NHS England

To: Rt Hon Caroline Nokes MP
Chair, Women and Equalities Committee
House of Commons
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cc. Maria Caulfield, Minister for Women, and Professor Dame Lesley Regan, Women's Health Ambassador

Dear Ms Nokes

Follow up to oral evidence session for 'women's reproductive health' inquiry

Thank you for inviting me to give oral evidence to the Women and Equalities Committee's inquiry on 'women's reproductive health' on 29 November. Following the session finishing early due to time pressures, I am now writing with a response to the remaining questions you have shared with us. Please find my responses to these questions below.

There have been calls to move away from using the term 'benign' to describe gynaecological conditions as it has contributed to their deprioritisation. What is the Department, and NHS England doing to support a shift in approach?

Use of the term 'benign' is not unique to gynaecology as it is widely used across a range of medical specialties. There are two areas where the term might be used and where there are two dichotomies at play – cancer/not cancer and disease/not disease that create a hierarchy of importance.

I. **Diagnosed diseases/No cancer** such as endometriosis or fibroids might be considered as benign even though the harms caused are significant. This applies to many conditions across different specialties and is the way of distinguishing from cancer. Calling a disease benign in this context potentially diminishes the importance given to timely and appropriate management which may not always be appropriate, e.g. two week wait pathways are purely to exclude cancer rather than, for example, managing a woman with extreme anaemia secondary to fibroids who may be unwell
II. **Symptoms/no diagnosed disease** – this is where women's health diverges from other areas because much of women's 'health' relates to the impact of reproductive symptoms - not necessarily disease based and referred to as benign, e.g. pain and heavy bleeding/incontinence. These can impact lives very significantly and are therefore harmful in effect and arguably not benign either.

We are aware of the Royal College of Obstetricians and Gynaecologists' call to move away from using the term 'benign' to describe gynaecological conditions and would welcome any evidence that can be shared. This is a complex issue and perceptions can be influenced by the clinical and non-clinical understanding of the term 'benign'.

What role does NHS England play in influencing the research landscape, and does it do enough to ensure these conditions receive the attention they need?

Whilst NHS England specifies national health and care priorities in the NHS Long Term Plan, including for research, Integrated Care Systems develop a detailed understanding of the health and care needs of their local population, and may develop their own local health, care and research priorities.

NHS England influences the research landscape by undertaking programmes and activities that increase the scale, pace and diversity of research, including by increasing opportunities for people to take part in research, developing system guidance and assurance, and by leading demand signalling for national research priority areas. NHS England is also leading on the development of the NHS Research Secure Data Environments (SDE) Network, a significant data asset for health and care research in England.

I'm aware the Committee also posed specific questions on research into women's reproductive health. However, the Department of Health and Social Care would be best placed to answer these as they commission research through the National Institute for Health and Care Research (NIHR). The Women's Health Strategy sets out the government's commitments to boost research into women's health issues through the NIHR.

I hope this information is helpful to the Committee and would be happy to provide any further details if required.

Yours sincerely,

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NHS England