Written Evidence from the Royal College of General Practitioners [WRH0034]

Introduction:

General practice acts as the point of access for many who are concerned about their reproductive health. Women make up 51% of the population and 47% of the workforce and it's important that general practice is able to care for them at every stage of their life. The needs of women are relatively predictable across the life-course; however the process will be different for each woman and each will require individual holistic assessment, management and support.

What constitutes healthy periods and reproductive health?

The World Health Organisation (WHO) defines reproductive health as a "state of physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so." [1]
Reproductive health is a term that encompasses much broader experiences than gynaecological or urogynaecological conditions, it can include, pregnancy loss, fertility care, abortion care, contraception and is perhaps beyond the scope of this short inquiry which seems to be largely focused on gynaecological or urogynaecological conditions.

A period is the part of the menstrual cycle where the lining of the uterus, which has thickened during ovulation, sheds and is dispelled from the body out of the vagina. The clinical focus of GPs is often on menstrual dysfunction. The RCGP toolkit on Menstrual Wellbeing states that, "Dysfunction of the menstrual cycle causes physical, social and psychological impact, compromising education, work, social and family life. There are many myths and stigma about periods meaning many women, girls and those assigned female at birth are too embarrassed to discuss their problems. Empowering women of all ages to raise their concerns openly, including any problems related to sex, improves the short and long-term outcomes." [2]

The toolkit further notes that menstrual dysfunction can sometimes be related to conditions such as endometriosis, premature ovarian insufficiency, or gynaecological cancers. One in 10 women of reproductive age suffer with endometriosis, affecting 1.5 million women - the same number diagnosed with diabetes – costing the health and social care economy an estimated £8.2 billion/year. Early management of endometriosis is important to reduce the long-term consequences of untreated disease: subfertility, ectopic pregnancy and chronic pelvic pain. Premature ovarian insufficiency (POI), defined as menopause aged less than 40, affects 1 in 100 women. Management with replacement hormone therapy reduces the long-term consequences of POI: cardiovascular disease, osteoporosis and cognitive impairment. Endometrial cancer is the commonest gynaecological malignancy in the UK with increasing incidence - exacerbated by obesity - with nearly 9000 new cases diagnosed in 2015. The psychological impact of menstrual disorders is underestimated; a recent survey of women with heavy menstrual bleeding found that of 1000 surveyed: 4% experienced anxiety and 67% suffered with depression.

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[1] WHO: Reproductive Health
[2] RCGP: Menstrual Wellbeing Toolkit

The National Institute for Health and Care Excellence (NICE) provide guidance on the assessment and management of heavy menstrual bleeding.[3] This guidance aims to help healthcare professionals investigate the cause of heavy periods that are affecting a woman's quality of life and to offer the right treatments, taking into account the woman's priorities and preferences. All GP practices are expected to take into account the recommendations in NICE clinical guidelines when deciding what treatments to offer people.

What are women's experiences of being diagnosed with, undergoing procedures and being treated for gynaecological or urogynaecological conditions?

The consultation process for the recent Women's Healthcare Strategy received almost 100,000 responses from women across the country, it provided a valuable insight into women's experiences of being diagnosed with, undergoing procedures and being treated for gynaecological conditions.

Access to information was highlighted as a key issue, with only 8% of respondents reporting they felt they had access to enough information on gynaecological conditions like endometriosis and fibroids. Concerns were also reported that women are not listened to in instances where pain is the main symptom such as painful periods and that there is a harmful normalisation of certain issues like incontinence and pelvic organ prolapse that should be accepted after childbirth.

As part of the Women's Health Strategy there were two procedures regularly sighted by respondents as being particularly painful to undergo, hysteroscopy and IUD insertion. Hysteroscopies are usually performed in gynaecological outpatient settings. The second edition of the RCOG Green-Top guideline, which provides best practice guidance for outpatient settings, is currently in development and will provide updated guidance on how best to manage pain in these settings.[4]

IUD insertions are sometimes used as a treatment option for gynaecological conditions and these fittings can be carried out within a general practice setting. It is important that any healthcare professional who performs IUD fittings are aware of the updated standard on consent from the Faculty of Sexual and Reproductive Health as well as their updated statement on pain with IUD insertion.[5, 6] It is unacceptable for any woman to walk away from an IUD fitting feeling traumatised by the level of pain she has experienced and GPs have a duty to ensure that all pain management options are discussed and that shared decision making takes place regarding analgesic options for IUD insertion.

Gynaecological or urogynaecological care can often be fragmented and it can be difficult for women and those assigned female at birth to get a timely diagnosis and treatment. Women have reported speaking to doctors on multiple occasions over many months or years before receiving a diagnosis for conditions such as endometriosis, for which the average time to diagnose is 7.5 years. There has been limited research into women's health issues and more research into gynaecological conditions is needed for a greater understanding of how these conditions impact women and how we can meet the health needs of women.

The RCGP recognise the important role that general practice plays in the experiences of women seeking diagnosis, treatment and undergoing procedures related to gynaecological and urogynaecology. The RCGP Curriculum topic guide stresses the need for GPs to "understand that some women may find it

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[3] NICE: Heavy menstrual bleeding: assessment and management
[4] RCOG: Hysteroscopy, Best Practice in Outpatient
[5] FSRH: Service Standard on Obtaining Valid Consent
[6] FSRH: Statement: Pain associated with insertion of intrauterine contraception

difficult to discuss intimate health issues, for many reasons." and that GPs should "endeavour to adopt a 'woman-centred life course' approach, using current
contact opportunities occurring over a woman's life (e.g. HPV immunisation, cervical screening, contraceptive consultations, pregnancy, menopause) for health promotion and potential interventions".[7]

The RCGP Women's Health Library provides up to date educational resources and guidelines on women's health that are relevant to GPs and other primary healthcare professionals, it includes a toolkit categorised into sections best representing the needs of women at different stages of their lives.[8]

What disparities exist in the treatment and diagnosis of gynaecological or urogynaecological conditions?

Disparities in the treatment and diagnosis of gynaecological and urogynaecological conditions stem from unequal access to healthcare, biases in diagnosis, and differences in treatment options. Factors such as race, socioeconomic status, and location can lead to delays in diagnosis, misdiagnosis, or inadequate treatment. Cultural, linguistic, and socioeconomic barriers, along with underrepresentation in clinical trials, contribute to unequal outcomes. Addressing these disparities requires raising awareness, promoting culturally sensitive care, improving access, and reducing biases in healthcare delivery.

The RCGP curriculum topic guide stresses the need for GPs to consider the "risk factors, including lifestyle, socio -economic and cultural factors" when considering gynaecological or urogynaecological conditions.

What barriers exist in the treatment and diagnosis of gynaecological or urogynaecological conditions?

GP practices are responsible for caring and supporting women through a range of reproductive health care needs, sometimes alongside secondary health care teams. Gynaecological and urogynaecological training is a key part the GP curriculum. GPs are however expert generalists and have the widest scope of medical training despite having the shortest training programme, at three rather than five years as common for most specialisms. GPs are trained to support patients with undifferentiated conditions, often identifying potential health problems at the earliest stage, when they are the most difficult to diagnose.

To help support GPs who want a fuller understanding of women's health the RCGP worked with Royal College of Obstetricians and Gynaecologists (RCOG) and the Faculty of Sexual and Reproductive Healthcare (FSRH) to put together an online library of educational resources and guidelines on women's health that for GPs and other primary healthcare professionals. It brings together national guidance, resources produced and accredited by the RCGP, and resources from the.

It is important that GPs are supported to and given enough time for continued training. However, a recent survey by the RCGP found that 63% of GPs do not have enough time to undertake training alongside their practice work. This has impacts on the level of care General Practitioners are able to deliver to their patients. General Practice is under immense pressure and is facing a workforce and workload crisis. The number of patients per GP 2,302 as of June 2023, this is an increase of 7.4% since 2019 and General practice staff delivered 340 million appointments in 2022, which is 9% more than in 2019.[9]

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[7] RCGP Curriculum Topic Guide
[8] RCGP: Women's Health Library

GPs need more protected training time in the next GP contract to ensure that general practitioners have proper time for continue professional development to enable them to deliver world-class care to all patients.

For many women, it is preferrable to be treated locally by their GP where possible and GPs want to be able to deliver the highest possible care to all patients. Treatment for gynaecological conditions, such a pessaries for prolapse or incontinence and coil fittings for heavy menstrual bleeding, can and should be delivered by general practice. However, very often GPs do not have the capacity to deliver this care themselves or are not able to access the appropriate funding to deliver this care and are forced to refer women into secondary care, where waiting lists for treatment are incredibly long.

Fragmentation of care remains a barrier to diagnosis and treatment of gynaecological or urogynaecological conditions. For example, the Health and Social Care Act 2012 led to the fragmentation of commissioning responsibilities for sexual and reproductive health provision in England between local authorities, CCGs (now ICSs), and NHS England. This has led to a system in which providers are delivering separate services without clearly defined accountabilities, and the linkages between different parts of the care pathway have been lost, such as ICSs commissioning abortion services, while local authorities commission contraceptive care. This creates a break in the care pathway which means that people who access abortion services are not automatically referred into full contraceptive or sexual health services. A coordinated approach to commissioning of sexual and reproductive health, pooling policy and shared aims, would not only improve patient pathways but would also make the entire system more robust.

The introduction of Women's Health Hubs (WHH) could help to alleviate some of the issues with fragmentation if the model is flexible enough for ICSs to develop systems that are best suited to local populations and are able to build effectively on existing services and community assets.

The RCGP support a vision of WHHs that results in more women being seen in the right setting, by the right professional, at the right time. What we would not support is a model where women's health is completely removed from the standard work of general practice. Women should have the right to be able to talk to their GP about any issue and GPs are trained to support patients with any health issue and make appropriate referrals.

We recently coauthored a shared position statement with other Royal Colleges and specialist societies representing healthcare professionals working across primary care, secondary care and sexual and reproductive health services.[10] The statement provides further detail on the key areas for consideration when outlining and developing the WHH model. Key passages from the statement are set out below:

- "The overarching ambition of the Women's Health Hub (WHH) model must be to improve women's access and experiences of care by better integrating the services and support they require throughout their reproductive life course. Integrated Care Systems (ICSs) have a unique opportunity to improve the way care pathways work for women living in their footprint, determining priorities based on local need."

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[9] RCGP: Key Insights and Statistics
[10] RCGP: Women's Health Hubs

- "The WHH model provides an opportunity for collaborative working between primary and secondary care, alongside sexual and reproductive health services, to ensure a holistic approach to women's healthcare provision."

- "GP practices care and support women close to home in a holistic manner and are responsible for meeting many of women's sexual and reproductive healthcare needs alongside all other care women and their families need."

- "It is important to recognise that implementing a WHH model will not always result in the creation of a new building or physical space as the 'hub'. Instead, ICSs should think of the hub model as building upon and better integrating the existing women's health services and support across general practice, secondary care and sexual and reproductive health (SRH) services. Co-location of services on existing sites will likely play a key part in the development of the WHH model."

- "DHSC must provide resources to support effective integration of services that looks at solutions to existing barriers to integration, including issues relating to commissioning structures, historic workforce employment arrangements, and clinical governance and leadership."

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