Written evidence from Royal College of Obstetricians and Gynaecologists (RCOG) [WRH0056]

RCOG response to the Women and Equalities' Select Committee Inquiry into reproductive health

RCOG welcomes the Women and Equalities Select Committee's decision to investigate women's reproductive health, with a focus on gynaecological and urogynaecological conditions. Gynaecological conditions was the area that members of the public most wanted covered by the Government's Women's Health Strategy[1]. Despite having a significant impact on individuals' quality of life, gynaecological conditions have been consistently deprioritised in public policy, health service delivery, and research and we welcome the opportunity this inquiry presents to bring this to light.

Good reproductive health is enabled by women and people who menstruate being able to make informed decisions about their health and care throughout their life course, and access high quality, personalised treatment and support when they need it. Good reproductive health is intrinsically linked with access to reproductive rights, and the freedom to decide if, when, and how often one has children. Reproductive health covers everything from access to contraception and abortion care services, fertility treatment and maternity care, to post-reproductive health and high-quality menopause care. We encourage the committee to explore in further detail all of these areas. Based on the questions set out in the call for evidence, our response focuses solely gynaecological and urogynaecological health, an area of reproductive healthcare which can often be deprioritised, or considered too narrowly in the context of fertility.

1. Key points and recommendations

- **There is a low level of understanding of what constitutes a healthy periods and good gynaecological and urogynaecological health.** Stigma and misinformation play a role in the lack of knowledge amongst the population, and the normalisation of symptoms such as heavy bleeding, pain and incontinence can often prevent women from accessing diagnosis and treatment.
- **Gynaecological and urogynaecological conditions and symptoms are prevalent amongst the population**; up to one in three women live with Heavy Menstrual Bleeding, one in ten women have Endometriosis, around 2 in 3 women will develop at least 1 Uterine Fibroids in their lifetime, and the prevalence of Urinary Incontinence has been pegged at as many as 40% of women.
- **The impact of poor gynaecological health is significant; with evidence showing poor quality of life and reduced ability to take part in work, school, family and social life.** The impact is now well understood in the health system, and the use of the term 'benign' misconstrues the true nature of living with a gynaecological condition.
- **Waiting lists in planned gynaecology services continue to rise more rapidly than all other elective specialties; and have more than doubled since the start of the COVID-19 pandemic.** Huge geographic disparities continue to exist, creating a postcode lottery for specialist care.
- **The RCOG are calling for a joint DHSC/NHSE-led taskforce to unlock the opportunities to reduce waiting lists in gynaecology**, and we continue to call for a national ring-fenced budget for recovery and long-term sustainability of elective gynaecology services.

[1] Results of the women's health strategy call for evidence, DHSC (2021)

- Current pressures on general practice have made it challenging to consistently deliver high quality care for women, including speedy diagnosis and medical and conservative management outside of specialist settings. **There must be investment in general practice to allow GPs to have the capacity to better meet women's needs, as well as protected time and funding to undertake continued professional development.**
- **There is potential for the women's health hub model to improve access and experiences in care for gynaecological and urogynaecological conditions.** There needs to be significant and continued investment in the model to make this a reality.

2. Understanding what constitutes healthy periods and gynaecological health

The definition of good gynaecological health and menstrual wellbeing should focus on women being able to live happy, healthy and fulfilling lives. What this looks like will be individual to every person, but every woman should feel equipped with the education and information to make decisions and manage their menstrual health. Crucially, they should have access to the right diagnosis, treatment and wider support when they experience poor gynaecological health, so that it does not inhibit their wider health outcomes or their quality of life.

Menstruation, or a period, is the shedding of blood and tissue from the lining of the uterus through the vagina. What constitutes a 'normal' period varies from person to person. The menstrual cycle (the time between the first day of a period and the start of the next one) can last anywhere between 21 and 40 days. 28 days is the average of people from 20 to 45 years old who are not using hormonal contraceptive medications or devices and do not have a health condition that can affect cycle length[2] . However, it is normal for a person's cycle lengths to vary by 2 to 4 days[3]. Cycle lengths also decrease with age[4].

Most people have periods that last between 3-7 days and, on average, lose 70-80ml of fluid (the equivalent of a double espresso cup)[5]. However, anything up to 160-170ml of fluid (the equivalent of a tall disposable plastic cup) is considered normal. Losing more than this is considered to be Heavy Menstrual Bleeding (HMB). HMB can also make a period last longer than a 'normal' one[6].

Missing a period or having a late period is not always a cause for concern. Periods naturally stop during pregnancy and at the start of menopause. Periods may also stop due to medication, including some contraceptives. However, missing more than three periods in a row may be a symptom of another health problem, such as polycystic ovary syndrome (PCOS), low body weight, high bodyweight or obesity.

Throughout the menstrual cycle, people may experience cyclical side effects. This is because menstruation, as well as ovulation and the thickening of the womb lining, are all inflammatory events. These changes are variable between individuals and may go up and down during the cycle.

Many women and people experience pain during a period. This can be direct pain due to womb or uterine cramps, or pain due to other menstrual changes such as pelvic muscle or spine inflammation, water retention, constipation, diarrhoea or trapped gas. These can be experienced as lower back

[2] Menstrual periodicity: statistical observations on a large sample of normal cases, Gunn, D.L., Jenkin, P.M. and Gunn, A.L. (1937)
[3] The normal variabilities of the menstrual cycle, Cole, L. A., Ladner, D. G. and Byrn, F. W. (2009)
[4] The Menstrual Cycle, Vollman, R. F. (1977)
[5] Menstrual Blood Loss... What's Normal? Menstrual Matters [Webpage accessed September 2023]
[6] A systematic review of methods to measure menstrual blood loss, Magnay, J. L., O'Brien, S., Gerlinger, C., & Seitz, C. (2018)

pain, a feeling of abdominal heaviness, or an aching vulva. For the majority of women, periods cramps are only mildly or moderately painful[7]. Severe period pain that is not relieved by anti-inflammatory approaches such as painkillers may be a sign of an underlying gynaecological condition, such as Endometriosis, Adenomyosis or Uterine Fibroids.

It is also common to experience mood changes during the menstrual cycle. Contrary to popular belief, these can be positive as well as negative. Premenstrual Syndrome (PMS) is the name given to physical and emotional symptoms that can occur in the two weeks before menstruation. PMS is frequently misunderstood to refer only to mood-related problems, such as low or changing moods and irritability. However, common PMS symptoms also include headaches, tiredness or problems sleeping, changes in appetite, and sore or tender breasts. Nearly all women and people who menstruate have some premenstrual symptoms, but between 2 and 4 in 100 women get PMS that is severe enough to prevent them from carrying out normal daily activities. A very small number of people experience severe negative mood changes during the premenstrual phase of the menstrual cycle, this is known as Premenstrual Dysphoric Disorder (PMDD).

3. Improving understanding of gynaecological and urogynaecological health

There is poor understanding amongst the population of what constitutes a healthy period and good gynaecological health. In response to the public consultation on the UK Women's Health Strategy, only 8% of respondents felt that they had access to enough information on gynaecological conditions and only 17% on menstrual wellbeing. Lack of menstrual health knowledge is particularly high among young women and girls, with one in seven reporting that they didn't know what was happening when they started their period[8].

Knowledge amongst the population around pelvic floor health is also poor, despite the fact that the most common symptoms associated with pelvic floor dysfunction (urinary incontinence, anal incontinence, and pelvic organ prolapse) are very common. Polling commissioned by the RCOG found that over one in 10 UK adult women do not know what the pelvic floor is, and this increases to nearly one in five women aged 18-34.This lack of knowledge permeates, and can also mean that poor menstrual wellbeing, gynaecological and urogynaecological health is not recognised and acted upon in health settings[9].

Stigma and misinformation play a large role in the lack of menstrual and gynaecological health knowledge amongst the population. There is an immense societal pressure on women and girls to conceal their periods due to beliefs that menstruation is unhygienic or unclean, and talking openly about periods is often not considered as a social norm. Women are expected to anticipate and tolerate period pain, heavy bleeding and negative mood changes.

Stigma also exists around symptoms of pelvic floor symptoms, with incontinence (particularly following pregnancy and childbirth) often being normalised. RCOG commissioned polling showed that over half (53%) of women who had experienced symptoms of pelvic floor dysfunction did not seek help from a healthcare professional, with 39% of these women believing their symptoms were normal, and 21% feeling too embarrassed[10].

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[7] The prevalence and risk factors of dysmenorrhea, Ju H, Jones M, Mishra G. (2014)
[8] Break the Barriers: Girls' experience of menstruation in the UK, Plan UK (2018)
[9] Pelvic floor health position statement, RCOG (2023)
[10] Press release: RCOG calling for action to reduce number of women living with poor pelvic floor health, RCOG (2023).

This normalisation of symptoms associated with urogynaecological and gynaecological ill-health is dangerous. It can very often leave those who are affected by menstrual or urogynaecological conditions to suffer in silence, with worsening symptoms that can have wide-reaching negative impacts on every aspect of their lives.

4. The impact of poor menstrual and gynaecological health

As recognised by the World Health Organisation, good reproductive health should be defined not only by the absence of infirmity or disease but a 'state of complete physical, mental and social wellbeing'[11].

Gynaecological and Urogynaecological conditions and symptoms are prevalent. Up to one in three women face Heavy Menstrual Bleeding[12] and one in 10 women have endometriosis, a similar number of women affected by diabetes[13]. Polycystic Ovary Syndrome (PCOS) is also thought to affect around one in 10[14], and around 2 in 3 women will develop at least 1 Uterine Fibroids at some point in their life (although many of these may be asymptomatic)[15]. Symptoms of Pelvic Floor Dysfunction are also incredibly common, with one study showing the prevalence of Urinary Incontinence amongst women at nearly 40%[16].

Gynaecological and Urogynaecological conditions and poor menstrual health can have an enormous negative impact on quality of life. Women surveyed by the RCOG reported reduced ability to participate in their work, school, family and social life as well as significantly lowered self-esteem as a result of symptoms[17]. These findings are echoed in other research, which shows that quality of life worsens with Endometriosis-related pelvic pain[18], Uterine Fibroids[19] and Prolapse[20].

The challenges of managing symptoms is exacerbated by the stigma associated with menstrual and pelvic health. Several women who were experiencing heavy bleeding and urinary incontinence as a result of their condition reported to RCOG feeling unable to leave the house at all for fear of symptoms being exposed in a public or social setting.

The burden of poor Gynaecological health is particularly heavy on women and people in deprived areas, who report more severe symptoms and poorer condition-specific quality of life[21]. For many low-income people in the UK, the cost of heavy periods can be unmanageable. A survey commissioned by ActionAid UK found that 21% of women and people who menstruate are struggling to afford period products[22]. This is particularly challenging for girls and young women at school, with research from Plan UK showing that nearly two million girls aged 14-21 in the UK have missed a part

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[11] Constitution, World Health Organization [accessed 2023]
[12] Information for women: Heavy periods, Women's Health Concern [accessed 2023]
[13] Endometriosis facts and figures, Endometriosis UK [accessed 2023]
[14] Polycystic ovary syndrome, NHS UK [accessed 2023]
[15] Fibroids, NHS UK [accessed 2023]
[16] Prevalence of female urinary incontinence and its impact on quality of life in a cluster population in the UK J Cooper et al (2014)
[17] Left for too Long, RCOG (2022)
[18] The Impact of Endometriosis on the Quality of Life and Incidence of Depression - A Cohort Study, Damian Warzecha et al (2020)
[19] Impact of uterine fibroids on quality of life, Fernandez Hervé et al (2018)
[20] Pelvic organ prolapse patient information leaflet, RCOG (2013)
[21] Sociodemographic differences in symptom severity and duration among women referred to secondary care for menorrhagia in England and Wales: a cohort study from the National Heavy Menstrual Bleeding Audit, Kiran A, Gurol-Uranci I, et al (2017)
[22] Cost of living: UK period poverty has risen from 12% to 21% in a year, ActionAid (2023)

day or full day of school because of their period[23]. **As a member of the FSRH Hatfield Vision Taskforce, the RCOG is calling for universal access to free menstrual products within health services and schools[24].**

There are also racial disparities in the incidence and experiences of Gynaecological conditions. Studies show that black women are three times more likely than white women to be diagnosed with Uterine Fibroids, develop them earlier in life and experience larger and more numerous fibroids, causing more severe symptoms, however more research is required to explain why this is the case[25].

As well as the costs to women and people themselves, gynaecological conditions and poor menstrual health has consequences for wider society and the economy, particularly due to reduced work. A survey of 1000 women by Health and Her estimated that menopause alone costs the UK economy 14 million working days per year in terms of time spent alleviating menopause symptoms – the equivalent of £1.8 billion loss in GDP[26].

5. Women's experiences of gynaecological conditions

It is important that the inquiry hears directly from women and people with Gynaecological and Urogynaecological conditions about their experiences. While experiences of treatment vary and many are positive, there are barriers to timely and respectful Gynaecological healthcare, which are outlined later in the submission.

Many women feel unheard and frustrated by healthcare professionals. The recent UK Government survey for the Women's Health Strategy reported that more than 80% of respondents felt that there had been instances when they, or a woman they knew, were not listened to by a healthcare professional[27]. This experience was more prevalent among those who identified as a gender different to their sex registered at birth than cisgender respondents. In recognition of the poorer experiences reported by trans and gender diverse individuals who need access to Obstetrics and Gynaecology services, the RCOG is currently developing a clinical guideline to support members to provide inclusive and accessible care for all[28].

The normalisation of symptoms, such as pelvic pain, is a major factor in women not feeling listened to in the health system. According to the Gender Pain Gap Index report, 56% of women feel that their pain was ignored or dismissed by health professionals[22]. Stereotypes about black women and women of colour having lower pain thresholds continue to underwrite racial disparities in maternal mortality[29].

Women and campaign groups continue to raise the poor experiences of women when undergoing gynaecological procedures. The RCOG is clear that women experiencing significant pain during procedures is not acceptable and should not be normalised. The College has recently published a best practice paper on pain relief and informed decision-making for outpatient hysteroscopy[30], and

[23] Nearly two millions girls in the UK miss school because of their period, Plan UK (2021)
[24] FSRH Hatfield Vision, Faculty of Sexual and Reproductive Health (2022)
[25] The Health Disparities of Uterine Fibroids for African American Women: A Public Health Issue, Eltoukhi HM, Modi MN, Weston M, Armstrong AY, Stewart et al (2013)
[26] Written evidence from health and Her (WEC select committee Inquiry into menopause in the workplace), Women and Equalities Select Committee (2021),
[27] Women's Health Strategy call for evidence, UK Government (2021)
[28] Draft guideline on the care of trans and gender diverse people within obstetrics and gynaecology, RCOG (2022)
[29] Racial Injustice campaign information, Birth Rights [accessed 2023]
[30] RCOG Good Practice Paper: Pain Relief and Informed Decision-Making for Outpatient Hysteroscopy, RCOG

we are supportive of the 2021 statement from the FSRH on pain associated with insertion of intrauterine contraception[31].

As set out by the First Do Not Harm report, not listening to women or acting on their experiences can have devastating consequences[32]. Addressing this issue is complex and cannot be considered in isolation; the value placed on women's voices and their experiences is tied up with patriarchal views that permeate throughout society, and action to improve the way in which women are listened to in relation to their health and care must recognise this.

6. Barriers to good quality gynaecological health

Education and information for women

Women should feel confident to seek advice about their menstrual, urogynaecological and gynaecological health. However, we know that many women do not talk openly about their health or seek support when required due to embarrassment, stigma or a lack of reliable information. 24% of women surveyed by the RCOG as part of our Left for too Long report felt unable to seek care because of embarrassment about their condition, and 15% because they felt judged[33]. If women do not feel they are able to seek help, this will prevent them from accessing the care and support they need. It will also likely lead to progression of disease and worsening of symptoms that may result in the increased need for clinical interventions and further impact on women's lives.

There needs to be high-quality education and information around women's menstrual and gynaecological health which is available and accessible to all women and people across society. Education about women's health must start from a young age so young women and girls better understand their bodies and what is normal, and feel confident to talk about gynaecological health. Comprehensive relationship and sex education (RSE) is critical to breaking down stigmas and taboos that exist about menstrual and reproductive health at an early age and which inhibit help-seeking behaviours and create barriers in accessing care. It is important that all young people, regardless or sex or gender, receive the same education around menstrual health and reproduction in order to prevent continued stigmatisation of womens' reproductive health. **The ongoing review of the RSHE curriculum in schools must consider how menstrual and gynaecological health is taught, and any further actions that could be taken to improve the quantity and quality of the education in this area.**

Improving access to information is also important. RCOG welcomes the Government's efforts to make the NHS website 'the first port of call for women and girls seeking health information, advice and signposting to sources', something which the RCOG has long called for. In polling conducted for our 2018 Better for Women report, we found that 85% of women surveyed found the NHS website to be a reliable source of information[34]. **It is vitally important that information is available in a variety of formats and is accessible to all regardless of background, education, disability or socioeconomic status - including those in institutionalised settings.** Information available must be evidence-based and easy to understand, as well as inclusive to the needs of all women and people who need to access it.

(2023)

[31] Statement on pain associated with insertion of intrauterine contraception FSRH (2021)

[32] First Do No Harm: The report of the IMMDS Review, IMMDS (2020)

[33] Better for Women, RCOG (2019)

[34] Better for Women, RCOG (2019)

Women's Health Hubs have a role in addressing this issue. As the roll-out of the hub model is being led by local Integrated Care Systems (ICSs), this provides a great opportunity for locally-tailored information that reflects the needs of local population to become part of what hubs offer. In our joint position on the women's health hub model[35], **we call for all hubs to be commissioned to deliver locally tailored information in a range of formats suited to their local population, as well provision of signposting and support for women to navigate the local system and understand what services are available to them and how to access these services.**

When women access care, they often report not being provided sufficient information with which to make choices about their treatment. A survey for the APPG on Women's Health found that 62% of women were not satisfied with the information that they received about treatment options and nearly 50% of women with fibroids and endometriosis were not told about the short term or long term complications from their treatment[36]. **It is important that healthcare professionals have high quality information to signpost women to, and that this can be tailored to local service provision. Women need to be able to make informed decisions about next steps in their care and support, and also feel empowered to self-manage symptoms where possible.** On the RCOG website, there are published patient information leaflets, including on specific gynaecological conditions and procedures. These leaflets are based on up-to-date clinical guidance and developed in partnership with members of the RCOG's Women's Network[37].

Access to diagnosis

There are significant barriers to accessing a diagnosis for many Urogynaecological and Gynaecological conditions. As described above, normalisation and stigma of many symptoms associated with these conditions, such as incontinence and heavy bleeding, often act as the first barrier to preventing women from seeking help from a healthcare professional.

As described earlier, when women do seek support with symptoms, many report feeling ignored or not listened to by health professionals. Experience of women feeling dismissed or not listening to, contributing to slower diagnosis, is common. Women often report having to persistently advocate for themselves to secure a diagnosis, not feeling listened to by healthcare professionals was a consistent theme across responses to the Women's Health Strategy for England. Frustration with diagnosis times has contributed to a perception of lack of education and understanding of women's health, particularly in general practice. A survey by Wellbeing of Women and Nurofen found that 27% of women felt that it was easier to self-diagnose due to wait times[38].

It is important that primary care health professionals are supported to diagnose gynaecological conditions. Many conditions, such Endometriosis and Adenomyosis, have non-specific symptoms, such as pelvic pain - symptoms which can overlap with other conditions or be associated with other underlying causes. Symptoms of PCOS, a hormonal disorder, vary widely according to the individual depending on the hormone affected. This can make it harder to rule out other causes for symptoms caused by gynaecological ill-health, and reach the correct diagnosis in order to provide the right treatment and support. Current pressures in primary care can make it challenging to ensure all primary care professionals are able to stay up-to-date with best practice around recognising and

[35] Achieving success with the Women's Health Hub Model: Joint position of the RCOG, RCGP, the FSRH and the BMS, RCOG (2023)
[36] Informed Choice? Giving women control of their healthcare, , All Party Parliamentary Group on Women's Health (2017)
[37] RCOG Patient Information Leaflets, RCOG [accessed 2023]
[38] Gender Pain Gap Index Report, Nurofen (2022)

diagnosing gynaecological conditions, and this can contribute to women feeling dismissed and further lengthen diagnosis times.

Better research into the causes of gynaecological conditions would support primary care in improving diagnosis times. On average, Endometriosis in the UK takes 7.5 years to diagnose[39]. The only definitive way to diagnose Endometriosis is by a laparoscopy, a minimally invasive surgery which detects signs of endometriosis with the aid of a camera. The need for surgery to diagnose endometriosis increases the likelihood of GPs wanting to rule out other diagnoses first. **There needs to be greater investment in non-invasive testing for conditions, like Endometriosis, that mean diagnosis can happen in a primary care setting and is not intensive for women and costly for the service.**

Access to specialist care

Once women are referred into secondary care, there continues to be significant barriers to accessing high quality care and treatment – and many women are waiting far too long to access specialist care.

RCOG's '*Left for Too Long*' Report exposed the impact of the COVID-19 pandemic on gynaecological services, which were already struggling to meet demand. The report laid bare the size and scale of waiting lists in gynaecology, highlighting the fact that as the only women-only specialty, gynaecology has had the highest percentage increase of any specialty since the start of the pandemic and is also one of the highest specialties in terms of absolute volume increase. This is still the case, and as of June 2023, there were almost 600,000 patients on the waiting list for gynaecology services in England, more than double pre-pandemic levels[40]. Gynaecology waiting lists were also growing faster than any other specialty long before the pandemic.

Huge geographic disparities exist in the length of waiting lists, creating a postcode lottery for gynaecology services. The North West is the most affected region, with 7 out of 10 of historic commissioner footprints (CCGs) with the longest waiting lists by population in this region. Those living in the North West are also waiting longer on average than any other region. **Elective recovery in gynaecology must focus on reducing the disparities between different regions and Trusts, ending the postcode lottery for gynaecology care.** Funding and support for recovery should be focused on areas where waiting lists are longest and, where disparities are greatest, the NHS should consider supporting women to travel further to access care earlier. The NHS in each UK nation should also commit to tracking and publishing progress on reducing disparities in elective waiting lists.

The NHS Constitution in England establishes that patients should be able to start consultant-led treatment for non-urgent conditions within a maximum of 18 weeks following referral from a GP. In England, the NHS target is for 92% of patients to have a referral-to-treatment time of less than this maximum. The number of women waiting over 18 weeks had already reached nearly 47,000 before the start of the pandemic, meaning only 84% of women were being treated within 18 weeks. As of June 2023, over a quarter of a million women – more than 45% of patients waiting for care – had been waiting over 18 weeks. Almost 36,000 had been waiting for over a year.

The impact on women waiting longer for care cannot be understated. More than 75% of women surveyed by the RCOG reported that their symptoms had worsened whilst on the list. This was echoed by 75% of RCOG members who felt that they were seeing women with more complex care

[39] Endometriosis in the UK: time for change, All Party Parliamentary Group on Endometriosis (2020)
[40] All statistics on waiting lists are derived from data provided by LCP: https://waitinglist.health.lcp.com/

and treatment needs as a result of waiting longer for care. Emergency admissions for gynaecology have increased since the start of the pandemic.

Living with the often worsening symptoms of their gynaecological condition whilst waiting for care has a limiting effect on many different aspects of women's lives; 77% reported that their ability to work or take part in social activities had been negatively impacted whilst being on a waiting list, and 80% reported that their mental health had also been negatively impacted.

7. Solutions to addressing long waits in gynaecology services

The solutions to addressing waiting lists in gynaecology are complex and multi-faceted, but as waiting lists continue to grow disproportionately, it is clear that the broader approach to elective recovery needs to be complemented by solutions that are unique to the speciality. **There would be huge benefit in a joint DHSC/NHSE-led taskforce to unlock the opportunities to reduce waiting lists in gynaecology. We continue to call for national ring-fenced funding for the recovery and long-term sustainability of elective gynaecology services.**

<u>The way the speciality is perceived and prioritised</u>

In RCOG's Left for too Long report, there was a strong view from RCOG members that a key reason for the unequal growth of waiting lists is a lack of awareness and understanding of the true impact of symptoms of gynaecological conditions on womens' health and their quality of life. RCOG members' felt that this is often the case for those who are responsible for allocating clinic and theatre capacity, which often results in gynaecology being the first service to lose capacity (either in the form of clinic space, theatre space or beds) when decisions are made around cancellation of elective services to protect capacity for urgent and emergency care services, particularly during the winter months.

The RCOG wants to raise awareness of the real impact of symptoms of gynaecological conditions on women and people's lives, and ensure this is adequately reflected in decisions that are made to allocate capacity. There is a need for high-level representation of women's health in NHS bodies locally and regionally to support this ambition.

We also want to see a move away from using the term 'benign' to describe gynaecological conditions, such as endometriosis, fibroids and polycystic ovary syndrome. 'Benign' is traditionally used in medicine to indicate non-cancerous conditions but has contributed to the deprioritisation of gynaecological conditions, misrepresenting them as not progressive and not adequately reflecting the significant impact on quality of life symptoms can have. Encouraging health systems to no longer use the term is crucial to supporting a better understanding of gynaecological conditions and their impact on women outside of the specialty.

During the pandemic, in order to manage extremely limited capacity, surgery was prioritised by clinical need through a framework developed by the Federation of Surgical Specialty Associations (FSSA) and fed into by the RCOG. This work began as a short term expedient to the pandemic and was not intended for long term use, but ongoing pressures created by a growing backlog in elective care has persisted and therefore the use of the framework has continued; in April 2023 the responsibility of its ongoing development was made the responsibility of NHS England.

A continued focus solely on clinical need has neglected the impact of ongoing symptom management on women's physical and mental health, and their quality of life. **The RCOG want to see reforms to the way in which clinical prioritisation of care works in the NHS nationally and locally, so it begins to take into consideration the wider impacts of an individual waiting for care.**

Capacity constraints

Much as in wider recovery of elective services, one of the biggest blockers to reducing waiting lists for gynaecology services is available staff. In RCOG's Left for too Long report, 45% survey respondents to our members' survey listed staffing as a barrier to reducing the backlog in care. Concerns were raised about staffing levels within gynaecology, but also about how wider staffing shortages particularly in nursing, impacted capacity on wards and in theatres. It is not plausible nor fair to expect services to continue to increase capacity in the service without addressing staffing shortages across the service. **We support the ambitions set out by the Government and the NHS in the long-term workforce plan published recently, and hope to see continued longer term workforce planning and investment. This is central to safeguarding the effective recovery of elective services in gynaecology and more broadly.**

RCOG members also highlighted access to beds as a barrier to reducing the backlog, with a lack of beds preventing an increase in the number of surgical and non-surgical procedures that can take place. Although this is clearly an issue in all specialties, combined with the lack of priority attributed to gynaecology services, this often results in gynaecology appointments and surgeries being cancelled to relieve the pressure on bed capacity caused by acute services. We therefore welcome the recent funding announcement to address bed shortages in urgent and emergency care, alongside wider efforts to improve capacity in community and social care to support discharge. However, it is important that beds are also protected for elective services. **We are supportive of the use of 'cold sites' and hubs to aid elective recovery, and encourage the use of these sites to reduce waits in gynaecology services.**

The role of primary and community care, including the expansion of the women's health hub model

Part of the solution to addressing waiting lists in gynaecology services is by focusing on designing and delivering a system that allows every woman to be seen at the right time, in the right setting, by a clinician with the right knowledge and skills. Much of the diagnosis and primary and conservative treatment of gynaecological and urogynaecological conditions can and should be delivered outside of specialist settings. General practice is fundamental to the effective diagnosis, treatment and support of women with gynaecological and urogynaecological conditions, and there is also potential for women's health hub model to also contribute to the effective delivery of care outside of secondary care.

Current pressures on general practice have made it challenging to consistently deliver high quality care and support for women. Demand for general practice continues to surge, making it challenging for GPs to protect time to ensure they continue to remain knowledgeable and skilled in supporting women with their gynaecological health. Conservative and medical management (such as coil fittings for heavy menstrual bleeding, or pessary fittings for prolapse or incontinence) can be delivered in primary care and allow women to access treatment closer to their home without having to be referred into specialist care. However, primary care professionals need to have the skills to deliver this care, as well as the capacity to be able to deliver it. **There must be Government action to address the significant and sustained pressure on primary care, to ensure that GPs have the protected time to grow and maintain the knowledge and skills to effectively support women with gynaecological and urogynaecological conditions.**

The expansion of the women's health hub model and attached Government funding is a great step towards delivering more care for women out of specialist care and nearer to home. We are supportive of the work ongoing to deliver this, **but there needs to be significant and continued**

long-term investment in the hub model to make it a reality. The RCOG has developed a full position, in collaboration with RCGP, FSRH and the BMS, on the opportunities presented by the women's health model and how these may be harnessed to improve women's health outcomes and access to care[41].

Investment in research

Research in to women's health has historically been and still remains underinvested, with less than 2.5% of publicly funded research dedicated solely to reproductive health according to the most recent data[42]. This lack of research in women's health, and more specifically into gynaecological conditions, has contributed to long diagnosis times and poorer treatment options, leaving women struggling with challenging symptoms that impact their health as well as their quality of life.

Women, and in particular black women and women from ethnic minorities, also continue to be underrepresented in clinical trials and studies. One study found that black women only comprise 15% of participants in published clinical trials for uterine fibroids, despite being disproportionately impacted by the condition[43]. **More attention must be paid to increasing levels of participation in research by women, and ensuring that a more diverse group of women take part, to prevent future inequalities in care.**

It is positive that the National Institute for Health Research (NIHR) are opening a new policy research unit (PRU) dedicated to reproductive health in 2024. RCOG particularly welcomes the emphasis on taking a life-course approach to reproductive health and including under-represented groups.

September 2023

[41] Joint position statement on achieving success with the women's health hub model, RCOG, FSRH, BMS, RCGP (2023)
[42] UK Health Research Analysis, UK Clinical Research Collaboration (2015)
[43] Racial diversity in uterine leiomyoma clinical studies, F Andrei Taran et al (2010)