Rotherham Women's Health Network

Nazreen Iqbal Healthy Hospital Programme Manager TRFT
Linda Strettle GP Partner at Village Surgery

Rotherham Women's Health Network

The Rotherham Women's Health Network (RWHN) **brings together stakeholders** across health, social care, community, and voluntary sectors to **improve women's health and wellbeing within Rotherham Place**. The RWHN is a partnership network aiming to address **health inequalities**, strengthen **service coordination**, and ensure **women's voices inform local decision-making**.

Stakeholders

Public Health	Primary Care	Gynaecology
RMBC	TRFT	ICB
Screening Team	Voluntary Action Rotherham	Healthwatch

Better Representation and coordination	**Sharing of Information**	**Health Needs Assessment**	Outcomes

Refreshed Women's Health Strategy

117 Actions

4 Commitments

10 year Horizon

2040 Cervical Cancer Elimination

1. Reverse Decline in healthy life expectancy

2. Raise healthy life expectancy in the poorest regions

3. Reduce time women spend in poor health as a share of their lives

Conditions in Focus

Endometriosis
Diagnosis takes avg. **9y 4mo**.
Dedicated NHS Online pathway & community 1st design

Osteoporosis
1 in 3 women will fracture.
20 new DEXA scanners; FLS nation wide by 2030

Cardiovascular
Women are **50% more likely to be misdiagnosed**. New CVD modern service framework 2026

Dementia
Leading cause of female death (16% in 2024) Barbra Windsor Dementia Goals Programme

Mental Health
1 in 4 women affected
Vs 1 in 7 men.
915000 to complete NHS Talking Therapies by 2029

Maternity
Black maternal mortality 3 x higher Amos investigation and gap closure target

Acting on Women's Voices and Choices

→ Women's Voices Partnership established by 2027

→PREMS & PROMS for Gynaecology outpatients.

→ NHS trust funding tied to women's feedback ("patient power payments")

→ Pain standards mandated for procedures like hysteroscopy

→ Free emergency contraception in all pharmacies, now

Transforming NHS Performance

→ Single access point for all gynaecology referrals

→ Menopause and menstrual health among the first 9 pathways on NHS Online (2027)

→ Explicit target to close the Black and Asian maternal mortality gap

→ 20 new DEXA scanners; fracture liaison services nationwide by 203

Acting on Women's Voices and Choices Supporting Healthy Prosperous Lives

→ Cervical cancer elimination target: 2040

→ HPV home testing kits and pharmacy vaccination from this year

→ BRCA1/2 and Lynch syndrome genomic testing expanded

→ Employers with 250+ staff must publish menopause action plans from 2027

Research and Innovation for Women

→ NIHR will no longer fund research that ignores sex-based differences

→ £1.5m FemTech healthcare challenge

→ Female founders accelerator via NIHR

→ AI Ethics Initiative: diversity standards for health AI datasets

Key Takeaways

84% of women report not being listened to by healthcare professionals.

Systematic **failure to listen** to women

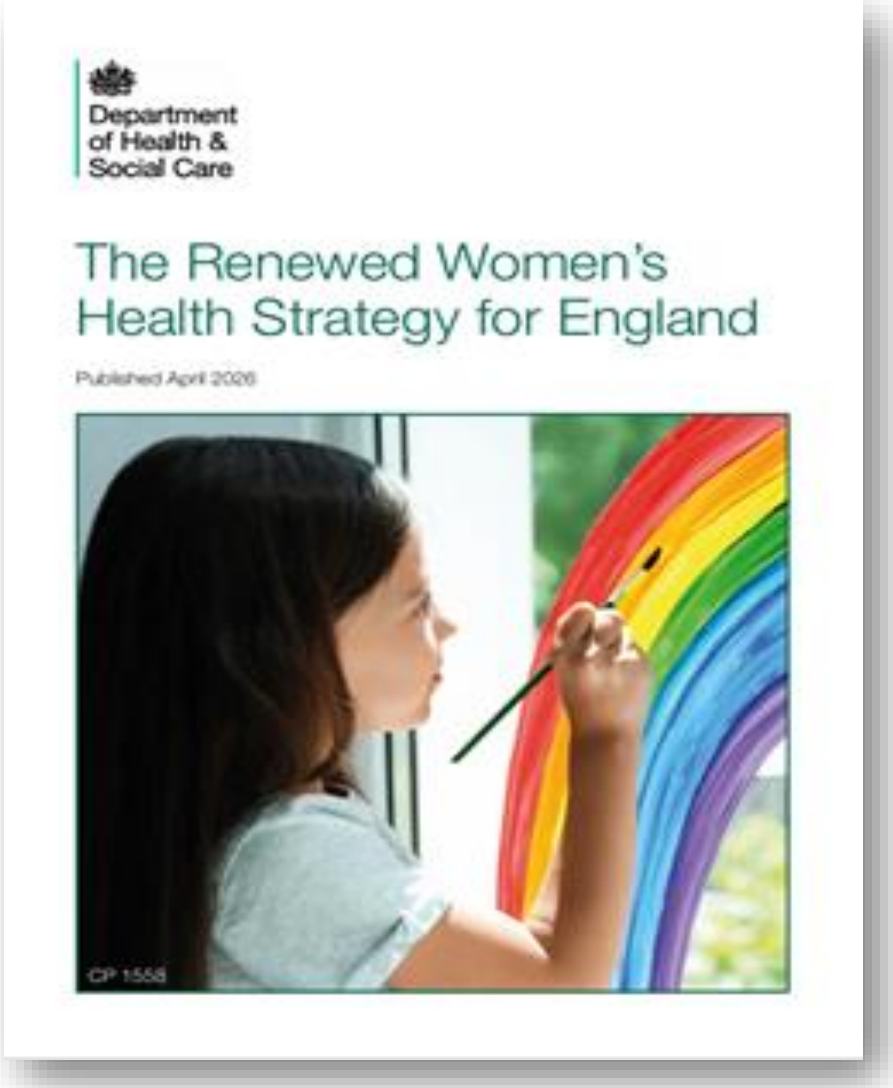
Culture of **unequal treatment**, and to tackle **unconscious bias** and **medical misogyny**.

Women's Health HUBS named

Disparity continues…

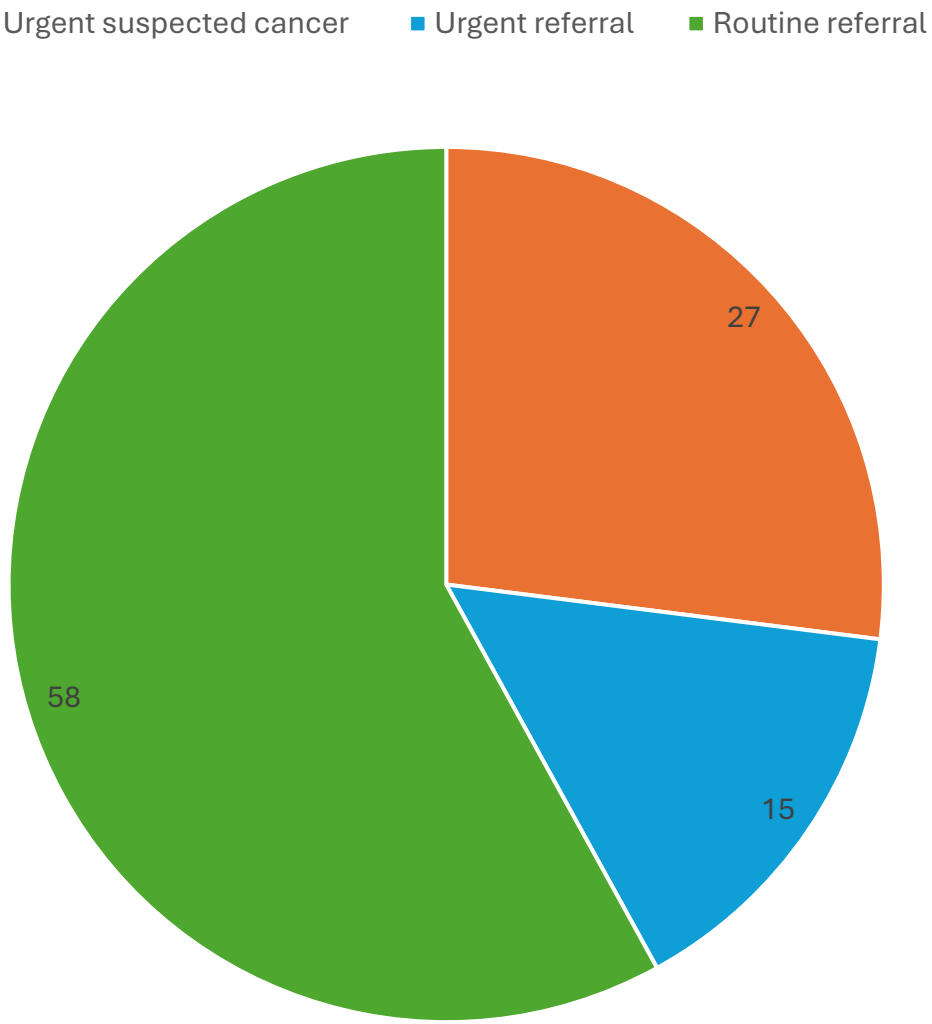
£1 million to improved education around period.
1.5 mill women's fem tech innovation.

(£6.3 offered for men's mental health.)

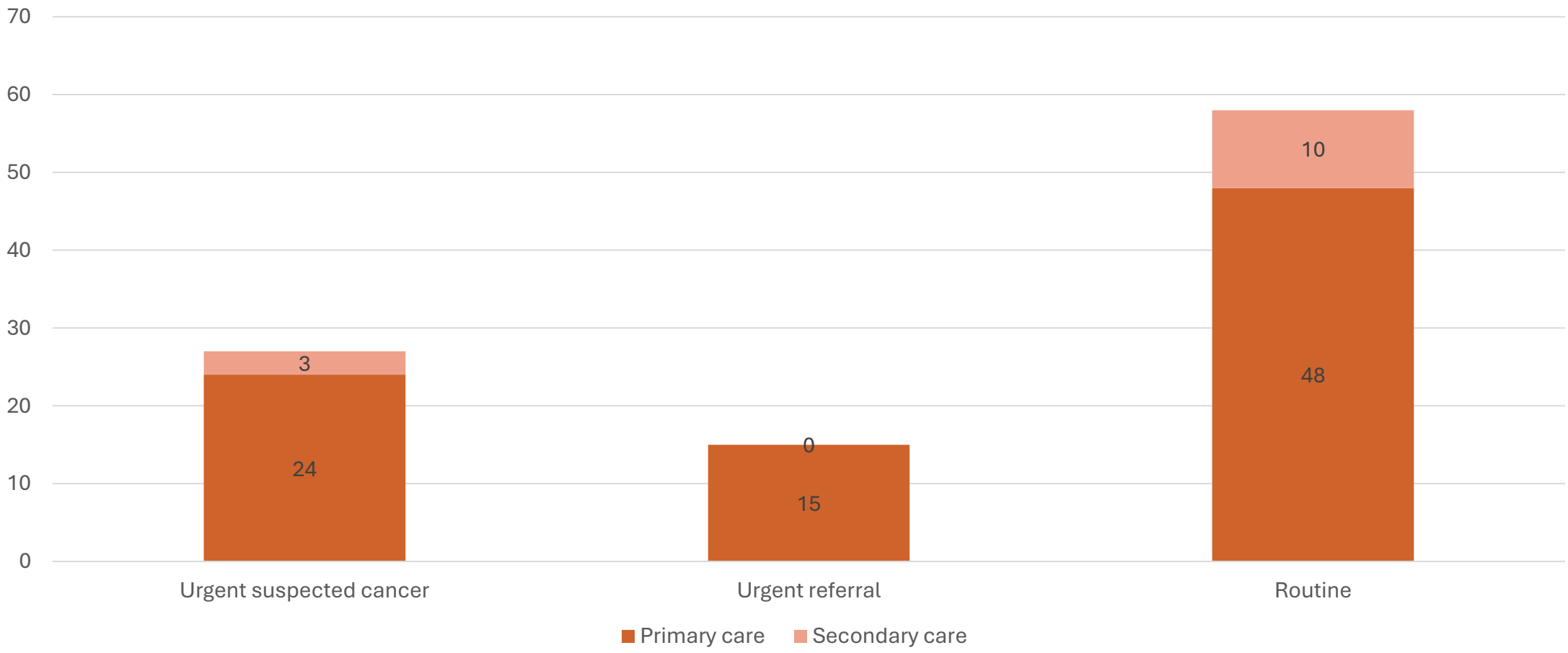


Audit

- 100 records from consecutive Gynaecology outpatient appointments Jan 2025 (reviewed Jan 2026)



Origin of referral – primary/secondary care



Reasons for referral

Urgent suspected cancer referrals

- Imaging suggestive of cancer and/or raised Ca125 (ovarian cancer marker)
- Wait time 12 days

Urgent referrals

- Menorrhagia and abnormal bleeding
- Wait time 64 days

Routine referrals

- Menorrhagia, pelvic pain, endometriosis, abnormal bleeding patterns
- Wait time 253 days

Outcomes

Two Week Wait - 60% discharged at first appt (mainly PMB)
Abnormal imaging/Ca125 not discharged
3 cancers diagnosed (1 endometrial, 1 ovarian, 1renal)
4 ongoing monitoring of ovarian cysts

Urgent referrals - 47% discharged at first appt

Routine referrals - 12% discharged at first appt

Routine referral outcomes n=58

- 56% needed secondary care input and referral,
  - Secondary care input needed with imaging, treatments such as GnRH analogues, follow up of ovarian cysts and surgery such as laparoscopy/hysterectomy among other outcomes
- 19 patients could have had actions in primary care/hub setting prior to referral.

Number of patients	Other options at referral
2	HRT queries - could have been dealt with via A&G rather than a referral
9	Bleeding problems or pain – treated with Mirena coil or contraception - ?could have been done in a community hub
8	Bleeding problems or pain & had not had an ultrasound scan, swabs or blood tests prior to their secondary care gynecology appointment.

Conclusions

Long wait times for routine gynecology appointments

- 250 days.
- Proforma for referrals could help ensure appropriate tests done pre-referral eg swabs, scans etc
- CASES or community hub could help screen and review referrals and triage/appoint in a hub setting

Conclusions

Community/hub clinics

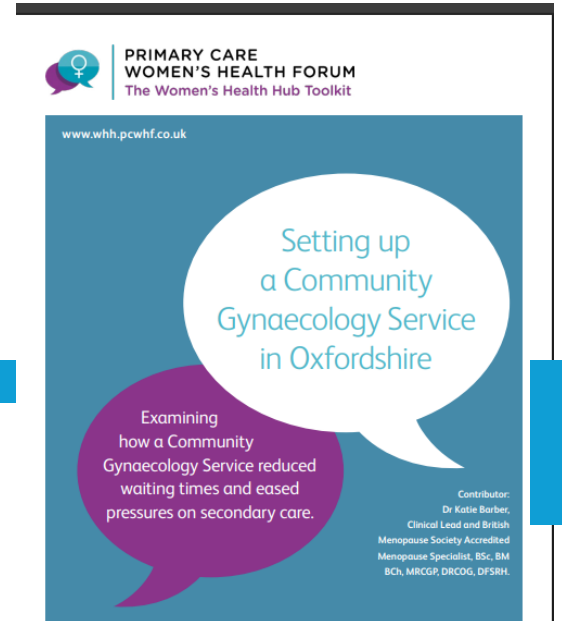
- Prescreening of referrals and triage to appropriate services/ tests
- Access to contraceptive, HRT and Mirena coils e.g. community gynecology clinics which is similar to other areas.
- Education for women for the treatment options eg coils
- Change in bleeding pattern over the age of 45 – community clinic or LES for endometrial pipelle prior to coil fit could avoid secondary care referrals.

There were potentially training needs for clinicians regarding recognizing cervical polyps, side effects of flushes on Depo-Provera and examining patients prior to 2ww for PMB for patients with a hysterectomy

There is a potential role for an ovarian cyst pathway - several patients had multiple ongoing reviews in secondary care following up ovarian cysts.

How could it work?

Oxford – referrals reviewed within 72hrs, appts at hubs/GP surgeries for 20-30min telephone/f2f, 25 clinical sessions/week (1/5th f2f, rest 50:50 triage/telephone)



Referrals

It was originally anticipated the community service would see 20% of the patients, with the remaining 80% still going to secondary care. However, the Community Hubs are managing between 45-55% of patients with approximately 45-55% being referred on to secondary care[1].

For example, an average month this year saw 650 referrals, 285 telephone contacts and 100 face to face consultations.

Examples of referral include:

- A 32-year-old with a dermoid cyst increasing in size – referred on to gynae. This model ensures that routine referrals with high cancer risk can be expedited on to secondary care gynae services.
- A patient whose HRT was not alleviating symptoms. Through simple EMIS record sharing, it was established that the solution would be to increase the dose, with a note sent to the GP to request this.

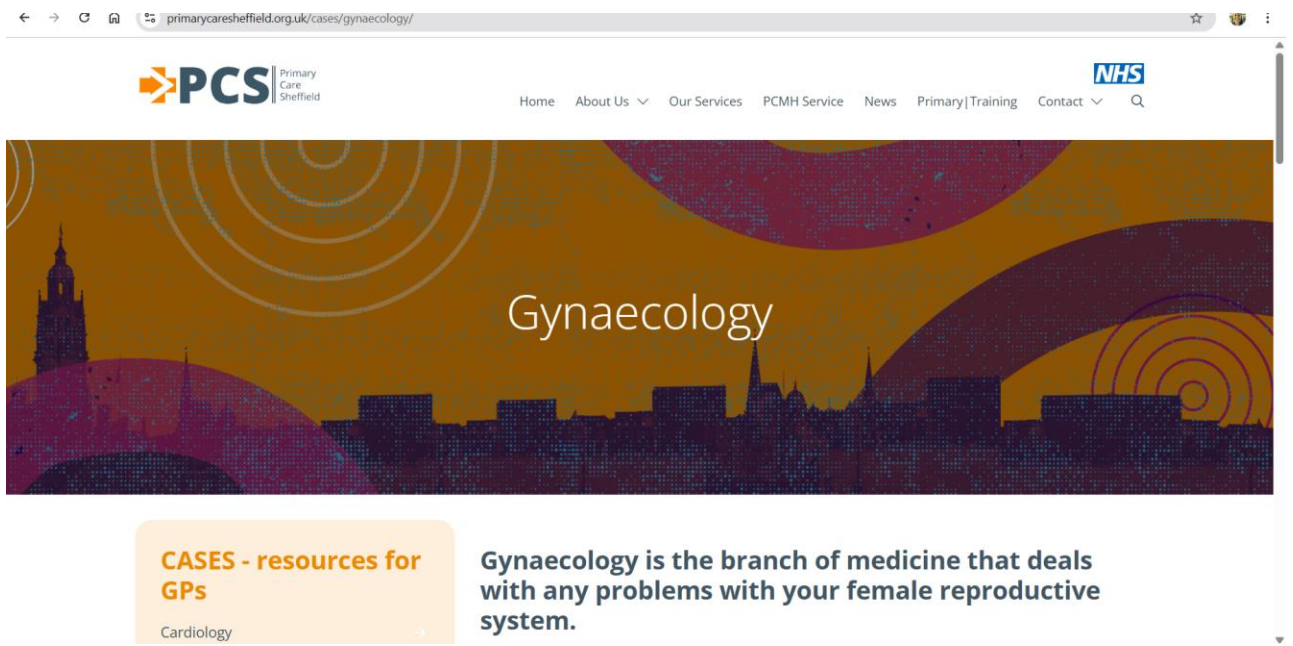
Appointments include face to face appointments and telephone consultations. Using laptops and telephone triage, GPs can work from home, their own surgeries or office based at one of the sites.

On average 6-8 cases are seen per hour by GP triage, if necessary, this can be flexed to suit the individual GP and patient requirements.

https://www.pcwhs.co.uk/_userfiles/pages/files/whh%20toolkit/settingupacommunitygynaecologyserviceinoxfordshire.pdf

Disparity across SY

- CASES in Sheffield
- ‘Overall CASES has resulted in an average 23.7% reduction in referrals across all specialties. ‘



https://primarycaresheffield.org.uk/wp-content/uploads/2023/02/Case-studies-brochure-7.pdf

Call To Action

Mainstream NHS spend + reprioritisation needed
Requires leadership focus on women's health
Commitment to specialist women’s health centres in every region. Expansion of community diagnostic centres (e.g. scans, tests for gynaecology)
Support for the expansion of the Rotherham Women’s Health Network (Admin support/Funding for a conference)
Creation of a women’s Health HUB in Rotherham