RFT Gynaecology Outpatient Department
New Patient Referral Audit
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This report summarizes all gynecology outpatient appointments seen in outpatient clinic at Rotherham Foundation trust between 1st January 2025 and 28th January 2025. A total of 100 anonymised new-patient appointments, their associated referral letters and subsequent outcomes were reviewed via a Meditech notes review by the authors in January 2026.

1) Summary Findings

The main Two week wait referrals from primary care were for Post Menopausal bleeding (PMB) and imaging suggestive of cancer and/or raised Ca125. Routine referrals from primary care were dominated by Menorrhagia and pelvic pain.

The waiting times from referral to being seen in the gynecology clinic (median)were for two week wait referrals 12 days, urgent referrals 64 days and routine referrals 253 days.

Overall outcomes from the first appointment included - 70% of patients were not discharged at first appointment, 25% were discharged at first appointment and 5% had patient initiated follow up (PIFU).

For cases, as deemed by the authors, that could have potentially been dealt with in primary care (n=17): these were all routine referrals. The commonest reason that the patients could have been dealt with in primary care and not been referred included coil fitting being either unavailable, or not taken up in primary care, or hormonal treatment such as contraception had not been done in primary care.

2) Referral Mix

- Two Week Wait referrals were primarily Post menopausal Bleeding (PMB) and malignancy concerns (abnormal imaging with or without a raised Ca125).
- Urgent referrals were dominated by Menorrhagia and abnormal bleeding patterns.
- Routine referrals most commonly relate to Menorrhagia, pelvic pain/endometriosis, and Intermenstrual bleeding (IMB)/Post Coital Bleeding (PCB).

Summaries of the referrals in each referral group are as follows

Two Week Wait Referral (2ww) from primary care:

Reason for referral	Number of patients
Abnormal Ca125	2
Abnormal Ca125 & imaging suggestive of cancer	1
Imaging suggestive of cancer	4
Post Menopausal bleeding (PMB)	17
Total	**24**

PMB consisted of - PMB =3, PMB & IMB =1, PMB not on HRT = 9, PMB on HRT =2, PMB on HRT & abnormal Ca125 =1, PMB & urethral lesion =1

Two Week Wait Referrals (2ww) internal secondary care referrals were all for imaging suggestive of cancer (n=3).

Urgent Referral from primary care:

Reason for referral	Number of patients
IMB / PCB	3
Coil request	1
HRT query	1
Menorrhagia	8
Ovarian cyst	1
Polyp (cervical/uterine)	1
Total	**15**

Routine Referral from primary care:

Reason for referral	Number of patients
HRT &/or testosterone related	3
Hot flushes on Depo-Provera contraception	1
Coil request	3
Bleeding and pain problems including combinations of – Dysmenorrhea/Menorrhagia/IMB/PCB/Pelvic pain	24
PCB	1
Polyp on cervical smear	1
Dyspareunia or pelvic pain or concerns re endometriosis	9
Fibroid	1
Labial/Vulval/Vaginal problem	4
Infertility	1
No info	1
Total	**48**

Abnormal bleeding was made up of - Made up of - Dysmenorrhea & Menorrhagia/IMB = 7,

IMB +/- PCB = 3, PCB = 1, Menorrhagia +/- IMB/PCB/Pelvic pain = 13

Routine Internal Referral from Secondary care:

There were 7 gynecology internal secondary care referrals, 1 colorectal (pelvic pain) and 2 from sexual health (1 = retrieval of coil, 1= sterilization request).

Gynecology internal referrals:

Reason for referral	Number of patients
Uterine/ovarian problem found during pregnancy	2
Ovarian Cyst	1
Menorrhagia +/- IMB/PCB/Pelvic pain	2
Endometriosis	1
Pelvic pain +/- menorrhagia	2
Total	**8**

3) Outcome & Waiting Times

Discharge at first appointment by referral type:

- Routine referrals have the highest number not discharged on first appointment – 12% discharged at first appointment.
- Two Week Wait referrals show a high discharge rate: 60% discharged at first appointment.
- Urgent referrals 47% discharged at first appointment.
- PIFU was only used in Routine referrals (5 cases).

Referral Type	Ongoing review	PIFU	Discharged at first appointment	Total
Two Week Wait	16	0	11	27
Urgent	8	0	7	15
Routine	46	5	7	58

- **2WW referrals** were seen **rapidly**, with most within the 2-week target.

- **Urgent referrals** were seen in **1–4 months**.
- **Routine referrals** were seen in **4–17 months**, depending on clinic pressures.

4)Referral documentation

For the two week wait referrals there was only one that could have been potentially dealt with in primary care – a concern regarding PMB that was actually lichen sclerosis in a patient who had had previous total abdominal hysterectomy. There had been no documented examination of the patient on the referral letter. 64% of those patients referred with post menopausal bleeding were discharged at first appointment. None of the patients with abnormal imaging or raised Ca125 were discharged at first appointment. Two patients were diagnosed with gynecological cancers (one endometrial, one ovarian cancer) and another patient was diagnosed with renal cell carcinoma. Four patients were having ongoing monitoring of ovarian cysts.

56% of patients referred routinely were deemed by the authors to have needed secondary care input and referral, as they needed secondary care input eg imaging, secondary care treatments such as GnRH analogues, follow up of ovarian cysts and surgery such as laparoscopy/hysterectomy among other outcomes.

For the routine referrals, the authors on review had considered that 19, of the 48, referrals could have had actions in primary care prior to referral. The following were cases of note that the authors reviewed and considered there could have been learning points.

Two patients who were referred to clinic for advice about HRT these could have been dealt with via Advice and Guidance rather than a referral (of note the NHSE Advice and Guidance came in for primary care in depth in April 2025, and this audit reviewed January 2025 patients).

A patient referred with a cervical polyp at routine smear was found to have ectropion on review and thus potentially this referral have been prevented with more training of the cervical smear taker. Another patient who was referred with concerns about her labia was reassured at secondary care gynecology that her labia was normal and no further action was taken.

Nine patients who were seen with bleeding problems or pain ended up with a Mirena coil or contraception – if a community gynae clinic was available potentially these procedures could have been done in a more timely manner in the community.

Eight patients were referred with bleeding problems or pain and had not had an ultrasound scan, swabs or blood tests prior to their secondary care gynecology appointment. A proforma that encouraged specific tests for certain presentations could help to ensure appropriate tests were being performed pre referral.

One patient was referred with Genitourinary symptoms of menopause and had simple treatment that could have been done in primary care.

5) Conclusions

In conclusion the authors have noted the following

1. All two week wait referrals bar one was appropriate and as per the guidance. The importance of considering an examination for Post Menopausal bleeding, especially in women who have had a prior hysterectomy, is a recommendation of this review.
2. Women had long wait times for routine gynecology appointments, waiting over 250 days. The documentation in referral letters was lacking in women with Menorrhagia and Pelvic pain as to whether they had had scans, swabs, smears and blood tests. A proforma that pulls this information from the record and/or recommends that certain tests are done pre-referral could ensure that women when arriving to clinic have all the pre clinic tests ready.
3. Access to contraception advice, HRT and Mirena coils could potentially prevent referrals or could be dealt with in another setting e.g. community gynecology clinics which is similar to other areas. Of the patients reviewed – 8 patients had a Mirena coil, 3 had treatment with contraception for their symptoms, 3 had advice on HRT/menopausal symptoms, dyspareunia with simple advice given and 2 on review had normal findings (cervical polyp not there and normal labia). So out of the 48 primary care routine referrals – 17 had clear simple management that could have been done in a community clinic.
4. Having some unified information on management of menorrhagia and/or abnormal bleeding for women in Rotherham, including information on hormonal coil could help women access this sooner in the community and avoid long wait times for clinic.
5. For patients with a change in bleeding pattern over the age of 45 it could be considered again that a service that can provide a pipelle sample of the endometrium could allow appropriate assessment of this and then proceeding to Mirena coil in the community could avoid secondary care referrals.
6. There were potentially training needs for clinicians regarding recognizing polyps, flushes on Depo-Provera.
7. There is a potential role for an ovarian cyst pathway, several patients had multiple ongoing reviews in secondary care following up ovarian cysts.