills. Integrated training needs to be developed further to maximise clinical opportunity and experience for medical, midwifery and nursing professionals.

The obstetrics and gynaecology training programme allows development of advanced skills which support the breadth of experience required of a consultant (generalist).

The changes proposed with respect to consultant roles and the setting of care will have a significant impact on the current model of training. Subspecialist and Advanced Training Skills Module training programmes will need to be coordinated to ensure that workforce numbers and skills match service requirements. The GP curriculum includes competencies in relation to women's health as well as skills in areas such as sexual health and contraception. These are supported by additional diplomas in obstetrics and gynaecology (DRCOG) and sexual reproductive health (DFSRH). Flexibility is the key.

“The British Society for Gynaecological Endoscopy in its evidence stated: *If elective gynaecology is devolved to a variety of providers, it might be necessary to insist that trainees receive part of their training in those facilities.*”

## 5.5 Commissioning

For a women’s health network to be successfully implemented and deliver truly integrated women’s services, the commissioners themselves must network to meet the demands of the service, in addition to addressing the following three challenges:

- the size of the network
- the life-course approach to women’s health care
- the concept of ‘any qualified provider’.

### 5.5.1 Size of the network

The size of the network could be based on a population of one to two million or 10 000–30 000 births, which will be larger than the scope of some commissioning organisations at present. There are a number of potential configurations which could be considered, including SHAs, PCTs, health boards, deaneries and other network maps. It would be sensible to coordinate any template to facilitate the commissioning of health and social care throughout the UK.

Notable geographies, such as rural and remote communities, may require a more disparate specialist model to ensure that high level care is available.

### 5.5.2 Life-course approach

The life-course approach to women’s health care will require commissioning of tertiary, secondary and primary services together with public health and a link to some social services.

### 5.5.3 Any qualified provider

All providers must work within the overall service provision framework of the network. Commissioners must ensure adequate provision of all services for their population without disadvantaging any provider, to prevent one provider cherry-picking the most profitable component of the service, for example.

### 5.5.4 Commissioning arrangements

The different commissioning models present in the UK mean that implementation of the women’s health network will have different implications for each country depending on the local structures.

#### England

The proposed new commissioning roles will mean that three organisations will be responsible for commissioning care across the spectrum of women’s health:

- The National Commissioning Board will be responsible for defining specialist services and contracting with GPs.
- The GP consortia will be responsible for commissioning secondary care and some community care services (maternity and gynaecological services).
- Local authorities will be responsible for the commissioning of public health, including sexual health services and termination of pregnancies.

Health and wellbeing boards have an important role, bringing together the three commissioning arms and public voice.

If the network is to be effective in breaking the boundaries between traditional settings of care and integrating the care given to women, these organisations will need to work together to ensure that a local commissioning plan is developed and delivered.

PCTs in the short term (to 2013), and subsequently GP consortia, will have to work together to jointly commission services for the women's health network, coordinating services for a population of one to two million. One model for this would be the lead PCT model, where a single PCT negotiates and commissions activity on behalf of other PCTs.

### **Scotland**

Local services are managed by the 14 regional health boards. These organisations are responsible for allocating funds to services within the region and also for managing the subsequent provision of care. The health boards are involved in planning, providing hospital care, defining and providing community services, contracting with GPs and commissioning specialist services. Specialist services are commissioned by the National Services Division.

The implementation of the women's health network is likely to involve working across regional health board boundaries where geography and specialist services dictate. The population size for the network may need to be adapted to take account of geography and proximity to services.

### **Wales**

NHS Wales reorganised its health services in 2009, creating seven local health boards which now plan, commission and deliver healthcare services in their areas. These replaced the 22 local health boards and the seven NHS trusts which together performed these functions in the past. Seven contiguous community health councils represent the interests of the public in the health service in their district.<sup>55</sup>

### **Northern Ireland**

Health and social care are already managed jointly, making integration simpler. The Health and Social Care Board is responsible for commissioning services from all five trusts. There are small regional commissioning units that would need to play a role in the commissioning process. The population size and commissioning structure should allow for a fully integrated commissioning network. Having one centralised commissioner should allow for a simpler approach. There will still be a need to challenge the provider structures.



## 6 Summary of findings and recommendations

- 6.1 The combined force of the NHS reforms and workforce and financial pressures, against a backdrop of rising demand, increasing complexity and changes in demographics, means that the status quo is not an option and the delivery of women's health care in the current configuration will not be sustainable. (Chapter 2)
- 6.2 While much works well in current provision, evidence tells us that more can be done to improve women's services. (Chapter 2)
- 6.3 Given the current workforce pressures, there is a need to think laterally about how services can be provided and by whom, as well as the input, role and training of the wider multiprofessional team. (Chapter 2)
- 6.4 A radical re-think of the current organisation and configuration of women's health care is required to ensure that the required efficiency savings can be achieved without compromising quality. This will require different ways of working and different configurations of multiprofessional teams to ensure appropriate use of skills and competencies. (Chapter 2)
- 6.5 While choice is supported in principle, there is a need to be mindful that choice has to be delivered in a realistic manner, balancing wants and needs with what is clinically safe and affordable and what resources can be made available without destabilising other services. (Chapter 2)
- 6.6 Different approaches to networks have all worked well in the UK, as long as the underpinning principles are followed and local needs are taken into account in designing the service. (Chapter 3)
- 6.7 At present, the service tends to fire-fight as a reactive response to disease rather than be proactive in preventing ill health. Now is the opportunity to reconfigure services, using every opportunity to improve health gain in light of the unsustainable nature of the current arrangements. (Chapter 3)
- 6.8 Commissioning women's health care through a managed women's health network will facilitate better coordination of care, standardise delivery, improve clinical outcomes, be more cost-effective, support more multiprofessional working, improve access and lead to a better experience for women. (Chapter 3)
- 6.9 The women's health network will facilitate a shift from the traditional model to a life-course view of a women's health service. This will maximise every opportunity that the health service has with a woman to improve her lifestyle and her general health, ultimately improving her outcomes irrespective of her situation in society. Adopting such an approach to delivering health care will provide women with consistent information from a young age, enabling them to make better decisions about their own health. (Chapter 4)
- 6.10 All women around the time of their 50th birthday should be invited to attend an NHS health and lifestyle consultation to discuss a personal health plan for the menopause and beyond. (Chapter 4)
- 6.11 The women's health network will include all aspects of obstetrics and gynaecology, to incorporate sexual and reproductive health and primary care. Neonatal care and other co-dependent specialties, such as anaesthesia and emergency medicine, will have to be considered. (Chapter 4)
- 6.12 The network concept aims to encourage the transition of activity from secondary to community settings and will therefore have an impact on the configuration of all current health service settings. (Chapter 4)
- 6.13 It is likely that the medical workforce will need to be more flexible in the settings in which they work to facilitate this improvement in care for women. (Chapter 4)

- 6.14 Information and communications technology solutions are urgently required so that different providers and policy makers can have access to information to improve services for the population as a whole. (Chapter 4)
- 6.15 The Expert Advisory Group recommends the appointment of a National Women's Health Clinical Director to champion implementation and provide leadership. (Chapter 5)
- 6.16 Care must be evidence based and services must be commissioned using the RCOG's multiprofessional standards: *Standards for Maternity Care and Standards for Gynaecology*. It is imperative that the Care Quality Commission monitors against these national standards. (Chapters 2 and 5)
- 6.17 With the implications of the WTR and the likely reduction in trainee numbers within obstetrics, gynaecology and neonatology, careful consideration will need to be given to the need for the current number and configuration of delivery units, the majority of which remain within a hospital setting. It is likely that there will be an increase in the number of midwife-led units, which women will be able to use after validated risk assessment, ensuring choice where appropriate. (Chapters 2 and 5)
- 6.18 Careful planning needs to start now to match training numbers with future consultant opportunities. This process should be undertaken on a national basis. (Chapter 5)
- 6.19 A proactive approach is required by all multiprofessional groups to develop new training programmes to ensure that skills and competencies are appropriate for potentially different roles in the future. (Chapter 5)
- 6.20 For a women's health network to be successfully implemented and deliver truly integrated women's services, commissioners will need to address the size of the network, the life-course approach to women's health care and the 'any qualified provider' concept. (Chapter 5)
- 6.21 Commissioners must build into contracts the requirement to deliver services and manage performance against national standards. (Chapter 5)

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# Appendix A

## Expert Advisory Group

### Purpose

The Expert Advisory Group will be part of the structure and governance of the review *High Quality Women's Health Care: A Proposal for Change*. It will provide support for the Chair in conducting the review and in developing the final recommendations.

### Aims and objectives

- Determine the sources of information and evidence to be considered.
- Consider the reports and studies already undertaken in this area by other relevant organisations.
- Support the Chair in taking written and oral evidence from stakeholders.
- Discuss and support the analysis of the evidence and advise on the conclusions to be made to the RCOG.
- Monitor the progress of the review against the agreed objectives.
- Provide input to the final review report.

### Membership

The membership of the group is outlined below. Members to represent the views of the organisation to which they belong.

- Dame Joan Higgins (Chair)
- Ms Cath Broderick, RCOG Consumers' Forum
- Dr Chris Clough, National Clinical Advisory Team
- Mrs Charnjit Dhillon, RCOG Director of Standards
- Ms Deborah Evans, NHS Bristol (PCT)
- Dr Anthony Falconer FRCOG, RCOG President
- Dr Diana Hulbert, College of Emergency Medicine
- Ms Mervi Jokinen, Royal College of Midwives
- Miss Heather Mellows FRCOG
- Professor Neena Modi, Royal College of Paediatrics and Child Health
- Professor Lesley Regan FRCOG
- Professor Wendy Reid FRCOG, RCOG Vice President (Education)
- Dr David Richmond FRCOG, RCOG Vice President (Standards)
- Professor Steve Robson FRCOG, British Maternal and Fetal Medicine Society
- Dr Judy Shakespeare, Royal College of General Practitioners
- Dr Anne Thornberry, Royal College of Anaesthetists
- Professor Suzanne Truttero
- Mr Sanjay Vyas FRCOG
- Professor Cathy Warwick, Royal College of Midwives
- Invited member: Miss Christine Robinson FRCOG,  
Faculty of Sexual & Reproductive Healthcare

Support was provided by:

- PA Consulting Group
  - Miss Elaine Garrett, RCOG
  - Mrs Karen Cheung, RCOG
- } Evidence gathering and synthesis

## Appendix B

### Participating organisations

Association of Early Pregnancy Units  
BirthChoiceUK  
Bliss: the special care baby charity  
British Association of Perinatal Medicine  
British Fertility Society  
British Gynaecological Cancer Society  
British Maternal and Fetal Medicine Society  
British Society of Gynaecological Endoscopy  
British Society of Urogynaecology  
Care Quality Commission  
Child and Maternal Health Observatory  
Children, Young People and Families' Network  
The College of Emergency Medicine  
Department of Health  
East Midlands Public Health Observatory  
East of England Specialised Commissioning Group  
Eastern Region Public Health Observatory  
Faculty of Sexual & Reproductive Healthcare  
Infertility Network UK  
King's Fund  
Making it Better (the Greater Manchester Children, Young People and Families' NHS Network)  
Medical Education England  
Mid Staffordshire NHS Foundation Trust  
National Childbirth Trust  
National Clinical Advisory Team  
National Perinatal Epidemiology Unit  
NHS Bristol  
NHS West Midlands  
Royal College of Anaesthetists  
Royal College of General Practitioners  
Royal College of Midwives  
Royal College of Nursing  
Royal College of Paediatrics and Child Health  
Trent Cancer Registry  
University Hospitals Coventry and Warwickshire NHS Trust  
Walsall Manor Hospital

# Appendix C

## Review methodology

The review gathered information, opinion and evidence using the following methods:

- literature review
- written evidence
- oral evidence.

## Literature review

A literature review was conducted before, and independently of, the written submissions and oral evidence hearings. The literature review was developed through the following six stages:

- initial literature search (1990–2010)
- initial shortlist
- review and appraisal of initial shortlist
- second literature search
- shortlist and prioritisation
- literature review.

A rigorous methodology was applied to ensure that the identification of literature was logical, transparent and attuned to the review's overarching aims. In total, 72 documents were reviewed. For each document, a summary of methodology and key findings was produced.

## Written evidence

A total of 29 written evidence responses were received from a range of organisations. All written responses were analysed and inputted onto the review evidence database and used to inform report writing. The organisations included:

- professional societies
- RCOG Council members
- regulatory bodies
- training bodies
- public health observatories
- service user groups
- trusts, SHAs and specialised commissioning groups
- research bodies.

## Oral evidence

Oral evidence was reviewed and used to inform the development of the report. Oral evidence was gathered from the following ten organisations:

- British Gynaecological Cancer Society
- Department of Health (Strategy, Workforce, Midwifery)
- Department of Health National Diabetes Team
- Faculty of Sexual & Reproductive Healthcare
- Making it Better (the Greater Manchester Children, Young People and Families' NHS Network)
- National Childbirth Trust
- National Clinical Advisory Team
- Royal College of General Practitioners

- Royal College of Midwives
- Royal College of Nursing

## Scrutiny group

In addition to the Expert Advisory Group, a further scrutiny group of nine (members of the RCOG Council) was established to test the assumptions and conclusions of those drafting the report.

# Appendix D

## Generic principles of high quality women's health care

### Quality

***High quality women's services should eliminate unwarranted variation in clinical practice and intervention rates.***

- All services should be compliant with essential standards (Care Quality Commission, NICE, NHS Litigation Authority/Clinical Negligence Scheme for Trusts, medical royal colleges).
- All services should facilitate normal childbirth wherever possible, with medical interventions recommended only when they are of benefit to the woman and/or her baby.
- Seamless care should be provided across the whole system; care should follow the woman across a whole pathway that incorporates links with other agencies, including social care.
- Care must be monitored as part of the delivery of the service.

***High quality women's services should achieve improved outcomes for women and their families.***

- Outcomes should be based on implementation of evidence-based practice (including NICE, SIGN, RCOG guidelines) as well as NICE quality standards.

***High quality women's services should promote family-centred care underpinned by strong clinical leadership working across providers and with a common set of values.***

- Women should be involved in planning and making decisions about their care, supported by advice and information from professionals.
- Services should respect the values, culture and preferences of each woman and her family.
- Women should be provided with clear information at all stages of treatment.
- The care provided should be reliable, appropriate and provided in systems that foster coordination and a safe culture.

***High quality women's services are delivered by high performing multiprofessional teams, underpinned by strong clinical leadership and a common set of values.***

### Innovative

***High quality women's services should deliver the best possible outcomes with the most appropriate use of resources and technology.***

***High quality women's services should provide seamless care across the whole system.***

- Care should be coordinated across a care system.
- Services should be commissioned in a network that includes access to the provision of both routine and specialist care.
- Optimum models for staffing and skills mix should be deployed to achieve safe, sustainable service delivery.
- 'One stop shop' principles should apply wherever possible.

## **Productive**

***High quality women's health care should adhere to the principle of the right care delivered at the right time, in the right place and by the right person.***

- There should be a clearly defined pathway in place for relevant investigations, with referral arrangements in place.
- There should be ready access (depending on clinical need) to diagnostic support services, operating theatres, critical care facilities, emergency services and specialist/tertiary-level care.

## **Prevention focused**

***High quality women's services should tackle inequalities in care and reduce variations in safety, outcomes and experience.***

- All women and families should have access to, and receive, the same high quality, high value care.
- Services should be proactive in engaging all women, particularly women from disadvantaged groups and communities.
- Local arrangements should be in place for access to dietetics and smoking cessation services, with clear pathways in place and publicised to commissioners, providers and service users.

***High quality women's services should be accessible.***

- Services should be offered in a range of settings (appropriate to clinical need), with flexible service operating times.

# Appendix E

## Recommendations from the British Menopause Society

In considering the issues that affect the health of women after the menopause, the British Menopause Society makes the following recommendations. They are principally addressed to policy makers at national and local levels in the hope that they will contribute to actions that will lead to real improvements in the quality of life of women in their postmenopausal years. They are applicable across the UK.

### Key recommendation

Primary care teams should invite women on their register, around the time of their 50th birthday, to attend a health and lifestyle consultation to discuss a personal health plan for the menopause and beyond.

### Further recommendations

#### 1 National policy and strategy

- 1.1 We recommend that all local health communities should have an osteoporosis strategy and ensure that the prevention, detection and treatment of osteoporosis are effectively managed.
- 1.2 We recommend that all local health communities should have a strategy for cognitive impairment and its management to ensure that the prevention, detection and treatment of cognitive impairment and Alzheimer's disease are effectively managed.
- 1.3 We recommend that the NHS should, as an early priority, assess the quality and effectiveness of treatments, including surgical interventions, most frequently provided for women aged over 45 years.
- 1.4 We recommend that public health policy should specifically draw attention to opportunities for improvements in the health of elderly women.
- 1.5 We support the government's commitment to reduce deaths from cancer and recommend that the breast screening programme should, as a matter of course, include women over 70 years of age.
- 1.6 We recommend that within the government's plans to reduce deaths from coronary heart disease, special attention should be given to strategies for primary and secondary prevention of coronary heart disease among women.
- 1.7 We recommend to the Department of Health that they should provide clear, objective information about the benefits and risks of hormone replacement therapy, as they are known at the present time. This would reduce confusion and misinformation for both healthcare professionals and women.
- 1.8 We recommend that the NHS Executive and its regional offices review existing patterns of expenditure on research and development to identify the proportion that is committed to the expansion and improvement of knowledge about the health and health care of women over the age of 45 years.
- 1.9 We recommend that the development of new drugs and other therapies should specifically take account of the characteristics of women, including those who are members of ethnic minority groups and those who are elderly.
- 1.10 We recommend that NICE gives early attention to the conditions and procedures which most frequently affect women over the age of 45 years and develops guidelines in relation to these as a priority.
- 1.11 We recommend to the Department of Health that a premature menopause register should be established as a priority. All those women who have undergone premature menopause and are consequently at greater risk of osteoporosis, cardiovascular disease and cognitive decline should be on this register.

## **2 Community policy**

- 2.1 We recommend that senior schools and colleges of higher education consider expanding the relevant elements of the curriculum to ensure better knowledge about healthy and active ageing among the wider population, with awareness of the differences in health outlook between the sexes.
- 2.2 We recommend that free swimming be reintroduced for the over 60s as a positive aid to health and mobility.
- 2.3 We recommend that local organisations representing women and having an interest in various aspects of their health come together annually to organise a 'women's health day' to increase awareness.

## **3 Local healthcare delivery**

- 3.1 Primary care teams should invite women on their register, around the time of their 50th birthday, to attend a health and lifestyle consultation to discuss a personal health plan for the menopause and beyond.
- 3.2 We recommend that the new replacements for primary care groups and trusts take a whole population view of the needs of women aged over 45 years and work closely with local agencies, employers and voluntary organisations to develop health improvement strategies.
- 3.3 We recommend that primary care teams designate a doctor and nurse to take a special interest in the women aged over 45 years registered in their practice to ensure that needs are assessed, risks are identified and best practice for treatment and care is implemented consistently among this group.

# Appendix F

## Royal College of Midwives: workforce data for England, 2009

	Strategic health authority									
	North East	North West	Yorkshire and the Humber	East Midlands	West Midlands	East of England	London	South East	South West	Total for England
Number of births	29919	87999	66729	54050	71455	71684	129946	104145	58618	674545
Number of births in hospital	28124	82719	62725	50807	67168	67383	122149	97896	55101	634072
Number of midwives needed <sup>a</sup>	1004	2954	2240	1815	2399	2407	4362	3496	1968	22645
Number of home births and births in birth centre	1795	5280	4004	3243	4287	4301	7797	6249	3517	40473
Number of midwives needed <sup>b</sup>	51	151	114	93	122	123	223	179	100	1156
Total number of midwives needed (without natural wastage)	1056	3105	2355	1907	2521	2529	4585	3675	2068	23801
Plus 5% (natural wastage)	53	155	118	95	126	126	229	184	103	1189
Total number of midwives needed (with natural wastage)	1109	3260	2472	2003	2647	2656	4814	3859	2172	24992
Actual number of midwives (whole-time equivalent, 2009)	1064	3053	2063	1411	2234	1831	3784	2854	1943	20237
Shortfall	-45	-207	-409	-592	-413	-825	-1030	-1005	-229	-4755
Shortfall as percentage of total needed	4	6	17	30	16	31	21	26	11	19

a. Number of midwives needed for hospital births based on the recommended ratio of 1 WTE midwife per 28 births

b. Number of midwives needed for midwife-led birthing units and home births based on the recommended ratio of 1 WTE midwife per 35 births.

## Glossary

AQP	any qualified provider
BAPM	British Association of Perinatal Medicine
CCT	Certificate of Completion of Training
Community care	The collective term for care provided outside the GP practice and hospital setting
DEXA	dual-energy X-ray absorptiometry
FSMLU	freestanding midwife-led unit
GP	general practitioner
MLU	midwife-led unit
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
PA	programmed activity
PCT	primary care trust
Primary care	The collective term for all services which are people's first point of contact with the NHS
RCGP	Royal College of General Practitioners
RCM	Royal College of Midwives
RCoA	Royal College of Anaesthetists
RCOG	Royal College of Obstetricians and Gynaecologists
RCPCH	Royal College of Paediatrics and Child Health
Secondary care	The collective term for hospital services to which a person is referred for specialist medical services and care (outpatient and inpatient services)
SHA	strategic health authority
SIGN	Scottish Intercollegiate Guidelines Network
Specialist	A doctor on the General Medical Council Specialist Register
Subspecialist	A specialist having completed the RCOG subspecialty programme
Tertiary care	The collective term for hospital services to which a person is referred for complex specialist medical services and care (outpatient and inpatient services, usually provided by a subspecialist)
WTE	whole-time equivalent
WTR	Working Time Regulations