Bristol, North Somerset and South Gloucestershire Gynaecology Healthcare Needs Assessment 2026

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Key Messages

1. Gynaecological need in BNSSG is high and growing

- One in four women in BNSSG have presented to primary care with a recorded gynaecological condition within the last three years.
- Demand is increasing due to population growth, ageing, increasing diversity and greater awareness of women's health conditions.

2. Long waits are affecting outcomes and increasing pressure across the system

- Around 7,400 women are currently waiting for gynaecological care.
- One third are waiting longer than 18 weeks.
- Long waits in secondary care increase demand on general practice and contribute to worsening symptoms and reduced quality of life.

3. Significant unmet need remains

- Conditions such as endometriosis and fibroids appear to be underdiagnosed or under-recorded.
- Many women continue to normalise symptoms, delay seeking help or feel dismissed when they do present for care.
- The true scale of need is likely to be considerably higher than routine data suggests.

4. Inequalities in women's health are substantial

- Women living in deprived communities and women from minoritised ethnic groups experience poorer access, poorer outcomes and lower rates of diagnosis for some gynaecological conditions.
- HRT prescribing is around half as common in the most deprived communities compared with the least deprived.
- Barriers to care remain for women experiencing social, cultural, language and wider access challenges.

5. The current model relies too heavily on hospital-based care

- Many women are referred to hospital for care that could potentially be provided closer to home.
- Community capacity for pelvic health physiotherapy, pessary care and some specialist women's health services remains limited.
- Existing expertise within primary care and sexual and reproductive health services is not being fully utilised.

6. Pelvic health physiotherapy is a major pressure point

- Pelvic health physiotherapy is a first-line intervention for many pelvic floor conditions.

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- Waiting times exceed one year in parts of BNSSG.
- Restricted access to conservative treatment contributes to avoidable morbidity and increased demand for specialist care.

7. Community-based Women's Integrated Neighbourhood Services offer a major opportunity

- National policy is moving towards integrated neighbourhood-based models of women's health care.
- Evidence suggests these models can improve access, patient experience and system efficiency while reducing unnecessary reliance on hospital services.
- BNSSG is well placed to develop this approach.

8. Transformation is needed to meet future demand

- The current model is unlikely to be sustainable without significant service redesign.
- Future priorities should focus on prevention, earlier intervention, reducing inequalities, building community capacity and improving integration across the system.
- Improving gynaecological care should be considered a strategic priority for BNSSG.

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Executive summary

Gynaecological need in Bristol, North Somerset and South Gloucestershire (BNSSG) is substantial, and unequally distributed across the population. Demand for services is increasing, driven by population growth, ageing and diversity alongside an increased awareness amongst women. This impacts heavily on primary care, with one in four women having presented to general practice in BNSSG with a gynaecological issue within the last three years. This is further compounded by long waits for hospital treatment. These presentations span the life course but are most concentrated in midlife, driven by menopause related symptoms and menstrual health issues. Other common presentations also include vulvovaginal conditions, heavy or painful periods, and pelvic floor dysfunction, reflecting a high burden of chronic conditions that have a significant impact on women's quality of life, their healthy lifespan and the local economy. Despite a high level of activity, there is also evidence of underdiagnosis for conditions such as endometriosis and fibroids. Incomplete data and variable coding alongside an expanding private women's health sector mean that the true scale of need is likely to be significantly higher than recorded.

Qualitative insights highlight **normalisation of symptoms, delays in diagnosis, and many women reporting feeling dismissed or unsupported.** Inequalities are evident throughout, with variation in access and outcomes by deprivation and ethnicity. Women in BNSSG's more deprived areas and those from minoritised ethnic groups experience poorer access, lower coding of key conditions, a higher burden of some symptoms such as heavy menstrual bleeding, and greater barriers to seeking help.

This local picture mirrors the national context, where gynaecology has been identified as an area of high unmet need, long waits and fragmented pathways. National policy, including the Women's Health Strategy and Elective Recovery Plan, recognises that **many gynaecological conditions do not require a procedure or a hospital setting**, and sets a clear direction towards more integrated, community based models of care, supported by improved use of Advice and Guidance and a focus on prevention.

Increasing demand and complexity across the BNSSG system places significant pressure on both primary and secondary care. General Practice manages most initial presentations but, despite recent targeted local investment in clinician training for menopause and Long-Acting Reversible Contraception (LARC), and improved access to some diagnostics (such as pelvic ultrasound), primary care still faces considerable constraints in capacity, expertise and consistency and a lack of clarity within some local pathways contributes to further inefficiencies. Some PCNs have set up group education and group consultations to address capacity issues which have worked well. There is however variation in access to services with very limited access particularly to pessary care and pelvic physiotherapy. Due to current commissioning arrangements these are mostly delivered in hospital whereas arguably a community setting would be more appropriate. At the same time, hospital

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services continue to carry a large volume of activity, with over 46,000 outpatient attendances per year, nearly 60% of which are follow ups. Waiting lists have reduced but remain high, with approximately 7,400 patients currently waiting and around one third waiting more than 18 weeks and for those needing surgery the waits are even longer. These long waits for hospital care in turn impact back upon general practice who need to deal with worsening symptoms whilst women wait for specialist care.

A high proportion of hospital gynaecology care is unplanned. Around 60% of gynaecological admissions in BNSSG are emergencies. Whilst this is better than peers, it is substantially above national targets, and emergency admissions for some specific conditions such as heavy menstrual bleeding are higher than the national average. This suggests that many women are not receiving timely diagnosis or effective early management, resulting in deterioration of symptoms and escalation to emergency care. Pelvic health physiotherapy represents a key evidence-based first-line intervention for pelvic floor dysfunction, prolapse and urinary incontinence. Demand for the service is very high, and waits are extremely long (over a year at Southmead Hospital). This limits access to conservative treatment that can improve symptoms, enhance quality of life and reduce the need for more invasive interventions, contributing to avoidable morbidity and pressure on secondary care services. For those needing a gynaecological procedure, BNSSG hospitals are relatively efficient in delivering procedures in day case settings, but this alone is insufficient to address the scale of demand.

This needs assessment **highlights substantial inequalities in women's health**. Women living in more deprived communities, some minority ethnic groups, people with disabilities, those with language barriers and individuals with complex social circumstances often experience poorer access to services, longer delays in diagnosis and treatment, and worse health outcomes. These inequalities are compounded by limited awareness of available support, variation in health literacy and barriers to attending appointments as well as normalisation of symptoms or suffering in silence. As a result, some women experience prolonged symptoms and repeated contacts with healthcare services before receiving effective treatment. Although women from more deprived areas have higher rates of referrals in BNSSG, there are also higher rates of non-attendance, and rates of prescribing hormone replacement therapy (HRT) at half those from more affluent areas.

Patient feedback from our extensive local survey in BNSSG with over 4000 respondents indicates that **many women are satisfied with the compassionate clinical care they receive**, particularly when they can access specialist clinicians in whom there is a high degree of confidence. However, many women also describe delays in diagnosis leading to worsening of symptoms, lack of clear information, fragmented care, difficulties in navigating the health service and experiences of feeling dismissed, particularly for conditions involving pain or for menopause symptoms. Many women expressed a desire for understanding the cause of their symptoms and were frustrated by the limited range of treatments and lack of communication and continuity of care. Whilst social media is increasingly filling these gaps

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the quality and accuracy can be variable, highlighting the importance of ensuring that women have access to evidence- based information from trusted sources.

The BNSSG system for gynaecological care appears, like many areas, to be **largely hospital based, with insufficient intermediate care infrastructure or capacity to manage the volume of need effectively in the community**. Whilst consultant gynaecology capacity to deal with common gynaecological conditions is strained (and increasingly displaced by the rise in suspected cancer referrals), community gynaecological expertise within BNSSG sexual and reproductive health services is conversely not being fully utilised due to fragmented commissioning arrangements between the ICB and local authorities. Opportunities to both prevent ill health and to deliver care closer to home, including pessary fitting, specialist menopause management and pelvic physiotherapy within the community, are also not being realised at scale. This gap in community provision contributes to inefficiency, with unnecessary referrals to secondary care, longer waits, increased pressure on hospital services, and poorer outcomes for women.

Gynaecology should arguably be a major beneficiary of the three shifts stated in the NHS 10 year Plan and the move towards Neighbourhood Health and ICBs are being encouraged to work with providers and local authorities to develop intermediate community-based gynaecology services. Guidance on 'Women's Integrated Neighbourhood Services' (evolving from Women's Health Hubs) is anticipated. These models bring together primary, community and specialist care to improve access and patient experience, and are likely to be cost effective, with modelling suggesting around £6 million savings over 10 years for a PCN-sized service and such services in other parts of the country have demonstrated good outcomes. While BNSSG is aligned with this direction and has strong support from partners and service users, delivery will require a fundamental shift in how local services are organised, commissioned, funded and delivered and will require support for infrastructure and workforce.

Gynaecological conditions have historically been under researched, and this means there are gaps in our understanding of disease mechanisms in terms of prevention, effective treatment and understanding the true impacts on quality of life, however **opportunities for prevention and earlier intervention are apparent**. These focus on education (particularly around menstrual and hormone literacy) for women and a greater focus on prevention (especially around obesity, the use of hormonal treatments and earlier identification of gynaecological conditions in primary care), strengthening primary care capability and developing sustainable neighbourhood-based intermediate care utilising our BNSSG workforce skills more effectively. Alongside this, there is a need to clarify and standardise more treatment pathways, improve use of specialist advice and guidance and address significant inequalities especially around deprivation and ethnicity, in a targeted way with the support of our valued voluntary and community sector and service users.

Overall, this needs assessment indicates that the current model of gynaecology care in BNSSG is **unlikely to meet future demand without significant transformation**. Without such change, the current pattern of high demand, long waiting times and emergency presentations is likely to persist. Given the impact of gynaecological conditions on quality of

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life, employment, wellbeing and health inequalities, **improving gynaecological care should be a key priority for BNSSG.** Evidence from both national policy and local insights suggests that enhancing community-based provision could improve access, deliver cost benefits, reduce unnecessary hospital referrals, support earlier diagnosis and help address these widespread inequalities. Improving patient experience, alongside strengthening commissioning arrangements and data collection, will also be essential to achieving sustainable improvements in outcomes for women.

Summary of key themes for BNSSG primary care gynaecology

1. **High demand and activity**

High demand for gynaecology care in primary care, with over 25% of women having a recorded gynaecological presentation in the last 3 years.

Most common recorded presentations are:

- Vulvovaginal conditions
- Menopause
- Unscheduled bleeding
- Heavy and painful periods

Activity varies across the life course:

- Period problems are more common among younger women
- Menopause drives activity in mid-life
- Prolapse is more common among older women

2. **Improved recognition of gynaecological conditions but care is often symptom based reflecting diagnostic challenges**

- Care is largely symptom-based rather than diagnosis-based.
- Endometriosis and fibroids appear to be under-coded relative to expected prevalence, suggesting possible underdiagnosis, under-presentation, or symptom coding.
- HRT prescribing has significantly increased and is higher than nationally. Likewise, prescribing for heavy menstrual bleeding has increased, suggesting improved recognition and management.

3. **Variable expertise and provision**

- Specialist menopause skills have increased but remain variable between practices.
- Access to testosterone prescribing remains limited.
- Primary care is funded to deliver LARC for gynaecological purposes as well as for contraception and LARC provision in primary care is high but reducing and varies considerably between practices.
- Ability to undertake complex LARC procedures within primary care is very limited and results in a referral to secondary care if the LARC is not for contraception

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- Access to community pelvic physiotherapy is extremely limited, resulting in many referrals to secondary care.
- Ring pessary services are rarely available within primary care.

4. **Significant inequalities**

- Women in the most deprived areas present less frequently overall, particularly for menopause and prolapse.
- Heavy menstrual bleeding presentations are higher in more deprived communities.
- Women from minoritised ethnic groups present less often for many conditions, particularly menopause and prolapse.
- Heavy menstrual bleeding is recorded more often among Black and Mixed ethnicity women, though not to the extent expected based on need.
- HRT prescribing is significantly lower in the most deprived areas.

5. **Commissioning gaps remain for services that could be provided in community settings**

- Fragmented commissioning arrangements mean that GPs must refer women requiring LARC for gynaecological indications to hospital if procedure is complex or additional pain relief (such as a cervical block) is required.
- Pelvic physiotherapy provision is very limited within primary care.
- Practices are not funded to provide ring pessaries.

Summary of primary care healthcare professionals' views from focus groups

- **Unmet need:** Some women normalise symptoms or feel dismissed, particularly regarding pain and menopause, this appears more common in deprived communities.
- **Limited primary care capacity:** Short appointments and poor continuity of care can affect patient experience and management of complex conditions.
- **Workforce training gaps:** Training opportunities are limited and often self-funded.
- **Underfunded interventions:** Many GPs have skills to provide more care locally, but services such as coil fitting, pessary care and testosterone prescribing are insufficiently funded.
- **Challenges managing long-term conditions:** Conditions such as endometriosis and chronic pelvic pain can be difficult to manage effectively.
- **Unclear pathways** and poorly communicated changes to guidance can result in delays and rejected referrals.
- **Inequitable access:** Lack of interpreter availability and reluctance or inability to travel, particularly in deprived areas.
- **Impact of long waits:** Delays in secondary care can worsen symptoms and increase primary care workload.

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Summary of key themes for BNSSG secondary care gynaecology

1. **Referral management is currently underutilised**

   - Referrals to gynaecology have been gradually increasing.
   - True referral activity is difficult to quantify due to significant use of non-e-Referral routes.
   - Referral rates appear to be much lower than comparable areas but are higher among women living in more deprived communities.
   - Advice and Guidance is underused despite evidence that it can successfully reduce referrals to secondary care. This will change with the introduction of a nationally driven single point of access.

2. **Outpatient attendances are lower than other areas**

   - Outpatient attendance rates are low in BNSSG compared to England.
   - Outpatient 'non-attendance' rates (cancelled or rearranged appointments plus Did Not Attends (DNAs) are rising and higher than comparable areas.
   - True DNAs are around 5%.

3. **A substantial proportion of gynaecological care could be delivered outside of a hospital setting**

   - Significant numbers of referrals relate to conditions that could potentially be managed outside hospital settings.
   - Data is incomplete (no referral reason given for most referrals) but menstrual disorders are the leading reason for referral, alongside pelvic pain, endometriosis, and urogynaecology/prolapse, many of which could be managed in the community.
   - There is considerable unmet demand for pelvic physiotherapy, which is largely hospital based, with very long waits for both urgent and routine appointments.
   - Ring pessaries currently require referral to a hospital setting due to lack of funding for primary care, despite evidence that the latter would be much more cost efficient.

4. **Waiting lists are improving but women are still waiting too long**

   - Waiting lists are improving but remain above pre-pandemic levels.
   - Around 7,400 women are waiting for care, with one-third waiting more than 18 weeks.
   - BNSSG performs better than peers on waiting times but still does not meet national standards.
   - Less than half of surgical patients meet the 18-week treatment standard.
   - Waiting times for pelvic physiotherapy are extremely long.

5. **Surgical productivity is good with high rates of care delivered through day cases**

   - Most patients attending secondary care gynaecology do not require surgery.
   - BNSSG performs strongly in delivering care through outpatient and day-case pathways, with nearly 89% of suitable procedures undertaken in these settings.

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- Further potential opportunities exist to shift some pelvic floor and hysterectomy procedures away from inpatient care.

6. **There is a significant amount of unplanned activity**
    - Emergency admissions account for almost 60% of all admissions which is better than peers but substantially above national ambitions.
    - The high emergency admissions for heavy menstrual bleeding may indicate delayed diagnosis or treatment.
    - Emergency admissions are more common among younger women and those from deprived areas.
    - Emergency readmission rates exceed national benchmarks, particularly following hysterectomy and prolapse procedures.

7. **Health Inequalities are evident especially for deprivation (lack of data granular data limits understanding)**
    - Women from more deprived communities experience higher referral and attendance rates.
    - Women from deprived areas have higher levels of emergency admissions for heavy menstrual bleeding.
    - Non-attendance rates are higher in more deprived communities.
    - Pessary fitting rates are lower in women from the more deprived areas.
    - HRT prescribing is half the rate for women in more deprived areas.

Summary of secondary care healthcare professionals' views from focus groups

- **Demand exceeds capacity:** Gynaecology demand is growing faster than workforce and clinic capacity, compounded by:
    - ongoing elective recovery pressures
    - increasing urgent cancer referrals
    - rising emergency admissions and waits for diagnostic tests
    - changes to sexual health commissioning (vulval conditions and pelvic pain previously managed in sexual health services).
- **Case complexity is increasing** with greater investigation and diagnostic needs driving demand.
- **Some hospital referrals could potentially be managed in primary care but limited primary care capability** may be contributing to increasing referral volumes.
- **Fragmented commissioning** of women's health creates inefficiencies and gaps in care pathways.
- **Untapped specialist expertise:** Sexual and reproductive health consultants have the skills to manage some gynaecological conditions in the community but are not commissioned to do so.
- **Community based intermediate care could enable quicker access to cost effective care.**
- Support is needed for more **research and digital and diagnostic innovation.**

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Summary of patient and public views on gynaecology care in BNSSG from survey and focus groups

What is working well

- Most women report **compassionate, respectful care** and feel listened to when clinicians take time, explain conditions clearly and show empathy.
- Women have higher confidence in specialist clinicians (gynaecologists and GPs with additional women's health training) and value continuity of care.
- Improvements have been seen in menopause care, trauma-informed care and inclusive care.

Key challenges:

- **Symptoms are often normalised**, leading some women to delay seeking help and live with symptoms that significantly affect daily life, work, relationships and mental wellbeing.
- Many women report **feeling dismissed or not taken seriously**, particularly when seeking help for pain.
- **Long waits and difficulties navigating services** can worsen symptoms, increase anxiety and drive some women to seek private care.
- Women want **better communication and information** throughout their care, including while waiting, understanding test results and knowing what happens next.
- There is a strong desire to **understand the cause of symptoms**, not just receive treatment as well as **proactive and preventative** care.

Variation in care experience

- Trust is affected by perceived expertise, with **lower confidence in generalist care** compared with specialist services.
- Experiences can vary considerably **depending on the individual clinician** seen.

Treatment and follow-up concerns

- Some women report **inadequate pain relief and insufficient trauma-informed care** during procedures such as coil fitting, hysteroscopy and examinations.
- There is **lower satisfaction with treatment *outcomes*** than with clinician interactions, particularly for menstrual and womb health conditions.
- Some women feel the **range of treatments offered is too limited**, and **do not always understand or want hormonal treatments.**
- Many report **difficulties accessing advice and support following treatment** and managing ongoing symptoms.

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Inequalities

Barriers to care are greater for **minoritised ethnic groups, LGBTQ+ individuals and younger people**, with concerns about stigma, cultural appropriateness and discrimination affecting access and trust.

Key Issues for BNSSG

Demand is high and growing as BNSSG populations grow, age and diversify and cases are increasing in complexity.

- Common conditions (e.g. menstrual disorders, endometriosis, menopause, prolapse) generate **substantial need.**
- There are challenges in both diagnosing gynaecological conditions (overlapping symptoms and need for additional investigations) and there is likely to be **under-recognition and unmet need** although media and national policy has generated increased awareness amongst some parts of the population.
- There are still **gaps in our understanding how best to treat** due to historical lack of research.
- Demographic change likely to **increase demand further with increasing population size, diversity and ageing.**

Prevention and early intervention are underdeveloped

- Many women normalise symptoms and thus delay seeking help. Opportunities for earlier identification, education, menstrual health literacy and preventative care are not being fully realised.
- Group education around women's health has worked well in some practices but most are not providing this.
- A number of women surveyed highlighted their **desire for more proactive and preventative** care with particular mention of annual checks, online options for information, and some wanting **access to groups** for support.
- Primary care expertise in gynaecology is variable and likely to contribute to later diagnosis.
- Around 60% of gynaecology admissions are emergencies, suggesting opportunities for earlier diagnosis and intervention.
- Pelvic health physiotherapy is a core first-line clinical intervention for pelvic floor dysfunction, prolapse and urinary incontinence. Current capacity is insufficient to meet demand, with routine waits extending beyond a year in parts of BNSSG. This restricts access to effective conservative management, delays symptom improvement, and may increase demand for specialist including surgical services.
- Obesity management can reduce demand across gynaecological pathways by preventing or reducing Polyendocrine Metabolic Ovarian Syndrome (PMOS) complications, heavy menstrual bleeding and pelvic floor dysfunction and should be considered as a core intervention.

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There is significant variation and inconsistency in what is provided in primary care

- Menopause expertise within primary care has increased with additional resource recently but varies considerably and could be further enhanced.
- There is significant unexplained variation in HRT prescribing rates between practices.
- LARC is fitted for menopause as well as contraception reasons in primary care. Rates on average are high but variable between practices.
- Group consultations have worked well in those areas that have tried this approach, but this is underutilised across most practices/PCNs.
- GPs are not funded for pessary fittings and most practices are not providing this, yet this is significantly more cost effective to provide in primary rather than secondary care.
- Access to community pelvic physiotherapy is extremely limited.
- Long waiting lists in secondary care put pressure on primary care who must care for increasingly complex waiting patients.

There is unsustainable reliance on hospital care for conditions which could be managed outside of hospitals

- Waiting lists whilst improving remain very high.
- Local and national audits have demonstrated that hospital-based care is not necessary for most gynaecological conditions.
- Staff feedback suggests inappropriate referrals.
- There is minimal current use of Advice and Guidance although national changes are likely to increase this.
- Insufficient current community infrastructure exists in BNSSG as an alternative to hospital care.

Fragmented commissioning responsibilities creates inefficiencies and leads to poor utilisation of community healthcare expertise

- Commissioning arrangements between the ICB and Local Authorities create gaps in pathways.
- Sexual and Reproductive Health clinicians have expertise to manage a number of gynaecological conditions but are not commissioned to do so.
- Women are being referred to hospital for interventions that could be delivered more easily in the community, such as ring pessaries and pelvic physiotherapy.
- Women requiring LARC for gynaecological indications who need additional pain relief or have complexities currently need referral to hospital, whereas existing skills in community sexual health are not being utilised.

Considerable equity challenges remain

- Women in BNSSG spend much longer living in poor health (22 years compared to 18 years in men)- gynaecological conditions impact on women throughout the life-course.
- Women living in the most deprived areas present less often overall to primary care, particularly for menopause and prolapse, despite likely greater need.

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- Women from minoritised ethnic groups have lower rates of presentation for many conditions, especially menopause and prolapse- possibly due to normalising of symptoms.
- Referral rates higher for those from more deprived areas, but non-attendance is higher.
- The HRT prescribing rate in women from the most deprived areas is half that of the least deprived areas.
- Ring pessaries are lowest amongst women in the most deprived areas.
- Barriers to care are greater for some groups, including minoritised ethnic communities, LGBTQ+ individuals, and younger people.
- Inadequate pain relief for procedures is an issue particularly noted for Black and Mixed Black women and young people.

Patient experience highlights access barriers

Many women report:

- Feeling dismissed, particularly regarding pain and menopause symptoms and delays in diagnosis and treatment
- Long waits for appointments and treatment, and lack of continuity of care
- Difficulty navigating follow-up support and poor communication while waiting.
- Limited treatment options.

Confidence is higher when women see specialists or clinicians with additional women's health expertise.

Data limitations mean we are unable to fully understand the population need

- Primary care data are incomplete and subject to inconsistencies in clinical coding, limiting the reliability of prevalence and activity estimates.
- Although the new national Women's Health Dashboard now provides valuable information, some metrics do not align with provider-level or Model Hospital data because of differences in definitions, coding, data sources and reporting methodologies. It does not yet include all relevant measures, resulting in gaps in understanding of population need and service performance.
- A significant proportion of gynaecology referrals in BNSSG are not currently submitted through the NHS e-Referral Service (e-RS), making referral activity difficult to quantify accurately and compare consistently across services.
- Accessing local service data was challenging, limiting the completeness of this analysis.
- Detailed demographic data are not consistently available across all datasets, restricting the ability to fully assess inequalities in access, experience and outcomes.
- A proportion of women unable to access services in a timely way through the NHS will be receiving care through private providers - we have no access to this data.

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Summary of Recommendations

BNSSG should commence the shift from a predominantly hospital-based model of gynaecology care towards neighbourhood-based services to provide timely, equitable and person-centred gynaecological care closer to home.

This shift should be supported by a greater emphasis on prevention including menstrual and menopause health literacy, and services to address modifiable risk factors such as obesity, as well as increased access to pelvic physiotherapy to prevent or delay the need for surgical intervention. Primary care capability and capacity should continue to be strengthened through support to expand group education and group clinics and investment in workforce skills development to enable enhanced services such as pessary care to be delivered within primary care.

Community-based 'Women's Integrated Neighbourhood Services' could be developed to provide intermediate care and reduce unnecessary reliance on hospital services, while making better use of existing gynaecological expertise within BNSSG primary care and sexual and reproductive health services. Use of Advice and Guidance will be expanded in line with national developments and needs to be aligned to local, improved commissioning arrangements, increasing use of digital support and clear care pathways developed in conjunction with primary and secondary care to ensure women are seen and treated efficiently and within the most appropriate setting.

Alongside this, BNSSG should focus on improving patient experience through better communication, trauma informed and culturally sensitive practice and a greater focus on effective pain management, whilst working with the voluntary and community sector to target action to reduce inequalities experienced by women from deprived communities and minoritised groups.

Finally, system leadership, commissioning collaboration to address current gaps, research and improved data quality will be essential to support service transformation and ensure resources are directed towards areas of greatest need.

1. Strengthen Prevention, Early Intervention and Women's Health Literacy

Increase the focus on both primary and secondary prevention to reduce avoidable morbidity and demand for specialist services.

- **Expand resources to improve women's health literacy**: Increase awareness of menstrual, hormonal and gynaecological health through expanding proactive health promotion, self-care and educational resources, and myth-busting information in a range of formats and languages.
- **Raise awareness of preventative interventions**, including obesity reduction, hormonal management, pelvic floor health where appropriate and earlier treatment of symptoms.
- **Work with schools**, school nurses and youth services to strengthen menstrual, reproductive and gynaecological health education for young people. This should include awareness of symptoms that warrant medical assessment, improving

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confidence to seek help, tackling stigma and normalisation of symptoms, and supporting young people to navigate local health services and information sources.

- **Develop and expand group education** programmes within primary care and community settings to improve efficiency and peer support.
- Work with Public Health colleagues to ensure the forthcoming opportunities for the **NHS Health Check to proactively ask about menopause symptoms** are maximised and targeted to areas of current low HRT prescribing.
- **Expand access to pelvic physiotherapy** as a valuable early intervention.
- Work with **BNSSG VCSE organisations to raise awareness and co-produce services** with women, particularly those from underserved communities.

2. Build Primary Care Capability and Capacity

Enable more women to receive timely assessment and treatment closer to home.

- **Continue to upskill primary care teams** in the management of common gynaecological conditions, including menopause, chronic pelvic pain, pelvic floor screening, and menstrual disorders.
- Invest in additional primary care **skills, equipment and funding** to support investigations and procedures (such as pessary fitting, ultrasound and chronic pelvic pain management and provision of pain relief options such as local anaesthetic cervical blocks for women for Intrauterine Device (IUD) insertion)
- **Invest in ongoing workforce development in trauma-informed and culturally competent** care including the provision of face-to-face interpreting where needed.
- **Support practices where uptake of LARC is low** and ensure access to training, resources and ongoing support.
- **Fund and train primary care providers to offer ring pessary** fitting and management
- **Develop group consultation models** where appropriate to maximise clinical capacity and improve access.

3. Develop Community-Based Women's Health Services

Instigate a shift from hospital-based care to integrated community services where clinically appropriate.

- **Develop a business case to implement Women's Integrated Neighbourhood Services** (WINS) or equivalent intermediate care models to manage routine gynaecological conditions closer to home utilising learning from other areas, national guidance and this needs assessment.
- **Develop community capacity** for diagnostics and procedures, including routine and complex pessary services, and complex IUD insertion and implants for gynaecological indications.
- **Develop a sustainable pelvic health physiotherapy model** across BNSSG that expands provision closer to home whilst ensuring adequate workforce, estates and equipment in both community and specialist services. This model should include provision for educating primary care in pelvic floor screening and conservative care.

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4. Make Better Use of Specialist Expertise and Improve Pathways

Maximise the use of existing workforce expertise and reduce unnecessary referrals to secondary care.

- **Make greater use** of Sexual and Reproductive Health (SRH) clinicians and GPs with Extended Role (GPwERs) within integrated gynaecology pathways.
- **Consider commissioning SRH services to manage a broader range of gynaecological conditions** and referrals within the community, particularly where additional diagnostics are required.
- **Increase use of specialist Advice and Guidance** to support decision-making in primary care and avoid unnecessary hospital referrals.
- **Simplify and standardise referral pathways** and ensure Remedy pathways are clear, up-to-date, and co-produced with clinicians across both primary and secondary care.
- **Strengthen collaboration** between primary care, community services, SRH services and hospital teams.
- **Ensure secondary care capacity is focused** on women requiring surgical or highly complex medical management.

5. Improve Patient Experience and Access

Improve communication, continuity and support throughout the patient journey.

- **Provide clear information** about services, referral processes and how to access support.
- **Improve communication with women while they are waiting** for appointments or treatment.
- **Provide women with clear, accessible explanations** of the likely underlying causes of their symptoms, alongside shared decision making around investigation and treatment options, enabling women to feel heard and empowered.
- **Increase access to self-management resources and peer support** utilising digital innovations where appropriate to improve health literacy and confidence
- **Strengthen continuity of care** wherever possible.
- Embed **trauma-informed and culturally competent** care through ongoing healthcare staff training.
- **Improve adequate pain management** during investigations and procedures.
- **Explore reasons for high numbers of non-attendance** and identify opportunities for improvement.

6. Reduce Inequalities and Improve Equity of Access

Ensure services are designed to meet the needs of populations experiencing poorer outcomes and barriers to care.

- Target community service development towards deprived communities and minoritised ethnic groups.
- Develop culturally appropriate education, communication and engagement approaches.

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- Improve access to interpreting services.
- Raise awareness of inequalities in diagnosis, treatment, prescribing and outcomes amongst healthcare staff within training.
- Work with the VCSE to co-produce services with women who face the greatest barriers to accessing care.

7. Strengthen Data, Commissioning and System Leadership

Use data, research and commissioning levers to support service transformation.

- Improve the quality, granularity and accessibility of women's health data, including **working with DHSC on Women's Health Dashboard developments.**
- **Strengthen joint working between commissioners, managers and clinicians** in service design and pathway development.
- **Review commissioning arrangements** to maximise available workforce capacity, improve pathways for women and support community-based care.
- **Support research, evaluation and innovation in women's health**, including digital and diagnostic innovations such as an NHS-approved pelvic health app to support women whilst waiting for face-to-face appointments.
- **Further explore** variation in referral rates, service utilisation, non-attendance and outcomes to identify opportunities for improvement.

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1. Introduction

Gynaecology is the care of women and people with female reproductive organs who have conditions affecting the reproductive system, including the ovaries, fallopian tubes, womb, cervix, vagina and vulva. It encompasses a wide range of conditions such as endometriosis, fibroids, polyendocrine metabolic ovarian syndrome (PMOS), incontinence, vulval disorders, menstrual problems and menopause-related symptoms. These conditions are common and affect individuals across the life course, although they are not always recognised or formally diagnosed.

While women tend to live longer than men, they spend around 25% more time in poor health, and this is experienced throughout their lives rather than being confined to older age. Many non-cancerous gynaecological conditions, although not typically life-threatening, can cause significant and persistent symptoms, including pain and, in some cases, long-term disability. This is partly because many of these conditions are chronic, such as heavy menstrual bleeding, pelvic pain, fibroids and endometriosis. In addition, treatment options are often limited, with some conditions lacking a definitive cure other than surgery, which may not be suitable or acceptable for those wishing to preserve fertility.

1.1 About this healthcare needs assessment

This Gynaecological Healthcare Needs Assessment (HNA) is a systematic review of gynaecological healthcare in Bristol, North Somerset and South Gloucestershire (BNSSG). The assessment brings together multiple sources of information, including national policy, national guidelines and research literature, published epidemiological data on key conditions, local activity data from both primary and secondary care, and insights from staff and patients, including findings from a large public survey and focus groups with staff and patients. By synthesising these sources, the healthcare needs assessment seeks to identify key gaps and priorities, and to inform future service transformation, particularly in relation to the shift towards community-based care.

Cancer care, contraception, pregnancy and maternity, abortion and fertility services are not in the scope of this needs assessment. The Bristol, North Somerset and South Gloucestershire Sexual Health Needs Assessment (2022)[1] covered contraception and abortion.

The report is structured to give an overview of:

1. **The national picture**, including prevalence and aetiology of gynaecological conditions (also covered in Appendix 1), national policy, commissioning and provision of gynaecological care.

[1] See the Bristol City Council website for the list of Needs Assessments - https://www.bristol.gov.uk/council/policies-plans-and-strategies/social-care-and-health/joint-strategic-needs-assessment/health-needs-assessments

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2. **The local picture** – demographics of BNSSG, commissioning and provision of local service, activity data for primary and secondary care and healthcare staff views.
3. **BNSSG Patient and Public Engagement** – findings from a large survey and focus groups.

We use the term 'women' in this report and many of the data sets we reference are based on people *recorded* as female. However, we recognise that trans men, non-binary, intersex and gender-expansive people may require gynaecological care and where possible we have considered their specific needs in this assessment.

1.2 Acknowledgements

This needs assessment was collaboratively led and authored by the Bristol City Council Public Health Team and Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care Board, with input, expertise and oversight provided through the Gynaecology Healthcare Needs Assessment Oversight Group. The group included representatives from a wide range of organisations and stakeholders, including the University of Bristol, One Care, Bristol NHS Foundation Trust (formerly North Bristol NHS Trust and University Hospitals Bristol and Weston NHS Foundation Trust), Voscur, Womankind, service users, Community Pharmacy Avon & Wiltshire, North Somerset Council, South Gloucestershire Council and the University of the West of England.

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2. The National Picture

2.1 Prevalence of gynaecological conditions and risk factors

It is widely acknowledged that there is a paucity of evidence and data on gynaecological conditions including cause, prevalence, symptoms and treatment options[2]. This section provides high-level information on key areas based on available evidence.

Gynaecological conditions are common. It is estimated that around 1 in 10 women have endometriosis worldwide, however NHS hospital records linked to 2011 UK Census found only 2% had a recorded diagnosis[3]. Fibroids are extremely common, but often undiagnosed, with an estimated 70%-80% of women globally having fibroids by the age of 50[4]. Pelvic organ prolapse affects around 1 in 10 women over the age of 50[5]. Over a third of the female population in the UK (13 million people) are perimenopausal or postmenopausal[6].

Specific information on the most common gynaecological conditions including symptoms, risk factors and UK prevalence is provided in Appendix 1. It is important to note that many people attend NHS appointments with symptoms rather than a known condition, and diagnoses are often made only after further investigation.

The main risk factors for gynaecological conditions are:

Age

Many gynaecological conditions are closely linked to life stage. For example:

- The risk of developing fibroids increases with age during reproductive years until the menopause.
- Polyendocrine Metabolic Ovarian Syndrome (PMOS) usually starts during adolescence, however symptoms can fluctuate over time. It can lead to fertility issues which may only be picked up when trying for a pregnancy[7].
- Endometriosis is more common in women of reproductive age, and symptoms often reduce after menopause, but they may persist[8].
- Pelvic organ prolapse risk rises sharply with age due to decline in pelvic floor support and oestrogen levels

[2] DHSC (2022). Women's Health Strategy for England.

[3] ONS (2024). Characteristics of women with an endometriosis diagnosis in England: 27 March 2011 to 31 December 2021.

[4] Women and Equalities Committee (2024). Women's reproductive health conditions: First Report of Session 2024–25 [cited 2025 Dec 10].

[5] RCOG (2022). Pelvic organ prolapse [cited 2025 Dec 10].

[6] NHSE (2024). Menopause in the workplace [cited 2026 Jan 7].

[7] World Health Organization (2023). Polycystic ovary syndrome [cited 2025 Dec 12].

[8] Endometriosis UK. Jo's Hot Topics: Endometriosis and Menopause [cited 2025 Dec 12].

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- The average age of onset of the menopause is 51[9]. Menopausal symptoms often commence prior to menopause, in perimenopause, and may persist for many years after the final menses (period), sometimes indefinitely.
- Heavy menstrual bleeding (which can be caused by a range of diseases such as fibroids, endometriosis, adenomyosis) is most commonly reported in younger women who have just started their menstrual cycles, and older women approaching the menopause[10].
- Vulval conditions can present at any age, from pre-puberty to post menopause, however prevalence of the most common non-infective skin problems increases with age, for example Lichen Sclerosus is much more common in women over 50[11].

Ethnicity

- The prevalence of gynaecological conditions differs across ethnic groups, and the evidence indicates that ethnicity affects the likelihood of having a diagnosis. Estimates of rates broken down by ethnic groups should be cautiously interpreted.
- A population level analysis in England found that endometriosis diagnoses were highest in White British, Black Caribbean, and Mixed White and Black Caribbean ethnic groups, and lowest in Chinese, Arab, and Black African ethnic groups[12]. However, differences in diagnostic rates are likely due to historical bias, inequalities in access to healthcare and poorly conducted research in this area[13].
- Higher rates of PMOS are seen in women of Asian ethnicity[14].
- People of Black ethnicity, have a two to three times higher risk of developing fibroids, are more likely to develop them earlier, have severe symptoms and face longer delays in diagnosis and treatment[15].
- The average age of menopause onset in the UK is 51, however, evidence suggests earlier onset in women from some ethnic groups in the UK. For Indian women the average age is 46.7 years, Pakistani women 47.16 years, African women 49.6 years and Caribbean women 49.6 years[16].
- Women from a Black African or Caribbean background experience on average a longer duration of menopause transition and more severe symptoms (e.g. hot

[9] British Menopause Society (2023). Menopause in ethnic minority women: BMS Tool for Clinicians.

[10] TeachMeObGyn. Heavy Menstrual Bleeding [accessed 18 Feb 2026].

[11] NHS. *Lichen sclerosus* [cited 2026 Mar 20].

[12] NICE (2025). Endometriosis.

[13] Bougie, Olga, Ikunna Nwosu, and Chelsie Warshafsky. "Revisiting the impact of race/ethnicity in endometriosis." Reproduction and Fertility 3.2 (2022): R34-R41.

[14] Berni, Thomas R., Christopher L. Morgan, and D. Aled Rees. "Rising incidence, health resource utilization, and costs of polycystic ovary syndrome in the United Kingdom." The Journal of Clinical Endocrinology & Metabolism 110.5 (2025): e1580-e1589.

[15] NICE (2023). Fibroids.

[16] British Menopause Society (2023). Menopause in ethnic minority women: BMS Tool for Clinicians.

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flushes, night sweats). South-East Asian women suffer more from forgetfulness, joint and muscle pains, low libido and sexual pain, whereas South-Asian women experience more vulval symptoms and incontinence and have a higher incidence of cardiovascular risk factors during menopause transition[17].

Pregnancy and childbirth

- Pregnancy and childbirth can impact pelvic health and lead to a higher risk of prolapse and incontinence. Multiple births and larger babies increase the risk[18].
- Painful periods are more likely in someone who has not given birth[19].

Genetic and biological factors

- Having a family history can increase the risk of developing many gynaecological conditions[20, 21, 22].
- Obesity can increase the risk of prolapse and menstrual disorders including heavy, painful and irregular periods[23].

2.2 Patient experiences and outcomes

Gynaecological conditions, especially if undiagnosed and untreated, can have a significant impact on physical and mental health. A large survey carried out by the Royal College of Obstetrics and Gynecology (RCOG) in 2025 found that more than 60% of women reported **worsening of physical symptoms while waiting** for gynaecological care and 76% reported **worsening of their mental health** while waiting for treatment[24].

In 2019, RCOG had published its landmark report 'Better for Women', which recognised and highlighted the major systemwide issues in gynaecological care. The report found that women **struggled to access** basic healthcare, including contraception, menstrual health support and menopause care, and raised concerns about **fragmented services**, **lack of reliable information**, and the **limited preventive** care. It called for a national

[17] Ibid

[18] DHSC (2014). Annual Report of the Chief Medical Officer, 2014: The Health of the 51%: Women.

[19] NICE (2023). Dysmenorrhoea.

[20] Ajmal, Nida, Sanam Zeib Khan, and Rozeena Shaikh. "Polycystic ovary syndrome (PCOS) and genetic predisposition: A review article." European journal of obstetrics & gynecology and reproductive biology: X 3 (2019): 100060.

[21] University of Oxford (2023). Global study shows experience of endometriosis is rooted in genetics [cited 2026 Feb 11].

[22] Samimi, Parisa, Sarah H. Jones, and Ayush Giri. "Family history and pelvic organ prolapse: a systematic review and meta-analysis." *International urogynecology journal* 32.4 (2021): 759-774.

[23] Fielder, Stella, Mahshid Nickkho-Amiry, and Mourad W. Seif. "Obesity and menstrual disorders." Best Practice & Research Clinical Obstetrics & Gynaecology 89 (2023): 102343.

[24] RCOG (2025). Waiting for a Way Forward.

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women's health strategy, improved education and information, and the development of community-based women's health clinics to reduce **long waits** and improve access[25].

These issues were reinforced by the Government's 'Women's Health – Let's talk about it' survey, conducted in 2021 with almost 100,000 responses in England. **Only 8% of respondents felt they had enough information** about gynaecological conditions, 17% about menstrual wellbeing and 9% about the menopause. Although 71% felt comfortable discussing gynaecological concerns with healthcare professionals, 84% said there had been times when they were **not listened to by healthcare professionals**. These findings provided large-scale public evidence of poor experiences and information gaps in women's health[26].

In 2024, the RCOG 'Waiting for a Way Forward' report evidenced the impact of **continued system pressures** and **long waits**. Over 90% of primary care professionals reported a **severe impact on general practice due to long waits for hospital gynaecology services**, and 80% reported more complex presentations. Among women waiting, 76% reported worsening mental health and 69% reduced ability to undertake daily activities. RCOG also reported **impact on emergency admissions**, which increased by 33% between 2021–2024. A quarter of women surveyed reported attending A&E or an emergency department because of their symptoms, and one in ten went on to have an emergency intervention[27].

In 2025, the Office for National Statistics reported that women diagnosed with endometriosis aged 25 to 54 in England between April 2016 and December 2022, **earned significantly less** and were **less likely to be in employment** in years one to five after diagnosis, compared to the two-year period before diagnosis[28]. This emphasises the importance of research into and provision of effective treatment and management.

2.3 Economic impact of poor gynaecological health

A 2024 report by the World Economic Forum and McKinsey Health Institute[29] outlined the significant economic cost to global society from gynaecological conditions and cited the root causes for the gender inequity being **lack of research**, **poor data**, sub-optimal care and **lack of investment**. UK analysis by McKinsey suggested closing the gender gap by 2040 **could add £39bn to the UK economy** and give each British woman around **9.5 days of good health per year**[30].

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[25] RCOG (2019). Better for women: improving the health and wellbeing of girls and women.

[26] DHSC (2021). Results of the Women's Health – Let's Talk About It survey.

[27] RCOG (2024). Waiting for a way forward: voices of women and healthcare professionals at the centre of the gynaecology care crisis.

[28] ONS (2025). The impact of an endometriosis diagnosis on monthly employee pay and employee status, England: April 2016 to December 2022.

[29] McKinsey (2024). Closing the women's health gap.

[30] Graham, Sarah. "Closing the gender health gap: a£ 39bn boost to the economy, as well as lives." bmj 385 (2024).

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The NHS Alliance analysis showed absenteeism due to severe period pain and heavy periods, endometriosis, fibroids and ovarian cysts is estimated to **cost the UK economy nearly £11 billion per year.** Approximately 60,000 women in the UK are **not in work due to menopause** symptoms, costing £1.5 billion per year[31]. They evidence a **potential return on investment of £11 for each £1 invested in women's health services.**

2.4 National policy

National policy increasingly recognises gynaecology as a priority area. The 2022 Women's Health Strategy for England provided the first coordinated national framework. It built upon aspects of Getting It Right First Time (GIRFT)- an NHS England improvement programme which aims to support NHS services to identify and reduce unwarranted variation and to increase efficiency and quality of care including reducing elective care waiting times [32].

However, women's health sits alongside many other priority areas for the NHS. The most recent 10-year plan for the NHS[33] makes minimal reference to gynaecology care specifically. Furthermore, the recently released Neighbourhood Health Framework[34] is one of the main mechanisms by which the government is seeking to improve the delivery of NHS care but is predominantly focused on people with complex needs, multi-morbidity and frailty.

Women's Health Strategy (2022)

This strategy had the following priorities:

- **Improving integration and coordination of services.** It recognised that women often have to navigate multiple services and referral routes for their care. This leads to delays, repeated assessments and poorer experiences for those with complex or long term needs.
- **Reducing inequalities in outcomes.** Women from deprived areas and minoritised ethnic groups face longer waits, delayed diagnoses and poorer experiences of care. The strategy prioritised the care of underserved groups and the need to strengthen trust in services.
- **Improving data and research.** It called for better data collection by services. A new National Institute for Health and Care Research (NIHR) Policy Research Unit in Reproductive Health[35] was established to support policymaking in menopause, contraception, infertility and urogynaecology **Women's Health Hubs (2023)**

[31] NHS Confederation (2024). Women's health economics: investing in the 51 per cent.

[32] NHSE. Getting It Right First Time [cited 29 Jan 2026]

[33] DHSC (2025). Fit for the Future: 10 Year Health Plan for England.

[34] DHSC (2025). Neighbourhood health framework.

[35] UCL. Policy Research Unit in Reproductive Health [cited 14 Sep 2026]

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A top priority in the Women's Health Strategy was the development and expansion of women's health hubs[36]. These were defined as bringing together healthcare professionals and existing services to provide integrated women's health services in the community, focusing on improving access to care and reducing health inequalities. Each Integrated Care Board received £595,000 one-off funding to develop a Women's Health Hub which was to include the following core services:

- Menstrual problems assessment and treatment
- Menopause assessment and treatment
- Contraceptive counselling and provision of the full range of contraceptive methods
- Preconception care
- Breast pain assessment and care
- Pessary fitting and removal
- Cervical screening
- Screening and treatment for sexually transmitted infections (STIs), and HIV screening

Elective Recovery Plan (2025)

The government has set a target of **92% of patients receiving elective treatment within 18-weeks of referral by March 2029.** Gynaecology has been identified as a priority specialty due to historically long waits and high unmet need, particularly for conditions such as heavy menstrual bleeding and endometriosis. The Elective Recovery Plan[37] aims to meet this 18-week Referral to Treatment (RTT) standard by:

- **Community Diagnostic Centres** to expand diagnostic capacity and GPs enabled to book tests directly
- Increasing use of Advice & Guidance (A&G)
- Using elective **surgical hubs for high-volume** gynaecology and using independent sector
- Improving patient communication and digital referral systems including the NHS App
- Strengthening outpatient productivity and waiting list validation.

Getting it Right the First Time (GIRFT), 2021[38]

The 2021 GIRFT gynaecology report recommended:

- Maximise use of advice & guidance **(A&G) and virtual clinics**
- Introduce patient-initiated follow-up
- Optimising workforce skills. Including nurses, physiotherapists, advanced practitioners
- **Increase provision of intermediate care**
- Clinical Commissioning Groups (now ICBs) to **commission sexual health services to fit IUDs for heavy menstrual bleeding.**
- Undertaking appropriate procedures in **day case and outpatient** settings.

36 NHSE (2023). Women's health hubs: core specification

37 NHSE (2025). Reforming elective care for patients

38 GIRFT (2024). Maternity and gynaecology national specialty report [cited 29 Jan 2026]

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Fit for the Future: 10-Year Health Plan for England (2025)

This sets out a major reform programme aimed at restoring NHS sustainability, improving access, and strengthening prevention. The plan proposes three major shifts in how care is delivered:

- **From hospital to community**- through the creation of a Neighbourhood Health Service and new Neighbourhood Health Centres delivering local, multi-disciplinary care.
- **From analogue to digital**- with the NHS App acting as a "digital front door", a Single Patient Record shared across services, and expanded use of AI and wearables to support personalised care.
- **From sickness to prevention**- with stronger public health measures and earlier intervention to reduce avoidable illness[39].

Renewed Women's Health Strategy (2026)

In 2026 the Labour government renewed the Women's Health Strategy. It reflects these 3 shifts and reinforces the need to transform gynaecology services through community-based, integrated models that improve access, reduce waiting times and address inequalities, aligning closely with NHS elective recovery and GIRFT priorities.[40]

- **Put women's voices at the centre**-ensuring patients are listened to.
- Support prevention.
- Transform NHS services:
    - Expand community/neighbourhood-based women's health services
    - Reduce gynaecology **waiting times**- develop a single referral point
    - Offer effective **pain relief** for invasive procedures
    - Address systemic inequality and medical misogyny.
- Improve research and data.

2.5 Commissioning and provision of gynaecology care in England

Gynaecology services are currently commissioned by a range of organisations. The ICB is the main commissioner.

NHS Integrated Care Board (ICB) commissions:

- General practice: non-complex gynaecology, sexual health and contraception (excluding LARC)
- Hospital specialist gynaecology

NHS England (NHSE) commissions:

- Highly specialist hospital gynaecology (tertiary care). E.g. Endometriosis centres.

[39] DHSC (2025). Fit for the Future: 10 Year Health Plan for England - Executive Summary

[40] DHSC (2026). Women's voices to be at the heart of renewed health strategy

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- NHS Pharmacy Contraception Service

Local Authorities (Public Health) commission:

- Sexual and reproductive health services based in hospitals or community
- General Practice LARC (implants and coils)
- Health promotion and prevention services for sexual and reproductive health and HIV

This complex commissioning arrangement can lead to fragmented pathways with women needing to access care across multiple pathways, leading to delays and inefficiencies and variation in access. This has been identified in national policy and is a key driver for integrated models such as Women's Health Hubs to bring services together, improve access and reduce pressure on hospital care and waiting times.

2.6 Overview of Provision of Gynaecological Care in England

Prevention interventions

Whilst many benign gynaecological conditions have complex and incompletely understood causes (please see Appendix 1) and evidence for prevention is limited, opportunities exist to reduce risk factors, improve early identification and prevent progression to more severe symptoms and complications. Prevention is a key theme within the Women's Health Strategy and in relation to gynaecology focuses on earlier diagnosis of endometriosis to prevent disease progression and impacts on quality of life, preventing the complications of heavy menstrual bleeding such as iron deficiency anaemia. And preventing risks associated with menopause such as cardiovascular disease and osteoporosis.

Education around menstrual health for the public and professionals

Heavy menstrual bleeding and dysmenorrhoea (painful periods) are common, yet many women experience delays in seeking help or normalise symptoms that significantly affect quality of life and can lead to time off school/work, iron deficiency anaemia, and emergency attendance at hospitals. Women are increasingly relying on social media for health information, but the accuracy of this information is variable. Education through campaigns through schools, or colleges/university or primary care (such as group education) can support women to seek help and treatment early which can improve quality of life, reduce anaemia and enable earlier diagnosis of underlying conditions such as fibroids or endometriosis and receive treatment to prevent progression. In turn, routine enquiry about menstrual health by clinicians can support earlier diagnosis and treatment.

Healthy weight

Excess adipose (fat) tissue alters hormonal pathways through increased oestrogen production and insulin resistance, contributing to heavy menstrual bleeding, PMOS, endometrial hyperplasia and worsening symptoms associated with pelvic floor dysfunction such as urinary incontinence. Weight management interventions can improve menstrual

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regularity, ovulation and fertility in women with PMOS, reduce incontinence symptoms and support overall reproductive health[41].

Local weight management services (delivered through public health, primary care and the NHS) including GLP1 are available in most parts of the country but are limited and variable across the country. GLP1s in combination with a progestin appear to reduce risk of endometrial cancer in those with benign uterine disease compared to progestin alone[42].

Physical Activity

A recent report from Public Health Scotland[43] has outlined the evidence around the benefits of physical activity for addressing aspects of women's health (Women's health in Scotland - an evidence briefing - Publications - Public Health Scotland). It has been shown to reduce the impact of menstrual symptoms and can be an important intervention to support women through menopause. It can also improve metabolic health and support weight management which in turn can positively impact on gynaecological conditions.

Hormone treatments to prevent disease progression

Hormonal medications can be used to slow progression of some gynaecological conditions. Examples include endometriosis, where the combined pill or hormone releasing coil suppress growth of endometriosis tissue indirectly by reducing circulating levels of oestrogen or directly through the action of progestogens which induce atrophy of endometriosis tissue[44].

Local oestrogen is also used to prevent vaginal atrophy and urinary tract infections. Progestogen treatment can reduce the risk of progression of endometrial hyperplasia to more serious disease[45].

Pelvic Floor Physiotherapy

Physiotherapy can help prevent and treat symptoms of pelvic floor dysfunction and may reduce the need for specialist treatment. Pelvic health physiotherapy should be regarded as a core initial clinical intervention. NICE guidance recommends supervised pelvic floor muscle training as first-line treatment for many women with urinary incontinence and pelvic organ prolapse before consideration of surgical intervention. UA significant proportion of mild-to-moderate prolapse and incontinence cases can be managed non-surgically, making pelvic health physio a powerful cost-avoidance tool for secondary care elective budgets.

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[41] Lundegaard Haase et al (2023) Association between body mass index, weight loss and the chance of pregnancy in women with polycystic ovary syndrome and overweight or obesity: a retrospective cohort study in the UK.

[42] Yen, Ting-Tai, et al. "GLP-1 receptor agonists plus progestins and endometrial cancer risk in nonmalignant uterine diseases." JAMA Network Open 9.2 (2026): e2558205.

[43] Public Health Scotland (2026). Women's health in Scotland – an evidence briefing.

[44] REGAL trial protocol.

[45] RCOG (2026). Management of Endometrial Hyperplasia Green-top Guideline No. 67. RCOG/BSGE Joint Guideline.

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For pelvic organ prolapse, pelvic floor muscle training improves symptoms, improves quality of life, delays time for treatment and reduces the overall likelihood of needing *any* hospital-based treatment over long follow-up, but a clear, large reduction in prolapse surgery alone has not been consistently demonstrated [46] [47]

Primary Care Provision

Primary care services provide the first point of contact in the healthcare system, acting as the 'front door' of the NHS.

General practice

Most gynaecological care starts in general practice. This entails assessment, initial investigations and diagnosis and first line management of common conditions such as heavy menstrual bleeding, pelvic pain, menopause symptoms, vulvovaginal conditions and suspected endometriosis. This is in line with guidance issued by the National Institute for Health and Care Excellence (NICE), the Royal College of Obstetrics and Gynaecology (RCOG) and the College of Sexual and Reproductive Health (CoSRH). See Appendix 2 for NICE guidelines on gynaecology conditions. This care is associated with good health outcomes, assessed as cost-effective and reduces the need for invasive surgical procedures [48, 49, 50]. Care is delivered by GPs, advanced nurse practitioners, practice nurses, clinical pharmacists and sometimes pelvic health physiotherapists. Some practices have clinicians with a 'special interest in women's health'. These are clinicians who have often undertaken additional qualifications in contraception or menopause.

Conservative, medical and non-surgical treatments provided in general practice include the following:

- Topical vulval care- emollients, soap substitutes, topical steroids, topical oestrogen, antifungals
- Lifestyle medicine including advice and support with exercise, diet, smoking cessation and alcohol intake
- Psychological support or referral- therapies or stress management techniques
- Pain management (e.g. non-steroidal anti-inflammatory drugs such as mefenamic acid)
- Antifibrinolytics such as tranexamic acid or NSAIDs or hormonal treatments for heavy menstrual bleeding
- Hormonal contraception (for menstrual disorders)

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[46] Maxwell, Margaret, et al. "The POPPY trial participant data linkage study." Pelvic floor muscle training for women with pelvic organ prolapse: the PROPEL realist evaluation. NIHR Journals Library, 2020.

[47] Hagen, Suzanne, et al. "Individualised pelvic floor muscle training in women with pelvic organ prolapse (POPPY): a multicentre randomised controlled trial." *The Lancet* 383.9919 (2014): 796-806.

[48] Ben, Ângela J., et al. "Cost-effectiveness of pessary therapy versus surgery for symptomatic pelvic organ prolapse: an economic evaluation alongside a randomised non-inferiority controlled trial." *BMJ open* 14.5 (2024): e075016.

[49] NIHR Evidence (2017). Pelvic floor exercises may reduce need for further treatments for pelvic organ prolapse.

[50] UK Parliament Health and Social Care Committee (2023). Written evidence submitted by the Enhanced Community Gynaecology Service (ECGS) and other community gynaecology pilots. [cited 2026 Mar 13].

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- Oestrogen (oral, vaginal or transdermal)
- Hormone-replacement therapy (HRT) for menopause symptoms
- Advice on pelvic exercises to improve pelvic floor function.

Long-acting Reversible Contraception (LARC) includes sub-dermal implants (SDIs) and intrauterine contraception (IUC) commonly known as coils. There are two types of IUC: copper intrauterine devices (Cu-IUDs), which do not contain hormones, and levonorgestrel-releasing IUDs (LNG-IUDs), which release hormones. As well as being used for contraception, LARC are first line for management of various gynaecological conditions including heavy or painful periods, endometriosis, adenomyosis and some perimenopause symptoms. Provision of LARC is not part of the core GP contract resulting in patchy provision in England. Fitting LARC requires a formal qualification and regular re-validation of competency.

Vaginal ring pessaries are a non-surgical management option for pelvic organ prolapse which may be provided in some general practices but are not universally considered to part of the core GP contract and is therefore something that practices are not required to provide without additional funding[51]. They are removable devices inserted into the vagina to support the pelvic organs and provide symptomatic relief. Ring pessaries can be fitted by general practice clinicians. Although there isn't a formal qualification, informal training is needed along with enough regular fittings undertaken to remain competent.

Advice & Guidance

If a GP identifies that a patient needs specialist care, they can make a referral to secondary care and book them an appointment either through an e-referral or other routes such as an email. GPs can also use an Advice and Guidance (A&G) service that allows them to obtain timely specialist advice from a hospital gynaecologist and guidance on how to care for the patient without them needing them to be seen in an appointment. This is optional and GPs are currently paid £20 per request. From 2026, the A&G service is being expanded across all clinical specialities and GPs will be expected to use A&G before or instead of a referral, via a Single Point of Access with no separate funding. The hospital specialist will review the A&G request and either respond with advice on care or book the person for tests/investigations or a consultation or redirect them. Gynaecology is one of the first of ten specialties for this to be implemented.

This change aims to improve clinical collaboration between primary care and secondary care clinicians and reduce the number of unnecessary referrals.

Community Pharmacy

Community pharmacists can provide advice and treatment for menstrual health (peri)menopause and vulvovaginal health and recommend over the counter treatments. For example, non-steroidal anti-inflammatory medication, tranexamic acid and vaginal lubricants and moisturisers. Pharmacists will signpost people to general practice or urgent care where needed.

[51] BMA (2024) Enhanced services GP practices can seek funding for.

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Pharmacies may also initiate and continue prescribing oral contraception as part of the NHSE commissioned National Pharmacy Contraception Service. Like LARC in general practice, this is an additional service that pharmacies are not required to offer.

Sexual and Reproductive Health services

Sexual health services include direct access services such as STI testing and treatment and contraception. They may also provide specialist services that may require a referral from a GP such as complex contraception and, in some areas, menstrual health and menopause care.

Specialist care may be based in a hospital or in a clinic in a community health centre. Care is led by Genito Urinary Medicine (GUM) consultants and Sexual and Reproductive Health (SRH) consultants and supported by nurses and health advisors.

Pelvic Physiotherapy

Pelvic physiotherapy is a specialist form of physio that assesses and treats conditions affecting the pelvic floor muscles (the muscles that support the bladder, bowel and uterus and help control bladder and bowel function). It is used in gynaecology to prevent and treat pelvic organ prolapse, urinary incontinence, and chronic pelvic floor dysfunction, often as the result of pregnancy and childbirth, gynaecological surgery or menopause. It does not require hospital facilities but may be based within a hospital or the community.

Pelvic health physiotherapy should be regarded as a core first-line clinical intervention rather than an adjunct service. NICE guidance recommends supervised pelvic floor muscle training as first-line treatment for many women with urinary incontinence and pelvic organ prolapse before surgical intervention is considered. For many women, effective conservative management can improve symptoms, enhance quality of life and reduce or delay the need for specialist or surgical treatment.

NHS England made a commitment that by March 2024 all local health systems should have a Perinatal Pelvic Health Service in place to improve access to prevention, early intervention and support for people experiencing symptoms of pelvic floor dysfunction[52].

Secondary Care Provision

Secondary care is provided by specialists in a hospital and usually a GP referral is needed to access it. NICE guidance states that some benign gynaecological conditions are complex, long-term or difficult to manage and may require specialist care.

Hospital gynaecology services provide specialist diagnosis, management and surgical treatment. It is delivered by gynaecologists and supported by a wider clinical team including specialist nurses, pelvic health physiotherapists and psychologists.

Specialist services are usually required if:

- **Symptoms are not responding to initial treatment-** e.g. a 3–6-month trial of pain relief and hormonal treatment for painful periods, ongoing iron deficiency anaemia for heavy menstrual bleeding that has not responded to treatment, ongoing

[52] NHSE (2024). Implementation guidance: Perinatal pelvic health services.

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menopausal symptoms despite treatment with hormone replacement therapy or complex medical history requiring specialist input, incontinence that has not responded to 3 months supervised pelvic floor muscle training

- **Symptoms that have a significant impact on quality of life-** earlier referral may be appropriate
- **Uncertain diagnosis-** may require further diagnostics and specialist review
- **Where concomitant medical conditions make routine prescribing more complex** e.g. history of cancer, epilepsy.
- **Signs of more severe disease-** e.g. endometriosis involving the bowel, bladder or ureters or outside of the pelvic cavity, prolapse that extends beyond the vaginal opening, significantly enlarged fibroid uterus.

Hospital-based services typically include:

- **Consultations** on general gynaecology symptoms, endometriosis, vulvovaginal conditions, menopause, urogynaecology, reproductive conditions, early pregnancy including advance assessment and pelvic examination
- **Diagnostics**: including ultrasound, biopsy, MRI, laparoscopy, hysteroscopy, colposcopy. These may be done in a cost-effective outpatient setting where possible and appropriate[53] [54]
- **Medical Treatments**: hormonal (including Gonadotrophin-releasing hormone analogues), pain management, complex IUS fits, and pessary fitting for prolapse
- **Surgery**: Minor and major surgery, including polypectomy, endometrial ablation, myomectomy, hysterectomy, cystectomy and pelvic organ prolapse repair. Some procedures may be undertaken in an outpatient setting where possible and appropriate[55]
- **Emergency care**: assessment and treatment of urgent issues such as ectopic pregnancies and miscarriage, ovarian torsion, acute bleeding or severe pelvic pain, pelvic infections.

Also:

- **Cancer care (oncology):** investigation, diagnosis and management
- **Termination of Pregnancy services:** Complex abortions and abortions in later pregnancy. N.B. MSI Reproductive Choices and the British Pregnancy Advisory Service provide a large proportion of NHS-funded abortions.

ICBs may commission additional capacity from the independent sector to reduce waiting lists for routine gynaecology appointments, diagnostics or procedures.

Patients may also seek private care for their gynaecological needs.

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[53] Marsh, Fiona, Christian Kremer, and Sean Duffy. "Delivering an effective outpatient service in gynaecology: a randomised controlled trial analysing the cost of outpatient versus daycase hysteroscopy." *BJOG: An International Journal of Obstetrics & Gynaecology* 111.3 (2004): 243-248.

[54] NICE (2013). Heavy menstrual bleeding (QS47). Quality statement 2: Outpatient hysteroscopy.

[55] Clark, T. Justin, et al. "A randomised controlled trial of Outpatient versus inpatient Polyp Treatment (OPT) for abnormal uterine bleeding." *Health Technology Assessment (Winchester, England)* 19.61 (2015): 1.

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Funding secondary care

Hospital funding mechanisms are complex and change from year to year. The NHS Payment Scheme is a set of rules, prices and guidance that determine how providers of NHS-funded healthcare are paid for the services they provide[56].

Hospitals are usually paid for activity and they receive funding for each new patient they see in outpatients or for each surgical procedure undertaken, based upon a national tariff. For follow-up appointments they may receive a fixed sum of money each year irrespective of the number of appointments provided. There is separate funding for emergency care. ICBs fund most secondary care activity.

Demand for secondary care gynaecology in UK

Demand for hospital-based gynaecology is increasing across the UK, with a 24% increase in referrals between 2020/21 and 2024/25 to 1.61 million a year. Despite the national drive now appearing to impact on some elective waiting lists, gynaecology is not improving at the same rate and remains as one of the longest specialty waiting lists. As of December 2025, there were approximately 750,000 people waiting for gynaecological care in the UK, an increase of almost a third compared to January 2022 and double that of February 2020[57]. Over 40% of people in England were waiting for over 18 weeks for treatment as of December 2025, and over 15,000 were waiting for over 52 weeks[58]. Waiting lists have risen most sharply among women from Black and Asian backgrounds, with incomplete ethnicity data suggesting the true scale of this inequity may be underestimated[59].

Tertiary Care Provision

Tertiary care is highly specialist services that are not routinely provided at all hospitals. This includes:

- Specialist treatment for severe endometriosis
- Complex surgery for urinary incontinence and vaginal prolapse
- Complex gynaecology such as congenital gynaecological anomalies
- Fertility preservation
- Complex termination of pregnancy.

Community Diagnostic Centres

Community Diagnostic Centres (CDC) are places that offer a wide range of diagnostic tests across many specialities, not just gynaecology. They offer imaging, blood tests, endoscopy and physiological diagnostics such as echocardiograms (ECGs). CDCs are being set up across the country to enable faster diagnosis, reduce the need for multiple appointments and make it easier for patients to attend.

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[56] NHSE (2026). NHS Payment Scheme [cited 21 May 2026].

[57] RCOG (2026). As we enter 2026, almost three quarters of a million women remain waiting for gynaecology care – and inequalities are widening, warns RCOG.

[58] NHS England. *Referral to Treatment (RTT) Dashboard*.

[59] RCOG (2026). Gynaecology waiting lists rise despite overall NHS backlog falling, warns RCOG.

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Some CDCs in the country offer gynaecological diagnostics such as ultrasound, hysteroscopy and colposcopy but these are not part of the core contract.

Community Gynaecology Services (Intermediate Care)

Some local health systems across England have established Community Gynaecology services that provides 'intermediate' healthcare. Intermediate services sit in between general practice and hospitals. They provide care that Is not available in standard GP appointments due to the additional procedures and specialist skills required, but do not require full hospital facilities. Community Gynaecology services are often led by GPs with a special interest in women's health with support from consultants (such as gynaecology or sexual and reproductive health consultants) and appointments are held in community settings. Community Gynaecology services have existed for over 25 years in some areas of England. This has often been in response to national initiatives such as to provide care closer to home [60],[61] and GIRFT[62].

In 2023 each Integrated Care Board was tasked to work with partners to establish at least one 'Women's Health Hub' which arguably is similar to a Community Gynaecology service.[63]

A Community Gynaecology service may include care and treatment such as:

- Pessary fits for pelvic organ prolapse
- Cervical polyp removals
- Vulval conditions
- More complex menopause and menstrual health care
- IUD fits for gynaecological indications and contraception
- Investigation of lost IUD threads
- Triage of referrals from GPs to hospitals in partnership with local gynaecology consultants.

Evidence for **Women's Health Hubs**

A national mixed methods evaluation was undertaken of 17 UK hubs established before 2022 to inform national policy. Whilst women using these hubs reported positive experiences, challenges included fragmented commissioning, workforce shortages, and funding. The authors concluded that Women's Health Hubs have the potential to integrate and improve women's health, but that the heterogeneity of these hubs made firm conclusions difficult, and the authors suggested further evidence was needed of the impact of inequalities, population health and on the wider health system[64].

Examples of Community Gynaecology/ Women's Health Hubs services:

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[60] DHSC (2006). Our health, our care, our say: a new direction for community services. London: The Stationery Office.

[61] NHSE (2015). *New care models: Vanguards – developing a blueprint for the future of NHS and care services*.

[62] GIRFT (2024) Maternity and gynaecology national specialty report

[63] NHSE (2023) NHSE (2023) Women's health hubs: core specification

[64] Daniel, Kelly, et al. "Community Women's Health Hub models in England: a mixed methods evaluation." BMC Primary Care 26.1 (2025): 398.

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Birmingham Modality:[65] [66] The service is led by GPs with consultant gynaecologist oversight. It was set up to achieve lower waiting times, more patient-centred care and fewer contact points for patients. The service reports positive feedback from patients on consultation style and shared decision-making and short waiting times maintained.

Guildford and Waverley GP practice hub:[67] [68] The service is led by GPs. It was set up to make it easier for patients to access healthcare, reduce secondary care referrals and so reduce waiting times, be more cost-efficient and improve patient satisfaction through a one-stop model of care.

Oxfordshire Principal Medical Ltd:[69] [70] This service is led by GPs with consultant oversight. An evaluation of its menopause service in 2022-23 found that of 1291 referrals received 866 (**89.3%) were managed in-house**. patients received their appointment within 4–8 weeks of GP referral, and patients provided extremely positive feedback.

Tower Hamlets Women's Health Hub[71] is a community-based, multidisciplinary gynaecology service in London using a single point of access and specialist triage to manage the majority of referrals outside hospital, reducing waits and improving access. It is staffed by gynaecologists, sexual and reproductive health doctors, GPs, physiotherapists and nurses. Referrals are triaged by senior clinicians and then either managed in primary care (with specialist advice/guidance), referred to hospital or seen in the hub for care around menstrual health, menopause, pelvic floor, contraception etc. The model has resulted in **60% less hospital referrals** and most women are seen within 5 days. **Waiting lists for hospital care reduced by 30%** within a few months

The reported benefits of a Community Gynaecology service include:

- **Easier access** for patients, closer to home
- **Earlier intervention** and reduced unmet need
- **Improved patient experience** (with care delivered in one appointment where possible)
- **Improved health outcomes** and **reduced health inequalities**
- Improved access to health information and **supported self-management**

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[65] Primary Care Women's Health Society (2025) Setting up a Community Gynaecology Service in Birmingham: A case study.

[66] Daniel, Kelly, et al. "Women's Health Hubs: a rapid mixed-methods evaluation." Health and Social Care Delivery Research 12.30 (2024): 1-138. [see page 118]

[67] Guildford & Waverley Community Gynaecology Service. Guildford and Waverley Community Gynaecology Service. Shere Surgery; 2026.

[68] Daniel, Kelly, et al. "Women's Health Hubs: a rapid mixed-methods evaluation." Health and Social Care Delivery Research 12.30 (2024): 1-138. [see page p121]

[69] Principal Medical Ltd. Community Services – Community Gynaecology Service. Buckinghamshire, Oxfordshire & West Berkshire Integrated Care Board; 2026.

[70] Shah, Anupa, and Katie Barber. "Community Gynaecology Service Oxfordshire: How a local women's health hub improved access to menopause care." *Post Reproductive Health* 30.3 (2024): 195-198.

[71] RCOG (2026). As gynaecology waiting lists rise, a North London women's health hub shows the way forward.

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- **Reduced demand on hospitals**, leading to shorter waits for those who still need to be seen in hospital
- More **holistic care** than hospital gynaecology services- considers the wider, non-gynaecological health needs of a person
- Fosters good relationships between primary care and secondary care clinicians through multidisciplinary working and **supports optimisation of skills**
- Supports **staff well-being and retention**
- Improved **efficiency, and addresses fragmented commissioning** and lack of integration
- Enables better collection of data to help understand women's health needs
- **Cost-effective.**

2.7 Cost effectiveness of services that can be delivered in the community

Pelvic floor muscle training can reduce costs

Managing conditions earlier in primary care or community settings can reduce subsequent high-cost secondary care use and avoid more invasive procedures. Early support for risk factors such as obesity and pelvic floor strengthening has been associated with improved outcomes in conditions such as prolapse and heavy menstrual bleeding and can reduce the need for surgical management. For example, pelvic floor muscle training has been shown to improve symptoms and may reduce the need for further treatments such as surgery for prolapse [72] [14]

Pessaries for pelvic organ prolapse are cost-effective.

A randomised controlled trial demonstrated similar patient-reported outcomes from pessaries compared with surgery, with just under half of women initially managed with a pessary not requiring subsequent surgery. The study estimated overall healthcare cost savings of around €1,800 (~£1,560) per patient, demonstrating substantial potential economic benefit from a conservative management approach[73].

LARC and ring pessaries are much cheaper to fit in primary care than in hospital

The Primary Care Women's Health Society (PCWHS) found that LARC fitting in primary care is significantly cheaper than in hospital outpatient settings. With a GP insertion tariff of around £100 compared with £302 for the same procedure in secondary care. Similarly, ring pessaries, used to manage pelvic organ prolapse in older women, cost £45–£56 per insertion in primary care versus £181 in secondary care[74].

Modelling indicates that women's health hubs are likely to be cost-effective, with benefits outweighing costs, though real-world economic evidence is still emerging. In 2024 DHSC

[72] NIHR Evidence (2017). Pelvic floor exercises may reduce need for further treatments for pelvic organ prolapse.

[73] Ben, Ângela J., et al. "Cost-effectiveness of pessary therapy versus surgery for symptomatic pelvic organ prolapse: an economic evaluation alongside a randomised non-inferiority controlled trial." *BMJ open* 14.5 (2024): e075016.

[74] UK Parliament Health and Social Care Committee (2023). *Written evidence submitted by the Enhanced Community Gynaecology Service (ECGS) and other community gynaecology pilots* [cited 2026 Mar 13].

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published a cost benefit analysis of women's health hubs to consider value for money. This estimated that for every £1 spent on implementing a PCN sized hub that there were an estimated £5 benefits (with a range from £2-£13) or around £6million of saving over 10 years[60].

As with any such analysis there remains a degree of uncertainty and unquantified costs, however the report concludes that despite these limitations that:

> "*the policy is assumed to provide good value for money with the benefits outweighing the costs. This is because the benefits of hubs impact on a substantial proportion of the population, with opportunities to streamline in the health service, and often with limited implementation and ongoing costs. There are also additional unquantified benefits which strengthen the case for investment.*"

Table 9: value for money of one PCN-sized hub

Over 10-year appraisal period	Central scenario	Best-case scenario	Worst-case scenario
Sum of costs	£2m	£1m	£3m
Sum of benefits	£7m	£9m	£5m
Net present value	£6m	£8m	£2m
Benefit cost ratio	5	13	2

Figure 2.1: Table from DHSC guidance showing the value for money of one PCN-sized hub (real 2022 to 2023 prices discounted in line with Green Book principles of cost benefit analysis)[75]

Economic analyses suggest women's health hubs may offer good value

In 2025 an evaluation was undertaken by NIHR Applied Research Collaboration in Northeast and North Cumbria to consider the costs and benefits of Sunderland's Women's Health Hub. They concluded that the hub represents good value for money -for every £1 invested, the hub generates £8 savings over 10 years[76].

A consultant-led 'one-stop' community gynaecology clinic in Barnsley reduced waiting times to around six weeks, delivered cost savings per appointment (however the exact costs are unreported), and discharged 32% of patients at first visit, suggesting that many women could be managed without onward hospital referral.

[75] DHSC (2024). Women's health hubs: cost benefit analysis.

[76] NIHR North East and North Cumbria (2025). Does Sunderland Women's Heath Hub represent good value for money?

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Enhanced Community Gynaecology Service pilots in Wales reported resource savings of £268 per patient, with potential national savings of over £4.4 million if scaled, primarily through reduced inpatient and hospital resource use[77].

3. The Local Picture in BNSSG

3.1 BNSSG Demographics

BNSSG is an area in the South West of England, with a population of 1,025,309[70]. It includes Bristol, an urban area, North Somerset with more rural towns and villages and coastal communities, and South Gloucestershire, with more rural towns and villages.

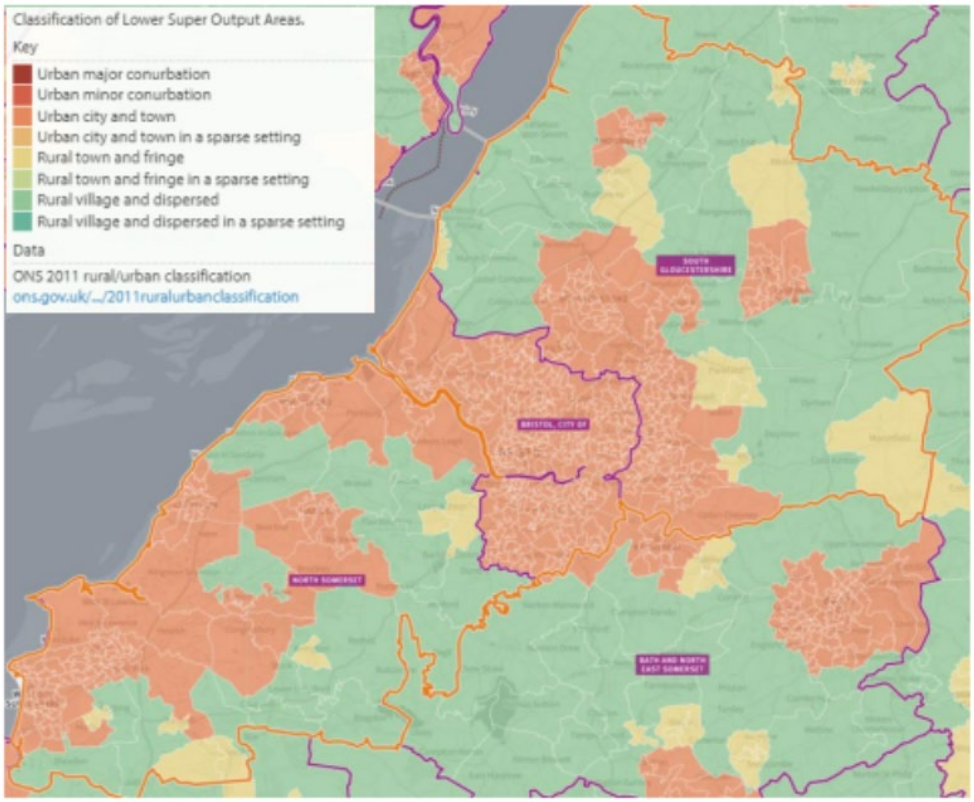
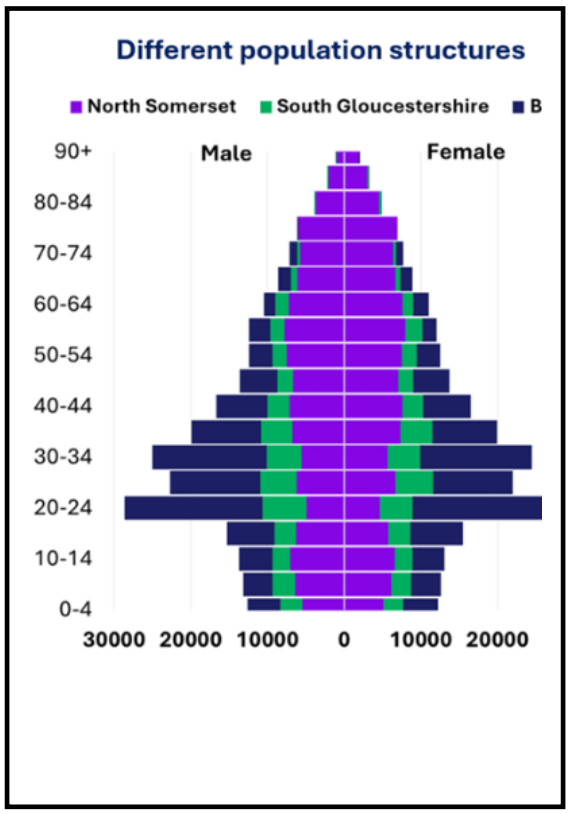


Figure 3.1: Map showing the urban and rural variation across BNSSG. Source: ONS 2011, SHAPE Tool

[77] Bevan Commission (2024). Advanced Community Gynaecology - Using Point of Care Diagnostics to Deliver Prudent Local Healthcare in Ceredigion and Hywel Dda.

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Age structure and ethnicity is very different for each local authority



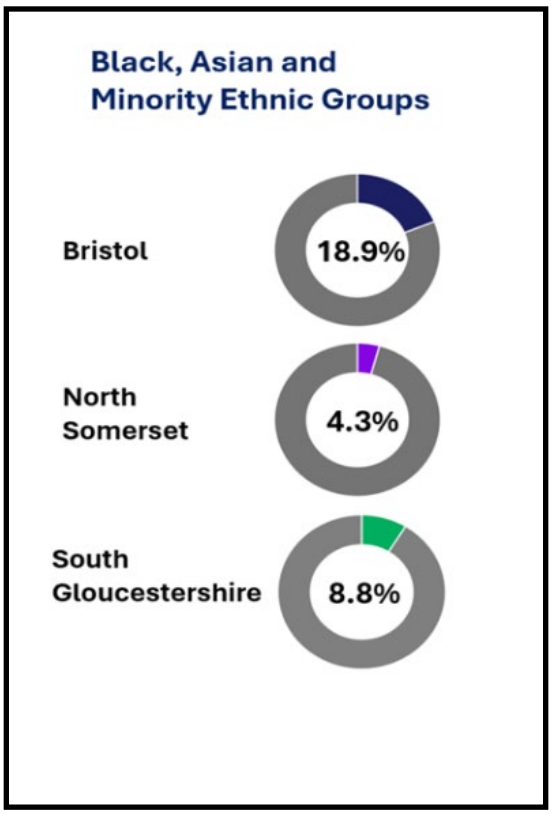


Figure 3.2: Age breakdown of BNSSG. Source: BNSSG ICB, Our Future Health Report – 3 Years On (2026).

Figure 3.3: Black and minority ethnic group percentages in BNSSG. Source: as above

Sex is split equally between male and females

BNSSG has around 518,700 females. All three localities have a near-equal male–female split[71].

Bristol has a higher proportion of young women; North Somerset has a higher proportion of women over 75

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The highest number of women live in in Bristol and tend to be younger than in North Somerset and South Gloucestershire. North Somerset has a significantly higher proportion of females aged 75 and over.

Bristol is much more ethnically diverse than North Somerset and South Gloucestershire

The proportion of residents from minoritised ethnic groups varies between Bristol, North Somerset and South Gloucestershire. Bristol is much more ethnically diverse, with 18.9% of the population from a Black, Asian and Minority Ethnic group (similar to the 19% England average).

Women in BNSSG spend more time in poor health than men- 22 years compared to nearly 18 years for men. Healthy life expectancy has declined in all 3 local authority areas.

- **Bristol**: Healthy life expectancy for women is 60.3 years, compared to 60.4 years for men.[75] Female life expectancy is 82.7 years, below the England average of 83.2yrs. The gap in life expectancy between the most and least deprived wards is 7.2 years for females[72].
- **North Somerset**: Healthy life expectancy for women is 65.4 years, compared to 65.5 years for men[89] Female life expectancy for North Somerset is 83.9 years, with a **gap of 15.3 years** between the most and least deprived wards[73].
- **South Gloucestershire**: Healthy life expectancy for women is 62.9, contrasted to 63.5 years for men[90]. Female life expectancy in South Gloucestershire is 84.9 years, with a gap of 6.07 years between the most and least deprived wards[74].

Bristol has much greater levels of deprivation, but pockets of deprivation are seen in North Somerset and South Gloucestershire

Deprivation refers to people's unmet needs and a lack of access to opportunities and resources which we might expect in our society. The Index of Multiple Deprivation (IMD) score is the official measure of relative deprivation in England, ranking neighbourhoods from the most deprived (IMD 1) to the least deprived (IMD 10) based on factors such as income, employment, health, education, crime, housing and the living environment[76].

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There are wide variations in deprivation in BNSSG. Around a third of Bristol's population live in the 20% most deprived areas compared to 15% in North Somerset and 13% in South Gloucestershire. Throughout BNSSG there are pockets of deprivation, such as in Weston-.

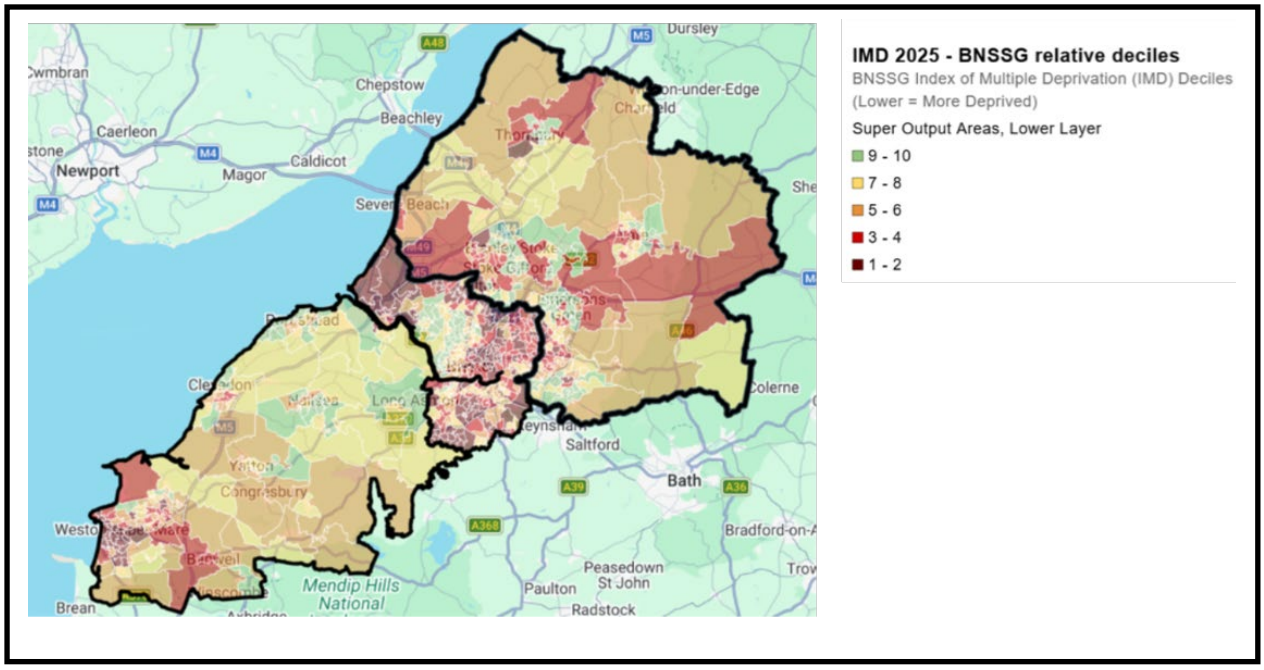


Figure 3.4: IMD Map of BNSSG. Source: South Gloucestershire Local Insight Map, 2026.

Super-Mare in North Somerset, Yate in South Gloucestershire and Inner City, and South Bristol as shown in Figure 3.4

3.2 Summary of Gynaecology provision and activity in BNSSG

Services provided within BNSSG primary care

- BNSSG has 70 General Practices organised into 20 PCNs providing first-line care, including assessment, investigation, management of common gynaecological conditions, and referral to secondary care currently via the BNSSG referral service, supported by extensive Remedy guidance for clinicians[78].
- Most of BNSSG's 154 community pharmacies are providing services such as oral contraceptive initiation and continuation, emergency hormonal contraception, over-the-counter treatments, and signposting.
- Community Diagnostic Centres are available in North Bristol and Weston Super Mare and provide GPs with direct access to pelvic ultrasound.
- Women's Health Hub funding in BNSSG in 2024 **strengthened primary care capability**, **improved access to menopause and LARC training** for primary care clinicians, **increased access to information** and **supported underserved groups**, rather than establishing a standalone women's health hub model. Funding has now ended.

[78] Healthier Together (2026). Remedy BNSSG ICB.

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General practice activity in BNSSG

- There is a **high level of general practice activity** for gynaecological conditions, with over 25% of registered women having a coded gynaecological presentation in the last 3 years.
- **Vulvovaginal conditions are the largest contributor** to gynaecological attendances **followed by menopause**. **Unscheduled bleeding** (post-menopausal, postcoital plus intermenstrual bleeding) contributes to a significant proportion of gynaecological consultations as do **periods** (heavy or painful).
- **There is a high burden of symptom-based care**. Endometriosis and fibroids appear to be under-coded compared to known population prevalence. This may indicate underdiagnosis, women not presenting, or coding of symptoms (such as heavy menstrual bleeding or pain) rather than the underlying cause.
- **HRT prescribing has significantly increased but is inequitable-** much higher in the least deprived areas.
- **Access to testosterone is limited**.
- **Prescriptions for heavy menstrual bleeding have increased** in primary care suggesting greater awareness.
- **Activity is concentrated in mid- life driven by menopause** consultations. Younger women are more likely to be seen for period issues. Prolapse is more common in older women.
- **There are fewer presentations of gynaecological conditions in the most deprived areas** overall, with menopause and prolapse presenting less in areas of highest deprivation. HMB shows the opposite pattern with more presentations in the most deprived areas.
- **Differences in presentation with ethnicity reflect unequal access relative to need**. White women have the highest presentation rates overall, with **minoritised ethnic groups having lower presentation rates** especially for menopause and prolapse. Heavy menstrual bleeding is recorded more often in Black women and women of a Mixed ethnic background than Asian or White women **but not to the extent that would be expected based on need.**
- **There is inconsistent provision of interventions within general practice**, constrained by commissioning arrangements and training.
- **LARC provision in primary care is high but variable and reducing.** Primary care provides most of the LARC in BNSSG including LARC for gynaecological purposes.
- **If LARC for gynaecological purposes** unable to be fitted in primary care, women must be referred to hospital due to commissioning fragmentation**.**
- **There is very little access to community pelvic physiotherapy**, with most needing to be referred to secondary care services.
- There is **very little provision of ring pessaries** within primary care.
- **Specialist menopause trained clinician provision has increased but is variable** across practices.

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Services provided by secondary care

- Specialist gynaecology care is provided by Bristol NHS Foundation Trust (a recent merger of University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) and North Bristol NHS Trust (NBT)).
- Yuno Sexual Health provides specialist and community based sexual and reproductive health services.
- Sexual and Reproductive Health consultants are trained in gynaecological assessment and procedures but their **skills are not fully utilised in BNSSG provision due to commissioning arrangements.**

Secondary Care activity summary

- There are over 10,000 E-referrals to secondary care gynaecology each year.
- **E-referral numbers for BNSSG have gradually increased but rates are much lower than peers.**
- A **large proportion of referrals are outside of the E-referral** service currently, making true referral activity difficult to ascertain or benchmark.
- E-**referrals are higher for women from more deprived** areas.
- **Advice and guidance is currently under-utilised** in BNSSG- (half the national rate) but appears effective at diverting referrals when used.

- **There is a high volume of potentially community-manageable conditions coming to secondary care.** Menstrual disorders are the most common reasons for referral to secondary care plus, urogynaecology/prolapse, endometriosis and pelvic pain.
- Virtually all ring pessaries are undertaken in secondary care. In 2025, 2,610 pessaries were fitted in outpatients in BNSSG.
- There were **46,000 outpatient attendances** in 2025, 19,000 new and 27,000 follow ups. This rate of attendance is **much lower than the England rate.**
- **Rates of 'non-attendance' are increasing and higher than peers.**
- **DNAs are around 5%.**

- **Waiting lists are long but improving** but remain above pre-pandemic levels.
- Around **7,400 women are currently on the waiting list** in BNSSG with **a third waiting more than 18 weeks.**
- Waiting times **do not meet national standards** for timely treatment but BNSSG performs **better than peers.**

- Most people do not require surgery but of those who do, **less than 50% of people waiting for surgery meet the 18-week standard.**
- BNSSG **performs well compared to peers for day-case and outpatient procedures**. 88.6% of suitable gynaecological procedures in BNSSG are already delivered in outpatient or day-case settings.
- Potential **opportunities to shift additional procedures** into outpatient or day-case settings have been identified for some procedures including pelvic floor surgery and hysterectomy.

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- Some conditions (e.g. endometriosis and fibroids) show **higher admission rates** than peers, which could reflect both elective recovery and unmet need presenting later (e.g. endometriosis, fibroids).
- **Inpatient length of stay is slightly longer** than peers.
- **Almost 60% of admissions are as emergencies,** which is better than peers but much higher than national targets (26%), suggesting potential for increased early diagnosis and management and access to planned care.
- **A higher than average proportion of admissions for heavy menstrual bleeding are as emergencies** which could indicate late or delayed diagnosis and treatment. The proportion of emergency admissions are higher amongst younger women and in women from more deprived areas.
- **Emergency readmissions are higher than national benchmarks,** particularly for hysterectomy and prolapse procedures (1 in 5),

- **There is a large unmet demand for pelvic physio.** Pelvic physiotherapy receives around 800 referrals per month (300 at UHBW and 500 at NBT).
- **Waits for both urgent (5-9 weeks) and routine pelvic physio appointments (18-81 weeks) are very long.**

3.3 Gynaecology in BNSSG Primary Care (General Practice and Pharmacies)

Community Pharmacies

Community pharmacies in BNSSG provide good coverage of the NHS Pharmacy Contraception Service, which allows pharmacies to initiate oral contraception and provide ongoing monitoring and supply. 151 out of 154 pharmacies (98%) are signed up to the service.

General Practice

There are 70 GP practices organised into 20 Primary Care Networks (PCNS). PCNs are groups of local practices that work together to provide services[79].

Gynaecology presentations in general practice

General practice activity data has been used to help understand demand on primary care and how demographics impact.

50 out of 70 BNSSG practices agreed to share their SNOMED data for this HNA. The shared data was collated by One Care, the GP federation in BNSSG that provides a range of support services including business intelligence and analytics. Data is for presentations for gynaecological conditions over the previous three-year period.

For further information on SNOMED codes used see Appendix 3.

[79] NHSE (2023). Primary care networks.

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Main findings

Gynaecological presentations within primary care are common

Of the of 338,091 females registered in the participating practices (all ages), 85,958 had a coded gynaecological presentation (an appointment) between February 2023 and February 2026, which is 25.4% of the female population.

The most frequently conditions are outlined in Figure 3.5. Vulvovaginal conditions are the commonest gynaecological reason for presenting to general practice, followed by menopause. If Heavy Menstrual Bleeding, painful periods, fibroids and endometriosis are grouped together as menstrual and womb health conditions and symptoms, the rate is 63.8 per 1000 females. This is slightly higher than menopause rates.

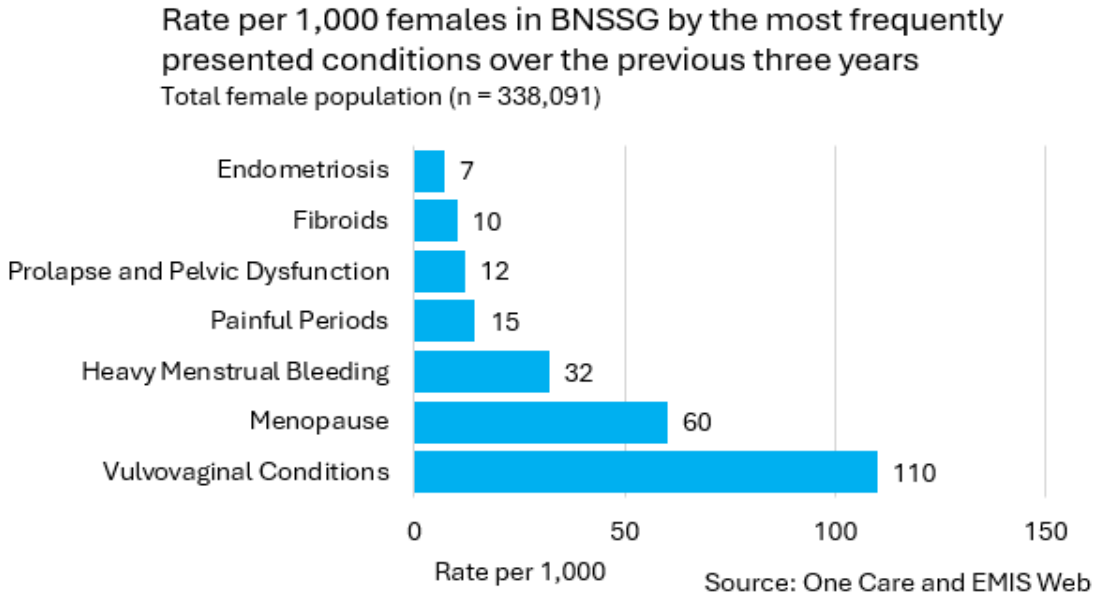


Figure 3.5: Rate of female gynaecological conditions presented in general practice in BNSSG in the last 3 years. Source: One Care data, 2025.

Nationally, it is estimated that around 10% of women of reproductive age may have endometriosis, and by the age of 50 more than 80% of Black women and 70% of White women may have uterine fibroids[80]. Reasons for the lower rates seen locally include national population estimates using a narrower, age-specific denominator, people having conditions with no symptoms[81] [82], not presenting to or unable to access general practice, underdiagnosis or delayed diagnosis, and because symptoms such as heavy menstrual bleeding are recorded rather than the underlying diagnosis.

Age: presentations are most common in middle age

When the data is broken into down into age specific rates, gynaecological presentations are most common in women of middle age, with a peak in women aged 40–49, where 437 per

[80] NICE (2023) Fibroids: How common is it?

[81] Endometriosis UK (2024) What is Endometriosis?

[82] NHS (2026) Fibroids

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1,000 women had at least one relevant code recorded. Women aged 50–59 also show high activity (425 per 1,000), largely reflecting menopause-related consultations.

Younger women also have substantial levels of activity. Among those aged 20–29, 292 per 1,000 women had a coded presentation, with common issues including painful periods (37 per 1,000) and irregular or absent periods (27 per 1,000). Adolescents aged 10–19 present mainly for menstrual problems such as heavy or painful periods.

In older age groups, overall consultation rates decline, but prolapse and pelvic dysfunction become more prominent, particularly among women aged 80–89, where rates are 42 per 1,000.

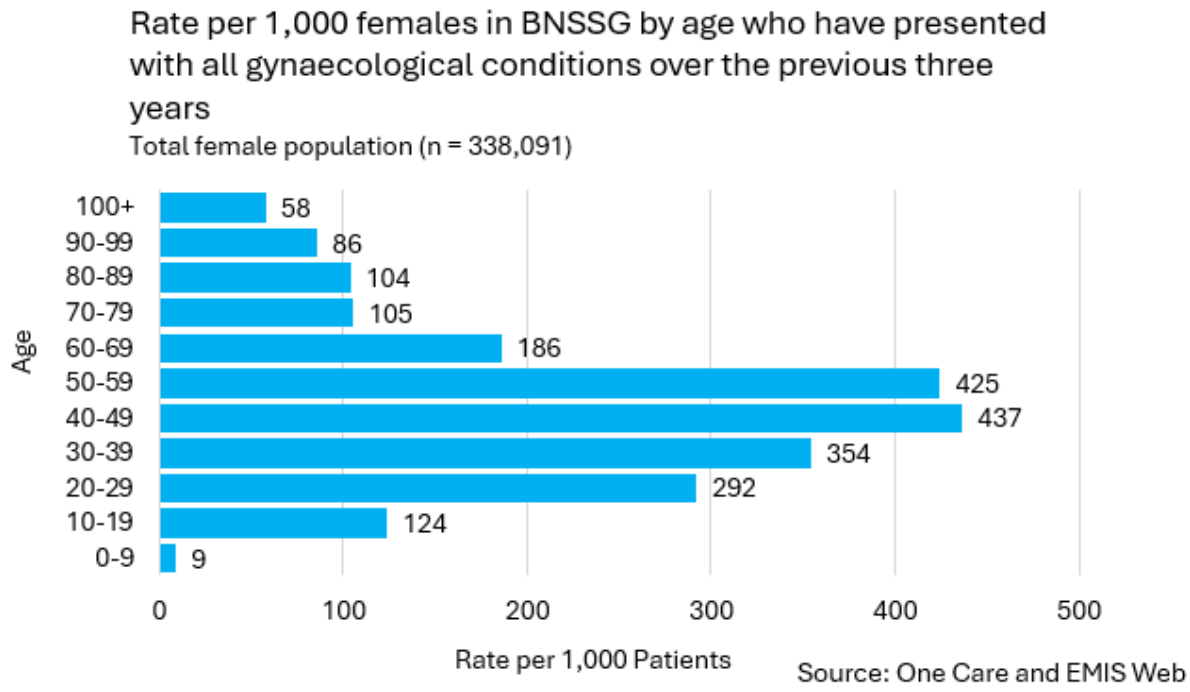


Figure 3.6: Rate per 1,000 females in BNSSG who have presented with a gynaecological condition in the previous three years by age. Source: OneCare data, 2025.

Deprivation: presentations are generally lower for women in deprived areas except for Heavy Menstrual Bleeding

While there is no clear gradient, coded gynaecological presentations are slightly lower in women in more deprived areas, with overall rates of 220 per 1,000 women in the most deprived (IMD 1) compared with 257 per 1,000 in the least deprived (IMD 10).

For menopause and prolapse, the variance in rates between most and least deprived is starker. Whereas Heavy Menstrual Bleeding presentations shows the opposite pattern. This is illustrated in table 3.1.

Table 3.1: Variance in patient presentation rates between most and least deprived areas of BNSSG, for menopause, heavy menstrual bleeding and prolapse.

	IMD 1 (most deprived)	IMD 10 (least deprived)
Menopause	47 per 1000	69 per 1000

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Heavy Menstrual Bleeding	36 per 1000	27 per 1000
Prolapse	8 per 1000	14 per 1000

The variance in menopause presentations reflects national data on variance in HRT prescribing for people in most and least deprived areas.

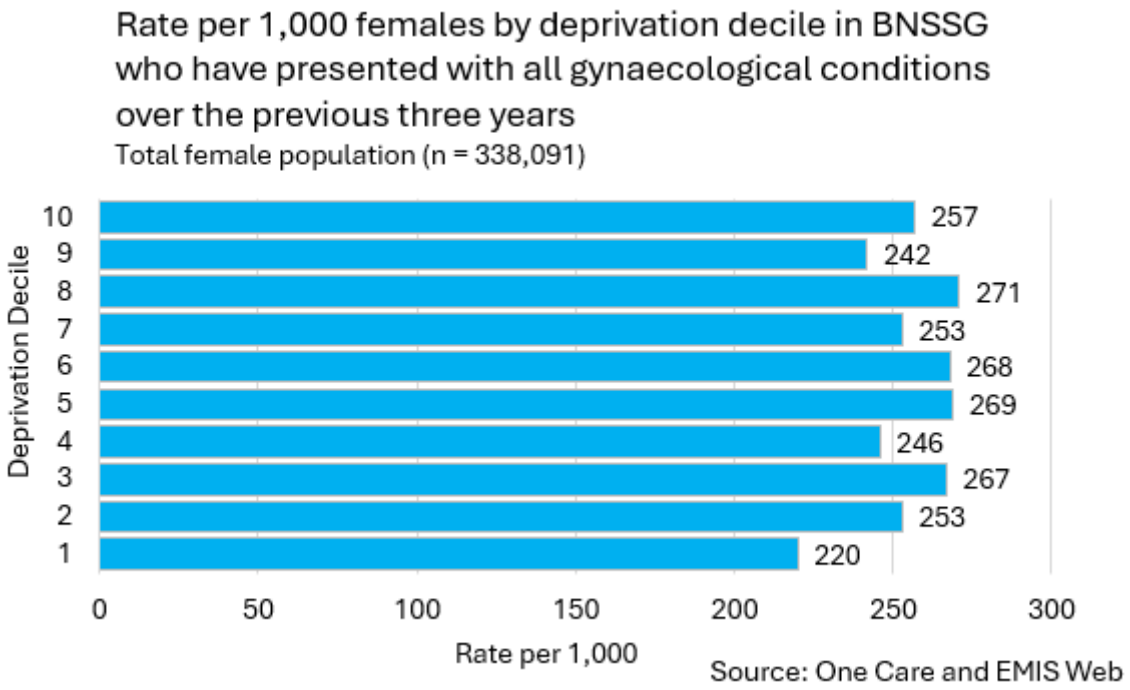


Figure 1.7: Rate per 1,000 females in BNSSG who have presented with a gynaecological condition in the previous three years by deprivation. Source: OneCare data, 2025.

Ethnicity: White women are much more likely to present to primary care, especially for menopause and prolapse; Black women present more for heavy menstrual bleeding but not as much as expected

There is significant variation in coded presentations by ethnicity. White women have the highest overall rate of gynaecological presentations (270 per 1,000).

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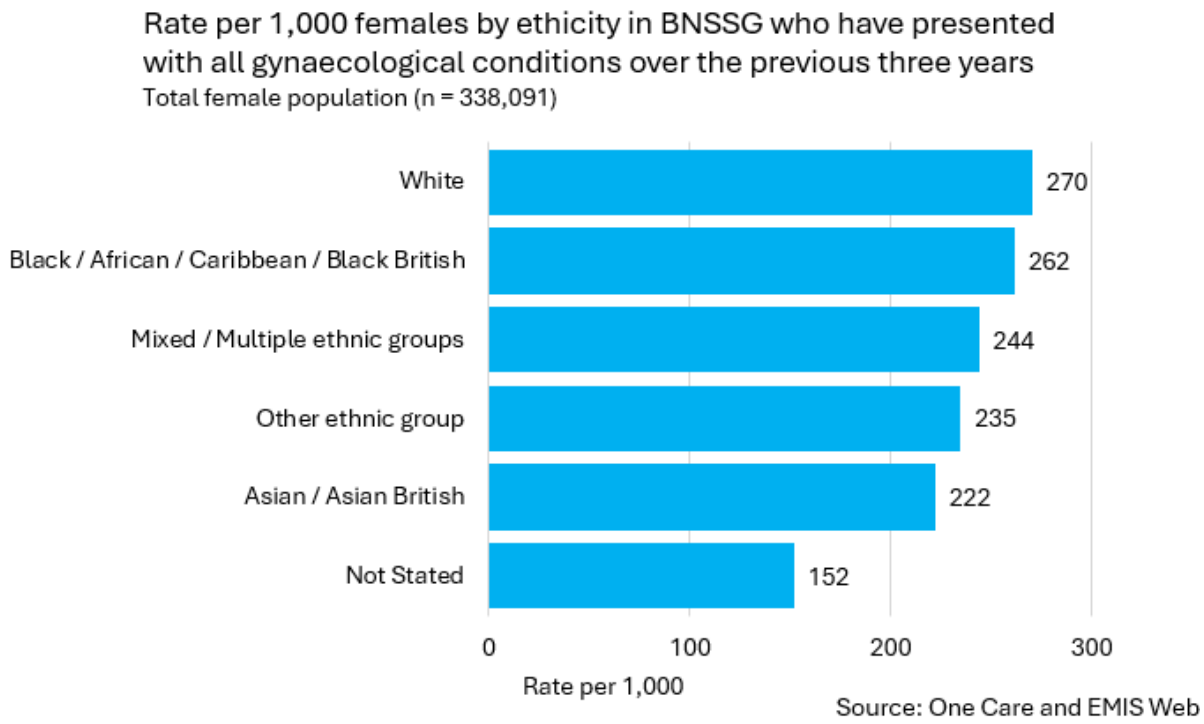


Figure 3.8: Rate per 1,000 females in BNSSG who have presented with a gynaecological condition in the previous three years by ethnicity. Source: OneCare data, 2025.

Menopause presentation rates are significantly higher in White women compared to minoritised ethnic groups: 71 per 1,000 compared with 34 per 1,000 in both Black/ African/ Caribbean/ Black British women and Mixed/ Multiple ethnic groups, 32 per 1,000 in Asian/Asian British women and 36 per 1,000 in those recorded as Other ethnic groups.

Prolapse rates are also significantly higher in White women compared to minoritised ethnic groups: 15 per 1,000 compared with 7 per 1,000 in Black/ African/ Caribbean/ Black British women, 5 per 1,000 in Mixed/ Multiple ethnic groups and Other ethnic groups, and 4 per 1,000 in Asian/ Asian British women.

In contrast, Heavy Menstrual Bleeding rates are highest for Black/ African/ Caribbean/ Black British women: 42 per 1,000, followed by 40 per 1,000 in Mixed/ Multiple ethnic groups and 37 per 1,000 in Other ethnic groups. Whereas for Asian/ Asian British women and White women the rate is 31 per 1,000.

Black women are known to have a much higher prevalence of fibroids (possibly 2-3 times higher) suggesting local presentations are not reflective of true need[83] [84].

There is variation in delivery within primary care

[83] NICE (2023) Fibroids: How common is it?

[84] Mitro, Susanna D., et al. "Uterine fibroid diagnosis by race and ethnicity in an integrated health care system." *JAMA network open* 8.4 (2025): e255235.

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There is variation between practices in the services offered. This is mainly a result of the varying skills and qualifications of clinical staff and contract arrangements. Key areas of variation relate to pelvic health care, LARC and menopause care.

There is minimal provision of ring pessaries and pelvic physiotherapy in general practices in BNSSG

There is no central database of clinicians who fit pessaries in general practice in BNSSG, nor nationally. A short survey to ascertain the number of practices in BNSSG that provide enhanced gynaecology care including ring pessary fits was carried out as part of this Healthcare Needs Assessment. Although only 33 of 70 practices responded to the survey, the results demonstrate the variability in provision. For pessary fits the number of staff trained in pessary fitting ranged from 0 to 10 per practice, with four practices reporting no pessary fitters. One practice specifically stated that they have five GPs trained who can fit pessaries but will only fit them if the activity is funded.

Practices can refer patients directly to the nurse-led pessary clinics in hospitals, both UHBW and NBT, which is where most pessary fit activity occurs.

BNSSG is not an outlier for pessary fits compared to other local health systems. Although some areas provide additional funding to practices via a Local Enhanced Service, for example Lancashire and South Cumbria ICB[85]. Data from the NHS England Women's Health Dashboard indicates that the majority of pessary fits are undertaken in secondary care in England. For July 2025, there were 12,755 in outpatients compared to 710 in primary care in England. For BNSSG, there were 230 outpatient fittings compared to 20 in primary care in the same time period. In 2025, BNSSG had 2610 ring pessary fittings, of which only 105 were in primary care.

Figure 3.9 shows data for BNSSG. It shows a similar pattern of far lower number of fits in general practice compared to secondary care.

[85] For example, Lancashire and South Cumbria ICB set up a LES for ring pessaries in May 2025 - https://primarycare.lancashireandsouthcumbria.nhs.uk/wp-content/uploads/2025/05/Ring-Pessary-25-26-last-updated-01.05.25.pdf?x23654

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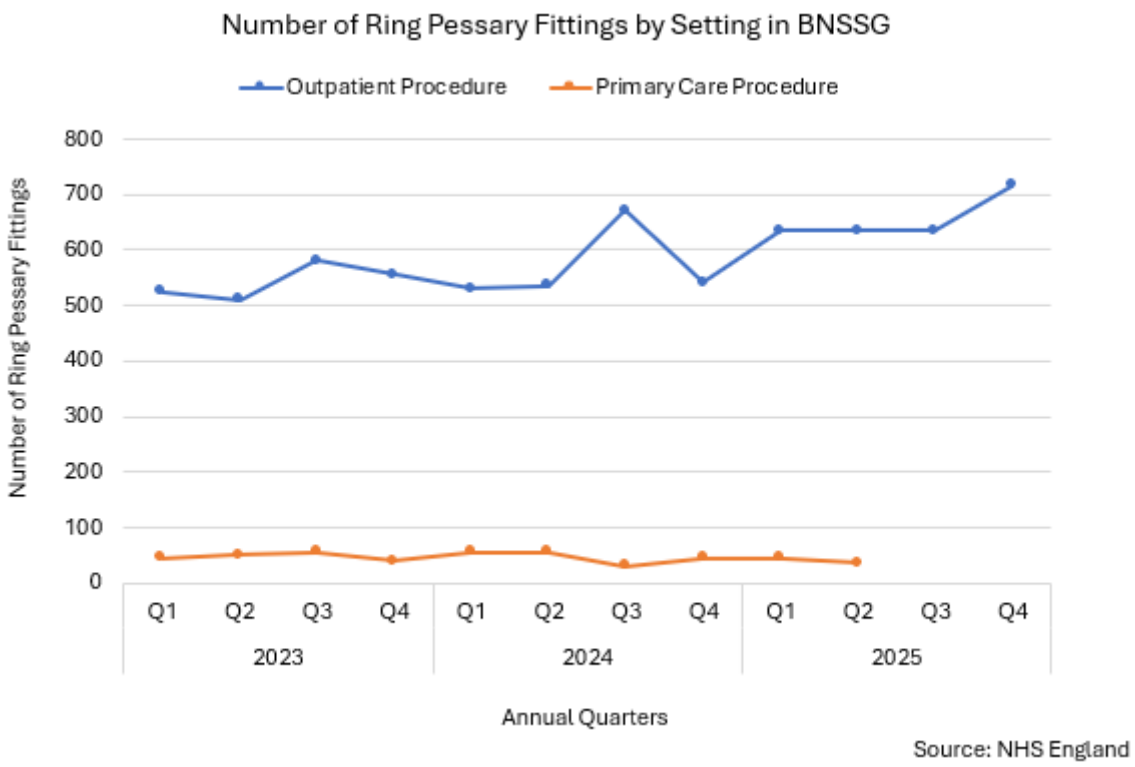


Figure 3.9: Ring pessary fits by setting over time for BNSSG (January 2023- December 2025). Data from Quarter One 2026 was removed as there is only 2 months of data available. Source: NHS England Women's Health Dashboard

With regard to pelvic physiotherapy, only a small number of practices provide this in-house. Most practices refer to the dedicated pelvic physiotherapy service at NBT or UHBW, or people self-refer.

LARC provision in general practice is significantly higher than the national average but rates are variable and declining

Each Local Authority in Bristol, North Somerset and South Gloucestershire commission the provision of routine LARC in general practice. In 2025, harmonised funding rates for fits and removals were agreed across the three Local Authorities. Local Authorities (Public Health) are responsible for commissioning LARC for contraceptive purposes. Locally, there is an agreement that BNSSG Integrated Care Board contributes funding to each Local Authority so that the GP LARC service covers fits for both gynaecological and contraceptive purposes. This is not the case for all areas of the country.

All but one practice in BNSSG has signed up to provide a LARC service. There is no central database of clinicians who are qualified to fit LARC in general practice in BNSSG. However, it is understood from previous local audits that there are LARC fitters within almost all practices, and certainly within all PCNs.

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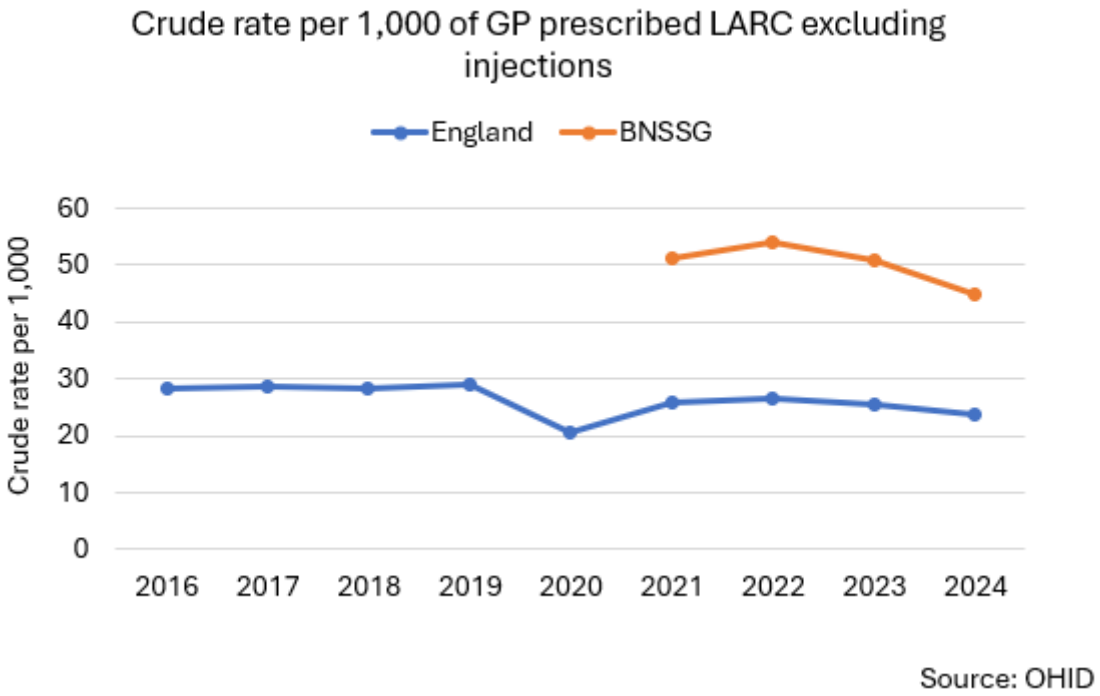


Figure 3.10: Crude rate per 1,000 of GP prescribed LARC (excluding injections) for BNSSG and England (2016-2024). Source: OHID, based on NHS Business Services Authority and Office for National Statistics data.

Although the rate of LARCs fitted in general practice in BNSSG as a whole is significantly higher than the national average[86], there is wide variety between practices in terms of number of fits and wait times[87]. Figure 3.10 above suggests a reduction in LARC both nationally and locally in recent years in primary care. This could be due to several reasons including concerns around hormones, access to primary care services, change to abortion care meaning this is an easier option than previously as well as an increase in length of time a coil can be used for contraceptive purposes.

Some of the NHSE Women's Health Hub funding was allocated to PCNs in BNSSG in 2024-25 to improve their LARC provision. Many practices trained more LARC fitters, some practices worked together to provide joint clinics or offer weekend appointments, and some reviewed their processes for offering and providing LARC to make them more efficient and patient friendly. These improvements along with the increased funding rates for LARC have improved access, reduced waiting times and helped reduced some variation although delivery on a PCN wide basis (rather than at practice level) has proved challenging. A comprehensive pack on improving LARC provision including how to access training and setting up PCN clinics was also developed and shared with all BNSSG practices.

The skills for fitting *complex* LARC for gynaecological reasons are available within community sexual health services, but commissioning barriers mean that women must be referred to hospital

[86] DHSC (2026) Public Health Fingertips profiles

[87] Bristol City Council (2022) BNSSG Sexual Health Needs Assessment [see section 5.3]

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Yuno (specialist sexual health service) is also commissioned to provide LARC for contraception- for both complex LARC (such as difficult fittings, significant medical conditions) and for women who prefer to be seen in a SRH clinic (e.g. for access to full pain relief). If complex LARC is needed for gynaecological reasons, the patient currently needs to be referred to gynaecology due to commissioning issues.

Menopause and menstrual health care clinical expertise has improved but remains variable

First line menopause and menstrual health care is provided by all general practices. However, as is the case nationally, there is evidence that the quality of this care can be vary considerably depending on the clinician. See Section 4 on the results of our public survey for more detail.

There are many reasons for this variation in care that are not due to local factors, such as gynaecological conditions being absent from the general practice Quality and Outcomes Framework (QOF) which incentivises practices to achieve certain outcomes and the proportionally small amount of time spend on gynaecological conditions in medical education[88]. Furthermore, many GPs will not have undertaken further training in gynaecology as part of their GP training.

For menopause, clinicians with extensive experience and/or a qualification in menopause from the College of Sexual and Reproductive Health (CoSRH) such as the Menopause Care Professional Diploma or British Menopause Society (BMS) Advanced Certificate in Menopause Care, can provide more advanced menopause care. This can often negate the need to refer a patient to secondary care. Of the 33 practices that responded to our survey about enhanced gynaecological care, nine (27%) reported having clinicians either with the CoSRH or BMS qualifications or are undertaking the training.

Part of the Women's Health Hub funding in BNSSG was used by practices to improve their provision of menopause care. Examples of improvements included:

- Staff training sessions on menopause.
- Funding for the BMS Advanced Certificate in Menopause Care (13)
- Review of HRT prescribing pathway to make it more effective and robust.
- Establishing group education and group consultation sessions. Out of the 8 PCNs who delivered this, 7 will continue
- Formalising in-house advice and guidance so that clinicians can contact a colleague with a special interest in menopause for advice about a patient with complex symptoms.

Access to testosterone gel is limited in primary care

For menopausal women, testosterone gel can be used for the treatment of low libido causing distress in women with optimised HRT. BNSSG prescribing guidelines only allow menopause specialists (clinicians with the CoSRH or BMS qualification or equivalent

[88] DHSC (2025) Women and Equalities Committee's first report of session 2024 to 2025: women's reproductive health conditions [see recommendation 25]

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experience) to initiate testosterone gel to ensure it is safe and appropriate. However, this does mean that many women are referred to secondary care if their practice does not have menopause specialist. Moreover, many menopause specialists in general practice do not initiate testosterone because it is not funded as an enhanced service.

Hormone Replacement Therapy (HRT) is increasing but prescribed much less for women from more deprived areas

The NHS England Women's Health Dashboard includes data on the number of HRT prescriptions over time. There has been a clear rise in prescriptions, from 10,670 in January 2023 to 15,120 in July 2025, a 42% increase. This is similar to national trends.

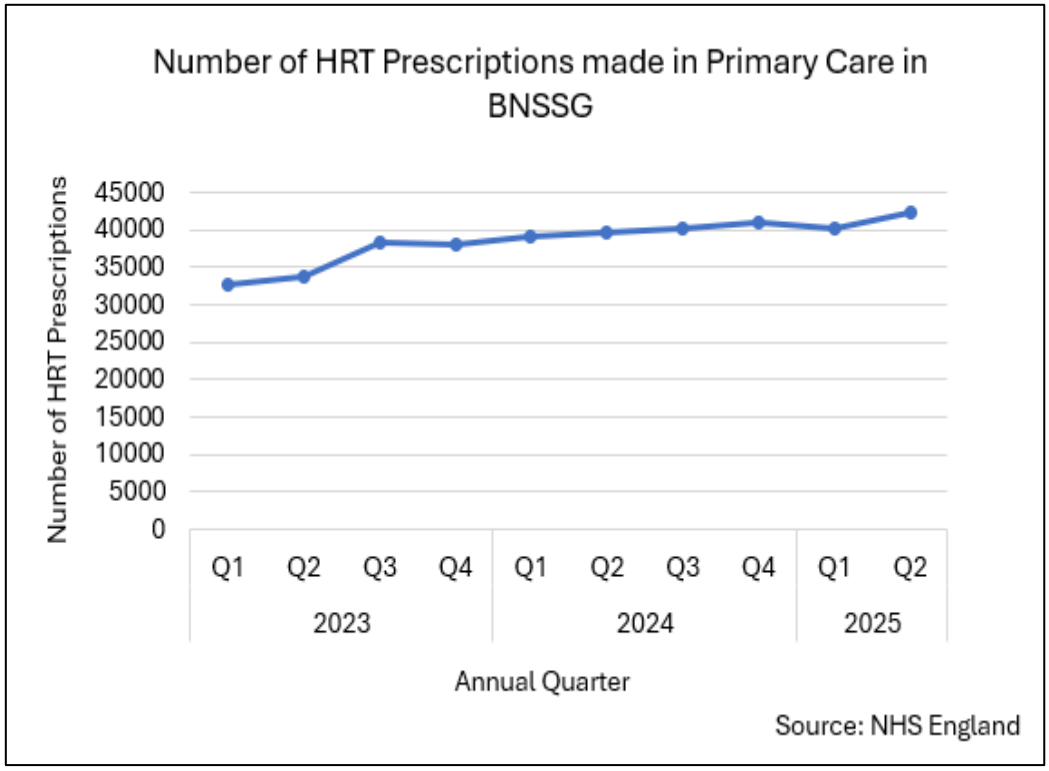


Fig 3.11: Number of HRT prescriptions in primary care in BNSSG between January and 2023 and June 2025.

The rate of HRT prescriptions are more than two times higher in the 20% least deprived (quintile 5) compared to the 20% most deprived (quintile 1). This is similar to national trends in HRT prescribing.

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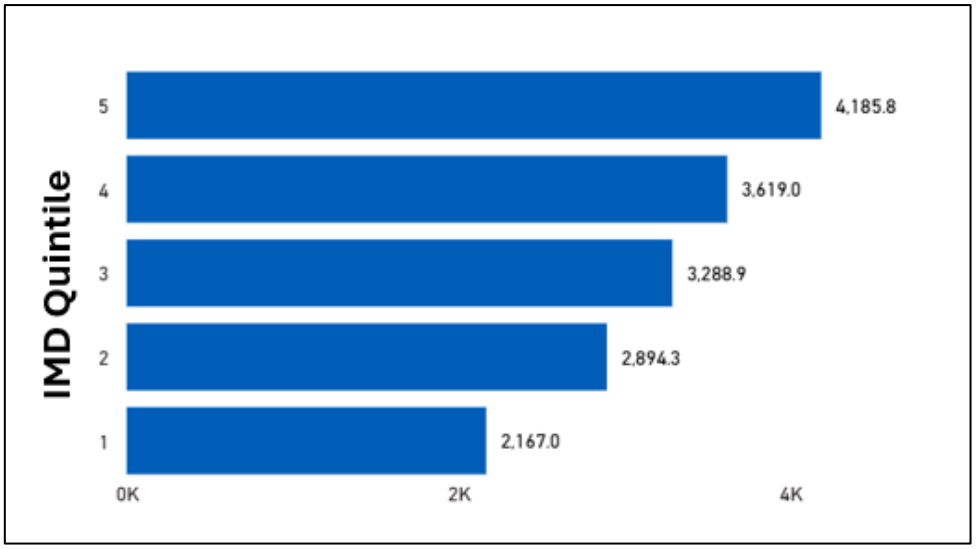


Figure 3.12: Rate of HRT prescribing by IMD Quintile (BNSSG, 2025 per 100,000 population).

Prescriptions for Heavy Menstrual Bleeding are increasing in general practice

Tranexamic acid and mefenamic acid are used to manage Heavy Menstrual Bleeding. The number of items prescribed in general practice per 1,000 registered in a GP practice in BNSSG increased from 0.91 per 1,000 in January 2021 to 1.10 in December 2025. BNSSG ranks 12 out of 42 ICBs for items prescribed per 1,000. Although this increase (which is also reflected nationally) could reflect an increasing prevalence, this is more likely to be the result of greater recognition and awareness amongst women or healthcare staff.

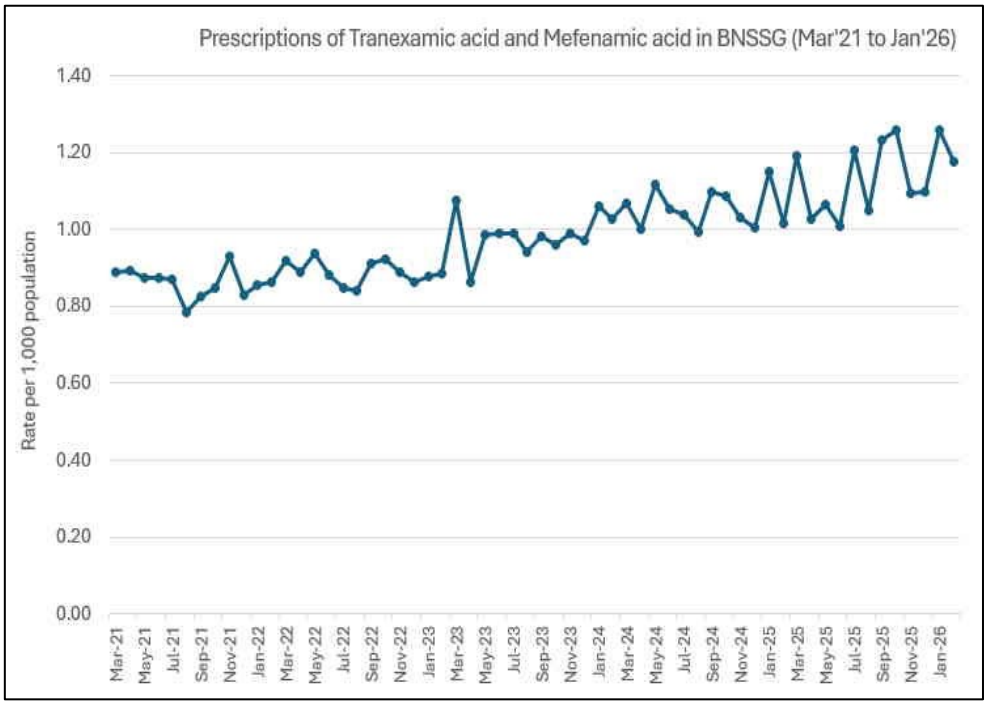


Figure 3.13: Tranexamic acid and mefenamic acid items prescribed per 1,000 patients in BNSSG. Source: OpenPrescribing, 2026.

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3.4 Referral support and direct access pathways

BNSSG Referral Support Service

The Referral Support Service for BNSSG has been hosted by the BNSSG Integrated Care Board and staffed by local clinicians and administrators. It has reviewed referrals for secondary care submitted by general practices. Following review, the service either directed the patient to the most appropriate hospital clinic, advised the referring clinician on how best to manage the condition, or recommend a more suitable alternative referral pathway. If the team were unable to review the referral within the agreed time limits, the referral was automatically directed to the hospital. Urgent and suspected cancer referrals were not sent to the Referral Support service.

The Referral Support Service has been reducing its functions in 2026 and is expected to close in autumn 2026 in line with the national changes to Advice and Guidance outlined in Section 2. Under the new NHSE guidance, BNSSG will be adopting a Single Point of Access for all referrals through e-RS and hospital teams will be responsible for reviewing the referral request, responding with advice or booking the patient in for an appointment. Gynaecology is one of the first areas expected to adopt the new process.

These services aim to ensure that referrals are appropriate, sent to the most appropriate hospital department and processed efficiently.

Remedy guidance

Remedy is a website hosted by BNSSG Integrated Care Board that outlines local referral pathways and prescribing guidelines. It supports the provision of consistent and evidence-based and timely care. It covers all conditions, and there are dedicated pages for a range of gynaecology conditions[89].

Remedy is a well-used resource by general practice and is a key mechanism for primary and secondary care clinicians to work together to update care pathways and publish them for use by all.

Community Diagnostic Centres

There are currently two community diagnostic centres in BNSSG, one in north Bristol and one in Weston-super-Mare. They provide imaging and scans as well as endoscopies and respiratory tests. GPs can directly request non-obstetric pelvic ultrasound- for example for suspected fibroids, heavy menstrual bleeding, chronic pelvic pain etc.

For unscheduled bleeding on HRT, GPs referring to NBT can request an urgent suspected cancer ultrasound and patients are then directed accordingly

3.5 BNSSG Women's Health Hubs

The national initiative to establish Women's Health Hubs referenced in section 2 did not result in the establishment of a new women's health 'hub' service in BNSSG. Instead,

[89] Healthier Together. Remedy - Gynaecology

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because the funding was one-off and needed to be spent within 18 months, the ICB ran a women's health programme that bolstered what was already provided by our local services[90]. The aim was to improve access to services, quality of care and to reduce health inequalities.

The programmed included the following areas:

Women's health in Primary Care Networks (PCNs)

Groups of general practices (PCNs) worked together to improve their women's health services. Initiatives included:

- Supporting and **training staff to fit coils and implants** (including for gynaecological reasons).
- Setting up **group education** sessions and **group consultations** on menopause.
- Improving the efficiency and effectiveness of **HRT reviews**.

Grants for VCSE organisations to support inclusion health groups

11 small grants were awarded to local voluntary, community and social enterprise organisations and community groups to deliver local, small-scale interventions. This included workshops in community settings about gynaecological symptoms, what NHS care is available and support to access it. For example:

- Bristol Community FM radio broadcast live radio shows on different women's health topics and turned them into a podcast series.
- Bristol Refugee Rights worked with a local GP to deliver 12 sessions on women's health for women and girls seeking asylum and living in hotels.
- Nilaari Agency ran five Black Women Talk Health sessions that were interactive and culturally sensitive.

See section 4.3 for a summary of the inclusion health grants evaluation.

Information on women's health and local services

A women's health resource directory was set up to bring together information and signposting to local support services. This is available on the local Well Aware website[91].

Training and information for professionals working in women's health

This involved:

- Funding a **Menopause Training** Clinic at St. Michael's Hospital for 6 GPs working in deprived areas.
- Offering a range of **online webinars** and in-person training days on contraception, pessary fitting, menopause, mental health, cardiovascular disease, and inclusive care for people with learning disabilities, trans and non-binary people, and racially minoritised groups. The webinars and training days were provided by a range of professional experts working within Bristol, North Somerset and South Gloucestershire. Over 500 people attended.

[90] Women's Health programme information - https://bnssghealthiertogether.org.uk/womens-health/

[91] Wellaware (2026) Women's Health Resources

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- **Trauma-informed practice training**, attended by over 400 people.

3.6 Gynaecology in Secondary Care

The local population is served by Bristol NHS Foundation Trust (BFT), a merger between two hospital trusts in summer 2026, that both provide a wide range of secondary care and some tertiary care services- Bristol and Weston (UHBW)[92] and North Bristol Trust (NBT)[93].

UHBW's Gynaecology services are delivered mainly at St Michael's Hospital in central Bristol and Weston General Hospital in Weston-Super-Mare. Some services are provided at South Bristol Community Hospital (pessary clinics, hysteroscopy and biopsies).

NBT's Gynaecology services are mainly based at Southmead Hospital in north Bristol, with outpatient services and access to ultrasound at some community sites including Cossham Hospital (general gynaecology), Yate West Gate Centre (pessaries only) and Thornbury Hospital (urogynaecology).

Most gynaecology services are provided by consultant gynaecologists, supported by other staff such as specialty doctors, nurses, obstetrics and gynaecology trainees, Sexual and Reproductive Health consultants and trainees. There are approximately 18 Whole Time Equivalent (WTE) Gynaecologists in UHBW and 14.5 WTE Gynaecologists in NBT.

Both hospitals offer broadly similar secondary care, and both are also tertiary centres, which means that they can see patients with more complex needs. NBT is an accredited Endometriosis Centre and UHBW has a specialist menopause oncology clinic and a paediatric and adolescent gynaecology service.

Hospital activity data is incomplete

Hospital gynaecology data is currently poorly suited to understanding gynaecological need and historically women's health conditions have been under-measured compared to some other areas of healthcare. Coding quality is often variable and symptoms may be recorded rather than underlying diagnosis. Ethnicity data is often incomplete and patient recorded outcomes such as quality of life or pain are not often captured. Data is mainly related to activity such as, admissions and referral to treatment times, and data sources used for this needs assessment. Local data, data from NHS Model Hospital, and data from the Women's Health Dashboard often don't correlate.

Referrals to Gynaecology

Menstrual disorders are the most recorded reason for referring to gynaecology in BNSSG but most referrals have no recorded reason

Referral data can provide insight into demand for secondary care. Data for referrals to gynaecology is now available from the new Women's Health Dashboard and in 2025, there

[92] University Hospitals Bristol and Weston NHS Foundation Trust (2026). Gynaecology – St Michael's Hospital: what we do.

[93] North Bristol NHS Trust (2026). Gynaecology. Bristol: North Bristol NHS Trust

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were 10,090 e-referrals to Gynaecology in BNSSG[94]. Over three quarters of referrals were for routine care (77.7%, 7835) and around one in five were urgent referrals (22.0%, 2220). The vast majority of referrals did not include a specific reason. Of those that did give a specific reason, the top reasons were:

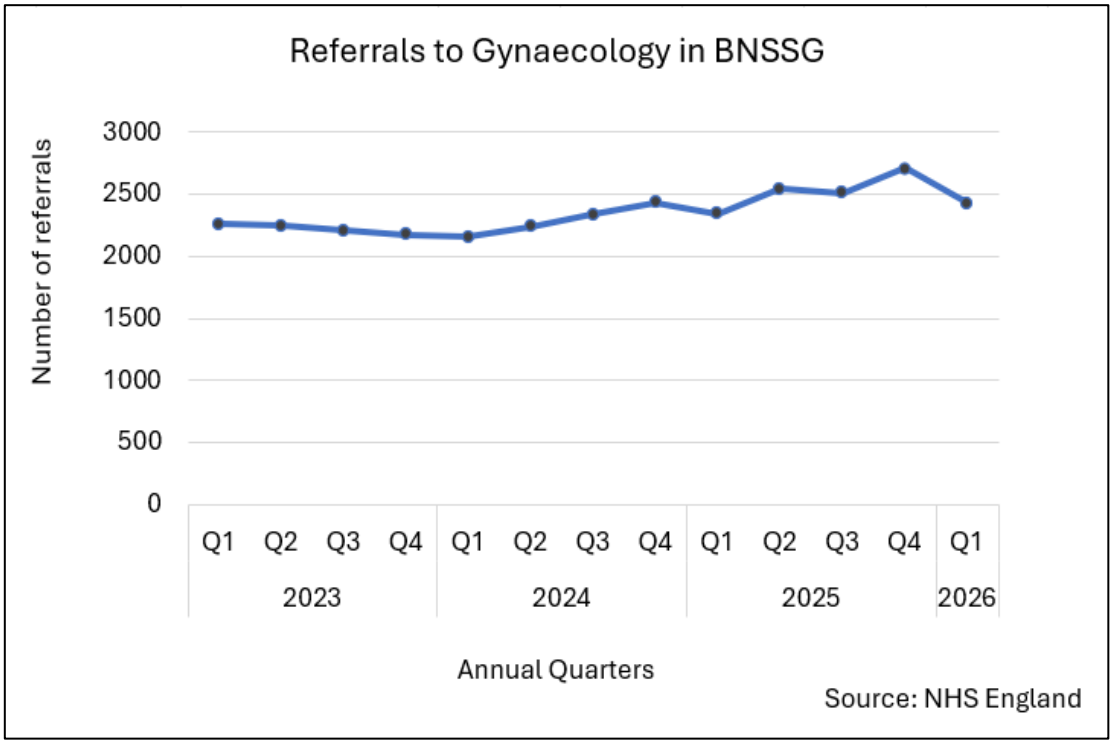
- Menstrual disorders (1765)
- Pelvic Pain (815)
- Urogynaecology/prolapse (805),
- Menopause (600)
- Colposcopy (460)

These referral numbers do not include those received outside of the e-Referral Service (e-RS). In addition to the above, our local Gynaecology departments receive a notable number of direct referrals for the pessary clinic, other hospital specialities and tertiary referrals from other hospitals[95].

Local data provided by St Michael's Hospital does not correlate with data from the Women's Health Data Dashboard, but does highlight the significant proportion of referrals that currently sit outside the e-referral process (around 35%). No comparative data was received from NBT.

E-referrals to Gynaecology are increasing

Figure 3.14 suggests that the number of referrals (via e-RS) have been gradually increasing.



[94] Future NHS (2026) NHS England Women's Health Dashboard [access for staff on request]

[95] Data from UHBW General Gynaecology manager indicates c30% received outside of e-RS.

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Figure 3.14: Number of NHS e-Referrals to Gynaecology in BNSSG over time (January 2023-March 2026). Source: NHS England Women's Health Dashboard

E-Referral rates are higher for women in the more deprived areas.

The rate of referrals to secondary care were highest for women in IMD 2 and 3 (266.7 and 261.3 respectively) and lowest for IMD 5, the least deprived quintile, at 222.6 per 100,000 population.

E-Referral rates in BNSSG are consistently much lower than peers and England

BNSSG ICB ranks the lowest rate for Gynaecology referrals to secondary care in the South West at 219.71 per 100,000 population and is lower than England (338.98). Within BNSSG referral rates are highest for South Gloucestershire (232.97) and lowest for North Somerset (206.29).

BNSSG also ranks lowest when compared to ICB peers. The reasons for this are not clear. This could be for different reasons such as:

- a data issue
- GPs are managing patients within primary care and are only referring appropriate patients (although 2024 audit did not demonstrate this)
- the E-Referral process is not so mature in BNSSG (although all GPs use E-Referral)
- the referral service is not accepting unnecessary referrals or there is lower need
- direct referrals (such as to pessary clinics and pelvic physio are included in referral numbers in other areas)
- there may be a capacity constraint limiting activity.

E-Referral rates would benefit from further exploration.

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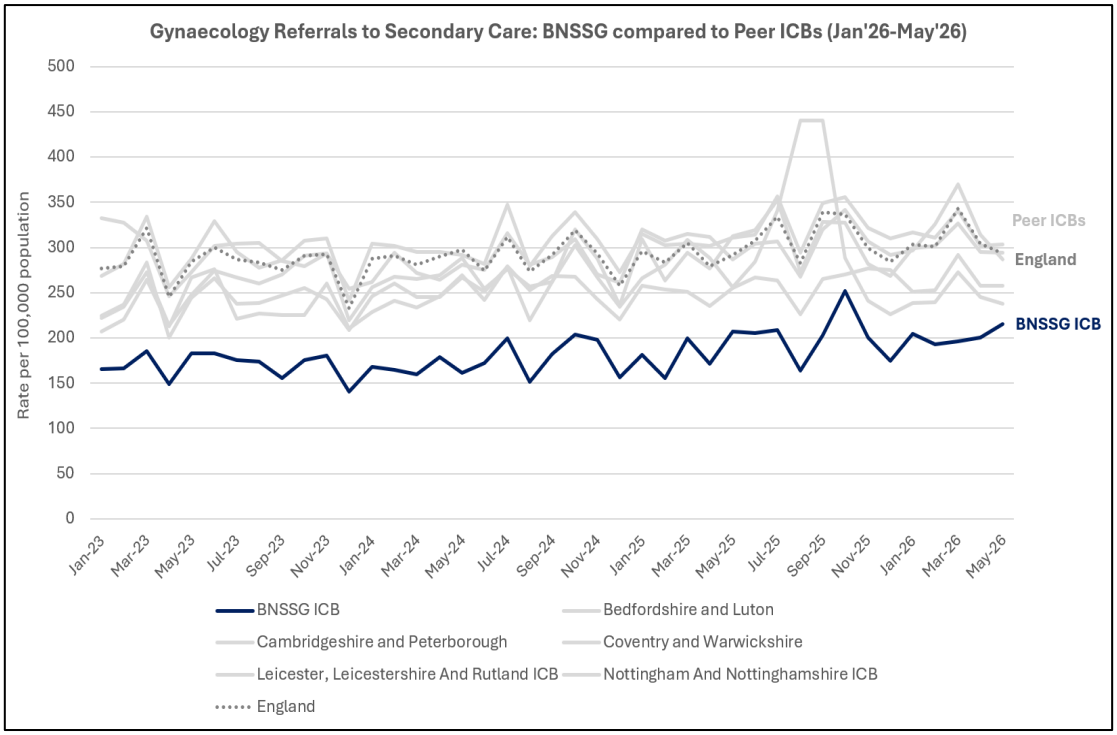


Figure 3.15: Rate of NHS e-Referrals to Gynaecology in BNSSG compared to Peer ICBs (January 2023-May 2026). Source: NHS England Women's Health Dashboard

Local Referral Audit

Audit suggests potential for community based intermediate care

In July 2024, the BNSSG GP Clinical Lead for Women's health (experienced in gynaecology and menopause care) undertook a rapid audit of GP gynaecology referrals coming through the BNSSG Referral Support Service to understand how many local gynaecology referrals could potentially be seen in a Community Gynaecology service if it existed. A small sample of 34 referrals were reviewed by the Clinical Lead alongside an administrative member of the Referral Support Service. For context, the Referral Support Service received on average 32 gynaecology referrals per day in 2024.

Key findings from the audit:

- 24/34 (71%) of the referrals were 'accepted' as appropriate and sent on to either NBT or UHBW gynaecology services[96]. 10 were not appropriate.
- Of the 24 referrals sent to a hospital gynaecology department, it was deemed that 16 (67%) could have been seen in a Community Gynaecology setting if such a service existed.
- 8/34 were appropriate for hospital gynaecology (24%).

Note: a lot of referrals do not fully reflect the complexity or number of problems that are identified on actually reviewing the patient in clinic

[96] The other 10 referrals were either sent back to the GP (for example because further information was required or the referral did not meet eligibility criteria) or sent on to the Unity (now Yuno) Sexual Health Service or Emerson's Green treatment centre.

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Conclusions from the audit:

There is potential for a Community Gynaecology Service to see patients that could have remained in primary care if reviewed by a GP with a Special Interest in Women's Health but, a larger audit of referrals with a pilot of patient satisfaction and clinic outcomes is needed first.

Outpatient activity[97]

Hospital Attendances

The rate of outpatient attendance is much lower than England

In 2025, there were 46,200 outpatient attendances for gynaecology of which 18,885 were first attendances and 27,315 were follow up attendances across BNSSG. This is around 3,850 attendances per month. The *rate* of attendances for outpatient attendances in BNSSG (1105.8 per 100,000 women aged over 15) is much lower than England (1488.0 per 100,000) over the last 12 months. This was lowest for Bristol (1081.7) and highest for South Gloucestershire (1137.2). Attendance rates for women from more deprived areas are slightly higher.

BNSSG ranks 38th out of 42 ICBs in England for attended appointments in the last 12 month period and has the second lowest rates when compared to Peer ICBs.

There is a higher and increasing number of 'non attended' appointments

There were 24,085 appointments that were offered but not attended across BNSSG during 2025. Of these, 11,175 were first attendances, and 12,910 were follow-up appointments. This includes appointments that were cancelled, rearranged or people didn't attend (DNAs). **These are higher than the rates in England** and may reflect that pathways are not working smoothly or a lack of patient choice, convenience, or access issues. Non-attendance rates are higher in women from more deprived areas.

Figure 3.16 below shows that there has been an increase over time in non-attendance for outpatient appointments.

[97] Future NHS (2026) NHS England Women's Health Dashboard [access for staff on request]

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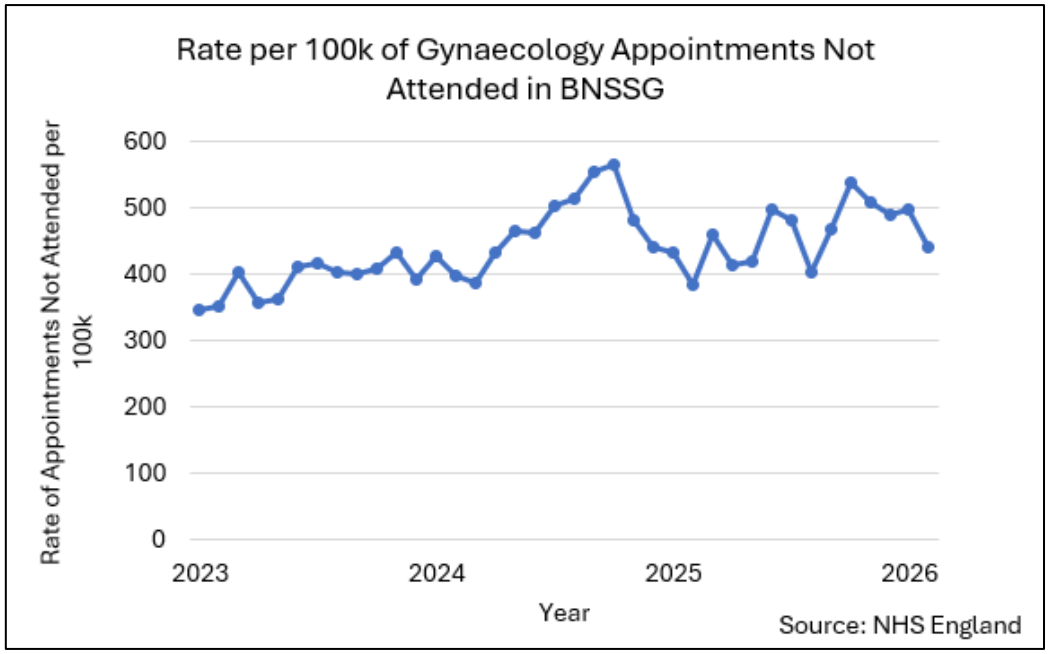


Figure 3.16: Rate per 100k of gynaecology outpatient appointments that were not attended in BNSSG over time (Jan 2023 – Feb 2026).

There are around 300 DNAs per month

The rate of true DNAs for first attendances was 5.1% (1535) and 5.1% (2060) for follow-up appointments. This equates to over 300 DNAs per month. It is not possible to compare this with peers.

A large proportion of procedures are delivered in outpatients or as a day case

Outpatient and day case procedure rates can be benchmarked against the British Association of Day Surgery (BADS) standards. These indicate the extent to which activity is being delivered in the most cost-efficient setting that is good for patient experience. BADS identifies which gynaecology procedures should primarily be delivered in outpatients or as day cases rather than as an inpatient procedure.

BADS metrics should only be used to indicate potential opportunities for further exploration, rather than definitive targets.

Our local hospitals have reviewed the Getting It Right First Time (GIRFT) guidance,[98] which includes guidance on undertaking procedures as day cases or in Outpatients. This led to changes such as more hysterectomies being undertaken as day cases and hysteroscopies in Outpatients. However, patient experiences of pain during outpatient procedures has meant that inpatient or day case procedures have been more appropriate for many patients.

For BNSSG, 88.6% of BADS-coded gynaecological procedures in patients aged over 16 were delivered in outpatient or day case settings in December 2025, compared with a peer median of 85.1% and national median of 86%.

[98] GIRFT. Gynaecology

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Pelvic Health Physiotherapy

Pelvic health physio waits are very long

This service is provided by secondary care from BFT acute trust (previously UHBW and NBT[99]). They treat a range of pelvic health conditions including prolapse, bladder and bowel issues, menopause and there is a dedicated Perinatal Pelvic Health Physiotherapy team. People can self-refer into the services which are held for UHBW at St Michael's Hospital, Weston General Hospital and for NBT at Southmead Hospital and Cossham Hospital.

Between November 2024 and October 2025 there were 3542 outpatient referrals (average of 295 per month) for UHBW pelvic physiotherapy services and 5939 referrals (average of 495 per month) for the NBT pelvic health physiotherapy service.

Waiting times are long: March 2026 data shows the average wait time for UHBW for urgent appointments is 5-6 weeks in Bristol and 3-4 weeks in Weston, and for routine care 18 weeks in Bristol and 23 weeks in Weston[100]. Average wait time for NBT for urgent appointments (April 26) is 12 weeks, and for routine 86 weeks.

A range of initiatives are in place to help deal with the waiting lists including text reminders to reduce DNAs, overbooking clinics and on-line advice, educational videos and group sessions (for prolapse, urinary incontinence and antenatal).

Despite the long waits, and initial reservations about group and online provision, feedback from patients for such interventions has been very positive.

Ring pessary fittings

Nearly all ring pessaries in BNSSG are undertaken in secondary care and rates have gradually increased over time. Fitting rates as expected are much higher for those over 75 years of age. The rate of fitting of ring pessaries overall however is lowest for those in the most deprived areas. In 2025, 2610 ring pessaries were fitted in secondary care, and 105 in primary care.

[99] BNSSG ICB. My Joint Health Hub - Pelvic Health Physiotherapy Service

[100] Healthier Together (2024) Remedy – Pelvic Health Physio

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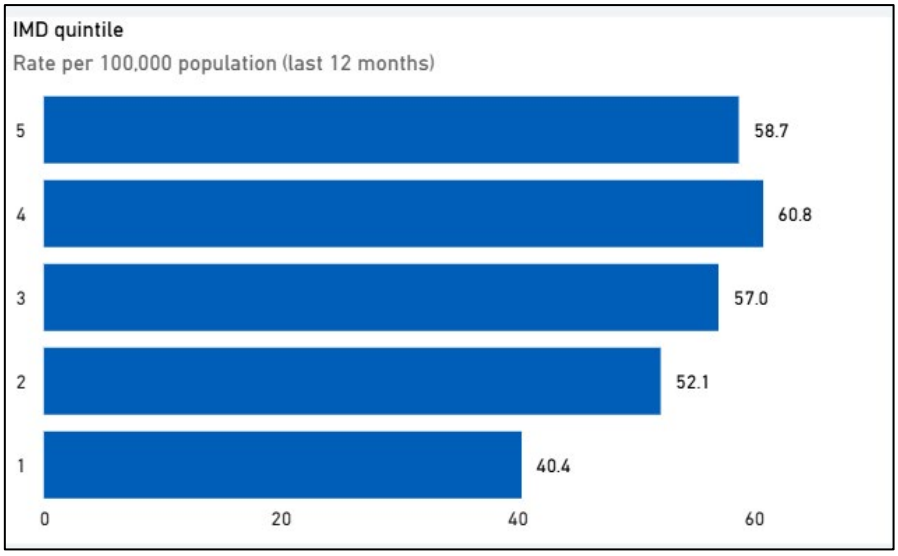


Figure 3.17: Rate of ring pessary fitting in secondary care per 100,000 population.

Gynaecology Waiting Lists

Gynaecology has one of the longest waiting times amongst all specialities nationally and locally. Some of this will be due to the backlog from Covid. Some of it may be due to better awareness of conditions such as endometriosis and menopause symptoms. Other reasons could include the level of investigations required before a treatment decision can be made, or due to workforce/theatre capacity issues including healthcare strikes.

Note: for this section data from the NHSE RTT dashboard has been used. This data differs to data published in the national Women's Health Dashboard, which shows a smaller number of people on the waiting list for BNSSG. This is due to differences in the definitions of the data.

Referral Time to Treatment (RTT): The time taken from a referral (usually GP) of a patient to a consultant-led service for non-urgent treatment, to when they start their first treatment (such as surgery or medical treatment). NHS Patients have the right to start treatment within 18 weeks from GP referral, unless they choose to wait longer or it is clinically appropriate to wait longer. The performance standard is 92%. It does not include direct access appointments such as referrals to nurse led pessary clinic or pelvic physiotherapy.

Decision to Admit (DTA): is where a clinical decision is taken to admit a patient for either day case or inpatient treatment and the patient is added to the waiting list. The DTA date is recorded

Waiting list targets are not being met, but BNSSG performs better than peers.

When compared to ICB peers, BNSSG has the highest (best) proportion of people on the waiting list that are seen and treated within 18 weeks at 70% (Range: 52.2% to 70%) and has the lowest median waiting time in weeks overall at 10.2% (Range: 10.2-17.0%). The average waiting time is 10 weeks, with the longest waits around 35 weeks (92nd Percentile). There were 17 people waiting for 52 weeks or longer (0.2%).

Waiting lists are long but are improving

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There has been a reduction in the number of people on the waiting list for Gynaecology. In the last 3 years, the highest number of people waiting for treatment for Gynaecology[101] was in January 2024 at 9,691. The latest data for March 2026 shows that there were 7,412 people waiting for treatment. This includes people waiting for their first appointment or waiting for treatment in outpatient clinics, day surgery and inpatient care.

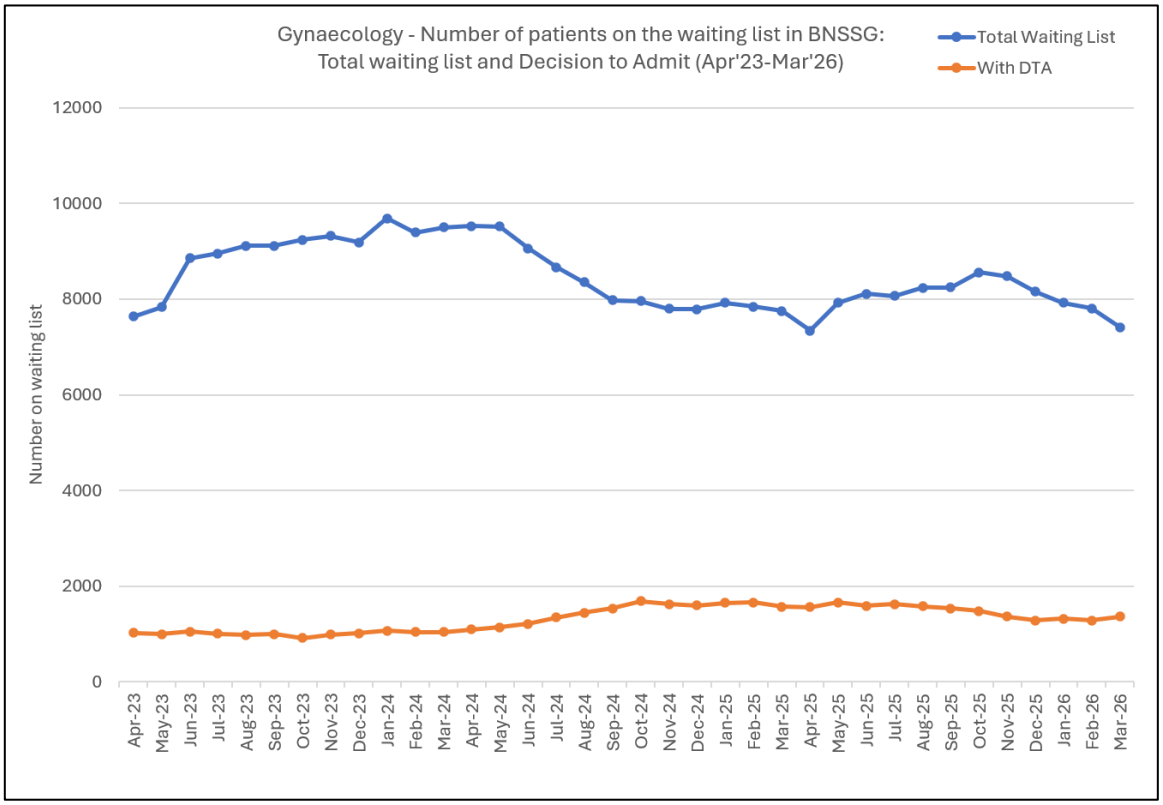


Figure 3.18: Monthly total waiting list for BNSSG ICB – Gynaecology (April 2023 to March 2026)[102]

Figure 3.18 shows that there has been a reduction in the number of people on the waiting list for gynaecology and there has been a notable decrease from October 2025 onwards.

Most people do not require surgery (don't have a 'decision to admit')

Of these people above, a proportion will have been seen by the consultant who has decided they need to be admitted for a procedure or surgery (such as hysterectomy, prolapse repair, laparoscopic removal of ovarian cyst) either as a day case or inpatient.

In March 2026, in BNSSG there were 7,412 people on the waiting list, of these, 1360 had a decision to admit (18.3%). Figure 3.19 shows that there has been an increase over time in the proportion of people who are waiting 18 weeks or less for treatment both for the total waiting list and for those with a decision to admit.

Less than half of those needing surgery are treated within 18 weeks

[101] RTT incomplete pathways represent all patients currently waiting to start consultant-led elective treatment, including both non-admitted (outpatient based) and admitted (inpatient or day case) pathways.

[102] NHSE (2026) RTT Dashboard - NHS England public data gateway [accessed 22.04.2026]

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Currently less than half of those people who need to be admitted for a procedure or surgery are meeting the 18 week target.

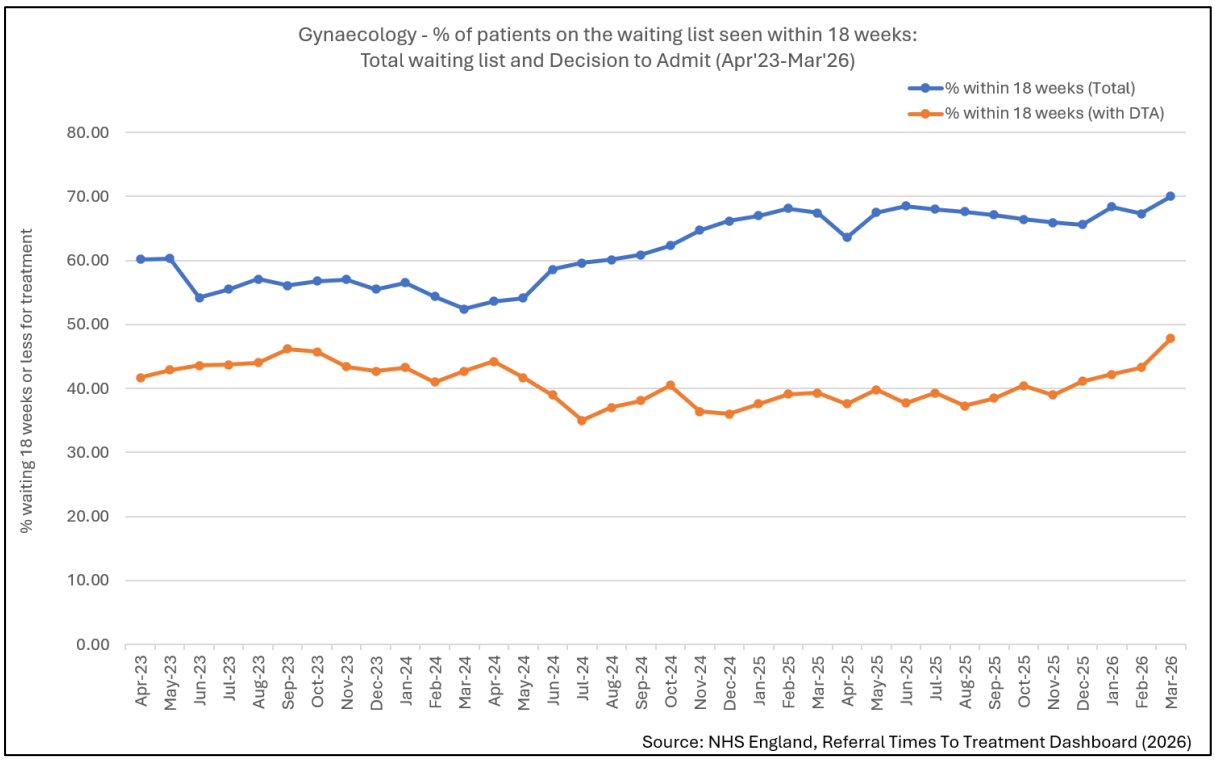


Figure 3.19: % of patients waiting 18 weeks or less for treatment in BNSSG – Total waiting list and decision to admit (Apr-23-Mar'26)

Only a small proportion of individuals referred to hospitals need a procedure. The assumption is that many of those on the waiting list for hospital care who do not have a decision to admit could be seen more quickly and effectively in a community or primary care setting. However, complex medical gynaecological conditions often do not need admission but still need specialist medical input.

Hospital Admissions

A high proportion of admissions are emergency admissions

According to Model Hospital data In Q2 2025-6, 59% of all gynaecology admissions in BNSSG were emergencies (non-elective). Whilst this is lower than peers (71.4%) it is still significantly higher than the recommended GIRFT target of 26.4%. This could indicate that there are many emergency admissions that could have been avoided with more proactive care.

Note: Although Bristol is a tertiary care cancer and endometriosis centre with more complex surgical and medical comorbidities this data just relates to BNSSG residents.

The proportion of admissions for Heavy Menstrual Bleeding (HMB) which are emergencies is high, and highest for more deprived or younger women

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The NHS England Women's Health Dashboard includes a metric on the percent of admissions for HMB that are elective or emergency. This metric can help understand how effective proactive care for HMB is.

At national level, emergency admissions for HMB (43.5%) are lower than elective admissions (56.5%). See Figure 3.20 below.

In BNSSG, there appear to be a higher proportion of emergency admissions for HMB (47.8%), and a lower proportion of elective admissions (52.2%) compared to England. There is a much higher proportion of emergency admissions amongst younger women and women from the most deprived areas.

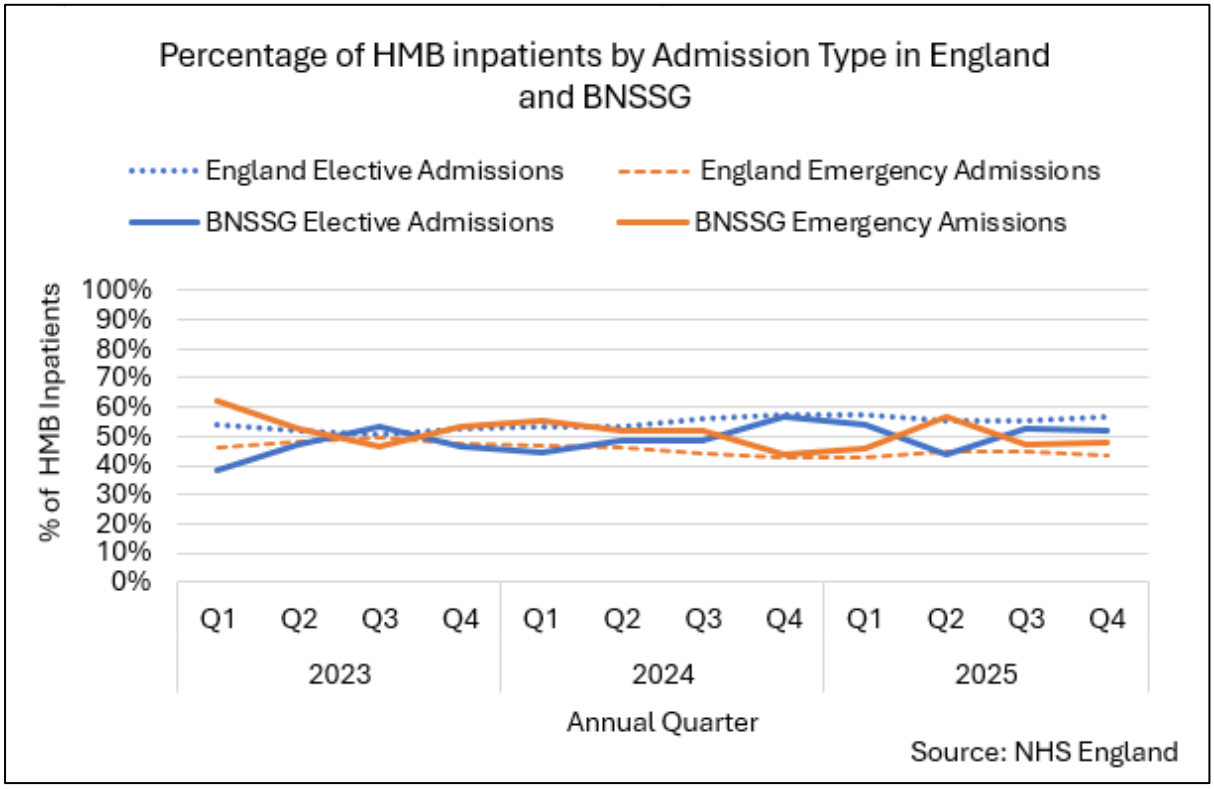


Figure 3.20: Trend over time of percentage of HMB inpatients by admission type for England and BNSSG. Data from Quarter One 2026 was removed as there is only 2 months of data available. Source: NHS England Women's Health Dashboard.

Admission rates (elective plus emergency) for endometriosis and fibroids are higher than peers

The total admission rates Q2 2025-6, are notably higher than peer ICBs:

- Endometriosis: 79 admissions per 100,000 females compared to peer average of 60 per 100,000.
- Fibroids: 88 per 100,000 compared to peer average of 61 per 100,000.

The higher rates could reflect higher prevalence or increased awareness of these conditions (Bristol hosts a tertiary service for endometriosis) or ongoing unmet need in primary care resulting in the need for more acute care or higher prevalence of these conditions or successful elective recovery post-pandemic.

Readmissions after some gynaecology procedures are common

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In BNSSG, around one in five people had a readmission for hysterectomy for benign conditions (under 50). This is higher than ICB peers. For over 50s, this rate was double when compared to peers. This has increased since pre-pandemic levels.

Readmissions after vaginal prolapse procedures was also around one in five. This is lower than ICB peers but higher than pre-pandemic levels.

Short lengths of stay are less common

In BNSSG short lengths of stay (1-2 days) are less common than in peer areas for both elective (67.4% vs 71.7%) and emergency admissions (37.6% vs 47.8%). Reducing length of stay could free up bed capacity. National benchmarking suggests that 31 bed days for vaginal prolapse and 133 bed days for abdominal hysterectomy could be saved through reducing length of stay, however again this does not account for clinical complexity nor other factors preventing discharge.

3.7 Integrated Sexual and Reproductive Health service

Yuno sexual health is the Integrated Sexual and Reproductive Health service in BNSSG[103]. It is open access and provides a wide range of services, including all forms of contraception, STI testing and treatment, and targeted, community-based interventions to support those who face greater health inequalities.

Although Yuno is not commissioned to provide general gynaecology, some individuals may present with gynaecological symptoms such as vaginal discharge (Bacterial Vaginosis and thrush), pelvic pain, or abnormal vaginal bleeding or vulval skin conditions.

The workforce includes specialist sexual health professionals including Genitourinary Medicine and Sexual and Reproductive Health consultants and doctors, nursing staff and health advisors.

Digital services

Online access to STI testing and some treatments, treatment for bacterial vaginosis and thrush, photo diagnosis of warts and herpes, condoms, emergency contraception and Pre Exposure Prophylaxis (PrEP) for HIV prevention and Doxycycline for syphilis prevention (DoxyPEP)

Clinical services

In-person clinics for STI and HIV, Hep B and Hep C tests, microscopy and STI treatment, all contraception choices including long-acting reversible contraception for routine and complex cases, opportunistic cervical screens, vaccinations for Hep A and B, HPV, Mpox and gonorrhoea

Health Promotion and Outreach

This is provided by Brook and Brigstowe and includes:

- Health promotion - through campaigns and social media

[103] Yuno website

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- Condom distribution to community settings
- Outreach to young people and vulnerable groups
- Resources for schools
- Training for professionals

The gynaecological skills within the sexual and reproductive healthcare workforce are not being fully utilised

There are currently four Sexual and Reproductive Health consultants and three resident doctors working within the Yuno Clinical service who are trained to provide gynaecological care. This includes assessment, investigation and medical management of gynaecological symptoms and conditions, including menstrual disorders and abnormal bleeding, menopause, fibroids, vulval conditions, pelvic or vulval pain and PMS. They have procedural skills in pelvic ultrasound, pessary management, vulval skin biopsy, hysteroscopy and endometrial biopsy. This skillset is not being fully utilised within the current system due to the current commissioning and funding arrangements.

3.8 Independent sector women's health services in BNSSG

BNSSG has a number of private hospitals offering dedicated women's health services (including The Spire and Nuffield Health) as well as standalone private clinics such as Bristol Menopause, the Women's Health Clinic, The May Wellness Centre, and The Lagom Clinic.

3.9 Healthcare professionals' views on gynaecological healthcare

General practice views:

Small focus groups comprising six GPs and practice nurses in total were held to understand experiences of managing gynaecology in general practice. Written feedback was also received via email. The key themes are outlined below.

There is unmet need through normalisation or dismissal of symptoms

- Some patients "**put up with" symptoms**, which may be due to societal or cultural norms and lack of confidence to seek help. This is particularly observed in more deprived communities.
- Many staff were aware of patients reporting **feeling dismissed**, particularly in relation to pain and menopause symptoms. Suggestion that even amongst excellent healthcare professionals, the societal subconscious tendency to **minimise the seriousness of symptoms** can be present.

Primary care capacity is limited

- Appointment lengths are often insufficient for more complex gynaecological care.
- Lack of continuity – women seeing various clinicians can lead to dissatisfaction

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Workforce training is inadequately funded

- **Training opportunities** are limited and often require the healthcare professional to self-fund, which restricts workforce development.

Gynaecological interventions in primary care are not funded

- Many clinicians have the skills to provide more complex gynaecological care, which can negate the need for a hospital appointment. However, interventions such as fitting a coil, pessaries, and testosterone prescribing can be considered **underfunded or unfunded in general practice**.

The lack of effective treatment for long term gynaecological conditions is challenging

- Effective management of ongoing conditions chronic pelvic pain and endometriosis can be challenging, especially if a patient struggles to manage their condition due to their circumstances.

Lack of clarity and communication around referral pathways

- **Referral pathways for non-urgent cases not always clear.**
- Changes to Remedy guidelines and referral criteria (e.g. ultrasound) **have not always been well communicated**, leading to delays and rejected referrals.

Access to services is more challenging for some groups

- It can be difficult to access interpreter services
- People in some areas (often deprived) tend **not to want to travel** out of the local area.

Long waiting times for secondary care impact on symptoms and primary care workload

- Patients with conditions such as fibroids, prolapse and heavy menstrual bleeding often experience **complications following long waits.**

Improvement suggestions:

Develop community-based intermediate gynaecology care

- There was **strong support establishing intermediate, community-based services** for common gynaecological conditions such as menopause, fibroids, chronic pelvic pain and endometriosis.
- Local provision of such clinics is important, **especially in more deprived** areas and where public transport is limited.

Provide targeted outreach for underserved groups

- Tailored, **proactive outreach** (e.g. education and clinics in community settings) to meet needs of underserved groups.

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Upskill and fund the primary care workforce to undertake investigations and interventions

- Training in ultrasound, pessary fitting and chronic pelvic pain management could enable general practice to provide more care (with requisite funding).

Provide clearer referral pathways and guidance

- Improve pre-referral guidance and have clearer pathways for gynaecology care.

Secondary Care Views

Gynaecologists, and Community Sexual and Reproductive Health (SRH) consultants and resident doctors were asked to share their views on local gynaecology care. The key themes from feedback are outlined below.

Demand is increasing faster than capacity

- Demand is increasing faster than capacity, both in terms of clinic space and staffing. This is on top of the long tail of elective recovery post-Covid 19 pandemic.
- Obstetric workload reduces trainee availability for gynaecology clinics, further limiting capacity.
- High rates of referrals for urgent suspected cancer appointments and increasing numbers of emergency admissions **displaces non-cancer** gynaecology care capacity.
- **Waits for diagnostic tests** create downstream bottlenecks.
- Demand is driven by **rising complexity and diagnostic need.**
- Referral volumes may be increasing due to **reduced gynaecology skills and provision in primary care.**
- Following the recently re-commissioning of Sexual Health services, the service no longer manages a range of gynaecological conditions including vulval disorders or chronic pelvic pain (if STIs have been excluded). This may have **shifted some demand into general gynaecology**.

Disjointed commissioning contributes to gaps and inefficiencies

- Disjointed **commissioning between the ICB and Local Authorities** contributes to gaps and inefficiencies across pathways.
- SRH consultants noted that many menstrual problems, and chronic vulval and pelvic conditions are within their competency to manage but the **Sexual Health service is not commissioned to provide this care.**

Some referrals could be managed in primary care

It was observed that there are some patients seen in hospital appointments who could be managed in general practice if the requisite staff competency and equipment and funding were in place. For example:

- Heavy Menstrual Bleeding and dysmenorrhoea: initial medical management
- Chronic pelvic pain initial management.
- Removal of cervical polyps (with requisite equipment and funding)

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What could make the biggest difference to improving gynaecology care for patients in BNSSG?

Improve access

- **Self-referral pathways** for post-menopausal bleeding to reduce delays in diagnosis.
- Continue to **increase capacity in community for diagnostics and procedures** (e.g. IUDs, implants, pessaries, ultrasound) to reduce referrals into secondary care.
- **Develop intermediate care** across all Primary Care Networks to improve access and bring care closer to home.

Commissioning and system working

- **Commission sexual health services** to manage a wider range of gynaecological conditions.
- **Strengthen joint working** between commissioners and frontline clinicians in service design and delivery.

Care delivery

- Reduce **variation in care**, particularly in menopause management.
- Support **research and digital and diagnostic innovation.**

Community gynaecology model in BNSSG could enable quicker and more cost-effective care

There was in principle support for a community gynaecology intermediate care service that could enable **quicker access to cost-effective specialist care, reduce hospital waiting lists, and provide more equitable care.**

With the requisite commissioning and funding arrangements, the **Sexual and Reproductive Health clinicians could play a key role accepting gynaecology referrals**, particularly where diagnostics (e.g. microscopy, biopsy) are required.

It was also felt that the **incoming Advice and Guidance process** (see section 2) would help to ensure that referrals are appropriate. A community gynaecology service could support with referral review and would need to integrate with the Advice and Refer process.

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4. Patient, professional and public engagement: experiences of gynaecology care in BNSSG

4.1 Summary of feedback and key issues

Many women are satisfied with the compassionate and respectful care they receive in BNSSG. Survey data indicates a high satisfaction with clinician attitude and most feel listened to and satisfaction was high where clinicians took time, explained conditions clearly and expressed empathy.

High confidence was expressed with more specialist clinical care. Women consistently reported higher confidence and satisfaction when seen by gynaecologists or GPs with additional women's health training rather than by generalists such as pharmacists. They also expressed that continuity of care with the same clinician was important.

Improvements in menopause, trauma informed and inclusive care. Compared to other areas, menopause care tended to receive higher satisfaction ratings – the recent investment in menopause support may be having a positive impact. People attending appointments with perimenopausal symptoms at a younger than average age tend to have poorer experiences. Some patients with previous trauma reported feeling supported and respected. There were also some examples of inclusive care for LGBTQ+ individuals, including awareness of pronouns and sensitivity to individual needs.

Alongside these strengths, the feedback highlights several recurring challenges and significant variation in experience of care, which is often dependent on individual clinicians. These issues are seen across survey data, free text responses, and focus group discussions.

Normalisation of symptoms is leading to unmet need and significant impact on wellbeing

Many women experience significant gynaecological symptoms, particularly for pelvic health but do not seek help. This is driven by normalisation of symptoms, lack of awareness of what is treatable, and uncertainty about how to access care. Some women also report feeling they do not want to waste clinicians' time.

Many women describe living with debilitating symptoms which have a significant impact on daily life, work, relationships, and mental health, as well as feelings of isolation and loneliness.

Feeling dismissed

A dominant theme is feeling dismissed or not taken seriously, particularly regarding pain. Symptoms are often described as being normalised or minimised by clinicians, which undermines trust and discourages further help-seeking.

Access barriers and long waits contribute to worsening symptoms

Long waiting times for specialist care, and pelvic health services are a major concern. These delays contribute to worsening symptoms, significant impacts on quality of life and work, and increased anxiety. Poor communication while waiting further compounds this issue- participants wanted more clarity on waiting times and what to expect during the care

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pathway. This is further exacerbated by **challenges navigating the healthcare system** – such as which service to access and how to get in contact. Some women seek private care as a result.

Poor communication and insufficient information

Women report insufficient information at all stages of care, including while waiting for appointments, during consultations, and after treatment. Patients prefer clear verbal explanations from clinicians supported by culturally relevant written or digital information. Being able to talk it through with someone has significant therapeutic value. Some found communication pre- and post-appointments lacking, for example what happens with test results or what to do if symptoms worsen.

There is strong desire to understand the cause of symptoms

A number expressed a need to understand the cause of their symptoms but not all clinicians were supportive of this need, and some explanations were seen as too technical.

Variation in perceived healthcare expertise reduces trust

There is wide variation in the perceived expertise of healthcare professionals, particularly in general practice. Women report higher confidence in specialists or GPs with additional training, and lower confidence in generalists and pharmacists.

Lack of adequate pain relief for painful procedures

Some women report painful procedures such as coils or hysteroscopies or internal examinations without adequate pain management or trauma-informed care. These experiences can lead to fear of future care, reduced trust and disengagement from services. This was particularly noted in feedback from Black and Mixed Black women and young people.

Dissatisfaction with the limited range of treatments offered

Although many women reported positive interpersonal experiences with clinicians, satisfaction with treatment and outcomes was considerably lower. This was starker for menstrual and womb health and early menopause symptoms compared to pelvic health and menopause overall. Many people were concerned with under-treatment (some with over-treatment), and many do not want hormonal treatments or do not understand why they are being offered them.

Navigating follow-up care and support after hospital treatment can be hard

People reported feeling left on their own to manage their condition with changing symptoms, side-effects, understanding results and knowing if pelvic exercises were being done correctly. Contacting services to speak to a specialist or make an appointment can often be difficult.

Barriers to care are greater in some minoritised groups

Barriers to care are greater for some groups, including minoritised ethnic communities, LGBTQ+ individuals, and younger people. Experiences of racism, stigma, and lack of culturally appropriate care affect trust and access to services. Positive suggestions to address this include outreach services in safe community settings, inclusive language and trauma-informed practice.

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A desire for better preventative and proactive care with peer support

A number of people highlighted their desire for more proactive and preventative care with particular mention of annual checks, online options for information, and some wanting access to groups for support.

4.2 Gynaecology Healthcare Needs Assessment Public Survey 2025/26

As part of this Needs Assessment a short survey was used to collect public and patient experiences. The survey was for anyone living in BNSSG and had at least one of the following:

- Heavy, very painful or irregular periods
- Perimenopause or menopause
- Bladder incontinence
- Prolapse
- Other gynaecology symptoms (e.g pelvic pain not related to periods)

The survey was available to be completed electronically between 2nd December 2025 and 18th January 2026 and was promoted via several networks and groups. This included:

- BNSSG Women's Health Network of professionals in health and care.
- BNSSG GP bulletin to general practice staff which prompted some practices to send text messages to their patients.
- ICB social media.
- Local radio Bristol Community FM on Real Women Talk Health 16th December 2025.
- Six VCSE organisations were funded £500 to actively promote and support people to complete it - Nilaari Agency, C'aafi Health, Safe Link. a Roma Group, Refugee Women of Bristol and BSB Better Together. This aimed to increase responses in traditionally underserved groups.

A total of 4,434 people completed the survey, with 4,284 people included in our final sample.

Survey respondent demographics

The survey respondents are not a representative sample of the BNSSG population therefore the findings should be treated as a point of discussion rather than definitive evidence. As expected, there were a higher proportion of female respondents than representative of the population. However, there were also a smaller proportion of responses from ethnic minority groups compared to the BNSSG population, especially for the Asian/ Asian British group. Responses to questions have been broken down by demographics where a significant difference between groups was noted.

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Sex, gender and sexual orientation

- 95.4% of respondents reported their gender as Female. 3.7% were Unknown, and less than 1% as non-binary or male.
- 95.4% of respondents reported their gender as the same as the gender they were assigned at birth.
- 85.6% of respondents were Heterosexual, 5.7% Bisexual, queer or pansexual and 1.9% Gay or Lesbian. The remaining were Unknown (6.8%).

Ethnicity

The majority of respondents reported their *broad* ethnic group to be White (87.6%), 3.1% were Black, African, Caribbean or Black British, 2.9% Asian or Asian British and 2.36% Mixed or multiple ethnic groups. A small proportion did not report ethnic group (4.1%).

Respondents were also given the opportunity to report detailed ethnic groups which are reported in Table 4.1, but not all respondents answered this question.

Table 4.1: Detailed ethnic group breakdown of survey respondents.

Ethnic group (detailed)	Percent
Asian: Bangladeshi	0.2%
Asian: Chinese	0.4%
Asian: Indian	0.9%
Asian: Pakistani	0.7%
Black: African	1.8%
Black: Caribbean	0.7%
Mixed: White and Asian	0.6%
Mixed: White and Black African	0.2%
Mixed: White and Black Caribbean	0.5%
White: Gypsy/Irish Traveller	0.1%
White: Irish	0.6%
White: Roma	0.1%
White: UK/British	76.7%
Unknown	16.5%

**Note Unknown category is just for detailed ethnic group, the missingness in higher level groups is <5%, but we cannot ascribe categories to the lower-level groups based on those responses.*

Long term conditions

45.5% of respondents report having a physical or mental health condition or illness lasting or expected to last 12 months or more. Those that answered yes were asked about the impact this had on their ability to carry out day –to-day activities; 21.8% stated ‘a lot’, 42.4% stated ‘a little’, with the rest reporting they were unaffected.

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Location

Responses were received from 34 out of 43 postcode areas in Bristol, North Somerset and South Gloucestershire.

Problems reported and seeking NHS care

Many respondents reported having more than one gynaecological symptom or condition.

Many people reported not seeking help for their problems from the NHS. People could then select a reason why:

- I didn't feel I needed help from the NHS.
- I didn't know these symptoms might be due to the menopause
- I was dealing with other things in my life.
- I didn't know that I could get medical help.
- I didn't know which NHS service could help me.
- I was worried about what was happening to my body and what it might mean for my health.
- I was worried about what might happen at the appointment
- I paid for private healthcare.
- Other – please describe.

Although a significant number of people reported that they did not feel they needed help, this needs to be considered in the context of some lack of awareness of what gynaecological symptoms are "normal" and what treatments are available. On the other hand, a significant number of people entered a free text response about not seeking help because they did not think the NHS would take their problems seriously and/or it was too much difficult to get an appointment.

Periods

48.8% of all respondents reported problems with periods in the last two years. The age group which reported most problems with periods was 31-44 years. The majority of people reported multiple different period problems (45%), followed by irregular periods (23.3%), heavy periods (18.6%) and painful (13.2%).

63.6% of people sought help for their period problems. For those who didn't seek help, the most common response was that they didn't need help from the NHS for their problems or that **they didn't know that they could get help or which NHS service to access.**

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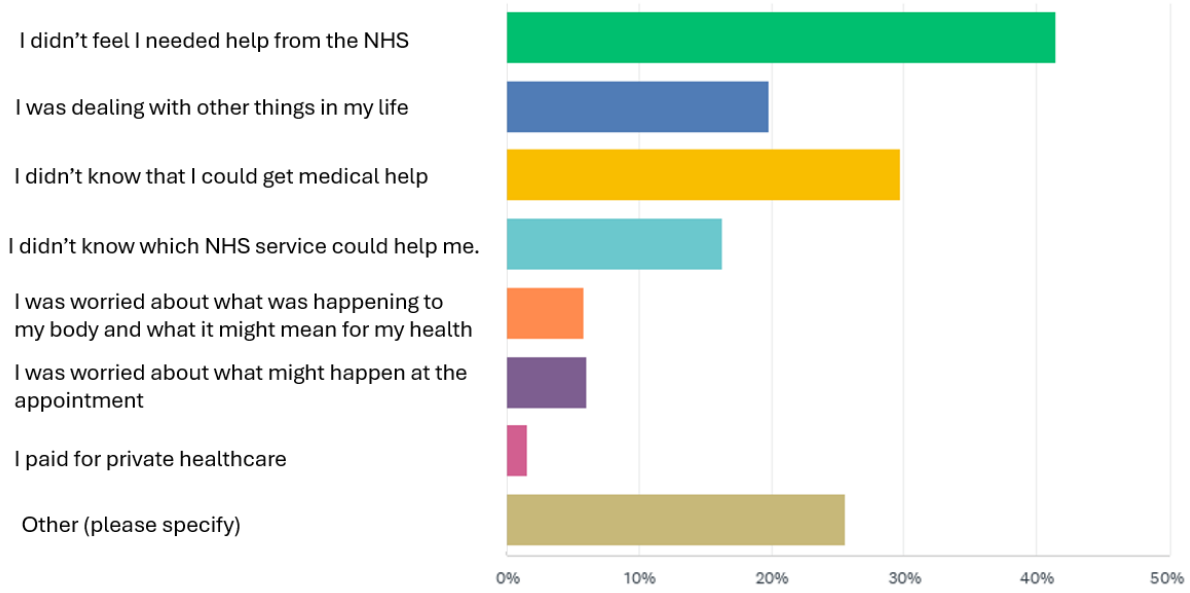


Figure 4.1: Reasons given for not seeking help for period problems (n = 747). Source: BNSSG ICB Survey Monkey.

Menopause

61.2% of all respondents reported problems with menopause in the last two years.

Of those who reported having problems 36.8% were 45-54 years, 25.9% were 55-64 years, 22.1% were 35-44 years and 8.1% were 65-74 years.

63.0% of people sought help for their menopause problems. The primary reasons given were not needing help from the NHS (30.6%) or were dealing with other things in their life (24.3%).

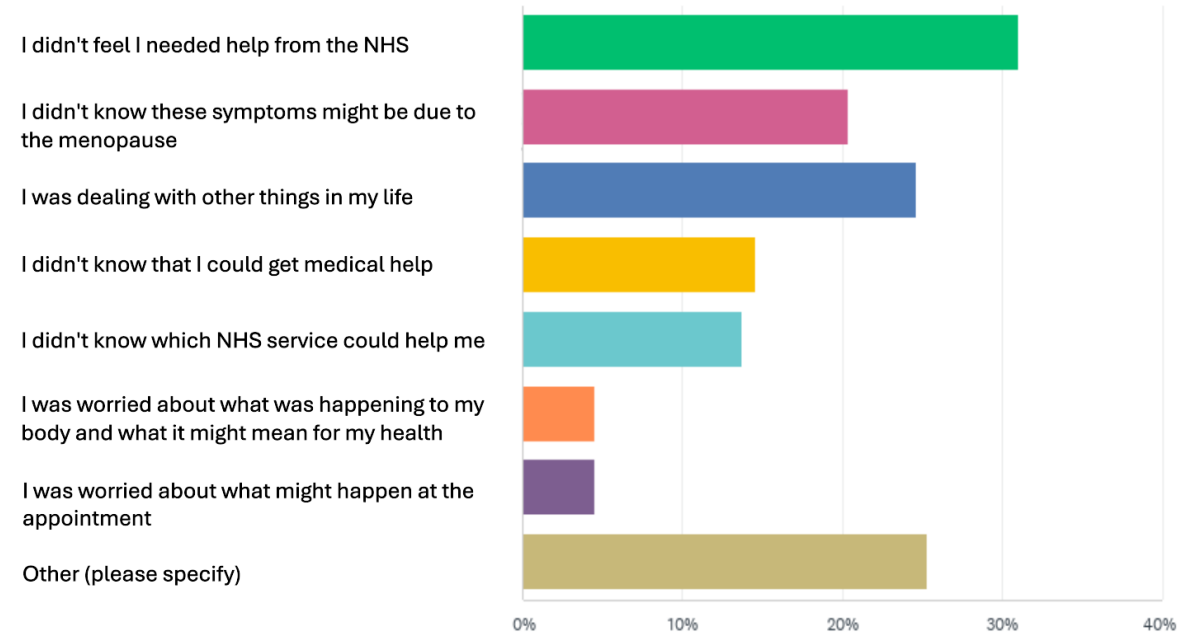


Figure 4.2: Reasons given for not seeking help for menopause problems (n = 967). Source: BNSSG ICB Survey Monkey

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Pelvic health

50.4% of all respondents reported pelvic floor problems in the last two years.

Less than half of respondents with pelvic health problems sought NHS help (41.6%). Of those that didn't seek help, the primary reasons were the same as for menopause: not needing help from the NHS (35.3%) or were dealing with other things in their life (30.4%).

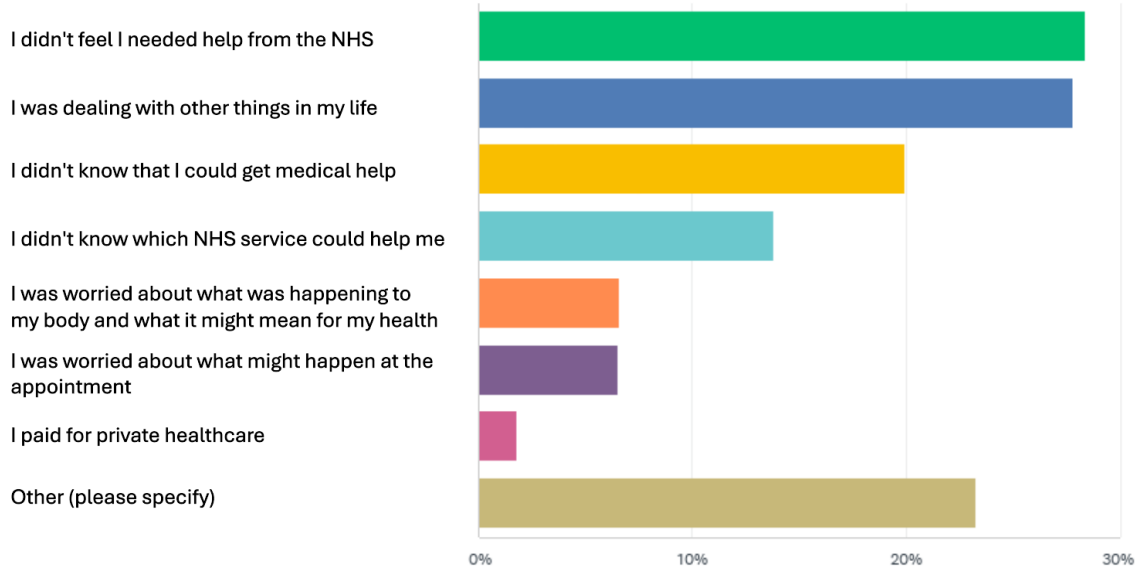


Figure 4.3: Reasons given for not seeking help for pelvic health problems (n = 1,276). Source: BNSSG ICB Survey Monkey

The pelvic health physiotherapy service is for simple pelvic health conditions and is open to self-referral. Only 8.6% of respondents had an appointment in the last two years in the pelvic health physiotherapy or bladder and bowel service that provides non-surgical treatment.

Other gynaecological problems

44.8% of all respondents reported other gynaecological problems in the last two years. The 'other' category was described as symptoms such as irritation in the vagina or vulva, pelvic pain not related to periods, lumps and bumps or discharge from the vagina that is not wee. The high number of respondents to this question and analysis of the free text responses suggests that these responses include people reporting conditions such as endometriosis, adenomyosis, PMOS and fibroids.

27% of respondents reported not seeking help from the NHS. Similar to the previous, most people said they did not feel like they needed NHS help.

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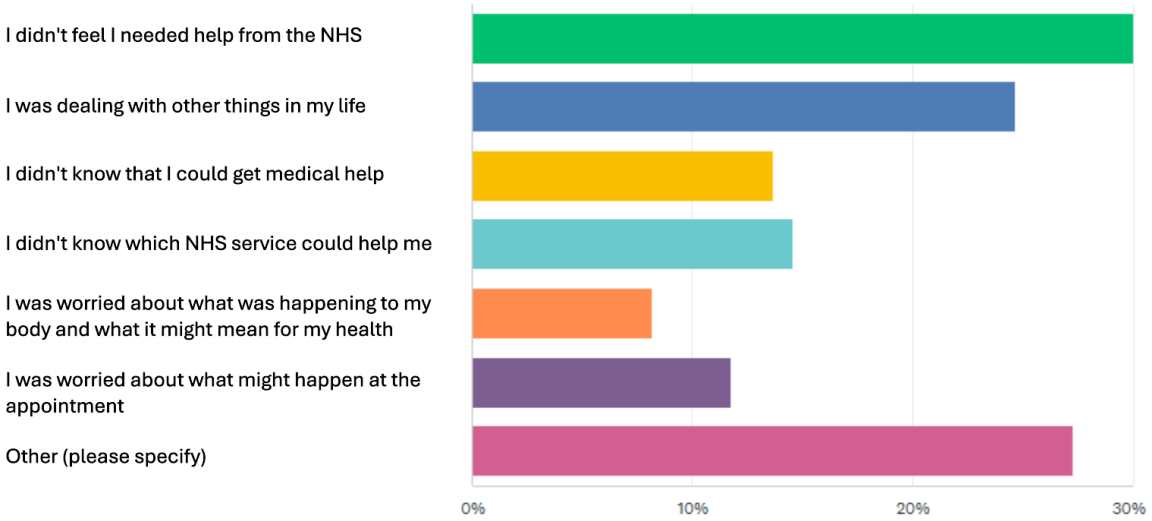


Figure 4.4: Reasons given for not seeking help for other gynaecological problems (n = 527). Source: BNSSG ICB Survey Monkey

The survey asked which NHS service people sought help from for these problems. Table 4.2 shows the responses. Over half (56.2%) sought help from their GP. The 'Other' category reflects any other source of help and people could enter free text. Private healthcare was frequently mentioned, with a smaller number of mentions for pelvic health services, community pharmacy 'over the counter' medications and online advice.

Table 4.2: NHS service people reported they sought help from for their gynaecological problems

Location	Percent (%)
Emergency department	1.5%
GP	56.2%
Other	32.5%
Pharmacist	3.4%
Sexual health clinic	6.4%

General Practice care

For those who sought help from their general practice for periods, menopause, pelvic floor or other problems, respondents indicated how satisfied they were with their experience on a scale of 1 to 5 through the following questions:

Thinking about your most recent appointment at the GP practice...

- How satisfied were you with the knowledge of the healthcare professional?
- How satisfied were you with the attitude of the healthcare professional?
- How satisfied were you with the treatment and/or advice you received?

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Note: all graphs is the following section use the scale outline in Figure 4.5, from very dissatisfied to very satisfied.

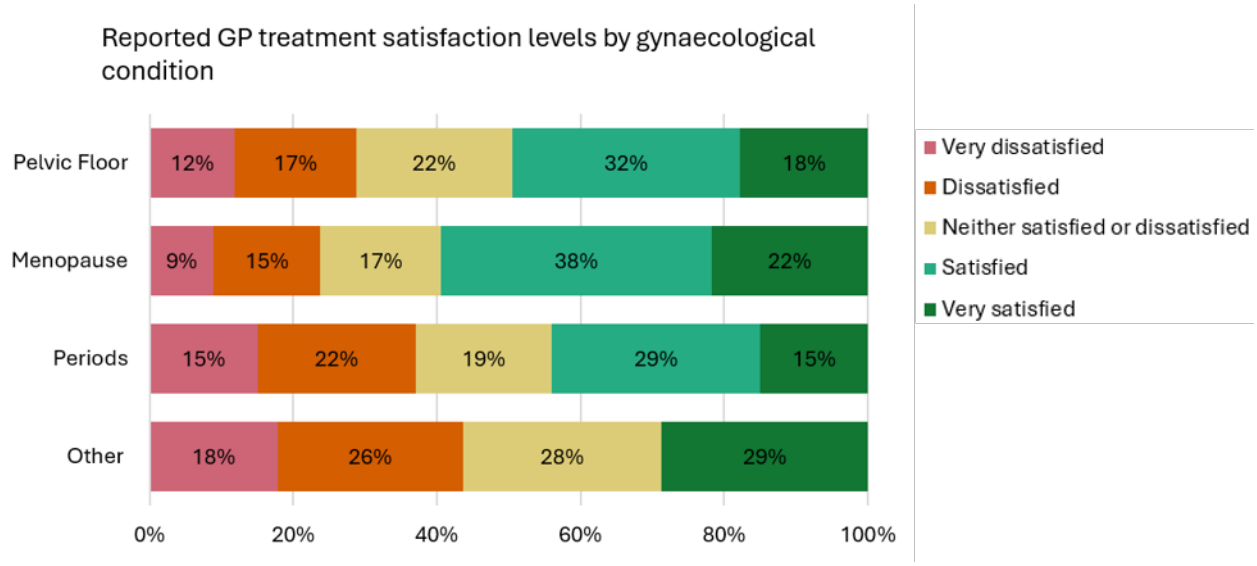


Figure 4.5: Respondents experiences of GP treatment for primary care help sought for pelvic floor, menopause, periods and other gynaecology problems. Source: BNSSG ICB Survey Monkey.

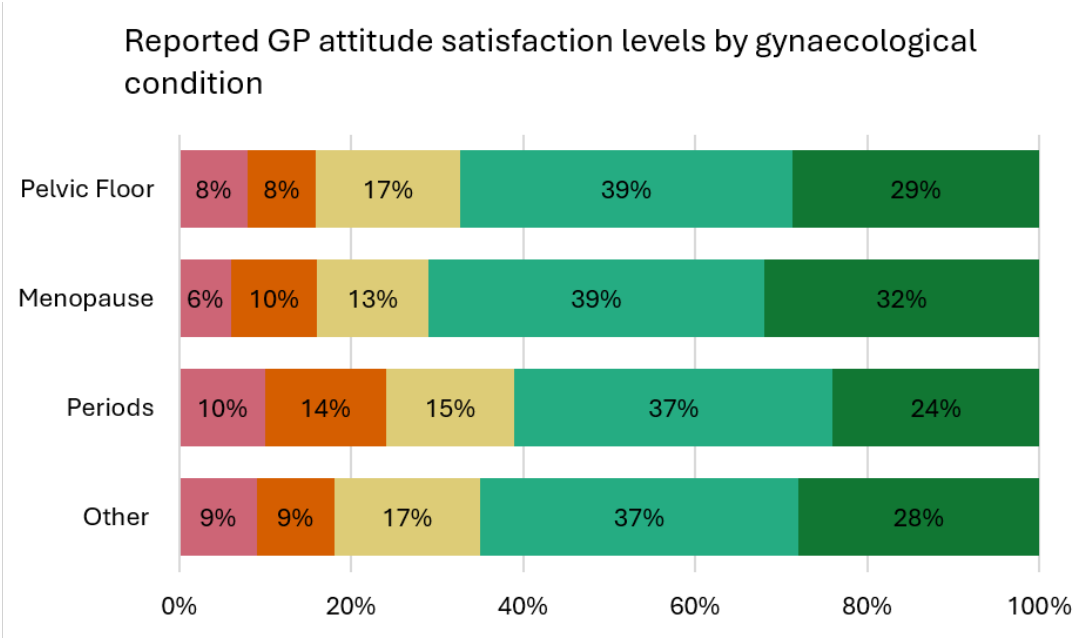


Figure 4.6: Respondents experiences of GP attitude for primary care help sought for pelvic floor, menopause, periods and other gynaecology problems. Source: BNSSG ICB Survey Monkey.

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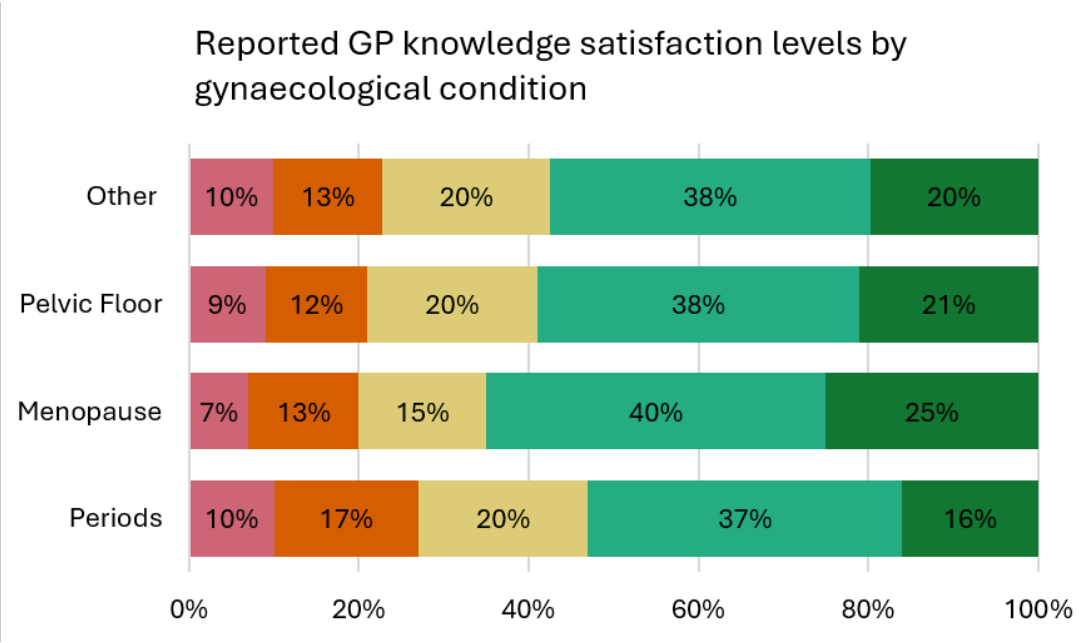


Figure 4.7: Respondents experiences of GP knowledge for primary care help sought for pelvic floor, menopause, periods and other gynaecology problems. Source: BNSSG ICB Survey Monkey.

Overall, the **majority of respondents were satisfied or very satisfied** with the care they received. The highest levels of satisfaction were with menopause care, and the lowest were with period care. Table 4.3 below pulls out the number of **dissatisfied or very dissatisfied** respondents across the conditions.

Table 4.3: Proportion of respondents dissatisfied or very dissatisfied with care

	Knowledge	Attitude	Treatment
Periods	27%	24%	37%
Menopause	20%	16%	24%
Pelvic health	21%	16%	29%

Across all problems, the least satisfaction was reported with treatment. The analysis of the free text responses to the survey illustrates some of the reasons for this.

It is notable that **most respondents report satisfaction with the attitude of their healthcare professional**, given the well-documented concerns nationally of women feeling dismissed, not taken seriously or not listened to. The challenge remains to ensure that all women have good access to supportive care.

Variation in satisfaction by demographic

Analysis of responses by ethnicity, age and gender identity generally did not reveal significant differences to the overall picture. There two differences that are summarised below. The small number of respondents mean that findings should be treated cautiously.

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Menopause and age: Although menopause care shows the highest levels of satisfaction overall, people reporting perimenopause/menopause aged 35-44 years (n=219) were notably less satisfied with their care, outlined in Figure 4.8 below. This chimes with the concerns raised in the free text survey responses about feeling dismissed and not being satisfied with the treatment options offered.

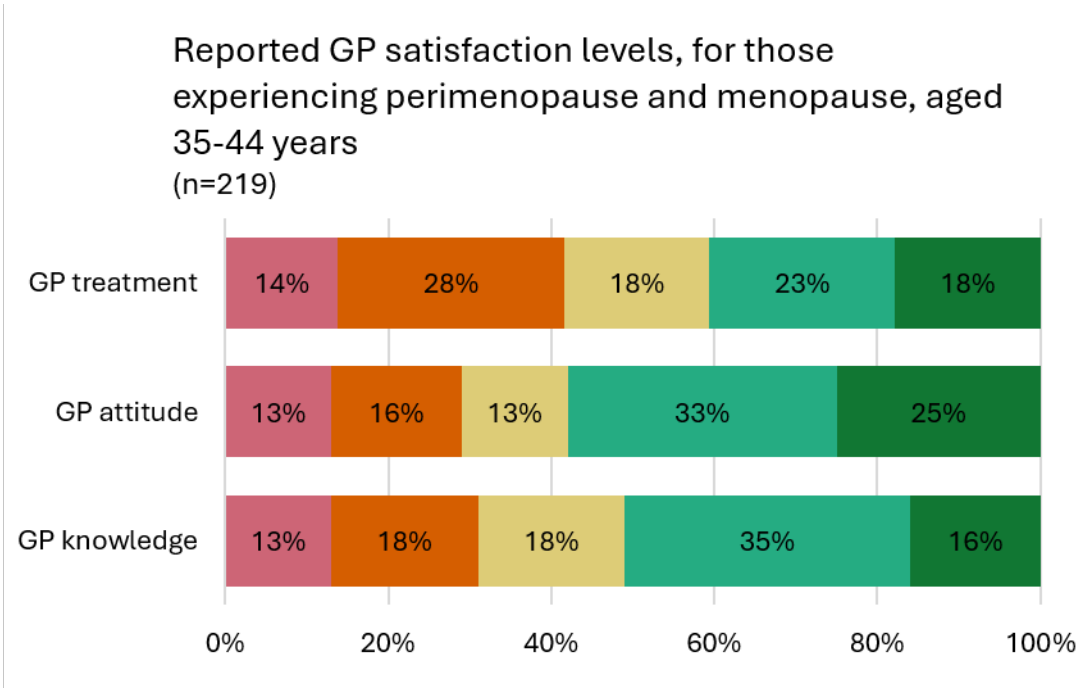


Figure 4.8: Respondents experiences of GP treatment, attitude and knowledge for those reporting perimenopause/ menopause aged 35-44 years in BNSSG. Source: BNSSG ICB Survey Monkey.

Periods and gender identity: For people who have a different gender identity to sex assigned at birth, satisfaction with knowledge and attitude of clinicians was broadly similar to the overall picture. However, for treatment and advice, there was more dissatisfaction:

There were 22 responses.

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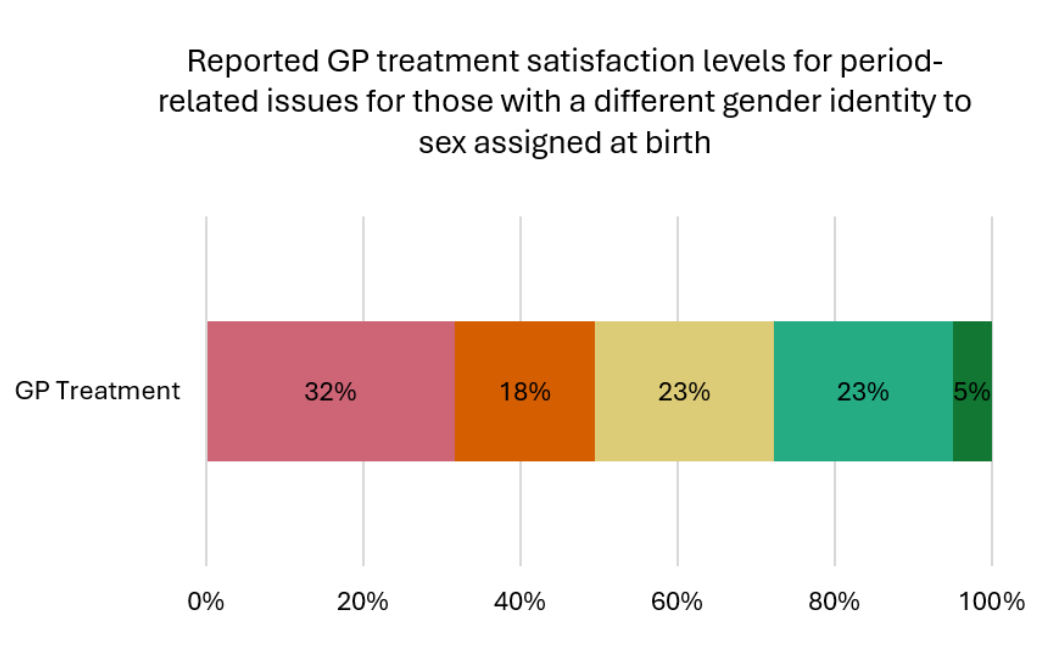


Figure 4.9: Respondents experiences with GP treatment for period-related conditions, for individuals with a different gender identity to their sex assigned at birth in BNSSG. Source: BNSSG ICB Survey Monkey.

Hospital care

Overall Satisfaction with Hospital Care

27.9% of respondents had a hospital appointment at Southmead Hospital (NBT), St Michael's Hospital or Weston Hospital (UHBW) or Emerson's Green in the last two years for their gynaecology symptoms.

The majority of people were satisfied or very satisfied with their care. As with GP care, the least satisfaction was with the treatment and advice received.

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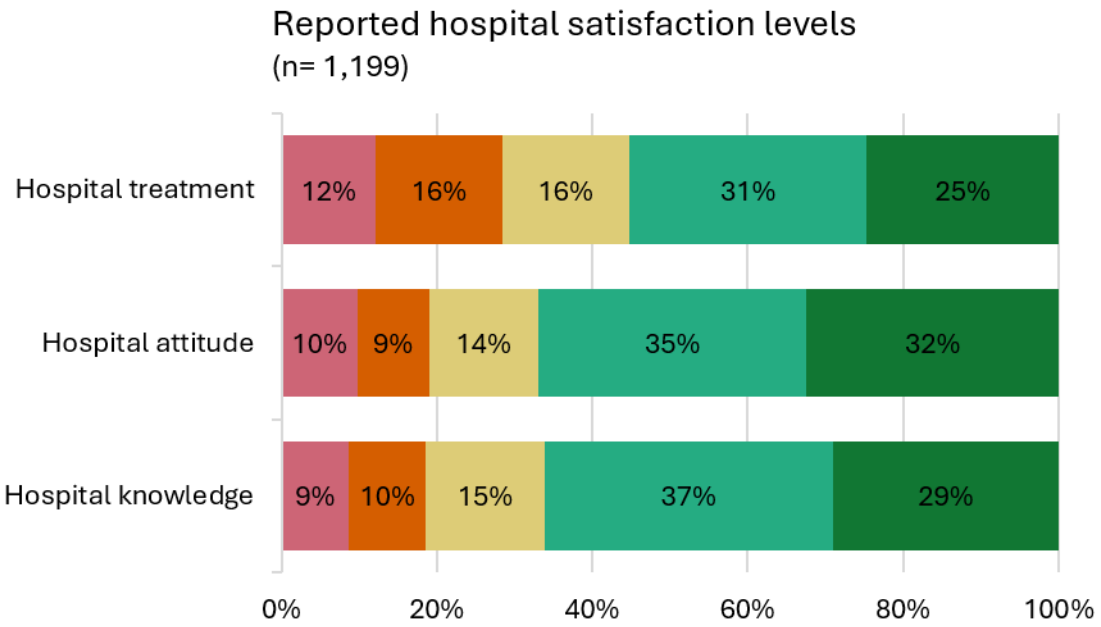


Figure 4.10: Respondents experiences of hospital treatment, attitude and knowledge in BNSSG. Source: BNSSG ICB Survey Monkey.

Given the large number of respondents who have received care, we've reported satisfaction by age group and ethnic group in Figures 4.11-4.16.

Satisfaction with Hospital Care by Age Group

Broadly, **satisfaction with hospital care is higher in older age** groups. The lower satisfaction in younger women could be related to menstrual and womb health care, as this tallies with the lower satisfaction in general practice and the themes arising from the free text responses around concerns with hormonal treatment and the desire to understand causes of symptoms. The number of respondents in the 13-17-year-old group is low, so these should be interpreted with caution.

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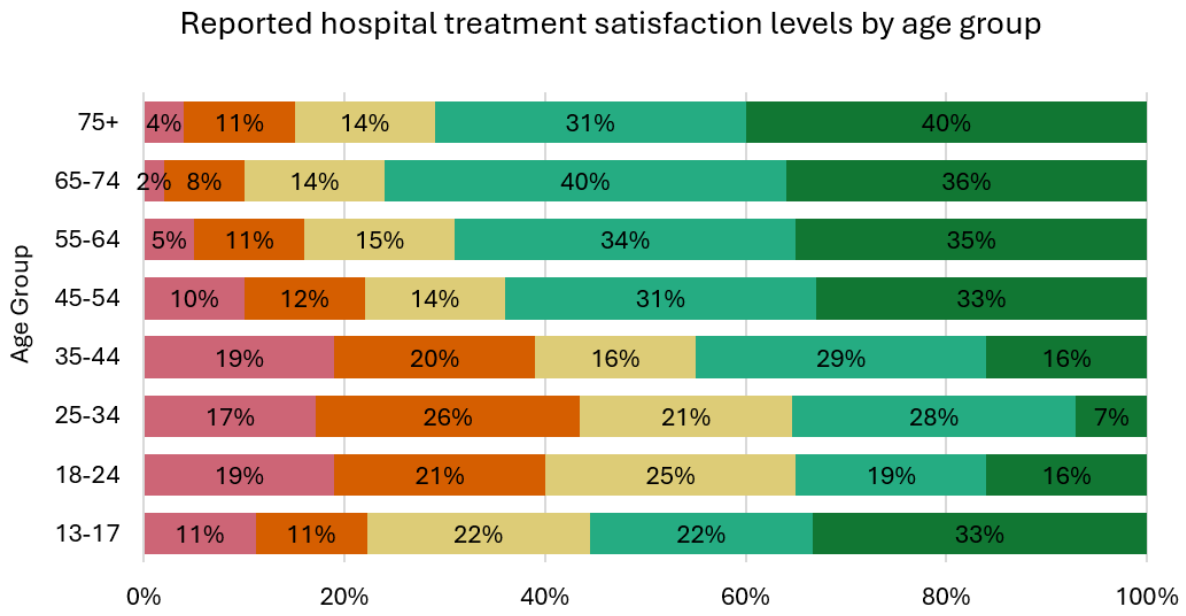


Figure 4.11: Respondents experiences of hospital treatment by age group in BNSSG. Source: BNSSG ICB Survey Monkey.

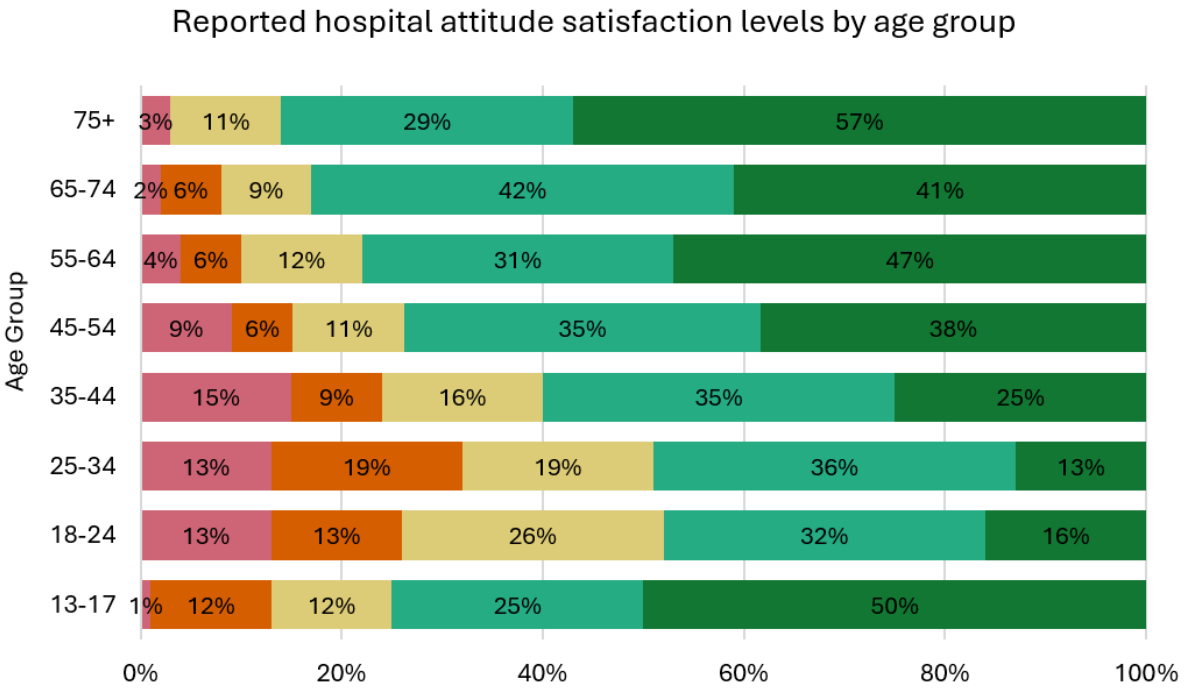


Figure 4.12: Respondents experiences of hospital attitude by age group in BNSSG. Source: BNSSG ICB Survey Monkey.

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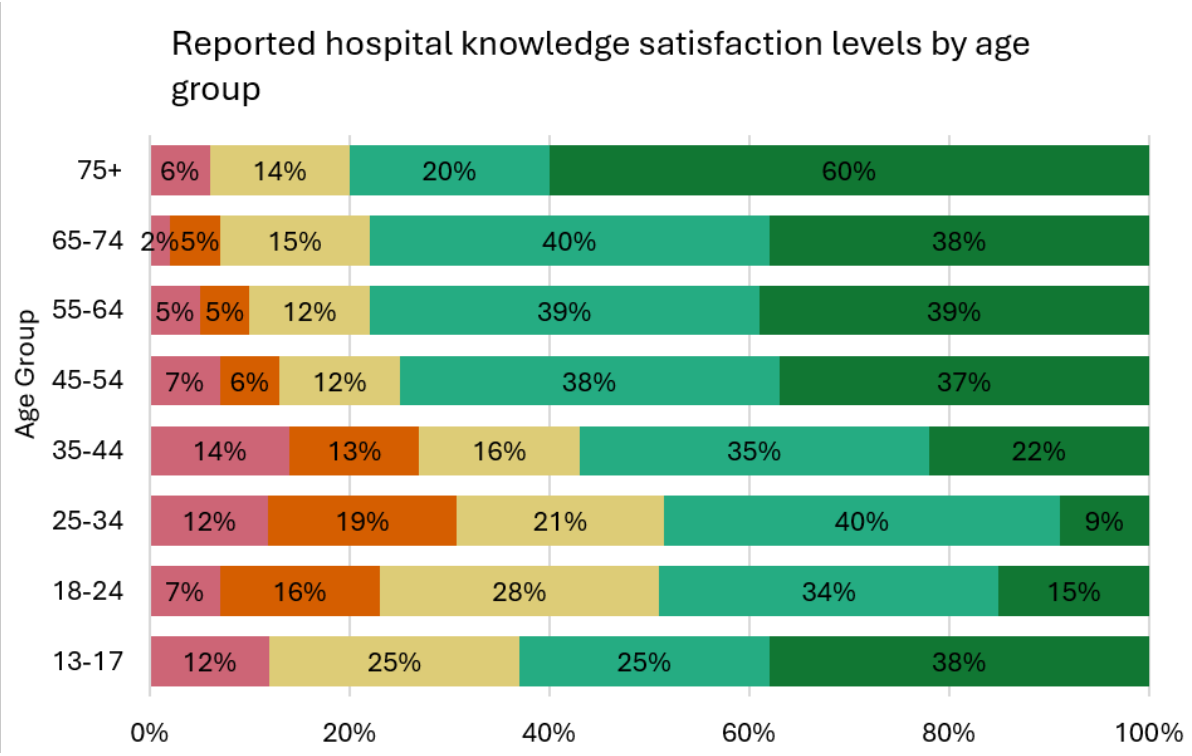


Figure 4.13: Respondents experiences of hospital knowledge by age group in BNSSG. Source: BNSSG ICB Survey Monkey.

Satisfaction with Hospital Care by Ethnicity

Variation in satisfaction is also seen by ethnic group with those in the White and Mixed or Multiple Ethnic Groups reporting higher satisfaction overall. Although the proportion of people in Mixed or Multiple Ethnic Groups reporting 'very dissatisfied' is almost twice that of those in the White group.

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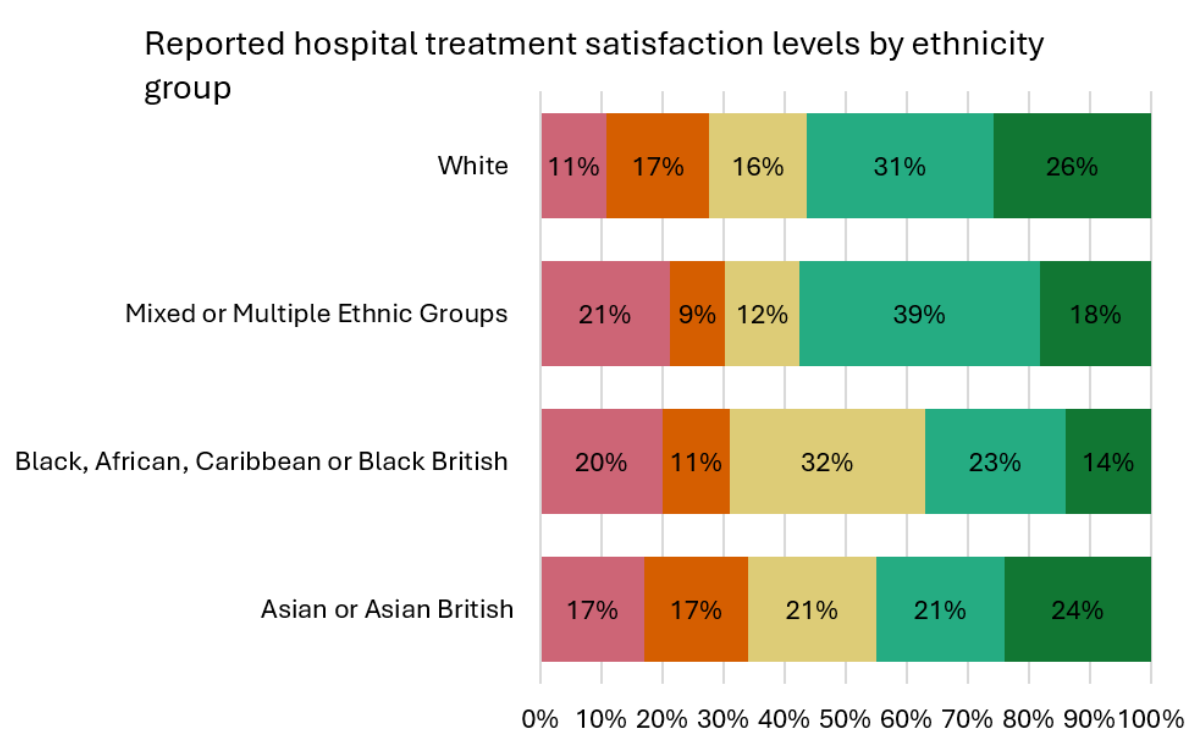


Figure 4.14: Respondents experiences of hospital treatment by ethnicity group in BNSSG. Source: BNSSG ICB Survey Monkey.

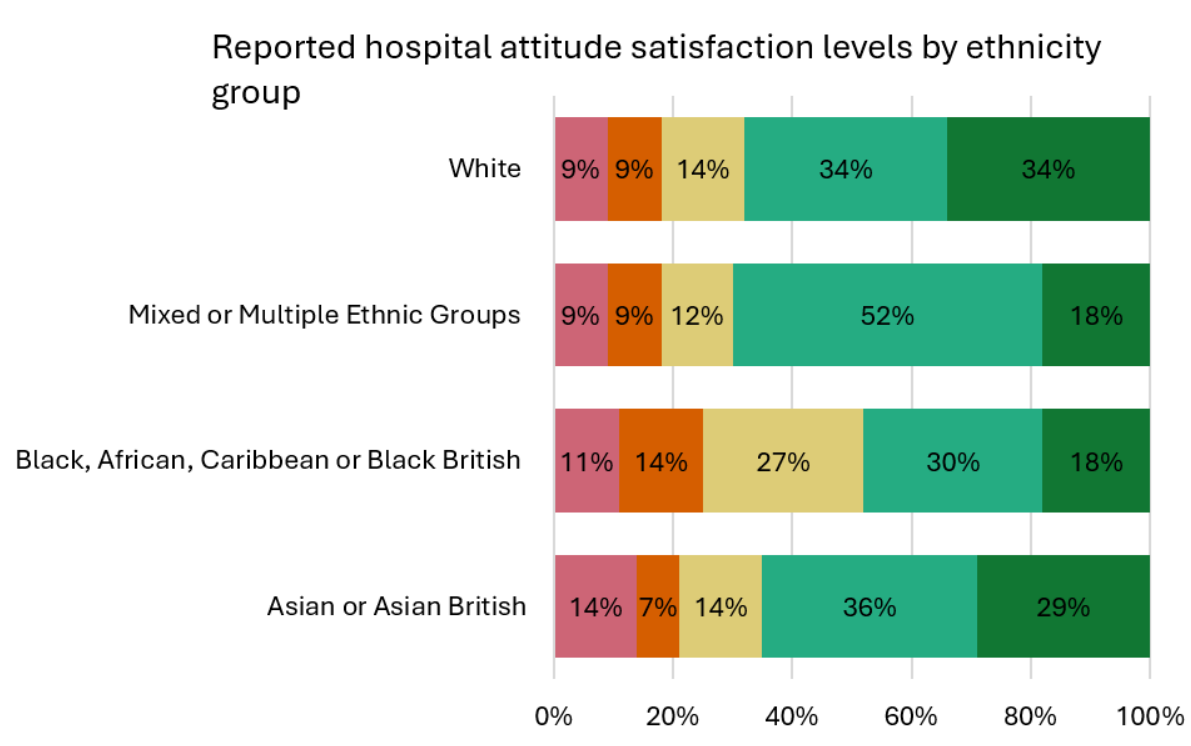


Figure 4.15: Respondents experiences of hospital attitude by ethnicity group in BNSSG. Source: BNSSG ICB Survey Monkey.

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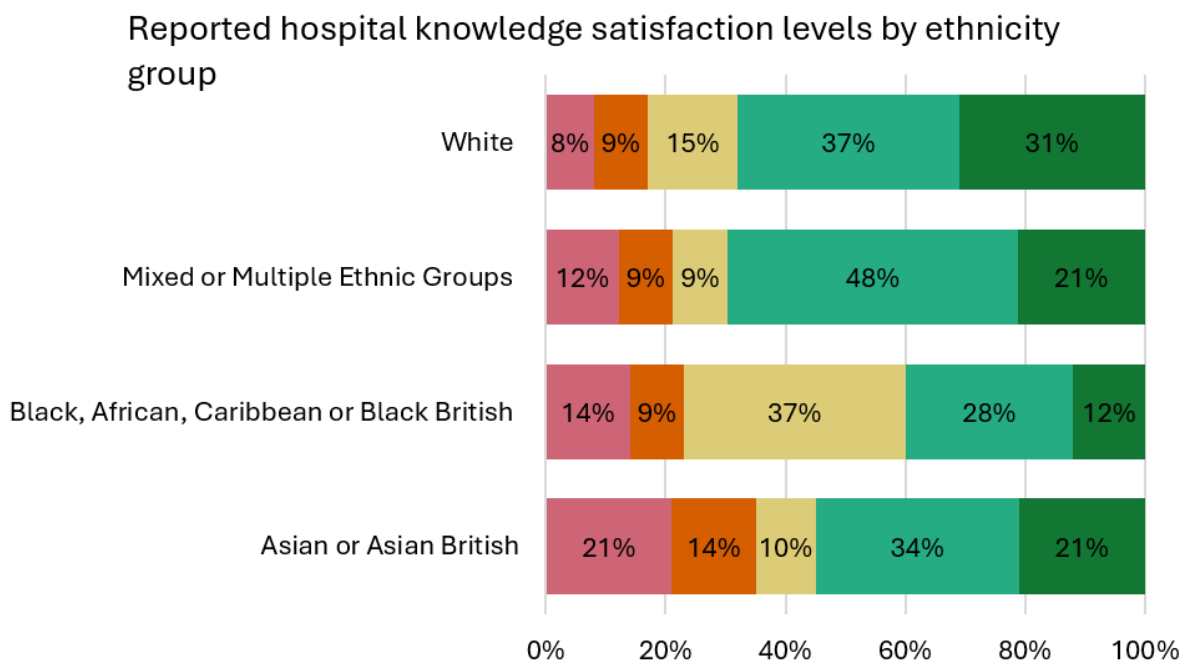


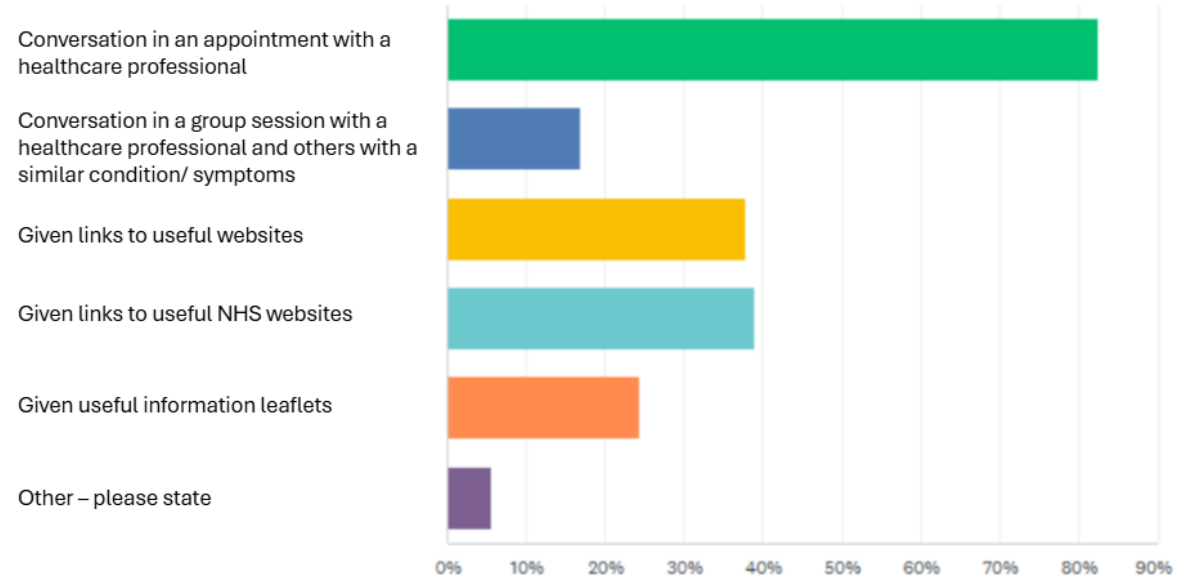
Figure 4.16: Respondents experiences of hospital knowledge by ethnicity group in BNSSG. Source: BNSSG ICB Survey Monkey.

Improving gynaecology care

Survey respondents were asked three multiple-choice questions related to improvements to gynaecology care:

1. **How would you like to receive information from the NHS on gynaecology symptoms and conditions?**

The majority wanted to have a conversation in an appointment with a healthcare professional (82.6% of respondents to this question). Responses didn't significantly vary by demographic groups.



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Figure 4.17: How people wanted to received information (n=3404). Source: BNSSG ICB Survey Monkey

2. **What gives you the most confidence that NHS gynaecology care will meet your needs as much as is possible?**

3457 people answered this question. Overall respondents reported more confidence in talking to clinicians than no confidence, except for pharmacists. People were most confident in speaking to clinicians with additional training in gynaecology or specialists. The percentages are summarised in table 4.4 below.

Table 4.4: *Proportion of respondents Not at all confident / not so confident versus Very confident / extremely confident with different Gynaecology care options*

Clinician	Not at all confident / not so confident	Very confident / extremely confident
A GP in your GP surgery	17%	45%
A nurse in your GP surgery	19%	42%
A pharmacist in your GP surgery for medication such as contraceptive pill or Hormone Replacement Therapy for menopause	50%	17%
A GP in a surgery near to where you live who has had additional training in gynaecology	7%	61%
A gynaecology specialist in hospital (a women's health healthcare professional work works in hospital)	3%	79%

The small number of comments in 'Other' (n=63) mainly related to the primary importance the clinician being sufficiently knowledgeable and understanding, whoever they are.

3. **What gives you the most confidence that NHS gynaecology care will meet your needs as much as is possible?**

The factor that was most important to respondents was **feeling like the healthcare professional understands what I am saying and experiencing, closely followed by knowing that the healthcare professional has had additional training**.

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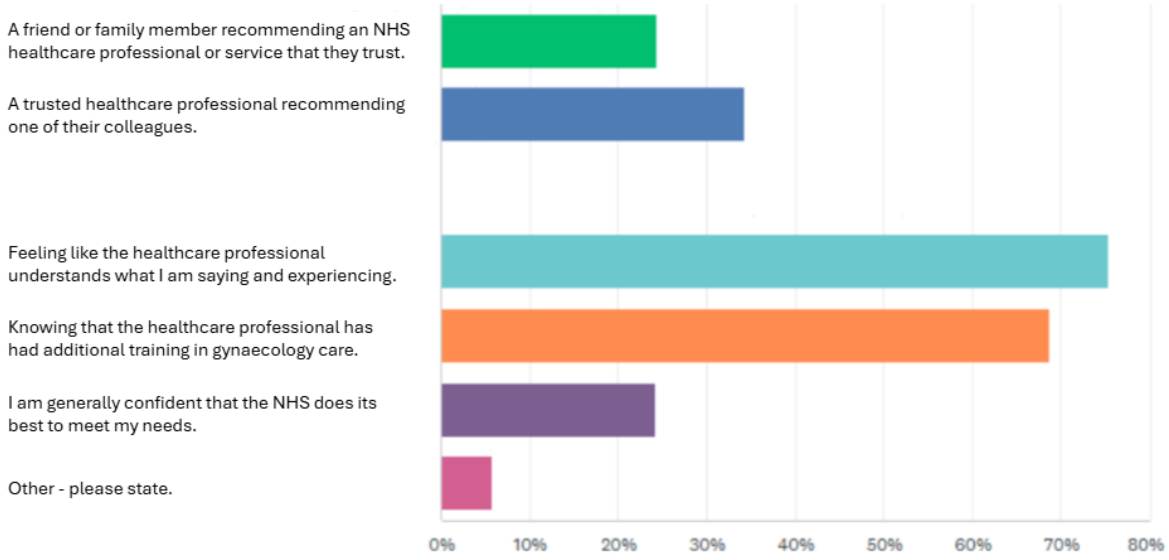


Figure 4.18: What helps make people feel confident they will get the care they need. (n=3426) Source: BNSSG ICB Survey Monkey.

Free text responses

This section provides a summary of the main themes from responses to the open question: **'Is there anything else you would like to tell us about your experiences?'**

1205 people responded to this question (excluding responses such as N/A or no). Two colleagues from the BNSSG Integrated Care Board conducted qualitative analysis of this data to identify key insights and themes. Responses were reviewed alongside the open question: **'Please share the name of a healthcare professional or service who you have had good experience with for your gynaecology care so that we can thank them and spread good practice'.**

Some people reported an overall good experience or overall bad experience. However, what is clear from the analysis is that many people reported a very mixed experience of gynaecology care at different times with different clinicians – from very good to very poor.

Long waits for hospital services

A common theme was the long waits for care, predominantly for Gynaecology hospital services and Pelvic Health Physiotherapy. As a result of long waits **some people reported choosing to opt for private health care**, with a few people considering, or going to, extreme lengths to come up with the finances to speed up their care due to **debilitating symptoms**. Some people also reported confusion and **lack of communication while they were waiting** for care. For example, not receiving any information on appointments for a long time after self-referral to Pelvic Health Physiotherapy, appointments being cancelled, and not being able to speak a person in the hospital to enquire about prospective care.

> *"I'm waiting on an appointment at the hospital with a Gynaecologist. It's an urgent referral but I was advised the wait list is 7/8 months. Wait times like this when you're in pain and it's having an impact on your quality of life is super frustrating. Especially when GP say there is nothing they can do."*

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Concerns about conditions and treatment and wanting to understand causes

One of the biggest themes was concern over a condition or treatment, whether that be about under- or over-treatment, wanting more holistic treatment, concerns with hormonal treatment, wanting information about procedures in advance, or wanting to understand the condition or treatment better. The **desire to understand the underlying causes of symptoms** was often mentioned, with an associated sense that healthcare professionals were not supportive or interested in this. This relates to the theme of **feeling dismissed.** This concern often came up in relation to menstrual and womb health and for people who experienced perimenopause symptoms at a relatively young age.

> *"I have had a variety of symptoms related to hormonal changes, **but no definitive answer as to what is causing it**. I have met with GP/ Gynaecologist several times in past few years regarding these changes... My GP is lovely & caring, but I still feel like we've hit a wall in regards to explaining my symptoms."*

> *"They simply kept prescribing different pills and then told me only a coil is the next thing to 'try'. **No attempt to find out what was causing** the issues or considering other options."*

A number of people described **fears about invasive procedures** or concerns about going back to services following bad experiences. As a result of concerns many people feel very alone with their conditions or diagnoses and feel they have to do their own research.

> *"I had quite [an] experience in BRI hospital when I attended a transvaginal ultrasound and the person who did the scanning didn't talk to me during the process or explain anything. They just did the scanning and then I was told that I will receive the results in about a week. The results show that I have fibroids and **no one has said what's next or what that means**, if I have to follow up on it or if I have to do something about it."*

> *"I have found that there seems to be very little help when it comes to period pain. I did manage to eventually have an ultrasound which came back clear, but my period pains are still extreme and the only suggestion is hormonal contraception. I cannot take **hormonal contraception because it really negatively affects my mental health**, and **I am not the only person** who seems stuck in this loop."*

Delays in diagnosis or misdiagnosis

A less prominent theme was people reporting delays in diagnosis. There were various reasons cited for this such as waiting times and feeling like concerns weren't picked up by health care professionals early enough. In quite a few cases conditions such as endometriosis or PMOS only became apparent when fertility issues were investigated. A number of people also touched on misdiagnosis; of note were concerns around being diagnosed for anxiety when people believed or later found out they were perimenopausal.

> *"Even though I have suspected endometriosis for many years, it took 8 years from first reporting symptoms to a GP to finally getting referred to gynaecology this year and I still have at least another year wait for surgery. The delays in diagnosis and treatment for gynaecological conditions is unacceptable. In the meantime my health has deteriorated to the point where I've had months of sick leave and had to half my working hours..."*

Variation in healthcare professional expertise

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Respondents described **variation in gynaecology expertise** in the healthcare professionals they saw, particularly in general practice. Many respondents also noted the need for more research on gynaecological health. This variation and lack of expertise in some cases, whether perceived or actual, influences peoples' confidence in healthcare professionals' treatment and advice, with people reporting a **clear preference to see a specialist Gynaecologist.** However, there were cases where people felt a GP specialist could meet their needs. There were comments around choosing private care to be able to see a specialist if a GP referral had not been made or to access more investigations. In cases where people reported poor experiences over many years there was a complete **lack of trust in the NHS being able to meet their Gynaecology needs.**

> *"I feel like the information you get from different GPs can vary widely - I would feel much **more confident knowing that additional training** had been in place. I would also feel **more confident talking to a female** GP about this…"*

> *"I've had ongoing gynaecological issues for probably 15 years now and I just have **no confidence in going to the doctors** about it anymore because it's never been solved or taken seriously. It became too exhausting to continue so I just gave up (apart from smear tests - still get those)"*

Lack of follow up or support after appointment or surgery

Respondents reported **a lack of follow up** support and aftercare, particularly following hospital appointments and procedures. Concerns included a lack of wrap around care and support for menopause and Hormone Replacement Therapy management, long waits for a follow-up appointment at the hospital, **difficulty booking follow-up appointments at a hospital**, lack of contact after a diagnostic procedure and a lack of post-operative care.

> *"I've had surgery to remove endometriosis. There were a few complications but I was eased by my doctors and their advice afterwards. Still no post-op check though and it's been 4 months."*

> *"I had investigations into extremely heavy periods (an ultrasound at Southmead) three different things were picked up on the scan and 12 months later I have received **absolutely no follow up from my GP or anyone else**. I have not seen a gynaecologist and have received no treatment or even advice on what treatment might be available."*

Feeling dismissed

A common theme was around feeling dismissed, which in some cases put people off seeking future care. This feeling of dismissal was underpinned by a range of issues, some people talked about the style and tone of their interactions with health care professionals being abrupt or lacking compassion, and in some cases minimising or **normalising bad symptoms, particularly pain.**

> *"**Women don't seem to be listened to**. Heavy, irregular and painful periods - told it's normal and to live with it. Pelvic prolapse and incontinence - told it's to be expected and normal after childbirth, and **to live with it.** Crippling peri menopause symptoms - fobbed off appointment after appointment for years. Women need to be listened to and taken seriously. Every GP practice should have someone who specialises on women's health"*

Painful procedures

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This feeling of dismissal was also apparent in a number of people reporting painful procedures and **not being offered sufficient pain management**. For example, for coil fitting, hysteroscopy, hysterectomy, transvaginal ultrasound, cervical screening, fitting pessaries, colposcopy and cervical, endometrial and polyp biopsies. Comments also highlighted a **lack of trauma-informed care** for people who have experience trauma such as sexual assault.

In addition, there were a number mentions of poor experiences with male health care professionals, **preferences to see a female health** care professional, or more general systemic misogyny[104]. Although this was not universally the case, good experiences with male professionals were not uncommon and was usually in relation to a hospital gynaecology specialist.

> *"I was a bit taken aback by the male doctors attitude to HRT following my total hysterectomy. He seemed to suggest I wouldn't need it whereas I was thinking - all my hormones are gone suddenly, of course I may need it? His attitude was very different from female doctors".*

Living with debilitating symptoms

Respondents reported ongoing pain or symptoms that haven't been addressed. In some cases where people perceived their symptoms to be relatively mild or moderate they described '**suffering in silence'** or ignoring the symptoms. Some people described not actively seeking care because they **don't want to waste healthcare professionals time** or they are **too busy to seek care**. In a few cases people described **giving up** out of frustration, exhaustion, lack of faith anything will change, and having to live with very debilitating symptoms.

> *"I have dryness and a Prolapse I just live with it"*

Challenges navigating the healthcare system

Respondents describe the repetitive nature of trying to get their issues resolved, feeling they are pushed from 'pillar to post' and having to advocate for themselves to access the treatment they need, which relates to the theme around follow up care. These comments also touched on a **lack of continuity** in care received by different health care professionals.

> "*Getting stuck in loops never getting answers. Regularly discharged because one gynaecologist you saw once after a year wait decided it didn't fit. Yet the one before was very concerned. I've been in this area for maybe 15 years* ***still cycling through the system with the same issues of extreme pain and no answers****…There's no continuity. Years between appointments… I have to constantly chase. No one knows what's going on."*

Wanting proactive and preventative care

A number of people highlighted their **desire for more proactive and preventative** care with particular mention of annual checks, online options for information, and **access to groups** and to hear from others. However, this was not universal with a few people citing not finding groups helpful.

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[104] A recent term coined for this is "medical misogyny" - Women's and Equality Committee - Women's reproductive health conditions. First Report of Session 2024–25

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"If appointments allowed it would be great to have a scheduled regular follow up to monitor for changes and issues after commencing HRT. A dedicated women's health clinic in primary care for all things gynaecology related would be fantastic."

Many had a positive experience

Around **a seventh of responses referenced an overall positive experience** in their feedback, touching on a range of topics from good care in a specific service, to the benefits of being prescribed medications like Hormone Replacement Therapy. Many of these responses also referred to being taken seriously, having care explained clearly, and trauma-informed approaches used.

*"I had very heavy periods but thought they were usual. I went to the GP with anaemic symptoms which is when my heavy periods were highlighted as a problem. The GP was fantastic, but **I wish that I'd known to ask for help earlier, and that my heavy periods were abnormal."***

*"I've experienced sexual assault and I get extremely anxious with examinations etc. The **GPs have been incredible**, so gentle and supportive, I have a nurse with me for comfort and I feel respected and able to go at my pace. It never used to be like that and I'm so grateful things have changed."*

*"Seeing a specialist [in a Gynaecology department]... who could see straight away what the problem was and who gave me a plan that we worked through and who **gave me the time I needed** to go through my problems - she helped me with different ones, made me feel safe and looked after."*

*"She [pelvic health physiotherapist] is incredible at what she does and clearly wants to make a positive difference to women's lives. She **listens carefully, believes you** and makes you feel heard."*

*"People doing their best to use the right pronouns or understanding why taking feminising hormones (e.g. the pill) may not be a good solution goes a huge way and will make the experience so much more bearable for those people. Thank you to the **kind staff who do their best** in this area, it really makes a bigger difference to people's lives than you may understand. :)"*

Focus groups

Six focus groups were carried out to understand in more depth experiences of gynaecology care.

Four of the focus groups were run by local VCSE organisations. This enabled us to hear from groups who are more likely to experience health inequalities and/or have more particular needs and perspectives. Two focus groups were run by the ICB and Bristol City Council colleagues, one focusing on pelvic health and one on menstrual health. People with a range of demographics and experiences were approached from the list of survey respondents who had expressed an interest attending a focus group.

Table 4.5: Summary of focus groups conducted

Focus group lead	Population group	Focus group attendees
The Diversity Trust	Lesbian, Gay, Transgender, Queer	9 participants.

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	and gender questioning	Cis women, trans men and queer women. Age 20–50 years. White English and dual-heritage participants.
Learning Partnership West	Young people	19 participants. 18 female and 1 non-binary Age 13-18 years. All White British. 11 participants had a diagnosis or suspected diagnosis of neurodiversity 7 identify as LGBTQ+.
Nilaari Agency	Black and Mixed Black	5 participants. All female. Age 31-39 years. Black or Mixed Black heritage. All mothers.
BSB Better Together	Polish	10 participants. All female. Age 35-56 years. All Polish.
Integrated Care Board	People with pelvic health problems	8 participants. Age bracket 25-74 years 1 Black African background 7 White
Integrated Care Board	People with period problems	4 participants. Age bracket 25-54 years All White

Key themes from the focus groups are outlined below.

A clear theme across all groups was that **experience of care felt very dependent on the individual clinician**, with both very good and very poor experiences described.

Participants in all groups described how **poor experiences put them off accessing healthcare** and some people lost faith that they would be well cared for. This sometimes led to reluctance to seek care until symptoms reached a crisis point. In the group of Black and Mixed Black women led by Nilaari it was reported that this feeling could be particularly acute, with **experiences of racism and intergenerational fear passed down from parents.**

Clinician attitude

- **Compassionate, unrushed consultations**: In keeping with national reports on gynaecology experience and our local survey responses, positive experiences were characterised by feeling respected, listened to, and treated as an individual within calm, compassionate, and unrushed consultations**.**
- **Dismissal of symptoms**: Being told that symptoms were “normal” felt dismissive and gave the impression that their problems were not serious enough to merit a healthcare appointment. Some people **felt they were ‘wasting the GP’s time’**. This

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was particularly noted by young people and those in the pelvic health group, even when those symptoms were negatively impacting day-to-day life.

- LGBTQ+: Participants discussed the importance of clinician demeanour and approach extensively. **Inclusive, gender-neutral language (when possible)** and use of correct pronouns was valued. Some participants reported **feeling judged** about their gender identity and felt uncomfortable if the clinicians seemed to 'freeze' up when gender identity was mentioned.
- Black and Mixed heritage participants in the Nilaari group: Emphasised the **importance of actively seeking to understand levels of pain** and distress as opposed to minimising or normalising it. For example, not assuming that a person is not in pain because they are silent or calm.
- Young people: Most concerned about potential **embarrassment** and judgment when discussing symptoms.
- Improvements in attitude, understanding and trauma-informed practice was seen as a key priority in all groups. Small adjustments can make a big difference.

Treatment and clinical care

- **Women want a range of treatment options**: Participants across the groups often felt that they were not offered the full range of treatment options, with some reporting a desire for longer-term treatment plans. Some participants felt their symptoms were not fully investigated in general practice, contributing to delayed diagnosis and prolonged distress. This was a strong theme in the menstrual health focus group, with many participants reporting that they felt there was too much focus on contraceptive options to manage symptoms and **limited explanations** of why pills and/or IUDs would help.
- **Internal/intimate examinations evoked anxiety or pain**: gynaecological examinations were frequently described as uncomfortable, anxiety-inducing, or painful especially for young people. Some Polish participants felt that the couches used in general practice were simple and not designed for internal examinations, which caused discomfort and felt undignified.
- **Pelvic physio was valued but there is limited follow up**: Pelvic health focus group participants valued the physiotherapy service. Problems related to limited follow-up or long gaps between appointments because it can be hard to know if you are doing the exercises correctly, especially when there is a lack of sensation. It was also felt that non-exercise-based treatment options were not often discussed by clinicians.
- **Clarity and understanding of cause**: In the periods and pelvic health groups, there were discussions around the importance of clarity and realism around what is 'curable', what isn't, how likely it is that symptoms would ease and what the treatment plan was. People wanted to know what the cause of their symptoms was. For LGBTQ+ participants it was important for clinicians to understand their specific needs where relevant.
- **Specialist care preferred**: Being able to see a women's health specialist in a GP surgery was seen as helpful for improving treatment options and being listened to and understood. A clinician who understands the 'full picture' of women's health and how different symptoms and conditions interlink physically and mentally was seen as valuable. However, there was concern about requiring a GP referral to get an

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appointment if the GP did not take the person's concerns seriously enough. For Polish women, there is a clear contrast between gynaecology care in England and in Poland. In Poland, gynaecologists see women for routine care without the need for a GP referral. Some participants in the focus group reported that the GPs they saw were 'untrained' and that they worried they would be prescribed medication without the relevant prior investigations that they had received previously.

Access and continuity of care

- **People like to see the same clinician**: The value of seeing the same clinician was mentioned in a number of groups. This was seen as particularly important for menstrual and womb health when diagnostics and different treatment plans were being undertaken. It felt confusing to have different clinicians giving different advice.
- **Need for communication about long wait times**: Hospital appointment waits had a detrimental impact on quality of life. Some participants wanted more clarity on waiting times and what to expect during the care pathway. Some, especially in the focus group on periods, found communication pre- and post-appointments lacking, for example what happens with test results or what to do if symptoms worsen.
- **In-person appointments valued alongside some interest in group support:** There was some interest in group appointments from in the pelvic health group, alongside as it sat alongside 1-1 appointments. There were a number of comments about **how lonely it can feel** having pelvic floor dysfunction and it felt good to have a dedicated space to talk about it with others. In-person appointments were seen as essential for demonstration of pelvic physio exercises.
- **Clinical outreach to community settings can build trust**: The LGBTQ+ and young people's group talked about the value of clinicians attending community settings or schools to build trust and talk more informally together.
- **Female doctors preferred by young people**: Some of the young people mentioned a strong preference for female doctors a few times.

Communication and information

- **Clear explanations needed**: A common theme across the groups was that when clinicians talked about conditions it was sometimes unclear, overly technical, or insufficiently explained. Simple written and visual summaries that sit alongside clear verbal information were seen as valuable.
- **Social media is the major source of information for young people:** The growth of social media and online women's health communities has increasingly influenced how women learn about gynaecological issues. Whilst these platforms provide accessible information, peer support and validation of symptoms and can increase confidence to seek help from healthcare professionals, the quality and accuracy of information can be variable
- **Access to interpretation services is vital**: Access to suitably qualified interpreters when needed was seen as vital but not always provided. In the Polish focus group, it was noted that poor quality AI-generated translations seemed increasingly common and very unhelpful.

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4.3 Previous public engagement work in BNSSG related to gynaecology

Bristol City Listening Project 2019-20

The Bristol City Listening Project[105] was led by Bristol Women's Voice. The Project spoke with 530 women via small groups and interviews, with a focus on those experiencing the greatest health inequalities. Findings covered a wide range of issues, with health and wellbeing a key theme. Within that, menopause was a key theme, with participants reporting that hormone replacement therapy (HRT) was prescribed without any accompanying advice on its impact or alternative treatment options. Long waits for contraceptive clinics in general practice was also a concern.

Healthwatch: Your NHS menopause experience 2023

Healthwatch conducted a survey in 2023 'Your NHS menopause experience: Bristol, North Somerset and South Gloucestershire'[106]. Published in five languages, with free postal returns and telephone support provided, 379 residents responded.

The survey identified the following key issues, which chime with the Bristol City Listening Project findings:

- **Delays in diagnosis** and difficulty accessing timely care
- **Inadequate information** and **limited discussion of treatment options**
- Concerns about **HRT risks** and limited exploration of alternatives
- **Inconsistent follow-up** and continuity of care
- Cultural and informational barriers affecting **access and understanding**
- **Reliance on private care** due to NHS access challenges

Recommendations for the NHS included improved access to specialist clinics, better training, culturally appropriate information, and stronger primary care leadership.

The PePPER Study: Perceptions of Pelvic Pain and Endometriosis in Diverse communities 2025[107]

The PePPER study explored pelvic pain and endometriosis experiences among 54 Somali, Black African, Black Caribbean and Black British women in Bristol. It is currently in the process of being peer reviewed for publication. It found:

- **Lower diagnosis rates** not explained by biological factors
- **Normalisation of pelvic pain** and delayed help-seeking

[105] Bristol Women's Voice (2020) Bristol City Listening Project

[106] Healthwatch Bristol (2023). Your NHS menopause experience: Bristol, North Somerset and South Gloucestershire

[107] Gamlin et al. (2026) The PePPER Study: Perceptions of Pelvic Pain and Endometriosis in Diverse Communities. Centre for Academic Primary Care, University of Bristol, 2025.

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- **Limited culturally appropriate information**
- Experiences of **dismissal and perceived bias reducing trust** in services

Key recommendations include culturally tailored information, better training for clinicians, more proactive care pathways, and approaches to rebuild trust.

Women's Reproductive Health Survey 2023

The Women's Reproductive Health Survey[108] was a national survey commissioned by Department of Health and Social Care to collect information from women about their reproductive health, including periods, gynaecological conditions, and menopause. It received 13,450 responses received nationally, of which 1,681 were from BNSSG,

Analysis of the 1,681 BNSSG respondents found the respondents were predominantly White and degree-level educated and therefore not a representative sample of the local population. Key findings included:

Menstrual health- Pain and heavy bleeding are common but many do not seek help

- Heavy periods were commonly reported, alongside significant levels of period pain. Despite this, most respondents with symptoms **had not sought help,** indicating unmet need.
- Where treatment was received, hormonal contraception and tranexamic acid were the most reported options.
- Satisfaction with support for menstrual symptoms was mixed, with a notable proportion of respondents **reporting dissatisfaction**, suggesting gaps in effective management and treatment options.

Menopause- symptoms impact a significant proportion, gaps in information and NHS provision

- A substantial proportion of respondents reported menopause symptoms, with many reporting its impact on quality of life and work.
- Less than half of respondents reported receiving healthcare advice about menopause, highlighting gaps in information provision.
- HRT was used by a minority of respondents, alongside a range of self-management approaches such as lifestyle changes and complementary therapies.
- Satisfaction with both NHS care and information was mixed, with a significant number reporting dissatisfaction.
- A proportion of respondents reported seeking care from private providers, indicating limitations in NHS provision and access.

Other gynaecological conditions- many do not seek help

- Commonly reported symptoms included pelvic pain, pain during or after sex, and urinary incontinence, alongside abnormal discharge and bleeding.

[108] The Reproductive Health Survey for England | LSHTM

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- Help-seeking behaviour varied, with only around half of respondents accessing GP services and **a significant proportion not accessing care at all.**
- Satisfaction with care varied by condition, with particularly **high levels of dissatisfaction reported among respondents with endometriosis, PMOS, and uterine fibroids**, indicating gaps in diagnosis, treatment options, and ongoing management.

UHBW survey hospital patient experience insights 2025/26

The following insights were shared by the patient experience team at UHBW, collected from gynaecology inpatient (155 responses) and outpatient (74 responses) patient surveys between March 2025 and February 2026. Key findings are outlined below.

Communication before the appointment or admission

- Around three-quarters (76.5%) of outpatients said they received confirmation that their referral had been received. 28.4% reported receiving no information while waiting for their appointment.
- 78.8% of inpatients felt they received helpful information while waiting on the list, but 10% wanted more and 3.8% received none.

Communication during care

- 89.2% of outpatients reported that they definitely felt listened to and no one said they didn't feel listened to at all.
- 71.2% of inpatient reported definitely feeling listened to and only 3.9% felt not listened to at all.
- 86.9% of inpatients said they received the right amount of information about treatment/condition.
- 83.8% of outpatients felt they had enough time to discuss issues.
- 89.2% of outpatients were told what would happen next in their care.
- **Only 52.6% of inpatients said they definitely knew what would happen after leaving hospital** and 11% said they were not told what would happen next at all.

Involvement in decisions about care

- 79.7% of outpatients said they **definitely felt involved in decisions** about care.
- 55.9% of inpatients said they were involved 'a great deal' and 30.9% 'a fair amount'.

Experience of kindness, dignity, and respect

- 90.5% of outpatients always felt **treated with respect and dignity** and 85.1% always felt treated with kindness and understanding.
- **75.7% of outpatients rated their overall experience as very good and 18.9% as good.**
- 85.7% of inpatients always felt treated with respect and dignity and 83.8% always felt treated with kindness and understanding.
- 68.8% of inpatients rated their experience as very good and 26.6% as good.

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UHBW patient feedback demonstrates generally **positive experiences**, with most outpatients and inpatients feeling listened to, well-informed, and treated with kindness and dignity. However, **communication before appointments** was more varied, particularly for outpatients.

BNSSG Women's health hubs – inclusion health grants evaluation

BNSSG ICB was allocated £595,000 of one-off funding for local delivery a women's health hubs programme. This programme of work delivered five initiatives (2023-26), see Figure 4.19. As part of the health equity initiative the ICB awarded 11 grants[109] totalling £105,000 to local organisations and community groups who have trusted relationships and experience supporting people in the following inclusion health groups:

- Migrants in vulnerable circumstances, including asylum seekers and refugees
- People facing multiple disadvantage
- Gypsy, Roma, and Traveller people.

A summary of impact is outlined below[110].

Summary of impact

Health agency and empowerment

Participants reported feeling:

- More confident talking with clinicians
- More able to make informed decisions
- Less isolated
- More proactive in accessing care

Digital literacy improved, supporting appointment and prescription management.

Sessions built collective knowledge, reduced barriers and normalised conversations about women's health

Access to services

- Women supported to register with a GP.
- Dedicated one to one GP appointments during project workshops.
- Signposting to community support, women's health services, and access information
- Peer support to help each other access care

Health knowledge attitudes

Participants reported:

- Enhanced awareness of women's health concerns

[109] BNSSG Healthier Together - Inclusion health grants for women's health [accessed 23 Jul 2026]

[110] A Researcher in Residence from the University of Bristol supported grant-holders to evaluate their projects and consolidated these into a programme evaluation. To access the BNSSG women's health hubs programme report and evaluation findings, email bnssg.womenshealth@nhs.net.

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- Correction of previously held misconceptions
- Sharing information informally with family members and friends

The sessions further facilitated acculturation by discussing UK values related to equality, diversity, and LGBTQ+ inclusion.

Learning:

... for healthcare professionals who took part in the projects

- **Insights** gained into beliefs and preferences held among diverse groups
- Skills in how to have fruitful discussions
- Broadened knowledge of VCSE services
- Learning taken back to their organisations

... for future ways of working across BNSSG

- Fruitful partnerships were formed between VCSE organisations, healthcare providers and the Integrated Care Board
- The VCSE's role as a **'boundary spanner'** (trusted link) between statutory services and the communities they serve was essential to the success of this work. This role must be recognised and nurtured.

... for the Integrated Care Board as commissioners of healthcare

Partnerships: Partnership working between VCSE organisations and the NHS to helped address inequities, build system and community capacity, and build health literacy within underserved communities.

Longstanding issues remain:

- **Trust**: There is **low trust in statutory services**, shaped by discrimination, racism and previous negative experiences. People need to believe that healthcare and wellbeing activities are **for** them, otherwise they are less likely to attend or benefit.
- **Workforce**: Lack of **workforce diversity in NHS** that is reflective of different population groups.

Working with the VCSE sector:

- The straightforward application process for the women's health grant was appreciated.
- Ensure that evaluation metrics and reporting requirements are clear and reasonable. Include a requirement to include evaluation resources in project budget.

BNSSG Women's health – showcase March 2025

As part of the BNSSG Women's heath hubs programme over 90 local health, care and VCSE colleagues with an interest women's health were brought together to hear about all the work going on to improve women's health. At the Showcase people were asked what they think is top priority for women's health in BNSSG in the next few years. Here are the key themes:

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1. **Education and awareness raising for the public and healthcare professionals:** Especially for contraception and menstrual health, listening skills, training for those who are not already interested!
2. **Co-production and collaboration:** doing good work together, in-person events, sharing the learning and maintaining networks to keep the momentum up
3. **More funding for services**
4. **Accessibility:** reaching underserved groups through outreach into the community, understanding DNAs, making reasonable adjustments
5. **Re-positioning women's health on the agenda:** a renewed focus and vigour within both research and day-to-day practice to create enduring, embedded change and improvements for women, girls, and society as a whole!

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Appendices

Appendix 1 - Overview of Gynaecological Conditions

Endometriosis[111]

Definition: Growth of endometrium-like tissue outside the uterus, most commonly on ovaries, peritoneum, uterosacral ligaments, and pouch of Douglas. Rarely extra-pelvic (e.g., bowel, pleura).

Cause: Not well understood, may be associated with retrograde menstruation (blood flows backwards into the pelvis), genetics, metaplasia (cell transformation), and environment.

Symptoms: Chronic pelvic pain ≥6 months, period-related pain affecting daily life, deep dyspareunia (painful intercourse), cyclical gastrointestinal or urinary symptoms, infertility.

Prevalence: Affects 1 in 10 women of reproductive age in the UK.

Diagnosis: Examination, transvaginal ultrasound imagining (normal results do not rule out disease), MRI, laparoscopy.

Management: Pain relief, medical or hormonal therapy (e.g. the contraceptive pill or IUD), managing complications such as chronic pain, infertility or mental health issues, surgical treatment (excision, ablation, hysterectomy).

Amenorrhoea[112]

Definition: Absence or cessation of menstruation.

- Primary- No menstruation by age 15–16 (with normal secondary sexual characteristics) or 13–14 (without secondary sexual characteristics).
- Secondary- Cessation of previously established menstruation for ≥3 cycles or ≥6 months.

Cause:

- Primary- Anatomical/genetic abnormalities, functional hypothalamic amenorrhoea (stress, eating disorders, weight loss, excessive exercise), PMOS
- Secondary- PMOS, functional hypothalamic amenorrhoea, premature ovarian insufficiency, hyperprolactinaemia

Prevalence: Primary amenorrhoea has a quoted prevalence of <0.1% in the USA but no prevalence data for the UK, secondary amenorrhoea affects about 3–4% in women of reproductive age in the USA, increasing to 5–60% in competitive endurance athletes, and 19–44% in ballet dancers.

Diagnosis: Exclude pregnancy first, history & exam (menstrual, weight, stress, meds, signs of PMOS or thyroid issues), blood tests (FSH, LH, oestradiol, prolactin, TSH ± testosterone), imaging (pelvic ultrasound).

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[111] NHS (2026). Endometriosis

[112] NICE (2024). Amenorrhoea,

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Management: Treat underlying cause and manage risks

Dysmenorrhoea[113]

Definition: Painful cramping in the lower abdomen shortly before or during menstruation.

- Primary- No underlying pelvic pathology; caused by uterine prostaglandins. Usually begins 6–12 months after menarche once cycles are regular.
- Secondary- Due to pelvic pathology (endometriosis, fibroids, PID) or IUD insertion; may start after years of painless periods, pain may persist outside menstruation.

Risk Factors:

- Primary- Early menarche, heavy menstrual flow, nulliparity, family history.
- Secondary- Must be excluded before diagnosing primary dysmenorrhoea.

Symptoms:

- Primary- Lower abdominal pain, may radiate to back/thigh; non-gynaecological symptoms (nausea, vomiting, diarrhea, fatigue, headache, irritability). Pelvic exam normal.
- Secondary- Pain may persist outside menses; often associated with other gynaecological symptoms (dyspareunia). Pelvic exam may be abnormal.

Prevalence: 16–91% of women of reproductive age.

Diagnosis: Pelvic ultrasound to identify structural causes, consider referral for further evaluation (e.g., laparoscopy for suspected endometriosis).

Management: Treat underlying causes of secondary dysmenorrhoea, pain relief (NSAIDs, paracetamol), hormonal treatments (combined oral contraceptive pill, contraceptive implant, IUS).

Fibroids Error! Bookmark not defined.

Definition: Benign uterine tumours (leiomyomas) from smooth muscle and fibroblast proliferation; may be single or multiple, and variable in size.

Risk factors: Increasing age (pre-menopause), early menarche, older age at first pregnancy, obesity, hypertension, Black/Asian ethnicity, family history.

Symptoms: Heavy menstrual bleeding/dysmenorrhoea, pelvic pain, pressure, dyspareunia, abdominal bloating, back pain, urinary symptoms (frequency, urgency, incontinence, retention, UTIs), bowel symptoms (bloating, constipation, painful defecation), subfertility/infertility.

Prevalence: 12.8 cases per 1000 persons per year or cases diagnosed by pelvic examination, ultrasound, or hysterectomy and 2 cases per 1000 persons per year for hysterectomy-confirmed cases alone. A screening study carried out on 1364 women found 51% of pre-menopausal women with no previous diagnosis had ultrasound evidence of fibroids (higher for Black women (59%) compared with White women (43%)), and the estimated cumulative

[113] NICE (2023). Dysmenorrhoea.

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incidence of fibroids by the age of 50 years was more than 80% for Black women and nearly 70% for White women.

Diagnosis: Examination for pelvic tenderness/masses, pelvic ultrasound, MRI

Management: Medications (including NSAIDs, tranexamic acid, hormonal contraceptives, oral progestogens, gonadotrophin-releasing hormone analogues), uterine artery embolization and surgical treatments (including removal of fibroids (myomectomy) or removal of the uterus (hysterectomy)).

Urinary incontinence[114]

Definition: Any involuntary leakage of urine.

- Stress urinary incontinence (SUI)- Leakage with effort, exertion, sneezing, or coughing.
- Urgency urinary incontinence (UUI)- Leakage accompanied or immediately preceded by sudden, compelling urgency; often part of overactive bladder (OAB) (urgency ± UUI, usually with frequency and nocturia).
- Mixed urinary incontinence (MUI)- Features of both SUI and UUI.

Risk factors: Older age, lower urinary tract abnormalities, comorbid illness.

Prevalence: 34% of UK women.

Diagnosis: History (type of incontinence, severity, and impact on daily life), pelvic exam to identify abnormalities and evaluation of pelvic floor muscles, bladder diary, urinalysis (for infection or blood in urine).

Management: Lifestyle advice (weight loss, modified fluid intake, caffeine reduction, smoking cessation), manage contributing factors and complications, pelvic floor muscle training, medications (including duloxetine, anticholinergics), pessaries, surgical treatments.

Menopause[115]

Definition: Permanent cessation of menstruation due to loss of ovarian follicular activity; diagnosed clinically after 12 months of amenorrhoea.

- Perimenopause- Period before menopause; irregular cycles; ends 12 months after last period.
- Postmenopause- Time after ≥12 months of amenorrhoea.
- Early menopause- Ovarian function ceases between 40–45 years, not due to other causes.
- Premature ovarian insufficiency (POI)- Transient or permanent ovarian function loss before 40 years.

[114] NICE (2025). Urinary incontinence.

[115] NICE (2025). Menopause.

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Clinical features: Changes in menstrual pattern, vasomotor symptoms: hot flushes, night sweats, mood disorders, genitourinary symptoms (dryness, discomfort, urinary changes), altered sexual function, sleep disturbance.

Prevalence: Over 75% of women experience menopausal symptoms, with 25% describing these symptoms as severe. Between 27% and 55% experience vaginal dryness, up to 40% to 77% dyspareunia, and between 6% and 36% urinary symptoms.

Diagnosis: Peri-menopause is diagnosed in women aged 45 or over with menopausal symptoms and changes in their menstrual cycle, menopause is diagnosed in women aged 45 or over if they have not had a period in over 12 months or based on symptoms if they have had a hysterectomy. Follicle-stimulating hormone (FSH) levels may be taken to confirm menopause in women aged 40-45 and to confirm premature ovarian insufficiency in women under 40.

Management: Lifestyle measures (stop smoking, reduce alcohol intake, regular physical activity, weight loss, sleep hygiene), hormone replacement therapy (HRT), vaginal oestrogen for genitourinary symptoms, testosterone for low libido, cognitive behavioural therapy (CBT) and antidepressants for mood changes.

Menorrhagia (heavy menstrual bleeding, HMB)

Definition: Excessive menstrual blood loss interfering with physical, social, emotional, or material quality of life. May occur alone or with other symptoms.

Causes: Uterine fibroids, uterine cancer, endometriosis, systemic disorders (coagulation disorders, hypothyroidism), anticoagulants

Prevalence: Menstrual disorders account for ~12% of gynaecology referrals, ~1 in 20 women aged 30–49 consult a GP annually for heavy periods, ~50% of women have no identifiable cause.

Diagnosis: Clinical based on a woman's report of excessive menstrual bleeding. A full blood count may be required to test for anaemia. Further investigations such as an ultrasound or hysteroscopy should be carried out if structural abnormalities are suspected.

Management: If no identified pathology; fibroids less than 3 cm in diameter, which are not causing distortion of the uterine cavity; or suspected or diagnosed adenomyosis, first line management is a levonorgestrel-IUS, followed by non-hormonal treatments (such as tranexamic acid or NSAIDs) or hormonal treatments (combined hormonal contraception or cyclical oral progestogen).

Polycystic Ovary Syndrome (now called Polyendocrine Metabolic Ovarian Syndrome (PCOS/PMOS)) [116]

Definition: A heterogeneous endocrine disorder emerging around puberty, characterized by hyperandrogenism (clinical features: acne, hirsutism), ovulatory dysfunction (infrequent or absent menstruation), polycystic ovarian morphology on ultrasound.

[116] NICE (2025). Polycystic ovary syndrome: prevalence.

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Cause: Unknown, likely due to genetic and environmental factors.

Complications: Infertility, cardiovascular disease (CVD), metabolic disorders: impaired glucose tolerance, type 2 diabetes, obstructive sleep apnoea, psychological disorders (anxiety, depression), pregnancy complications: pre-eclampsia, gestational diabetes, endometrial cancer, non-alcoholic fatty liver disease

Prevalence: Ranges from 2.2-26% dependant on the criteria used and population studied, with many women undiagnosed.

Diagnosis: Diagnosis be considered if two or more of the following are present: infrequent or no ovulation (usually shown in infrequent or no menstruation), clinical or biochemical signs of hyperandrogenism (excess hair, acne, elevated testosterone), polycystic ovaries on ultrasound.

Management: Lifestyle advice and management of complications (e.g. weight loss, screening for type 2 diabetes and cardiovascular disease, investigation and treatment of obstructive sleep apnoea, management of psychological disorders), combined oral contraceptive pill, metformin (off-label, following specialist advice), fertility treatments.

Premenstrual syndrome[117]

Definition: Psychological, physical, and behavioural symptoms occurring in the luteal phase (post-ovulation to menstruation).

Symptoms: Depression, anxiety, irritability, mood swings, loss of confidence, bloating, breast pain, reduced cognitive ability, aggression

Premenstrual Dysphoric Disorder (PMDD): ≥5 of 11 symptoms (≥1 mood-related), causing significant distress or functional impairment (DSM-5 criteria).

Prevalence: Over 90% of women experience at least one symptom, with around 29–53% of women with clinically significant symptoms seeking medical help. Global prevalence of more severe premenstrual dysphoric disorder (PMDD) was 1.6%, with 3.2% having a provisional diagnosis

Adenomyosis[118]

Definition: Benign gynaecological condition where endometrial-like tissue is present within the myometrium. Can be focal (nodular aggregates) or diffuse (widespread infiltration).

Symptoms: Dysmenorrhoea, menorrhagia, dyspareunia, chronic pelvic pain, may be asymptomatic and found incidentally (e.g. infertility investigations, hysterectomy specimens).

[117] NICE (2024). Premenstrual syndrome: prevalence.

[118] BMJ Best Practice (2025). Adenomyosis.

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Prevalence: Estimates vary, most quoted 20% to 35% of women undergoing a hysterectomy and 21% to 34% on transvaginal ultrasound. Most commonly diagnosed in women aged 35 years to menopause.

Bartholin's cyst[119]

Definition: Non-infectious occlusion of the distal Bartholin's duct → retention of glandular secretions. A Bartholin's abscess is infection of a cyst or, less commonly, primary infection of the duct/gland.

Prevalence: Around 2% of women (US data). Most common in women of reproductive age.

Symptoms: cystic mass on the labia majora. Abscess is a painful, swollen, erythematous mass.

Chronic pelvic pain[120]

Definition: Pain arising from one or more pelvic organs.

Cause: Unknown

Clinical features: Pain lasting >6 months, often with functional impairment (cognitive, emotional, sexual). May involve bladder, bowel, uterus, adnexa, pelvic floor, abdominal wall. High prevalence of comorbid psychiatric conditions (e.g. depression and anxiety).

Prevalence: An estimated 15% to 40% of women of reproductive age experience chronic pelvic pain.

Premature ovarian failure/insufficiency[121]

Definition: Cessation of menses (periods) for **>1 year before age 40** due to loss of ovarian function.

Clinical features: Primary or secondary amenorrhoea, hot flushes, sleep disturbance, irritability and mood changes, vaginal dryness, painful sex, usually results in infertility.

Prevalence: 1 in 250 women by age 35, and 1 in 100 women before the age of 40 (in the US)

Management: Conservative (warm compress, sitz baths), marsupialisation (creating a drainage slit), catheter drainage, surgical excision, silver nitrate cauterisation, alcohol sclerotherapy, incision, antibiotics (if cellulitis present), incision and drainage (if abscess present).

[119] BMJ Best Practice (2025). Bartholin's cyst [cited 2025 Aug 19].

[120] BMJ Best Practice (2025). Chronic pelvic pain in women: Epidemiology.

[121] BMJ Best Practice (2025). Premature ovarian failure [cited 2025 Sep 26].

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Pelvic organ prolapse[122]

Definition: Symptomatic descent of one or more pelvic structures (anterior/posterior vaginal wall, cervix, uterus, or vaginal apex).

Symptoms: Vaginal bulge or pressure, urinary, bowel, sexual symptoms, or pelvic/back pain.

Prevalence: In primary care 8.4% of women reported a vaginal bulge or lump, and on examination prolapse is present in up to 50% of women. One in 10 women will need at least 1 surgical procedure, and the rate of re-operation is as high as 19%.

Vaginitis[123]

Definition: Inflammation of the vagina due to changes in the composition of the vaginal micro-environment.

Causes: Infection, irritants, hormonal deficiency (e.g. atrophic vaginitis)

Prevalence: Atrophic vaginitis may affect up to 40% of postmenopausal women, but very few seek medical care.

[122] NICE (2019). Urinary incontinence and pelvic organ prolapse in women: management.

[123] BMJ Best Practice (2025). Vaginitis.

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Appendix 2 - NICE guidelines

NICE guidelines are evidence-based recommendations developed by the National Institute for Health and Care Excellence to support high-quality, consistent clinical care in the NHS. They set out what assessment, treatment and management should look like for specific conditions, based on the best available research and expert consensus, helping clinicians make informed decisions with patients. NICE guidelines for key gynaecological conditions include:

Condition	Firstline management	Investigations (Primary care)	Indications for referral	Secondary care management
Endometriosis NG73[124]	• Pain relief- NSAIDs ± paracetamol. • Hormonal treatment: combines oral contraceptive pill (COCP) or progestogen only.	• Pelvic exam if appropriate. • Ultrasound if endometrioma (cyst) suspected (normal US does *not* exclude endometriosis).	• Symptoms persist despite treatment. • Suspected deep endometriosis or an endometrioma. • Fertility concerns.	• MRI for suspected deep disease. • Diagnostic laparoscopy ± excision/ablation. • Multidisciplinary management for complex disease (bowel/bladder/ureter). • Fertility management including referral to fertility services.
Fibroids NICE CKS[125]	• NSAIDs for pain relief and dysmenorrhoea consider tranexamic acid (TXA) for heavy bleeding. • Consider hormonal options (e.g. combined hormonal contraception or progestogen only methods) depending on bleeding pattern and patient preference.	• Pelvic ultrasound to assess size, number, and location of fibroids. • FBC to check for iron-deficiency anaemia.	• An uncertain diagnosis. • Severe heavy menstrual bleeding or compressive symptoms. • Symptoms which cannot be successfully managed in primary care. • Confirmed fibroids measuring 3 cm or more in diameter or suspected submucosal fibroids	• Gonadotrophin-releasing hormone-analogues (GnRH). • Ulipristal acetate (progesterone receptor modulator). • Uterine artery embolization. • Surgical options- hysteroscopic resection, myomectomy, hysterectomy (may be open, laparoscopic or vaginal approach) or second-generation endometrial

[124] NICE (2017). Endometriosis: diagnosis and management. NICE guideline NG73.

[125] NICE (2026). Fibroids: management - Clinical Knowledge Summary.

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			(for example on pelvic ultrasound scan) • Suspected fertility or obstetric issues associated with fibroids. • Rapid or unexpected growth of fibroids after the menopause.	ablation for heavy menstrual bleeding.
Menorrhagia (Heavy Menstrual Bleeding) NG88	• If no identified pathology- Levonorgestrel Releasing-Intrauterine Device (LNG-IUD) first line. • If unsuitable: TXA, NSAIDs, CHC, cyclical progestogens.	• FBC, pregnancy test. • Pelvic exam if symptoms suggest pathology. • Ultrasound if structural cause suspected.	• Persistent HMB. • Structural pathology suspected (fibroids >3cm/adenomyosis). • Red flags e.g. postmenopausal bleeding (PMB).	• Outpatient hysteroscopy ± biopsy. • Complex LARC insertion • Endometrial ablation (second generation techniques). • Surgical treatment including hysterectomy, depending on pathology and preference.
Dysmenorrhoea (Painful periods) NICE CKS[126]	• NSAIDs first line. • Add hormonal contraception (CHC, POP, Depo injection, LNGIUS).	• Abdominal and pelvic exam (except in young women who are not sexually active if the symptoms are suggestive of primary dysmenorrhoea). • STI testing and pregnancy test if sexually active. • Ultrasound if secondary cause suspected.	• Pain not responding to initial treatment after 3-6 months. • Suspected secondary causes (endometriosis, fibroids, pelvic inflammatory disease).	• Further imaging (e.g., MRI for adenomyosis). • Laparoscopy if endometriosis suspected. • Treatment of underlying condition (e.g. excision of endometriosis, fibroid treatment).
Menopause NG23	• Individualise care. • Offer HRT for vasomotor symptoms unless contraindicated.	• Diagnosis is clinical if ≥45 years — no blood tests usually needed.	• Suspected premature ovarian insufficiency (POI). • Persistent symptoms despite optimised HRT. • HRT / treatments have caused side effects	• Specialist menopause clinic for complex cases. • HRT tailoring including transdermal/combined regimes. • Management of POI.

[126] NICE (2026). Dysmenorrhoea: primary dysmenorrhoea – management. Clinical Knowledge Summary.

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	• Vaginal oestrogen for genitourinary symptoms (GSM).		• Complex medical / cancer history requiring specialist input.	• Complex GSM management including vaginal oestrogen, pessaries, or specialist SRH input. • Testosterone initiation for low sexual desire. • Non-hormonal alternatives (with consideration to interactions) • MDT review of complex cases
Pelvic floor dysfunction NG210 **Urinary incontinence and pelvic organ prolapse in women: management NG 123**	• Lifestyle changes e.g. weight loss if BMI >30, diet changes, reduction in caffeine, moderate fluid intake • Constipation management • Supervised pelvic floor muscle training • Vaginal pessaries • Bladder re-training • Medical management depending on underlying diagnosis e.g. anticholinergic medications • Topical oestrogens for co-existing GSM	• Pelvic examination • Urinalysis +/- MC+S • Post-void bladder scan • Bladder diary	• Unsuccessful conservative and/or initial medical management • Persisting bladder or urethral pain • Palpable bladder on examination after voiding • Clinically benign pelvic masses • Associated faecal incontinence • Suspected neurological disease • Voiding difficulty • Suspected urogenital fistulae • Previous continence surgery, pelvic cancer surgery or pelvic radiation therapy.	• Further investigations including urodynamics • Vaginal pessary initiation and management • Specialist MDT input • Medical management where initial treatments have failed • Prolapse and incontinence surgery, including mesh procedures • Neurostimulation treatments e.g. percutaneous sacral nerve stimulation • Botulinum toxin type A injection • Intramural bulking agents • Management of mesh complications
Premenstrual syndrome[127]	• Lifestyle advice • NSAIDs – pain management • CBT • Drospirenone containing combined hormonal	• Retrospective symptom diary • Pelvic examination if indicated • Investigation and management of alternative or	• Unclear diagnosis • First line treatment strategies have failed to control symptoms	• Gonadotrophin-releasing hormone agonists (diagnosis, management) +/- add back HRT • Transdermal oestrogen with endometrial protection

[127] NICE (2024). Premenstrual syndrome.

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	contraceptive pill for eligible women (off label) • Consideration of selective serotonin re-uptake inhibitors (SSRI) (off label) – cyclical or continuous	contributing causes to symptoms		• Surgical management including bilateral salpingo oophorectomy
Polycystic ovary syndrome [128] (now called Polyendocrine Metabolic Ovarian Syndrome)	• Lifestyle changes, e.g. weight loss if BMI >30 • Managing cardiovascular risk • Consider combined oral contraceptive pills for eligible women (off label) for symptoms • Symptom management – e.g. acne treatments, hair removal • Cyclical progestogens, COC or LNG-IUD for amenorrhoea • Consideration of metformin with specialist advice	• Pelvic ultrasound scan (>18 only) • Blood tests – LH, FSH, prolactin, TSH • Free androgen index	• Thickened or abnormal endometrium on ultrasound • Not having regular bleeds (at least every 3 months) - despite or declining treatment • Complications requiring specialist input e.g. obstructive sleep apnoea, subfertility • Preconception counselling	• Management of complications including subfertility • Specialist medical management, including metformin, cyproterone acetate COC, anti-androgens e.g. spironolactone, inositol • Specialist management of non-gynaecological complications e.g. OSA, obesity

[128] NICE (2025). Polycystic ovary syndrome

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Appendix 3 - Snomed Codes

SNOMED coding is used by general practice to assign standardised codes to patient care including diagnoses, symptoms and test results. Codes were grouped into different gynaecological presentations, which included both symptoms, such as heavy menstrual bleeding and painful periods, and diagnosed conditions, such as endometriosis and fibroids. Below is a full list of SNOMED codes.

Condition	Group
[M]Fibroid uterus	Fibroids
[X]Other female genital prolapse	Prolapse
[X]Other specified abnormal uterine and vaginal bleeding	Bleeding (including IMB, PCB)
[X]Other specified irregular menstruation	Irregular/absent periods
Abnormal perimenopausal bleeding	Bleeding (including IMB, PCB)
Abnormal vaginal bleeding	Bleeding (including IMB, PCB)
Abnormal vaginal bleeding, unspecified	Bleeding (including IMB, PCB)
Abnormal vaginal discharge	Discharge
Adenomyosis	Adenomyosis
Administration of treatment via pessary	Pessary management
After menopause	Menopause
Anterior vaginal wall prolapse	Prolapse
Are you experiencing any irregular vaginal bleeding?=Yes	Bleeding (including IMB, PCB)
Assessment using GCS (Greene Climacteric Scale)	Menopause
Assessment using Menopause Symptom Scale (Greene Climacteric)	Menopause
Atrophic endometrium	Menopause
Bladder cystocele	Prolapse
Bladder-supporting pessary	Pessary management
Bleeding - vaginal NOS	Bleeding (including IMB, PCB)
Bleeding after menopause	Postmenopausal bleeding
Bleeding between periods	Bleeding (including IMB, PCB)
Bleeding from vagina	Bleeding (including IMB, PCB)
Bleeding of vagina	Bleeding (including IMB, PCB)
Break - through bleeding	Bleeding (including IMB, PCB)
Breakthrough bleeding	Bleeding (including IMB, PCB)
Break-through bleeding	Bleeding (including IMB, PCB)
Brown vaginal discharge	Discharge
Cervical fibroid	Fibroids
Cervical pessary	Pessary management
Change of vaginal pessary	Pessary management
Chocolate cyst of ovary	Endometriosis
Chronic female pelvic pain syndrome	Pelvic pain
Chronic pelvic pain of female	Pelvic pain
Chronic vaginal pain	Vulvovaginal conditions
Climacteric menorrhagia	Bleeding (including IMB, PCB)

Colporrhaphy	Prolapse
Complete uterine prolapse and anterior vaginal wall prolapse	Prolapse
Complete uterine prolapse with enterocele	Prolapse
Complete uterovaginal prolapse	Prolapse
Coughing incontinence of urine	Stress incontinence
Creamy vaginal discharge	Discharge
Cycle -menstrual - data	Periods
Cyclic pelvic pain	Pelvic pain
Cystocele	Prolapse
Cystocele and incomplete uterovaginal prolapse	Prolapse
Cystocele and rectocele and incomplete uterovaginal prolapse	Prolapse
Cystocele -no uterine prolapse	Prolapse
Cystocele with first degree uterine prolapse	Prolapse
Cystocele with second degree uterine prolapse	Prolapse
Cystocele with third degree uterine prolapse	Prolapse
Cystocele with unspecified uterine prolapse	Prolapse
Cystocele without uterine prolapse	Prolapse
Cystocoele and incomplete uterovaginal prolapse	Prolapse
Cystocoele and rectocoele co-occurrent with complete uterovaginal prolapse	Prolapse
Cystocoele co-occurrent with incomplete uterovaginal prolapse	Prolapse
Cystourethrocele without uterine prolapse	Prolapse
Deep endometriosis	Endometriosis
Delayed menopause	Menopause
Dysfunctional uterine bleeding	Bleeding (including IMB, PCB)
Dysfunctional uterine haemorrhage	Bleeding (including IMB, PCB)
Dysmenorrhea	Painful periods
Dysmenorrhoea	Painful periods
Dysmenorrhoea - non-psychogenic	Painful periods
Early menopause	Menopause
Endometrial cyst of right ovary	Endometriosis
Endometrioma	Endometriosis
Endometriosis	Endometriosis
Endometriosis (clinical)	Endometriosis
Endometriosis (disorder)	Endometriosis
Endometriosis NOS	Endometriosis
Endometriosis of appendix	Endometriosis
Endometriosis of cervix	Endometriosis
Endometriosis of intestine	Endometriosis
Endometriosis of left ovary	Endometriosis
Endometriosis of left ovary (disorder)	Endometriosis
Endometriosis of ovary	Endometriosis
Endometriosis of pelvis	Endometriosis
Endometriosis of pouch of Douglas	Endometriosis
Endometriosis of rectovaginal septum	Endometriosis

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Endometriosis of rectum	Endometriosis
Endometriosis of round ligament	Endometriosis
Endometriosis of umbilicus	Endometriosis
Endometriosis of uterosacral ligament	Endometriosis
Endometriosis of uterus	Endometriosis
Endometriosis of vagina	Endometriosis
Enterocele	Prolapse
Excessive and frequent menstruation	Heavy menstrual bleeding
Female climacteric state	Menopause
Female cystocele and uterine prolapse	Prolapse
Female cystourethrocele	Prolapse
Female genital organ symptoms	Other
Female genital symptoms NOS	Other
Female pelvic organ prolapse (disorder)	Prolapse
Female proctocele without uterine prolapse	Prolapse
Female rectocele	Prolapse
Female rectocele without uterine prolapse	Prolapse
Female rectocoele	Prolapse
Female stress incontinence	Stress incontinence
Female urethrocoele without uterine prolapse	Prolapse
Female urinary stress incontinence	Stress incontinence
Fibroid uterus	Fibroids
Fibroids	Fibroids
First degree uterine prolapse	Prolapse
Fishy vaginal discharge	Discharge
Flooding during periods	Heavy menstrual bleeding
Frequent heavy periods	Heavy menstrual bleeding
Fresh bleeding from vagina	Bleeding (including IMB, PCB)
Genital prolapse	Prolapse
Genuine stress incontinence	Stress incontinence
Green vaginal discharge	Discharge
Gynaecological history	Other
Gynaecological history NOS	Other
H/O: dysmenorrhoea	Painful periods
H/O: heavy periods	Heavy menstrual bleeding
H/O: inter-menstrual bleeding	Bleeding (including IMB, PCB)
H/O: menorrhagia	Heavy menstrual bleeding
H/O: painful periods	Painful periods
H/O: postmenopausal bleeding	Menopause
H/O: post-menopausal bleeding	Postmenopausal bleeding
H/O: stress incontinence	Stress incontinence
Heavy episode of vaginal bleeding	Bleeding (including IMB, PCB)
Heavy menstrual bleeding	Heavy menstrual bleeding
Heavy menstrual period	Heavy menstrual bleeding

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Heavy period	Heavy menstrual bleeding
Heavy periods	Heavy menstrual bleeding
Herniation of rectum into vagina	Prolapse
History of dysmenorrhoea	Painful periods
Hypomenorrhoea	Irregular/absent periods
Hypothalamic amenorrhoea	Irregular/absent periods
IMB - Intermenstrual bleeding	Bleeding (including IMB, PCB)
Incomplete uterine prolapse	Prolapse
Incontinence of urine during exercise	Stress incontinence
Infrequent periods	Irregular/absent periods
Insertion of pessary into vagina	Pessary management
Insertion of ring into vagina	Pessary management
Insertion of ring pessary into vagina	Pessary management
Insertion of shelf pessary into vagina	Pessary management
Insertion of supporting pessary into vagina	Pessary management
Intermenstrual bleeding	Bleeding (including IMB, PCB)
Intermenstrual bleeding - irregular	Bleeding (including IMB, PCB)
Intermenstrual bleeding - regular	Bleeding (including IMB, PCB)
Intermenstrual heavy bleeding	Bleeding (including IMB, PCB)
Intramural leiomyoma of uterus	Fibroids
Intramural uterine fibroid	Fibroids
Intramural uterine leiomyoma	Fibroids
Introduction of supporting pessary into vagina	Pessary management
Irregular intermenstrual bleeding	Bleeding (including IMB, PCB)
Irregular menstrual bleeding	Irregular/absent periods
Irregular menstrual cycle	Irregular/absent periods
Irregular menstrual cycle NOS	Irregular/absent periods
Irregular menstrual cycle=Irregular menstrual cycle	Irregular/absent periods
Irregular periods	Irregular/absent periods
Irregular uterine bleeding	Irregular/absent periods
Irritation - vaginal	Vulvovaginal conditions
Lactational amenorrhoea	Irregular/absent periods
Last Period Abnormal	Irregular/absent periods
Last Period Normal	Periods
Leiomyoma of body of uterus	Fibroids
Light and infrequent menstruation	Irregular/absent periods
Long menstrual cycle	Irregular/absent periods
Mechanical dysmenorrhoea	Painful periods
Menometrorrhagia	Bleeding (including IMB, PCB)
Menopausal and postmenopausal disorder NOS	Menopause
Menopausal and postmenopausal disorders	Menopause
Menopausal arthritis	Menopause
Menopausal concentration lack	Menopause
Menopausal depression	Menopause

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Menopausal endometrium	Menopause
Menopausal flushing	Menopause
Menopausal headache	Menopause
Menopausal hot flushes	Menopause
Menopausal hyperhidrosis	Menopause
Menopausal menorrhagia	Menopause
Menopausal muscular dystrophy syndrome	Menopause
Menopausal osteoporosis	Menopause
Menopausal problem	Menopause
Menopausal sleeplessness	Menopause
Menopausal state	Menopause
Menopausal symptom	Menopause
Menopausal symptoms NOS	Menopause
Menopausal urethral atrophy	Menopause
Menopause	Menopause
Menopause finding	Menopause
Menopause follow-up assessment	Menopause
Menopause initial assessment	Menopause
Menopause initial assessment (regime/therapy)	Menopause
Menopause monitoring	Menopause
Menopause monitoring (regime/therapy)	Menopause
Menopause present	Menopause
Menopause symptoms present	Menopause
Menopause: dietary advice	Menopause
Menorrhagia	Heavy menstrual bleeding
Menorrhalgia	Heavy menstrual bleeding
Menstrual cramps	Painful periods
Menstrual data	Periods
Menstrual data NOS	Periods
Menstrual loss data	Periods
Menstrual periods irregular	Irregular/absent periods
Menstrual periods regular	Periods
Metrorrhagia	Bleeding (including IMB, PCB)
Mid-cycle bleeding	Bleeding (including IMB, PCB)
Midline cystocoele without uterine prolapse	Prolapse
Mixed urinary incontinence	Stress incontinence
Moderate vaginal bleeding	Bleeding (including IMB, PCB)
Moderate vaginal discharge	Discharge
Normal menopause	Menopause
Normal periods	Periods
Observation of vaginal discharge	Discharge
Observations of vaginal bleeding	Bleeding (including IMB, PCB)
Odourless vaginal discharge	Discharge
Offensive vaginal discharge	Discharge

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Oligomenorrhea	Irregular/absent periods
Oligomenorrhoea	Irregular/absent periods
Other abnormal uterine and vaginal bleeding	Bleeding (including IMB, PCB)
Other endometriosis	Endometriosis
Other female genital symptom	Other
Other pelvic pain - female	Pelvic pain
Other repair of vaginal prolapse	Prolapse
Ovarian pain	Pelvic pain
Pain in female pelvis	Pelvic pain
Pain of ovary	Pelvic pain
Pain of uterus	Pelvic pain
Painful menorrhoea	Painful periods
Passing clots vaginally	Heavy menstrual bleeding
Passing large clots vaginally	Heavy menstrual bleeding
Passing small clots vaginally	Heavy menstrual bleeding
PCO - Polycystic ovaries	PCOS
PCOS - Polycystic ovarian syndrome	PCOS
Pelvic floor dysfunction	Pelvic floor dysfunction
Perimenopausal	Menopause
Perimenopausal atrophic vaginitis	Vulvovaginal conditions
Perimenopausal disorder	Menopause
Perimenopausal menorrhagia	Heavy menstrual bleeding
Perimenopause	Menopause
Period - menstrual-data	Periods
Period pain	Painful periods
Period pains	Painful periods
Periods have stopped	Irregular/absent periods
PMB - Postmenopausal bleeding	Postmenopausal bleeding
Polycystic ovarian disease	PCOS
Polycystic ovarian syndrome	PCOS
Polycystic ovaries	PCOS
Polycystic ovary syndrome	PCOS
Post hysterectomy vaginal vault prolapse	Prolapse
Post menopausal depression	Menopause
Postartificial menopausal syndrome	Menopause
Posterior vaginal wall prolapse	Prolapse
Post-hysterectomy vaginal vault prolapse	Prolapse
Postmenopausal	Menopause
Postmenopausal atrophic urethritis	Menopause
Postmenopausal bleeding	Postmenopausal bleeding
Postmenopausal osteoporosis	Menopause
Postmenopausal postcoital bleeding	Postmenopausal bleeding
Postmenopausal state	Menopause
Postmenopausal urethritis	Menopause

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Postnatal vaginal discomfort	Vulvovaginal conditions
Postpill amenorrhoea	Irregular/absent periods
Premature menopause	Menopause
Primary dysmenorrhoea	Painful periods
Primary oligomenorrhoea	Irregular/absent periods
Problem with vaginal pessary	Pessary management
Prolapse of female genital organs	Prolapse
Prolapse of ovary	Prolapse
Prolapse of uterine cervical stump	Prolapse
Prolapse of vaginal walls without uterine prolapse	Prolapse
Psychogenic dysmenorrhea	Painful periods
Psychogenic dysmenorrhoea	Painful periods
Pubertal menorrhagia	Heavy menstrual bleeding
Rectocele	Prolapse
Rectocele and incomplete uterine prolapse	Prolapse
Rectocele without uterine prolapse	Prolapse
Rectocoele	Prolapse
Rectocoele and incomplete uterine prolapse	Prolapse
Rectocoele in pregnancy, childbirth and puerperium	Prolapse
Recurrent stress incontinence	Stress incontinence
Regular periods	Periods
Relaxation of pelvic floor	Pelvic floor dysfunction
Removal of ring pessary from vagina	Pessary management
Renewal of ring pessary in vagina	Pessary management
Renewal of supporting pessary in vagina	Pessary management
Repair of vaginal wall prolapse	Prolapse
Replacement of pessary in vagina	Pessary management
Scanty and infrequent menstruation	Irregular/absent periods
Scanty or infrequent menstruation NOS	Irregular/absent periods
Scanty periods	Irregular/absent periods
Second degree uterine prolapse	Prolapse
Secondary amenorrhea	Irregular/absent periods
Secondary amenorrhoea	Irregular/absent periods
Secondary dysmenorrhoea	Painful periods
Secondary oligomenorrhea	Irregular/absent periods
Secondary oligomenorrhoea	Irregular/absent periods
Secondary physiologic amenorrhoea	Irregular/absent periods
Short menstrual cycle	Irregular/absent periods
SI - Stress incontinence	Stress incontinence
Sneezing incontinence of urine	Stress incontinence
Spasmodic dysmenorrhoea	Painful periods
Spotting between periods	Bleeding (including IMB, PCB)
Stress bladder incontinence	Stress incontinence
Stress incontinence	Stress incontinence

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Stress incontinence - female	Stress incontinence
Stress incontinence - symptom	Stress incontinence
Stress incontinence with pelvic organ prolapse	Prolapse
Stress urinary incontinence	Stress incontinence
Submucous leiomyoma of uterus	Fibroids
Submucous uterine fibroid	Fibroids
Submucous uterine leiomyoma	Fibroids
Subserous leiomyoma of uterus	Fibroids
Subserous uterine fibroid	Fibroids
Superficial endometriosis of ovary	Endometriosis
Superficial endometriosis of ovary (disorder)	Endometriosis
Superficial endometriosis of pelvic peritoneum	Endometriosis
Surgical menopause	Menopause
Third degree uterine prolapse	Prolapse
Urinary stress incontinence	Stress incontinence
Uterine fibroid	Fibroids
Uterine fibroid (disorder)	Fibroids
Uterine fibroid polyp	Fibroids
Uterine fibroids	Fibroids
Uterine fibroids (disorder)	Fibroids
Uterine fibroids in pregnancy, childbirth and the puerperium	Fibroids
Uterine leiomyoma	Fibroids
Uterine leiomyoma - fibroids	Fibroids
Uterine procidentia	Prolapse
Uterine prolapse	Prolapse
Uterine prolapse in pregnancy	Prolapse
Uterine prolapse without vaginal wall prolapse	Prolapse
Uterovaginal prolapse	Prolapse
Uterovaginal prolapse, incomplete	Prolapse
Vaginal bleeding	Bleeding (including IMB, PCB)
Vaginal blood loss	Bleeding (including IMB, PCB)
Vaginal cystocele	Prolapse
Vaginal discharge	Vulvovaginal conditions
Vaginal discharge NOS	Discharge
Vaginal discharge present	Vulvovaginal conditions
Vaginal discharge problem	Discharge
Vaginal discharge symptom	Vulvovaginal conditions
Vaginal discomfort	Vulvovaginal conditions
Vaginal dryness	Vulvovaginal conditions
Vaginal dryness on intercourse	Vulvovaginal conditions
Vaginal enterocele	Prolapse
Vaginal haematoma	Vulvovaginal conditions
Vaginal irritation	Vulvovaginal conditions
Vaginal pain	Vulvovaginal conditions

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Vaginal prolapse without uterine prolapse	Prolapse
Vaginal prolapse without uterine prolapse NOS	Prolapse
Vaginal vault haematoma	Vulvovaginal conditions
Vaginal vault prolapse	Prolapse
Vaginal wall prolapse	Prolapse
Vaginal wall prolapse without uterine prolapse	Prolapse
Vaginal wall prolapsed at introitus	Prolapse
Vulvovaginal discomfort	Vulvovaginal conditions
Vulvovaginal dryness	Vulvovaginal conditions
Vulvovaginal pain	Vulvovaginal conditions
White vaginal discharge	Discharge
Yellow vaginal discharge	Discharge

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