Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Invited Editorial

Preventing treatment delays for benign gynaecological conditions

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As we emerge from the Covid-19 pandemic we have seen many changes in the provision of medical services, in the way that patients are managed, and how healthcare is delivered. During the pandemic we saw a rapid introduction of new technology within clinical practice and new ways of working, hoping to streamline services whilst simultaneously continuing to provide medical care during a time of social isolation and political uncertainty. Now, as we are seeing the post-pandemic recovery, it is essential that we take time to re-evaluate the care pathways we have developed as well as to focus on how best to manage the substantial waiting lists that have developed.

1. The Scale of the Problem

Whilst the management of gynaecological oncology patients and care for gynaecological emergencies continued throughout the pandemic, there was considerable delay in the management of benign gynaecological conditions and we have now seen a dramatic rise in the waiting lists for surgery. Within England the waiting times for gynaecological operations continues to grow and as of June 2022 there were 540,488 patients waiting, with 34,317 patients waiting for over 52 weeks. In addition, the waiting list continues to grow by 9383 cases per month [1]. In a public health system, such as the National Health Service (NHS), with limited resources this represents a significant challenge which innovative ways of providing healthcare are hoping to solve.

2. Management in Primary Care

Throughout the pandemic, telephone and video consultations became widespread and there has been a permanent change in the way that consultations are delivered in primary care, and many practices are still limiting face-to-face contact. Pre-pandemic evidence has suggested that telephone triage leads to a 20% increase in total general practice consultations with no change in the number of outpatient referrals and out-of-hours attendances [2] whilst the use of physician associates has also been shown to be an effective and safe use of resources [3]. Despite unfavourable comments within the media, the evidence would also appear to suggest that remote consultations are generally regarded positively and increase patient convenience [4].

Guidelines from the Royal College of Obstetricians and Gynaecologists (RCOG) have now been published to help facilitate primary care management [5] and the British Society of Urogynaecologists (BSUG) has also published guidelines covering the management of urogynaecological conditions and the management of vaginal pessaries [6].

3. Outpatient Management

Whilst many benign gynaecological conditions may be managed effectively in primary care there are still considerable pressures on outpatient services. One-stop clinics with integrated scanning facilities are being introduced to help streamline service provision and reduce the need for follow-up appointments.

For those patients requiring further investigations there has been a rapid expansion of ambulatory services under local anaesthesia, including the use of outpatient hysteroscopy and cystoscopy. These include both diagnostic and operative hysteroscopic procedures such as resection of endometrial polyps and small submucous fibroids, as well as urogynaecological procedures such as intravesical administration of botulinum toxin for refractory detrusor overactivity and urethral bulking agents for the treatment of stress urinary incontinence.

Development of an ambulatory outpatient service reduces the need for day case admissions and many procedures are now performed by nurse specialists, resulting is significant savings in time and cost.

4. Inpatient Management

Perhaps one of the greatest challenges currently facing many healthcare systems is how to address the significant backlog in inpatient benign gynaecological cases which has accrued during the pandemic. Novel solutions have included moving NHS cases into the private medical sector as well as extending lists into the evening and weekends. However, even with this added capacity surgical waiting lists continue to increase in length and innovative solutions continue to be introduced.

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Getting It Right First Time (GIRFT) is a national programme [7] designed to improve the treatment and care of patients through in-depth review of services, benchmarking and using data-driven evidence to support change. Initially trialled in orthopaedic surgery, GIRFT is now being introduced nationwide in gynaecology to try to improve productivity and reduce waiting lists [8]. One of the key recommendations from this report is to focus low-complexity high-volume surgery, such as diagnostic procedures, in surgical centres which are often remote from the main hospital and by doing so reducing the need for inpatient capacity.

5. Conclusion

The provision of timely and responsive healthcare for benign gynaecological conditions has always been challenging as many specialities take precedence in terms of funding and capacity. Emerging from the effects of the pandemic we have seen an unprecedented rise in surgical workload and many women are now waiting for a substantial time before treatment. Clearly this has an important implication in terms of health-related quality of life (HRQoL) and well-being. Novel and innovative solutions are now central in trying to improve patient access to care and whilst this may initially seem to be a challenge, ultimately it may prove to be an opportunity to reappraise how we develop and deliver healthcare.

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