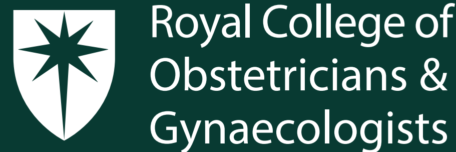

Restoration and Recovery: Priorities for Obstetrics and Gynaecology

A prioritisation framework for care in response to COVID-19

Version 2: Published Friday 29 May 2020

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Summary of updates

Version	Date	Summary of changes
2	29.05.20	**Foreword**: Added thanks to the Women's Network.
2	29.05.20	**Enablers to delivering the prioritisation framework:** Sentence added to point 3: 'System interoperability (for instance, with primary care) should be considered to minimise duplication and error, and increase the speed of transfer or information.'
2	29.05.20	**Enablers to delivering the prioritisation framework:** Sentence added to point 4: 'When restoring services, we should view this as an opportunity to develop pathways based on NICE guidance to reduce variation and increase quality.'
2	29.05.20	**Innovation and good practice:** Second bullet point updated to include women and girls with language difficulties, and clarification that those from a BAME background may be more at risk from coronavirus.
2	29.05.20	**Overarching considerations:** Added new sections on menopause, reproductive medicine, vulval disease and paediatric and adolescent gynaecology.
2	29.05.20	**Staffing:** Updated to specify redeployment includes specialist nursing colleagues, student midwifes and junior doctors, and statement added about retired staff.
2	29.05.20	**Early pregnancy:** Second bullet point amended from 'Caring for women experiencing miscarriage with refined pathways that include the offer of medication to assist the process of miscarriage with enhanced home support and information, manual vacuum aspiration and attending hospital for surgery and regional anaesthesia' to 'Refined pathways for women with diagnosed miscarriage should put more of an emphasis on conservative management, with enhanced home support and information, and the use of manual vacuum aspiration and regional anaesthesia to avoid the use of general anaesthetic for the surgical management of miscarriage'.
2	29.05.20	**Contraception and abortion:** Sentence added to fourth bullet point: 'Early data suggest these changes have significantly reduced waiting times for consultation and has led to a reduction in the average gestational age.'
2	29.05.20	**Gynaecological oncology:** Reference added to separate guidance from NHS England and Public Health England.
2	29.05.20	**Prioritisation of indications for outpatient assessment and procedures in obstetrics and gynaecology: Within 7 days:** Added pain and heavy manual vacuum aspiration for miscarriage as an indication for early pregnancy and abortion care.
2	29.05.20	**Prioritisation of indications for outpatient assessment and procedures in obstetrics and gynaecology: Within 14 days:** Removed post-menopausal bleeding or breakthrough bleeding on HRT as an indication for benign gynaecology, and added new indications for paediatric and adolescent gynaecology, and for vulval disease.
2	29.05.20	**Prioritisation of indications for outpatient assessment and procedures in obstetrics and gynaecology: Within 30 days:** Added post-menopausal bleeding or breakthrough bleeding on HRT as an indication for benign gynaecology, and indications for vulval disease.
2	29.05.20	**Prioritisation of indications for outpatient assessment and procedures in obstetrics and gynaecology: Over 30 days:** Added menopause and HRT, and presumed benign lower genital tract lesions as new indications for benign gynaecology. Added new indications for paediatric and adolescent gynaecology, and for vulval disease. Added insertion of pessary for procidentia as an indication for urogynaecology.
2	29.05.20	**Prioritisation for surgery, inpatient care and chemotherapy/radiotherapy in obstetrics and gynaecology: Emergency (within 24h) – Priority 1A:** Added new priorities for paediatric and adolescent gynaecology.
2	29.05.20	**Prioritisation for surgery, inpatient care and chemotherapy/radiotherapy in obstetrics and gynaecology: Up to 4 weeks – Priority 2:** Added new priorities for paediatric and adolescent gynaecology.

2	29.05.20	**Prioritisation for surgery, inpatient care and chemotherapy/radiotherapy in obstetrics and gynaecology: Up to 3 months – Priority 3:** Added 'or where there is significant pain uncontrolled with medical treatments (including GnRH analogues +/- addback HRT) or where such medical treatments are inappropriate (e.g. patient declines, adverse effects, contraindications)' to end of third priority for benign gynaecology. Removed 'Laparoscopic excision of superficial and/or deep endometriosis and/or ovarian endometrioma where there is significant pain uncontrolled with medical treatments (including GnRH analogues +/- addback HRT) or where such medical treatments are inappropriate (e.g. patient declines, adverse effects, contraindications) as a priority for benign gynaecology. Added new priorities for paediatric and adolescent gynaecology. Added surgery for significantly bothersome prolapse and surgical treatment for genitourinary fistula as priorities for urogynaecology.
2	29.05.20	**Prioritisation for surgery, inpatient care and chemotherapy/radiotherapy in obstetrics and gynaecology: Over 3 months – Priority 4:** Removed laparoscopic excision of endometriosis without bowel or ureteric obstruction as a priority for benign gynaecology. Added new priorities for paediatric and adolescent gynaecology.

Foreword

Coronavirus (COVID-19) has directly disrupted all aspects of health care. It has led to reduced assessments and procedures for patients, increased levels of sickness or self-isolation for clinicians, and we have all faced the pressure to respond to a rapidly evolving situation.

At the beginning of this pandemic, it was the right course of action to suspend aspects of care while we quickly buttressed core and essential services so they could continue to operate. We, along with our specialist societies, have continued to produce guidance based on the best available evidence. And the whole nation is indebted to our Fellows, Members and Trainees who have worked on the front line to deliver care at risk to their own health and safety.

I would like to thank everyone, but especially our specialist societies, who have contributed enormously to this prioritisation framework, which will hopefully guide the restoration of obstetrics and gynaecology across the UK. I would also like to thank the College's Guidance Cell, the hub of activity which creates and finesses the guidance we are currently producing at pace, as well as my team of Officers who have been crucial to how our specialty has responded to this crisis. Our Women's Network has also been integral; members of this group have been an invaluable source of advice and support. Finally, I would like to thank our members, who have shown their determination to provide the best care possible under circumstances I am sure we never envisioned when deciding on this career path.

When I was elected President of the RCOG, I did not think that we would be issuing guidance for resuming many basic aspects of the care we otherwise delivered routinely. It is necessary that we now take a measured approach to restoring some services as quickly as possible. But we should also recognise and celebrate the innovation and transformation that as occurred in a few short weeks. Some of these transformations to clinical services may well be for the better and work now needs to start, alongside restoration, to research, audit and understand whether there are some changes that should remain.

This framework is intended to be a document which can change and adapt based on the situation and the feedback we receive, so please continue to check the RCOG's coronavirus pages for the latest updates and information.

Ultimately, we are guided by what girls and women expect and deserve. And soon we hope that our speciality, and the NHS, will be able to reflect on this episode, and understand the positive lessons that can be learnt.

Mr Edward Morris
President, Royal College of Obstetricians and Gynaecologists

Introduction

The following advice is provided as a resource for UK healthcare professionals, managers and local systems to help plan care based on good practice and expert advice in partnership with service users and patient groups. Our priority is to ensure women and girls have access to safe, personalised and effective care, including during times of disruption to normal healthcare provision. This document provides a framework for the prioritisation of care during the coronavirus (COVID-19) pandemic, as services begin a phased return to regular activity.

This guidance has been developed with the expert advice of our specialist societies and will be kept under review. If you would like to suggest additional areas for this guidance to cover or any clarifications required, or to submit new evidence for consideration, please email COVID-19@rcog.org.uk. Please make it clear that your email relates to this piece of guidance. Note, the RCOG will not be able to give individual clinical advice or information for specific organisational requirements via this email address.

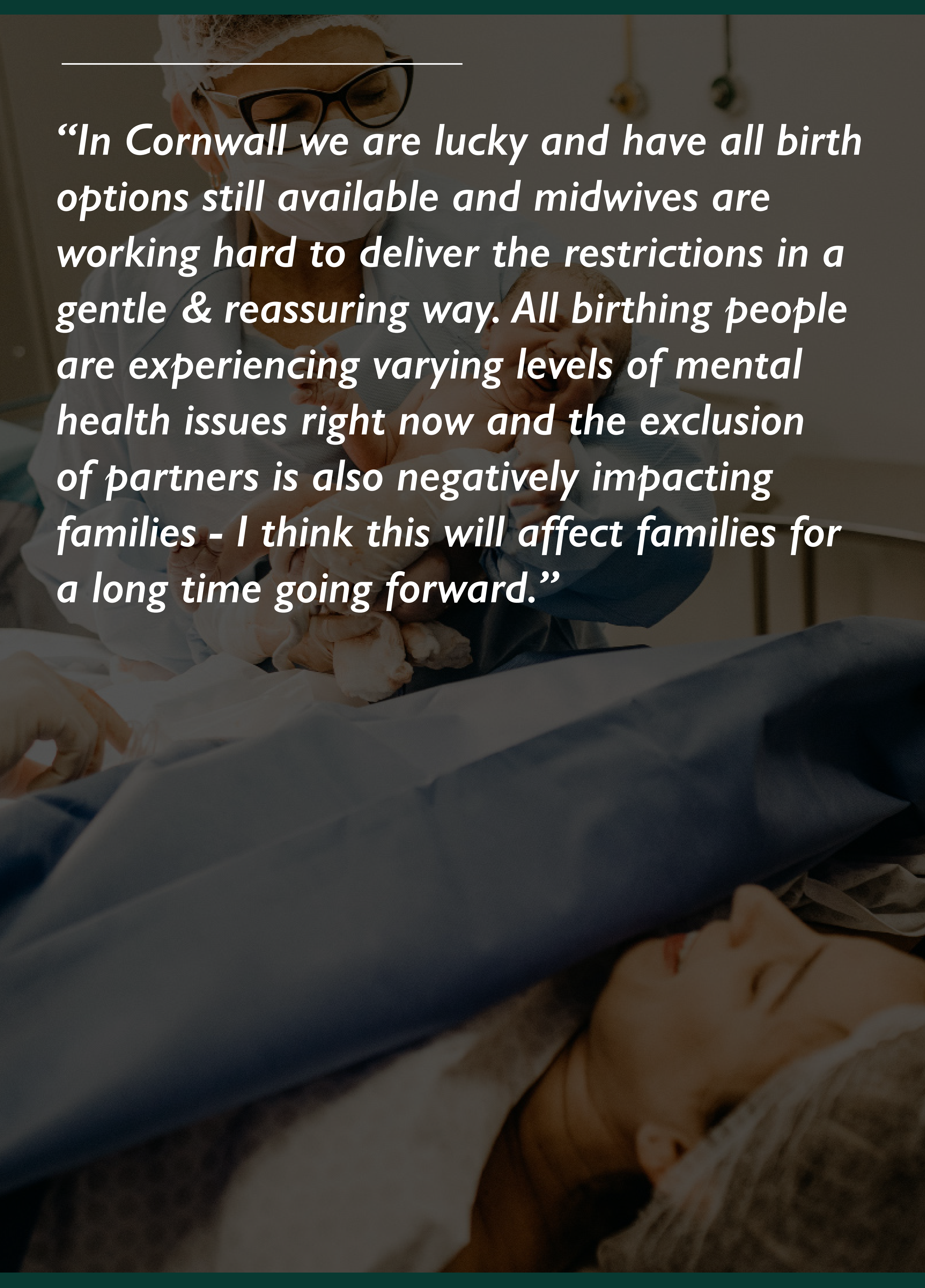
Prioritisation and delivery

Coronavirus (COVID-19) has presented considerable challenges to the routine delivery of healthcare services. There has been disruption to the way in which healthcare professionals prioritise the care of women and girls. Some services have been postponed while others rely more on remote consultation and assessment. In some cases, this will have inevitably led to anxiety, distress and, potentially, adverse outcomes.

It remains vital that girls and women can access the advice, support and care they need when necessary, and that the risk of avoidable harm is limited as much as possible. Throughout this pandemic, the RCOG has advocated for the maintenance of essential and personalised maternity and gynaecological services, and has worked with partner organisations, and its lay group the Women's Network, to provide the guidance necessary for the delivery of safe, effective and high-quality care, and useful patient information for girls, women and their families.

The RCOG has worked closely with the UK Government and devolved nations to ensure that they promote efficient use of resources, while also directly challenging any barriers to providing safe care. This has led to regulatory changes in all four nations, greater use of technology and telemedicine to deliver care and the adoption of new and innovative pathways for some services. This has only been possible thanks to the adaptability and resilience of our Fellows, Members, Trainees and Associates.

However, how we manage the prioritisation of care during a phased return to regular activity is just as important as how the healthcare system has adapted to the pandemic. This will include planning for those assessments and treatments which may have been postponed, with particular focus on how girls, women and vulnerable groups – like women of black, Asian and minority ethnic (BAME) and the elderly – may have experienced adverse outcomes during this period.



"In Cornwall we are lucky and have all birth options still available and midwives are working hard to deliver the restrictions in a gentle & reassuring way. All birthing people are experiencing varying levels of mental health issues right now and the exclusion of partners is also negatively impacting families - I think this will affect families for a long time going forward."

The effect of COVID-19 on obstetrics and gynaecology

Different services have been affected in different ways depending on the nature, urgency and deliverability of care that they provide, within the context of coronavirus. However, no area of health care has continued uninterrupted. All services will have been affected by:

- Redeployment of staff
- Staff sickness
- Staff self-isolating
- Implementation of social distancing measures for staff and patients

Many services will have delivered parts of their pathways in different ways. This might include:

- Consultations, clinical prioritisation and triage via telephone, video conferencing or electronic means
- Utilisation of different sites when providing some aspects of care
- Greater use of outpatient and ambulatory care when appropriate

Some of these changes may only be for the short and the medium term while delivering services as part of the restoration and recovery effort. However, in some cases, changes may represent more efficient and effective ways of providing care, and therefore have a role to play in the longer term. When restoring services, we should consider how this is an opportunity to improve them.

There will also need to be good patient information and education around the benefits of inpatient attendance against the increased risk of transmission of COVID-19. This is the case for girls and women with a benign or asymptomatic gynaecological condition, who may prefer to delay their treatment, especially if they are within the shielded population.

Some core services, like maternity, will not experience a drop in demand and it is important that they can continue to provide high-quality care. Maternity services have been classified as a core service both in the context of the current pandemic and in any potential future waves of COVID-19, but in some cases, women's choices have been limited. It is essential to have in place a sufficiently staffed and supported workforce across maternity, neonatal services, perinatal mental health and health visiting, to ensure the physical and mental wellbeing of women and their babies.

The RCOG is concerned at reports of mandatory redeployment of obstetricians and gynaecologists outside of maternity services in trusts and health boards. Our recent members' survey found that junior grade trainees, foundation doctors and locally employed doctors have been redeployed outside maternity services in 53% of the trusts and units that responded. In almost a quarter of these trusts and units, all junior grade doctors were redeployed without reference to specialty requirement. Over a quarter of respondents said they had concerns about the planning and implementation of the medical staff changes at their place of work.

There have been several consequences of this redeployment. Over 80% of respondents said they had missed out on training opportunities. Consultants and middle grade doctors have been placed under increased and unsustainable stress running a core service without a valuable part of the workforce. More than a quarter reported significantly longer hours for those available to work. A similar number stated they were unable to offer timely clinic appointments. There has also been a notable increase in locum use, with 37% of units

reporting an increase in the use of internal locums, reflecting the increased pressure on maternity services.

Given the continuous demand for maternity services, staff in these roles should be protected from redeployment as far as possible

The effect of COVID-19 on girls and women

Over the next months and years, the effects of the challenges and restrictions in place during the pandemic, and the disruption to health care, will be known more fully. Service user groups relating to the health, wellbeing and experiences across a woman's life course, such as Maternity Voices Partnerships (MVPs) and Maternity Services Liaison Committees (MSLCs), are well placed to inform work around restoration. When planning for the restoration of services, it will be important to consider:

- Late presentation to services. This may be due to fear of transmission of COVID-19, greater difficulties accessing care, increased travel difficulties or financial barriers. [1]
- Increasing levels of anxiety or perinatal mental health issues.
- Increasing rates of poverty during the pandemic and afterwards due to economic shock. This may negatively impact the social determinants of health and wellbeing.
- Warnings of increased alcohol consumption. [2]
- An increase in domestic abuse due to social distancing and isolation, as reported by Women's Aid.[3]
- Women and girls from BAME backgrounds and the effects of COVID-19 on them and their families.
- Other groups that often experience poorer health outcomes and experiences.

Obstetrics and gynaecology services should consider how any changes can prioritise prevention and the wider determinants of health and wellbeing. This key pillar of the NHS Long Term Plan is fundamental to the restoration of services. There is also an essential role for public health services in supporting girls, women and their families as services reopen. Public Health England, and other responsible organisations, should be able to access the funding they need to provide high-quality public health interventions in order to limit a series of different public health crises following, or alongside, the coronavirus pandemic.

Barriers to delivering the prioritisation framework

In collaboration with our specialist societies, the RCOG has gathered insight into what the barriers may be to deliver this prioritisation framework along with risks to restoration and recovery of services. These have been considered thematically.

1. **Demand for resources.** Understandably, there will be a significant accumulation of girls and women requiring appointments and treatment. It will be important for entire systems to work together in networked ways to prioritise and provide care. The RCOG sees the need for a greater focus on

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1 Thornton, J. (2020). Covid-19: A&E visits in England fall by 25% in week after lockdown, BMJ

2 Clay, J. M., & Parker, M. O. (2020). Alcohol use and misuse during the COVID-19 pandemic: a potential public health crisis?. The Lancet Public Health.

3 van Gelder, N., Peterman, A., Potts, A., O'Donnell, M., Thompson, K., Shah, N., & Oertelt-Prigione, S. (2020). COVID-19: Reducing the risk of infection might increase the risk of intimate partner violence. EClinicalMedicine, April 13,2020

collaboration, rather than competition, to make best use of the resources available in partnership with local service user and patient groups.

2. **Dependency on COVID-19-related services such as intensive treatment units (ITUs) and support services.** Some services will find it difficult to provide elective surgery which depends on ITU. The RCOG expects that some services, such as diagnostics and pathology, will come under significant pressure. Alleviating this pressure by expanding services where possible, whilst being cognisant of workforce constraints, will be important. The NHS should continue to make best use of 'COVID-protected sites' when delivering care. Advances in testing capacity will support this approach.

3. **Consistency and variation.** The interpretation of clinical priorities may differ across hospitals, trusts, health boards, clinical commissioning groups and local health systems. By focusing on safe care, positive experiences for girls, women and their families, good clinical outcomes and coproduced prioritisation frameworks, variation can be limited. This will depend upon collaboration and coordination at all levels.

4. **Suboptimal baseline staffing levels.** Long-standing rota gaps in specialty trainees and chronic understaffing in midwifery prior to the pandemic were already presenting significant challenges in attaining safe staffing levels. During the pandemic, staff restrictions have constrained service flexibility, choices available to girls and women, and therefore, possibly, safety. For example, many units were limited in their capacity to maintain or develop out-of-hospital care and home birth.

5. **Redeployment of healthcare professionals.** Returning healthcare professionals to their usual roles and responsibilities as infection rates slow will be important to support the increased delivery of restored services. Healthcare professionals redeployed to other areas may have seen a reduction in activity and will be motivated to return to their area of specialised expertise. Trusts should consider frequent reviews of staffing to facilitate a return to usual departments in order to support the restoration of services.

6. **Supply and confusion around personal protective equipment (PPE).** An ongoing shortage of PPE has led to confusion and anxiety among healthcare professionals delivering care. While there has been a global surge in demand for the right equipment, lack of clarity around supply at a local level has led to difficulties in planning. In turn, this has led to the closure of some clinics and facilities, especially in the independent sector. The Government should prioritise transparent communications on local supply which can be cascaded. As elective services restart, this will create additional need for PPE which will need to be factored into purchasing.

7. **Reduced coproduction with service user groups.** Developing plans for services with those who use them before, during and after the pandemic is essential during service restoration.

Enablers to delivering the prioritisation framework

In collaboration with our specialist societies, the RCOG has gained insight into what the enablers need to be to deliver this prioritisation framework. These have been considered thematically.

1. **Coproduced transformation and leadership.** Systems have been able to adapt at speed to respond to the pandemic due to clinical leadership and excellent management, and in maternity by meaningful engagement with MVPs and MSLCs. By prioritising clinical care in response to the urgent need for service modifications to protect staff and girls and women, there have been significant changes in days and weeks, which would have previously only been possible over a much longer period.

2. **Testing patients and clinicians for COVID-19.** Testing is rightly considered a key pillar of the UK Government and devolved nations' strategies to minimise transmission of COVID-19. Both the test for infection and the test for immunity will have an important role to play in the restoration and recovery

of services. It will help to reduce staff self-isolation rates and ensure timely identification of COVID-19-positive girls and women before they undergo treatment or procedures, especially in those who are asymptomatic and who are currently not being identified.

3. **Greater use of technology, including telephone and videoconferencing both for appointments with girls and women (and their families), and for management of multidisciplinary meetings.** Although this is not appropriate in all instances, telemedicine and access to electronic medical records can help provide greater efficiencies and convenience for girls and women. Electronic medical records are variable in quality, and this should be addressed quickly. Ongoing work to digitise records should be renewed at pace and research into the efficacy of remote consultations in different contexts should be ongoing. System interoperability (for instance, with primary care) should be considered to minimise duplication and error, and increase the speed of transfer of information.

4. **Evidence-based guidance.** Guidance which reflects the latest evidence for delivering and managing services has been well received by healthcare professionals and service user and patient groups. Close collaboration and discussion with patients and charity groups during ongoing development has been crucial. This will need to continue to aid the restoration and recovery of services. When restoring services, we should view this as an opportunity to develop pathways based on NICE guidance to reduce variation and increase quality.

5. **Delivery of online educational resources.** Such resources have been a supportive part of education for many years, but during the pandemic for some areas it has become the sole source of education. In healthcare, training opportunities continue but in a changed form. Loss of some training is a reality and organisations such as the RCOG should ensure that these are recorded and addressed later, or that media such as enhanced online learning are developed to compensate.

6. **Public and political support for the NHS.** The COVID-19 pandemic has demonstrated public and political appreciation for key workers and healthcare professionals, who have been asked to risk their own safety to maintain services. Political support will be necessary to ensure a well-equipped, well-staffed and well-funded NHS.

Innovation and good practice

In response to the coronavirus pandemic, systems and pathways have had to be redesigned to continue to provide services in different ways. While some of these changes will only be temporary, there is positive change which will have a lasting effect on the delivery of care. Reports from clinicians indicate that appetite for transforming services is high. This might include:

- Developing appropriate screening criteria for telephone and video clinics, assessing public opinion and involving service user and patient groups in the design of these services. This will help reduce variation between units.

- Coproducing greater choices over virtual or face-to-face appointments with service user and patient groups, taking into account the needs of and accessibility for vulnerable women and girls, those with language difficulties, and those from a BAME background who may be more at risk from coronavirus.

- Adoption of more 'one stop' services that can reduce the need for repeat appointments. This might include:
    - Integrating contraception pathways into maternity and abortion care.
    - Aligning serum tests for screening, ultrasound scanning appointments and antenatal clinics for pregnant women.

- In some areas, choice around home birth or giving birth in a midwifery-led unit (MLU) has been affected. However, in other areas, women have been supported if they choose to have a home birth or attend an MLU, reducing attendance at acute hospitals. Women should be supported to choose their birthplace where the evidence supports this.

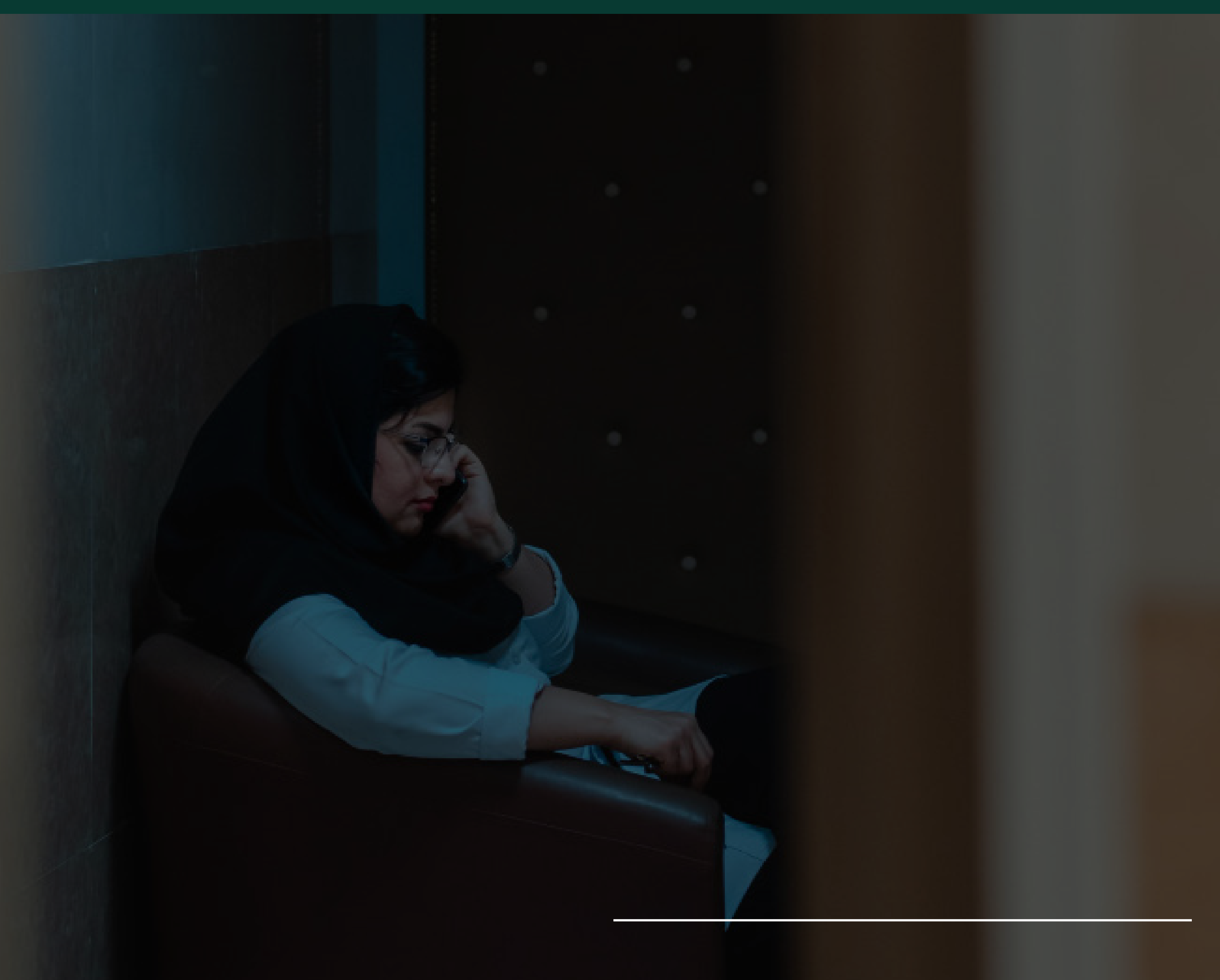
- Some maternity units have introduced telephone helplines and dedicated social media pages for clinical queries, staffed by dedicated personnel. These helplines, often tailored to specific areas of clinical need such as queries on antenatal care, postnatal care or planning for labour, act as a single point of contact for girls, women and their families. This may continue to be a beneficial measure to reduce in-person contact.

- The national focus on NHS staff and other key workers has led to a renewed focus on their health and wellbeing. Some measures will not be sustainable in the long term, but access to improved rest and break facilities, comfortable seating and better parking should be retained. There has also been greater understanding of psychological wellbeing and support for healthcare professionals. Trusts and health boards should proactively provide this support for all staff suffering from, or at risk of, stress and burnout, anxiety or a mental health problem.

- The rapidly changing ways of working have placed stress on frontline staff. However, strong leadership and positive relationships with service user and patient groups have allowed teams to respond quickly, and there is appetite to maintain agile ways of working and to introduce and measure change safely and at pace. This may require changes to bureaucratic processes whilst retaining appropriate governance and oversight and proper evaluation.

- Large infrastructure projects such as the Nightingale hospitals may be useful in the short to medium term as discharge planning areas, allowing improved patient flow. Continued relationships with private medical facilities should also be considered.

Much of this has been developed in rapid response, and so it will be important to ensure close collaboration with service user and patient groups and other stakeholders when embedding new models of care. There may need to be greater collaboration between different commissioners responsible for services which can be delivered together.



"Sharing something positive… Last week, I was due to see my gynaecologist. Understandably this was replaced with a telephone consultation and with a registrar I hadn't met before. I was really surprised! Over 20 minutes later we were still on the call. He kept asking me questions to make sure I understood everything he was saying and kept asking if I could hear him ok."

The outline framework

Overarching considerations

It is likely that local guidance will be needed on patient testing, cohorting of patients and patient flow within hospitals and other care settings. In addition, the RCOG, with its partner organisations and Women's Network, will continue to review the clinical evidence and consider how we can support this.

The reinstatement of services will be complex and will require leadership, teamwork and a genuine multidisciplinary approach. Identified clinical leaders within obstetrics and gynaecology need to collaborate with nursing, midwifery, anaesthetic, neonatal, managerial colleagues and service user and patient groups to ensure that the reinstatement of services is performed in a logical way which avoids duplication and maintains safety and flexibility, but which has the clear aim to do this in a coordinated fashion.

All involved in this process need to ensure that local policies and procedures are developed in a way that takes account of the potential for change over time, to consider the local and national picture. Service users will also provide invaluable input to this process to coproduce this updated service model.

This document is not intended as a detailed description of what to do in your trust or health board. Rather, it sets out the high-level considerations that must be addressed during this rapid, enforced period of system redesign.

It is not recommended that the aim should be to reinstate 'like for like' in all services. Opportunities for change must be considered where they are safe, where they fit with national pre-COVID-19 guidance (such as NICE or SIGN guidance) and where they offer a genuine improvement to service delivery, especially in the views of girls and women. Services that have departed from such guidance out of necessity during the pandemic should consider the return to standard practice but consider piloting new ways of working. These may provide benefits in terms of responsiveness, flexibility and resource utilisation, and should be carefully evaluated.

A fundamental element of the delivery of safe women's health care is recognising that it provides one of the 'front door' emergency services – alongside adult and paediatric emergency departments. Where progress in the return to full-service delivery is unnecessarily slow or otherwise impeded, clinicians and clinical managers should not hesitate in raising this with senior management teams.

Actions to consider

Staffing

Major changes in staffing through sickness and redeployment will have occurred and it is vital that redeployed staff be returned to work within women's health services as a priority and with a degree of urgency; this includes specialist nursing colleagues, student midwives and junior doctors. We also know that some retired staff have re-joined the workforce, and care should be taken to ensure that they are provided a manageable workload. Midwifery staff redeployed from the community into the acute sector should be returned to community care to ensure the safe delivery of community services, including home births and community midwifery.

Surgeons may not have operated for many weeks and consideration will need to be given to appropriate measures to support their return to activity, such as smaller operating lists or buddy operating between senior surgeons for support with complex cases until confidence is restored.

Infrastructure

Many units will have made changes to physical space, resources such as IT equipment, ward bed allocations and clinic space. In many trusts and health boards, bed spaces will have been diverted from maternity and gynaecology, so it will be important to re-establish the previous bed cohort as a minimum. A larger overall bed base may need to be considered to ensure that physical space exists for cohorted girls and women or other isolation areas for COVID-19 patients. Some trusts or health boards may require a stepped return as COVID-19 occupancy rates fall, and this is to be expected but should be clearly planned.

Units must consider the possible significant ongoing impact of social distancing on capacity in wards, waiting rooms and clinics. The need for novel approaches must also be sustained and built into recovery planning. Home working, electronic records, videoconferencing and the rapidly procured IT hardware to deliver such novel infrastructure changes should all be actively considered as part of the road to recovery, rather than a wholesale return to pre-pandemic practices.

Maternity services

Midwifery and obstetrics have undergone some fundamental changes that include placing women in specific cohorts, closure of midwifery-led birthing units, redirection of girls and women to other units or clinical areas, severe restrictions on visiting and birth partners, and major changes to physical antenatal clinics. These changes have included using streamlined approaches to screening, ultrasonography and the routine nature of antenatal checks for both uncomplicated and complicated pregnancies.

RCOG/RCM, along with specialist societies such as the British Maternal and Fetal Medicine Society (BMFMS) and the British Intrapartum Care Society (BICS), released a set of pragmatic guidance for pregnancy during the COVID-19 pandemic. During restoration of services:

- Frequency and content of visits should aim to return to those specified in NICE guidance. Some elements of antenatal care may continue to be appropriate for remote consultations.

- Frequency and indications for screening and ultrasound scans should return to national and PHE guidance with consideration of currently applicable social distancing regulations.

- Maternal medicine clinics may continue with some of the modernisations suggested during the pandemic but, overall, the aim should be to return to pre-pandemic levels until research identifies the safety and efficacy of these changes. A good example of change which should potentially be maintained is alternative testing for gestational diabetes given that glucose tolerance tests are difficult to deliver in a socially distanced fashion. Home blood pressure monitoring may also help to reduce contact where appropriate.

- Other major modernisations to delivery of specialised care to pregnant women with pre-existing medical illness have also occurred. While much of this care will require full reinstatement, many of the suggested modifications during the pandemic have recommended streamlining visits to ensure appointments with different specialties coincide and are held at the same time as key investigations. Virtual multidisciplinary team (MDT) meetings and telephone consultations could be safely maintained when the sole purpose is to communicate results and modification of therapies.

- Preparation for induction of labour and planned caesarean birth has also undergone efficiencies, many of which could continue into the post-pandemic period, especially during the transitional phase towards a full recovery, such as outpatient induction of labour. The emphasis on reducing interaction with secondary care and improving convenience to women and their families should continue.

- For intrapartum care, it is expected that birth partners should be welcomed in a more flexible fashion.

- Postnatal care should return to normal as soon as safe staffing levels allow in midwifery, health visiting and primary care. Particular attention should be paid to the signs of maternal mental health concerns during this time.

- As services are restored, there is the opportunity for local systems to reaffirm their commitment to the principles of safe and personal care set out in Better Births. Local Maternity Systems are therefore encouraged to return to co-producing service plans with Maternity Voices Partnerships to implement the return of delivering continuity of carer models.

Gynaecological services

During the pandemic, gynaecological services have undergone transformational changes that have arisen largely from withdrawal of the facilities that allow provision of anything but emergency and urgent care. This has led to the accumulation of significant waiting lists: in primary care for girls and women awaiting referral, those referred and awaiting their first appointment, and those waiting for definitive treatment, tests and/or surgery. These waiting lists are causing immense frustration and suffering for girls and women as well as concern for those who care for them.

Gynaecologists are particularly concerned that benign and urogynaecological services could be the last services to return to normality. It is therefore important that the needs of girls and women with these problems are represented at a local level while the RCOG continues national advocacy.

To assist planning for the resumption of services, the RCOG has worked with relevant specialist societies to produce a document which suggests the degree of priority with which many common clinical instances should be managed both in outpatient services and for those requiring surgery (Appendix 1). While this list is as extensive as possible, it is not exhaustive. Rather, it is intended as a guide to reinstate the most common procedures and indications.

Early pregnancy

As part of the emergency service provided by NHS trusts and health boards, early pregnancy assessment or emergency gynaecology units have largely continued to function but have streamlined services:

- Considerable reduction in face-to-face follow-up visits to review or discuss hCG levels in otherwise well women has been successful in some units, which again could lead to new protocols.

- Refined pathways for women with diagnosed miscarriage should put more of an emphasis on conservative management, with enhanced home support and information, and the use of manual vacuum aspiration and regional anaesthesia to avoid the use of general anaesthetic for the surgical management of miscarriage.

Contraception and abortion

Access to high-quality contraception, abortion and advice has been limited during the pandemic. In a survey by the Faculty of Sexual and Reproductive Healthcare, 66% of respondents stated that they had been forced to end or limit the provision of essential sexual and reproductive health care (SRH) services, and 55% of those who had been forced to end or limit the provision of essential SRH services stated that they were not

confident girls and women would be able to access this care elsewhere. However, access has been facilitated by the following:

- Regulatory changes in England, Scotland and Wales to allow the provision of both drugs for abortion at home, combined with careful implementation of the RCOG guidelines in appropriate cases, have supported many women to access the care they needed. The changes have been made under emergency legislation and are temporary.

- Early medical abortion services, and some services for women at a later gestation, are now running in Northern Ireland, reducing the need for women to travel to England for abortion care.

- Guidance from the Medicines and Healthcare products Regulatory Agency (MHRA) has permitted NHS units and independent sector clinics to assemble treatment packages for home use of mifepristone and misoprostol for the purposes of early medical abortion, reducing the pressure on NHS pharmacies who previously were responsible for assembly.

- A significant uptake in remote consultation and prescribing for early medical abortion, facilitated by regulatory change, has transformed the way abortion care is being delivered. Early data suggest these changes have significantly reduced waiting times for consultation and has led to a reduction in the average gestational age.

- Many units have been able to refine services through streamlined prescribing of contraception using efficient pathways between pharmacies and secondary and primary care.

- Device manufacturers have also provided data that give reassurance on the extended efficacy of intrauterine devices to permit safe delay of insertion of new devices. During recovery there should be a return to approved duration of efficacy.

Benign gynaecology

This term includes, among others, the commonly recognised conditions such as general gynaecology (elective and emergency), pelvic pain, paediatric and adolescent gynaecology, menopause, gynaecological endoscopy and the advanced management of endometriosis. This is where significant reduction in service has happened.

Planning a potential return to activity should consider the prioritisations within Appendix 1 for both clinic appointments and surgery. While many appointments and operations have been postponed, there have been innovations that could have sustained benefit:

- Widespread use of remote consultations has proved to be highly effective in circumstances such as routine follow-up where physical examination is not required, or triaged new appointments with a low likelihood of examination such as menopause.

- Efficiency, safety and service user opinion of virtual facilities should be audited prior to any return to routine clinics. There may well be considerable benefits to organisations in clinical space usage and compliance with social distancing and these should be championed during recovery of services.

- Extended nursing roles in both virtual and physical settings should also be supported by services where they comply with Nursing and Midwifery Council (NMC) regulations and local policies.

Menopause

Menopause services have continued in some units (where staffing has permitted) with the use of remote consultations, performed by either medical or specialist nursing staff.

- In some units the innovative use of staff who, for their own health reasons, are unable to work in clinical areas with potentially infected cases, has allowed some patients to be assessed remotely.
- Specialist menopause nurses should be returned to deliver menopause services as soon as possible if they have been deployed elsewhere.
- Use of 'Advice and Guidance' electronic requests from primary care are often beneficial by allowing online advice to pass from secondary to primary care.
- Use of pre-clinic validated questionnaires can also streamline both virtual and physical clinics.
- Combined specialist clinics such as those that combine menopause with cardiology or breast cancer teams should be arranged simultaneously or supported by one virtual appointment.

Urogynaecology

This subspecialty has probably suffered the greatest reduction in activity during the pandemic and it is particularly important that local teams advocate for the many women who are continuing to suffer by waiting for clinic review, surgery and seemingly simple procedures such as complex catheter or pessary changes.

- Virtual clinics are less useful in urogynaecology due to the need to perform clinical examinations and physical procedures
- Specialist nurse input is vital to prioritise women awaiting appointments and to arrange some outpatient procedures
- Some units have found that use of pre-clinic quality-of-life questionnaires, perhaps combined with a virtual clinic, can help selected women to start a treatment pathway with a commitment to physical examination at a subsequent visit

Gynaecological oncology

Extensive guidance on this topic exists on the website of the British Gynaecological Cancer Society (BGCS). While some cancer services have continued, these have largely been urgent diagnostic, surgical and medical gynaecological oncology. There has been a significant reduction in referrals to screening, diagnostic and therapeutic gynaecological cancer services as well as a reduction in women having less urgent surgery.

It is therefore imperative that units outwardly demonstrate not only that cervical screening programmes, colposcopy clinics and cancer services are returning towards normal over several weeks, but that they wish to receive referrals from primary care that meet the '2 week wait' suspected cancer criteria.

Separate guidance has been published by NHS England and Public Health England on the restoration of cervical screening services within England, and can be found here.

- MDTs have continued, some of which have been revolutionised by virtual technology, which may be useful to assist with social distancing in the near future.

- Postmenopausal bleeding clinics have continued in a reduced form in many units over the pandemic and urgent steps should be taken to ensure waiting lists are addressed, with priority to those who have waited longest.

- Extended use of specialist nurses to assist with liaison around complex pathways during the pandemic to reduce numbers of visits may help to make pathways more efficient in the future.

- Care will need to be taken in the identification of the pre-arranged high dependency recovery after radical surgery in the context of higher than average occupancy of beds in ITUs or high-dependency units while COVID-19 is still prevalent.

- Coproduction of services with service user/patient groups.

Reproductive medicine

The following principles should be applied in the approach taken to the recovery of fertility services:

- Resumption of fertility services must take place in a manner that minimises the chances of spread of COVID-19 infection to patients and fertility clinic staff.

- Centres should ensure a fair and transparent approach to any prioritisation policy.

- Resumption of treatment should not result in an undue burden on the NHS.

- Patients considering treatment should be fully informed about the effect of the ongoing pandemic on their treatment and give informed consent to having fertility treatment at this time.

- The fertility sector should adopt sustainable changes in working practices that help to build resilience against any future increases in the spread of COVID-19 in the community.

Vulval disease

Vulval disease should be considered as an essential core service with some conditions having a malignant potential. It is appropriate to cautiously increase vulval services, with some considerations.

- All patients should be triaged for their risk of severe COVID-19 disease and the urgency of their need to be seen within the vulval service. This should take into account factors such as age, background immune problems and underlying skin problems, allowing patients to be counselled accordingly.

- All patients with suspected malignancy should be seen as a 2-week consultation.

- If vulval clinic capacity is limited, then priority should be given to those with severe skin disease urgently requiring treatment or not responding to treatment already prescribed.

- For shielding or self-isolating patients, telephone consultations may be appropriate rarely, but genital images should only be sent to nhs.net email and only when password-encrypted images are possible (this may be complicated for some women to do). Currently there are very few safe systems for image transfer. Any system must be approved by the individual hospital trust.

- Genital images should not be stored on a computer hard drive or desktop but be loaded onto the electronic patient record (if available) or a secure server.

Paediatric and adolescent gynaecology

There has been a significant reduction in paediatric and adolescent gynaecology (PAG) elective clinics and surgery. Telephone and video clinics have been established, whilst MDTs lend themselves well to web meetings. Individuals with differences in sex development (DSD/intersex) should still have diagnostic investigations as a priority, with ongoing support from the DSD MDT. This allows a stratification of risk for deferral of any surgical procedures.

Obstructive müllerian anomalies must be appropriately imaged and reviewed in an MDT, with a clear management plan made. Many will require surgery within 30 days.

Prioritisation for outpatient appointments and surgery should be made according to Appendix 1, bearing in mind many clinics are co-ordinated by children's services and close liaison will be needed.

- Consideration should be given to ensuring confidentiality for the patient whilst balancing safeguarding concerns. Care should be taken to establish who is present at any remote consultation, and that reasonable privacy can be assured.

- For conditions requiring long-term care, some levels of monitoring may be possible with a telephone consultation and basic tests performed at the local GP surgery.

- Specialist nurses can act as a point of contact for PAG patients to offer clinical support.

- Some patients may require a face-to-face consultation after a telephone appointment.

Appendix 1: Prioritisation framework

This document has been produced with the assistance of the specialist societies of the RCOG. A full list of their websites is in Appendix 2. Please ensure that when considering the top-line recommendations in this document, consideration is given to topic-specific recommendations on the websites of these organisations, where there may be a wealth of information to consider.

The framework considers time periods within which it is considered acceptable to delivery a range of commonly received referrals and surgical procedures. This list is not exhaustive and is intended to provide assistance for those planning services:

- **Prioritisation of indications for outpatient assessment and procedures in obstetrics and gynaecology**
  - Emergency
  - Within 7 days
  - Within 14 days
  - Within 30 days
  - Over 30 days
- **Prioritisation for surgery in obstetrics and gynaecology**
  - Emergency (Priority 1A)
  - Within 72 hours (Priority 1B)
  - Up to 4 weeks (Priority 2)
  - Up to 3 months (Priority 3)
  - Over 3 months (Priority 4)

Prioritisation of indications for outpatient assessment and procedures in obstetrics and gynaecology: Emergency

Subspecialty	Assessment/procedure
Benign gynaecology	• Severe anaemia and/or haemodynamic compromise requiring emergency management from acute menstrual heavy bleeding • Outpatient management of Bartholin's and vulval abscesses • Acute pelvic pain, with or without fever, in a non-pregnant woman refractory to simple analgesia (i.e. suspected ovarian cystic accident; tubo-ovarian abscess)

Early pregnancy and abortion care	• Pain and heavy bleeding which may indicate complications of early pregnancy requiring urgent intervention, such as ectopic pregnancy or pregnancy of unknown location (with pain and/or bleeding) • Early pregnancy complication possibly requiring abortion for maternal compromise – e.g. sepsis, chorioamnionitis, severe pre-eclampsia, other physiological compromise • Women requesting surgical or medical abortion where approaching legal threshold (e.g. 23+6 weeks for all, 9+6 weeks [England & Wales] / 11+6 weeks [Scotland] for medical abortion at home, 12-14 weeks where procedure not provided by local NHS beyond this) • Feticide to permit legal abortion where approaching legal limit and unable to perform procedure prior to this threshold • Haemorrhage or other complication of miscarriage or post-abortion • Severe hyperemesis gravidarum requiring admission for immediate rehydration
Gynaecological oncology: chemotherapy	• Neutropenic sepsis post-chemotherapy • Acute abdomen including bowel obstruction/impending perforation/ peritonitis from gynaecological malignancy or treatment
Gynaecological oncology: radiotherapy	• Spinal cord compression from metastases • Brain metastases causing symptoms e.g. seizures • Heavy vaginal bleeding from gynaecological cancer – palliative radiotherapy
Gynaecological oncology: surgery	• Heavy vaginal bleeding from gynaecological cancer • Acute abdomen including bowel obstruction/impending perforation/ peritonitis from gynaecological malignancy or treatment • Acute presentation with pleural effusion/pulmonary embolism/acute abdomen
Reproductive medicine	• Fertility preservation consultations for men and women facing sterilising treatment, referred by oncology
Urogynaecology	• Urinary retention

Prioritisation of indications for outpatient assessment and procedures in obstetrics and gynaecology: Within 7 days

Subspecialty	Assessment/procedure
Benign gynaecology	• Any symptoms of postoperative complication of surgery in previous 14 days
Early pregnancy and abortion care	• Abortion – medical or surgical (all cases within 1 week of referral, NICE 2019) • Manual vacuum aspiration for miscarriage
Gynaecological oncology: chemotherapy	• New patient review for women with confirmed gynaecological cancer (chemotherapy) • Staging of severely symptomatic disease with CT and MRI (within 72 hours)

Gynaecological oncology: radiotherapy	• New patient review for women with confirmed gynaecological cancer (radiotherapy) • Intrauterine brachytherapy following completion of external beam radiotherapy for cervical cancer
Gynaecological oncology: surgery	• Smear with ?invasion or glandular neoplasia (best practice stretch target inside NHS Cervical Screening Programme target – to achieve 28-day diagnosis target) • Post-menopausal bleeding (to achieve 28-day diagnosis target) • Ascites +/- mass +/- raised CA125 in a woman who is clinically unwell • Significant heavy bleeding in a woman with uterine or cervical mass
Reproductive medicine	• Starting ovarian stimulation for women facing sterilising treatment
Urogynaecology	• Serious pessary problems: fistulation

Prioritisation of indications for outpatient assessment and procedures in obstetrics and gynaecology: Within 14 days

Subspecialty	Assessment/procedure
Benign gynaecology	• Post-coital bleeding with abnormal, absent or overdue cervical screening (see also gynaecological oncology below) • Pelvic mass, not previously identified as a fibroid • Vulval ulceration • Severe pelvic pain in women with endometriosis refractory to current medical treatments
Early pregnancy and abortion care	• Women with a history of recurrent miscarriage and who are pregnant • Abortion - medical or surgical where delay requested by woman
Gynaecological oncology: chemotherapy	• Completion of staging investigations for women with gynaecological cancer due to undergo chemotherapy
Gynaecological oncology: radiotherapy	• Completion of staging investigations for women with gynaecological cancer due to undergo radiotherapy
Gynaecological oncology: surgery	• Cervical screening – high-grade CIN/CGIN/BNC in glandular cells • Suspicious cervix • Post-coital bleeding, age >35 years, regardless of smear history • Symptoms concerning for recurrence in women with previous gynaecological malignancy • Women with symptoms suspicious of ovarian cancer with raised CA125 and abnormal ultrasound
Paediatric and adolescent gynaecology	• Imaging suggestive of müllerian obstruction
Gynaecological oncology: surgery	• Suspicious lesions – consider a 2-week wait (e.g. persistent [i.e. >4 weeks] sore, ulceration, induration, lumps)

Prioritisation of indications for outpatient assessment and procedures in obstetrics and gynaecology: Within 30 days

Subspecialty	Assessment/procedure
Benign gynaecology	• Heavy menstrual bleeding causing symptomatic anaemia • Persistent inter-menstrual bleeding, age >40 years • Pain in a non-pregnant woman with a normal pelvic ultrasound not adequately controlled with analgesia • Post-menopausal bleeding or breakthrough bleeding on HRT
Gynaecological oncology: chemotherapy	• Commencing primary chemotherapy treatment for women with gynaecological cancer • Commencing treatment with chemotherapy for women with recurrent gynaecological cancer • Response assessment to treatment e.g. CT and MRI
Gynaecological oncology: radiotherapy	• Commencing primary radiotherapy treatment for cervical/vulval cancer and other relevant suspected cancers
Gynaecological oncology: surgery	• Discussion of risk-reducing surgery following clinical genetics discussion • Post-coital bleeding, age <35 years, normal smear history (within 6 weeks but not routine) • Biopsy-proven VIN
Reproductive medicine	• Consultations for couples and individuals with infertility where the woman has a low ovarian reserve or is 40 years of age or older • Initiation of hormonal treatment for women with significant pelvic pain, for instance due to endometriosis
Urogynaecology	• Pessary problems/bleeding/ulceration • TWOC (postoperative or postnatal) • Examination and investigation of women with pessary and bleeding • Review of women with other pessary problems
Vulval disease	• Uncontrolled flare-ups of inflammatory skin disease • Significant vulval pain resistant to standard analgesics

Prioritisation of indications for outpatient assessment and procedures in obstetrics and gynaecology: Over 30 days

Subspecialty	Assessment/procedure
Benign gynaecology	• Pelvic mass, previously identified as a fibroid • Heavy menstrual bleeding not causing significant anaemia • Persistent inter-menstrual bleeding, age <40 years • Pelvic pain/dyspareunia • Presumed benign ovarian cyst seen on pelvic ultrasound • Vaginal discharge/sexual health concerns (following exclusion of STI) • Fertility control (e.g. intrauterine contraceptive devices, sterilisation requests) • Menopause and HRT • Presumed benign lower genital tract lesions
Gynaecological oncology: surgery	• Referral from another centre for continued follow-up of previous cancer • Cervical polyp • Persistent inadequate smears or referral to hospital cervical screening clinic for other reasons • Fertility treatment for couples and individuals where the woman has a normal ovarian reserve and age less than 40 years; however, delays due to commissioning arrangements make early treatment imperative for many • Colposcopy referrals for: low-grade cervical screening/high-risk HPV positive; persistent high-risk HPV positive with normal cytology/high-risk HPV-positive with normal cytology following previous treatment (test of cure; within 6 weeks)
Paediatric and adolescent gynaecology	• Concerns about labial appearance • Primary amenorrhoea • Other complex genitourinary conditions requiring gynaecology input (e.g complex congenital urology) • Transition of children with differences of sex development from paediatric services • New referral for an adult with differences of sex development
Reproductive medicine	• Consultations for couples and individuals where the woman is younger than 40 years and has a normal ovarian reserve • Fertility treatment for couples and individuals where the woman has a low ovarian reserve or is aged 40 years or older (within 3 months)
Urogynaecology	• Routine change of pessary • Suprapubic catheter change • Procidentia • Recurrent UTI • Prolapse and incontinence
Vulval disease	• Consultations for vulval disease

Prioritisation for surgery, inpatient care and chemotherapy/radiotherapy in obstetrics and gynaecology: Emergency (within 24h) – Priority 1A

Subspecialty	Assessment/procedure
Benign gynaecology	• Laparoscopic/open surgery for torsion of ovary • Laparoscopic/open drainage of pelvic/genital tract sepsis in an unwell patient not responding to antibiotics where interventional radiology is not available, failed or not feasible • Laparoscopy/laparotomy/vaginal surgery for genital tract trauma (e.g. vaginal tear, pelvic/vulvo-vaginal haematoma) • Laparoscopic/open/vaginal surgery for intra-abdominal bleeding arising from ovarian cystic accident: torsion, cyst rupture or postoperative (e.g. from an oncological procedure, emergency procedure)
Early pregnancy and abortion care	• Surgical management of miscarriage if bleeding heavily and unstable • Surgical or medical abortion for maternal compromise – e.g. sepsis, chorioamnionitis, other physiological compromise • Surgical abortion where approaching legal threshold (e.g. 23+6 weeks for England/Scotland/Wales, 12-14 weeks where procedure not provided by local NHS beyond this) • Laparoscopic/open surgery for ectopic pregnancy if clinically unstable or at an advanced stage
Gynaecological oncology: chemotherapy	• Metastatic spinal cord compression treatment • Superior vena cava occlusion treatment • Acute treatment toxicity – grade III and IV as per WHO classification • Acute renal failure (either treatment or malignancy related)
Gynaecological oncology: radiotherapy	• Spinal cord compression • Severe haemorrhage
Gynaecological oncology: surgery	• Emergency laparotomy – bleeding not responding to endoscopic/interventional radiology where there is reasonable expectation of surgery being curative and conservative measures have failed • Emergency laparotomy (peritonitis/abscess/necrotising fasciitis) • Laparotomy for postoperative complications (e.g. anastomotic leaks/bleeding) • Drainage of sepsis if not responding to antibiotics/interventional radiology • Washout open wound/infected/grossly contaminated wounds
Maternity care	• Emergency procedures (caesarean birth, instrumental birth, perineal repair, manual removal of placenta, cervical cerclage, emergency laparotomy, emergency hysterectomy)
Paediatric and adolescent gynaecology	• Incision and drainage of imperforate hymen

Reproductive medicine	• Fertility preservation for men undergoing sterilising treatment acutely – sperm storage • Oocyte collection for fertility preservation in women about to undergo sterilising treatment • Ovarian tissue storage for fertility preservation for women undergoing sterilising treatment
Urogynaecology	• Insertion of catheter for acute/chronic urinary retention

Prioritisation for surgery, inpatient care and chemotherapy/radiotherapy in obstetrics and gynaecology: Urgent: 72 hours – Priority 1B

Subspecialty	Assessment/procedure
Benign gynaecology	• Laparoscopic or open drainage of a pelvic collection/tubo-ovarian abscess not responding to antibiotics where interventional radiology is not available, failed or not feasible • Diagnostic laparoscopy for unresolved pelvic pain after 48 hours • Surgery for postoperative wound complications: evacuation of haematoma, repair wound dehiscence or evisceration, repair of incisional hernia • Incision and drainage/marsupialisation of Bartholin's abscess
Early pregnancy and abortion care	• Laparoscopic/open surgery for ectopic pregnancy where clinically stable and no intra-abdominal bleeding • Surgical management of miscarriage if not suitable for a manual vacuum aspiration • Surgical abortion (all cases within 1 week of assessment, NICE 2019)
Gynaecological oncology: chemotherapy	• Fistula repair (recto-vaginal, bladder-vagina) • Acute hydronephrosis • Brain metastases treatment • Treatment of symptomatic pleural effusions/ascites (simple drainage/IPC insertion)
Gynaecological oncology: radiotherapy	• Radiotherapy for gynaecological malignancy • Palliative radiotherapy for pain or bleeding from gynaecological cancer • Radiotherapy for brain metastases from gynaecological cancer
Gynaecological oncology: surgery	• Emergency laparotomy for bowel obstruction of single transition point not responding to conservative treatment in patient with ongoing treatment options (i.e. not end-stage setting) • Examination under anaesthesia and insertion of fiducial markers for cervical cancer staging and planning of treatment • Hysteroscopy for investigation of postmenopausal bleeding in woman with thickened endometrium and not amenable to outpatient sampling (referral to diagnosis target 28 days) • Emergency laparotomy – bleeding not responding to endoscopic/interventional radiology where there is reasonable expectation of surgery being curative and conservative measures have failed, but able to be temporised with transfusion etc

Urogynaecology	• Surgical intervention for serious pessary problems (e.g. fistulation)

Prioritisation for surgery, inpatient care and chemotherapy/radiotherapy in obstetrics and gynaecology: Up to 4 weeks – Priority 2

Subspecialty	Assessment/procedure
Benign gynaecology	• Hysteroscopy (outpatient/inpatient) and/or endometrial biopsy for diagnosis of suspected endometrial hyperplasia/cancer
Gynaecological oncology: chemotherapy	• Adjuvant and neoadjuvant chemotherapy treatment for newly diagnosed gynaecological malignancy • Palliative chemotherapy treatment for symptomatic patients with relapsed disease • Concurrent chemo-radiotherapy • First-line chemotherapy for advanced or recurrent cervical, endometrial, vulval cancer • Chemotherapy for second-line treatment • Neo-adjuvant chemotherapy for locally advanced disease (within 2 weeks)
Gynaecological oncology: radiotherapy	• Primary radiotherapy for cervical cancer • Primary radiotherapy for vulval cancer
Gynaecological oncology: surgery	• MDT recommended surgery for proven or suspected vulval/vaginal/cervical/uterine/ovarian cancer • Wide local excision for high-grade vulval intraepithelial neoplasia (VIN), vaginal intraepithelial neoplasia • Surgery for high-grade cervical intraepithelial neoplasia or early-stage cancer • Surgery for recurrence of gynaecological cancer • MDT recommended staging surgery for proven or suspected vulval/vaginal/cervical/uterine/ovarian cancer
Paediatric and adolescent gynaecology	• Surgery for non-obstructive vaginal anomaly (longitudinal vaginal septum, septate hymen) • Examination under anaesthesia/vaginoscopy for suspected vaginal abnormality

Prioritisation for surgery, inpatient care and chemotherapy/radiotherapy in obstetrics and gynaecology: Up to 3 months – Priority 3

Subspecialty	Assessment/procedure
Benign gynaecology	• Hysteroscopic, laparoscopic or open myomectomy for fibroids causing significant anaemia and medical treatments ineffective or inappropriate • Hysteroscopy (outpatient/inpatient) to investigate abnormal uterine bleeding or reproductive failure • Laparoscopic excision of endometriosis with bowel or ureteric obstruction where stenting is not available, failed or not feasible; or where there is significant pain uncontrolled with medical treatments (including GnRH analogues +/- addback HRT) or where such medical treatments are inappropriate (e.g. patient declines, adverse effects, contraindications) • Endometrial ablation or laparoscopic, vaginal or open hysterectomy for heavy menstrual bleeding/fibroids causing significant anaemia and medical treatments ineffective or inappropriate
Gynaecological oncology: radiotherapy	• Adjuvant radiotherapy for endometrial cancer (within 6 weeks of surgery) • Stereotactic radiotherapy for recurrent disease (within 6 weeks)
Gynaecological oncology: surgery	• Repeat local conisation procedures for stage Ia1 cervical cancer (any age) or high-grade cervical pre-cancer in women aged >50 years • Completion simple hysterectomy following local conisation (LLETZ) for Ia1 cervical cancer • Risk reducing bilateral salpingo-oophorectomy (BSO) or salpingectomy for BRCA1/2 women with recent normal CA125 and USS • Risk-reducing hysterectomy for women with Lynch syndrome • BSO for persistent complex ovarian cyst with low risk of suspicion of malignancy
Paediatric and adolescent gynaecology	• Laparoscopic excision of obstructed uterine horn after multidisciplinary review • Reconstructive vaginal surgery for vaginal agenesis with menstrual obstruction after multidisciplinary review (e.g vaginal septae, OHVIRA)
Urogynaecology	• Change of suprapubic catheter • Surgery for significantly bothersome prolapse (with bleeding/ulceration) such as procidentia/vault eversion not responding to conservative treatments • Surgical treatment for genitourinary fistulas

Prioritisation for surgery, inpatient care and chemotherapy/radiotherapy in obstetrics and gynaecology: Over 3 months – Priority 4

Subspecialty	Assessment/procedure
Benign gynaecology	• Hysteroscopic and associated interventions to treat heavy menstrual bleeding: levonorgestrel releasing intrauterine system, endometrial resection, second-generation endometrial ablation (outpatient/inpatient) • Operative hysteroscopy for uterine structural disorders associated with abnormal uterine bleeding or reproductive failure: polypectomy, myomectomy, septoplasty, adhesiolysis, cervical niche (outpatient/inpatient) • Laparoscopy for investigation of pelvic pain or subfertility • Laparoscopic tubal surgery for tubal factor infertility and/or symptomatic tubal disease • Laparoscopic excision of superficial and/or deep endometriosis without bowel or ureteric obstruction and/or ovarian endometrioma • Laparoscopic or open myomectomy for fibroids not causing anaemia • Laparoscopic, open or vaginal hysterectomy for abnormal uterine bleeding, pain, symptomatic fibroids and/or endometrial hyperplasia • Laparoscopic or open cystectomy or oophorectomy for ovarian cysts > 5 cm with a benign RMI • Surgery for symptomatic lower genital tract lesions (e.g. Bartholin's cyst)
Gynaecological oncology: surgery	• Closure of stoma
Paediatric and adolescent gynaecology	• Reconstructive vaginal surgery for vaginal agenesis or stenosis without menstrual obstruction after multidisciplinary review • Clitoral reduction surgery for differences of sex development after multidisciplinary review
Urogynaecology	• Surgical interventions for incontinence • Surgical interventions for prolapse

Appendix 2: RCOG specialist society website details

Association of Early Pregnancy Units (AEPU): **www.aepu.org.uk**

Faculty of Sexual and Reproductive Healthcare (FSRH): **www.fsrh.org**

British Association of Perinatal Medicine (BAPM): **www.bapm.org**

British Fertility Society (BFS): **www.britishfertilitysociety.org.uk**

British Gynaecological Cancer Society (BGCS): **www.bgcs.org.uk**

British & Irish Association of Robotic Gynaecological Surgeons (BIARGS): **www.biargs.org.uk**

British Maternal & Fetal Medicine Society (BMFMS): **www.bmfms.org.uk**

British Menopause Society (BMS): **www.thebms.org.uk**

British Society of Abortion Care Providers (BPAS): **www.bsacp.org.uk**

British Society of Biopsychosocial Obstetrics & Gynaecology (BSBOG): **www.bsbog.org**

British Society for Colposcopy and Cervical Pathology (BSCCP): **www.bsccp.org.uk**

British Society for Gynaecological Endoscopy (BSGE): **www.bsge.org.uk**

British Society for Gynaecological Imaging (BSGI): **www.bsgi.org.uk**

British Society for Paediatric and Adolescent Gynaecology (BritSPAG): **www.britspag.org**

British Society for Study of Vulval Diseases (BSSVD): **www.bssvd.org**

British Society of Urogynaecology (BSUG): **www.bsug.org.uk**

Institute of Psychosexual Medicine (IPM): **www.ipm.org.uk/**

British Intrapartum Care Society (BICS): **bicsoc.org.uk**

British Association for Sexual Health and HIV (BASHH): **www.bashh.org**

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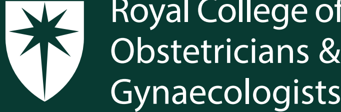

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