Lancashire and South Cumbria
Integrated Care Board

Scoping survey to gauge satisfaction with existing women's health services across Lancashire and South Cumbria

June 2024

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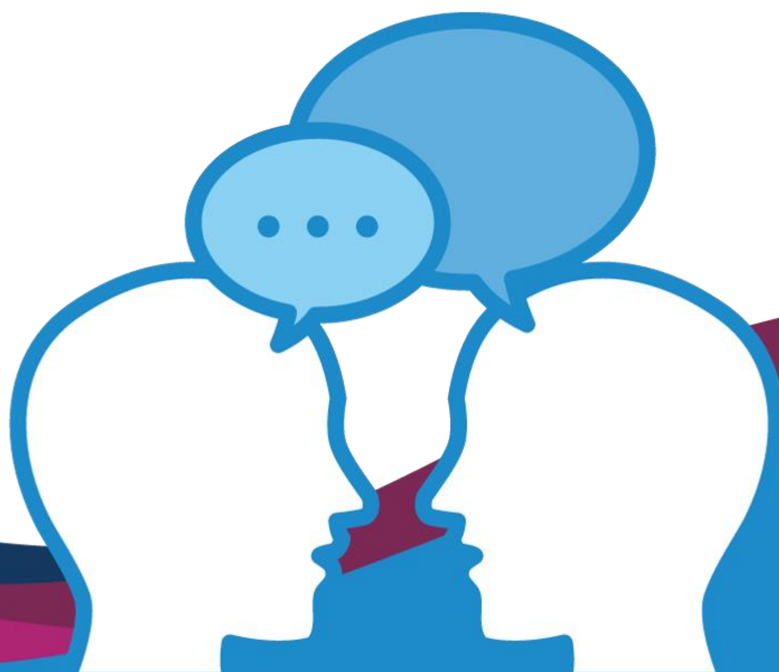

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Acknowledgements

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Introduction

There are around 1.8 million residents in Lancashire and South Cumbria – of those, around 917,000 are girls, women and people assigned female at birth (AFAB), aged from birth to over 90 years old.

To align with national priorities, Lancashire and South Cumbria ICB was awarded £595,000 of funding to deliver women's hubs focusing on areas of need. As part of this work, a requirement was to have one of the hubs operational by December 2024; in order to make the hubs as meaningful as possible to as many people as possible, we decided that we needed to ask women what they wanted to happen with any potential contraceptive and menopause services.

Executive summary

Lancashire and South Cumbria ICB received £595,000 of funding to deliver women's hubs through the Women and Children's programme workstream. A scoping survey was sent to over 300 organisations and individuals asking for women and people assigned female at birth to share their thoughts on current provision of contraceptive and menopause services.

The survey got 1549 responses, representing 0.2% of the eligible population, which seemed to indicate that whilst contraceptive services are reasonably accessible and useful there is a significant gap in provision for those in need of menopause care. Primary care services seem to struggle to meet demand and refer on to specialist gynaecology services when a specialist service might not be necessary. This has a knock-on impact on delivery of specialist services which are unable to meet demand. Specialist women's hubs may be ideally placed to support provision of menopause services and would be very much welcomed by people seeking support for peri- and menopause symptoms.

The main findings can be summarised as:
The survey was designed to ask women and AFAB people about their contraceptive and menopause needs. There were 1549 responses, with a number of themes and recommendations:

- Address unwanted variance in primary care- issues around services provided, accessibility, knowledge and specialism of staff.
- Make sure any future engagement is in non-medicalised language. .
- Greater provision of specialist/focused clinics staffed by well-trained, compassionate, and knowledgeable staff.
- Provide services locally at Place rather than centrally- consider issues such as transport, deprivation, rurality when planning service delivery.
- Utilise primary care/community spaces as people are already familiar with them- no need to build additional clinical spaces.
- Be mindful of LGBTQ+ service users; avoid gender-stereotypes in comms materials, use inclusive terms.
- Address menopause as holistic condition- does not always require referral to gynaecology or mental health services.
- Improve accessibility- language/ location/ estates e.g. disabled access.

Who have we heard from?

Deciding who to talk to

Based on the most recent Joint Strategic Needs Assessment (JSNA) information available at the time of planning, there were 916,718 girls, women, and people assigned female at birth (AFAB) aged between 0 and 90 years across Lancashire and South Cumbria out of a total population of ~1.8 million. To align with national priorities, Lancashire and South Cumbria ICB was awarded £595,000 of funding to deliver women's hubs focusing on areas of need. As part of this work, a requirement was to have one of the hubs operational by December 2024.

The team working on this project designed a survey, based on some assumptions from what the system already knows about how services focused on women and AFAB people already work. The main assumptions were that contraception would be important to the majority of women and AFAB people for a variety of reasons other than just pregnancy prevention, and that women aged around 40 and over would at some point have need of menopause services, which are currently inconsistently provided within primary care.

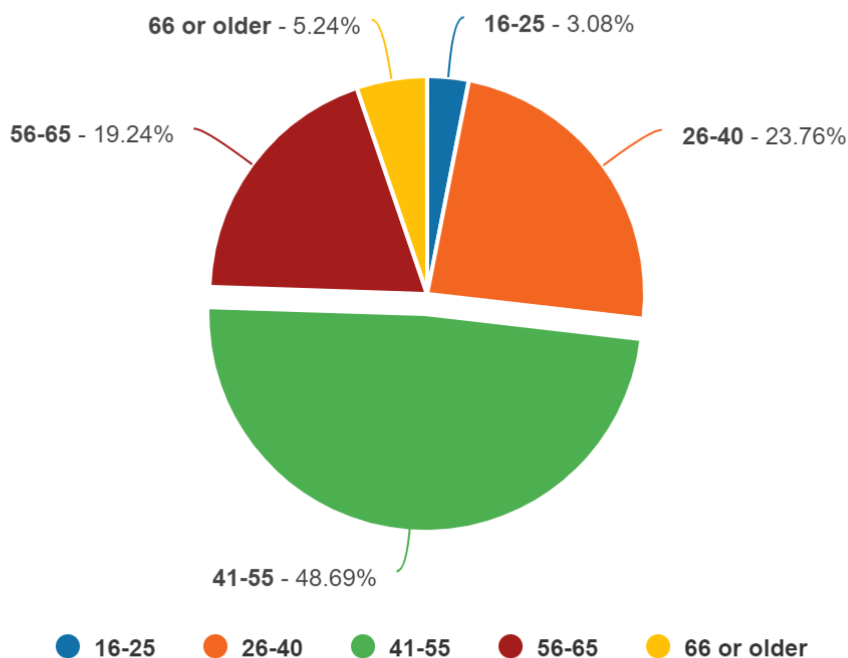
How many people got involved?

Demographics

The survey gathered 1549 responses.

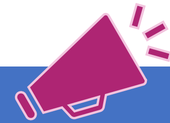
Respondents were asked their age, location, ethnicity, and sexuality. Below are breakdowns of each demographic.

Age



Of 1549 responses, 1528 responded to the question about age with 21 declining to answer. Respondents were predominantly aged between 26 and 55 (72.45%), with fewest responses from women aged between 16 and 25 (3.08%). Women over 66 were under-represented

How did we speak to people?



To meet tight timelines, an online survey was conducted. This was an English- language survey, shared with more than 300 stakeholders and colleagues for cascade.

Questionnaire

The questionnaire asked respondents to consider 14 questions:

1. How satisfied are you with women's health services in your area?
2. Are you currently using contraception?
3. Which contraception do you use?
4. Why do you use contraception?
5. Have you ever struggled to get contraception?
6. Please tell us about your experiences of accessing contraceptive/ sexual health services.
7. Do you know what Long Acting Reversible Contraceptives are?
8. Have you ever been advised by a healthcare professional to use the implant, injection or coil (LARC)?
9. Do you know about any additional benefits of having LARC?
10. How could contraceptive/ sexual health services be improved?
11. Do you know what perimenopause is?
12. Are you experiencing any perimenopause symptoms?
13. Are you having ay treatment for your symptoms?
14. How could menopause services be improved?

Respondents were able to choose from a range of drop-down boxes, text boxes, and radio buttons depending on the question.

What did we hear?

Responses to each question were analysed, showing numbers of responses, responses themselves, and emergent themes.

Question 1: How satisfied are you with women's health services in your area?

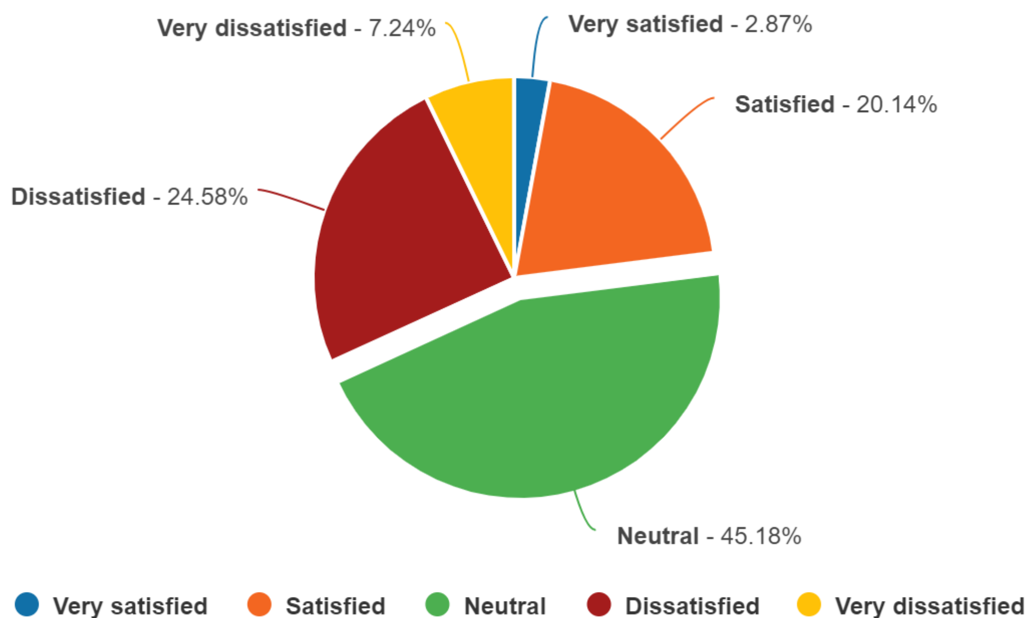


Figure 1: Responses to Question 1: How satisfied are you with women's health services in your area?

Responses: 1534

Comments: 654

In fig.1 we can see that the majority (45.18%) of respondents feel neutrally about the women's services in their areas, with only 23.01% feeling very satisfied/ satisfied with services available. Almost a third (31.82%) are dissatisfied/ very dissatisfied with services available to them.

Question number	Theme	Number of mentions
1	Appointments/ waiting time/ access	404
	Health/ symptoms	295
	Services	261
	Menopause/ perimenopause/ HRT	253
	Difficult/ issues/ lack (gaps in provision)	144
	Care/ staff knowledge	96
	Sexual health/ smear test	89
	Gynaecology/ specialist services	86

Above we can see the themes from the text box portion of Q1 develop into eight main areas of concern; unsurprisingly, appointments, waiting time and access to services are the biggest concerns. This is discrete from services themselves, which described dissatisfaction with the services available- a significant number of respondents flagged that they were unaware of

women's services in their area, although we have been working on the assumption that there are at least primary care services universally available.

Many respondents raised their concerns that overall health and symptoms were dismissed, ignored or missed, especially in relation to perimenopause/ menopause. A significant number of respondents flagged issues with gaps in either service provision or staff knowledge around women's health, and raised concerns that women are routinely referred to specialist gynaecology services (with extensive waiting lists) for issues which could be readily addressed by a specialist women's health provider.

Question 2: Are you currently using contraception?

Responses: 1533

Yes, go to Q3: 31.25%

No, go to Q5: 68.75%

Question 3: Which contraception do you use?

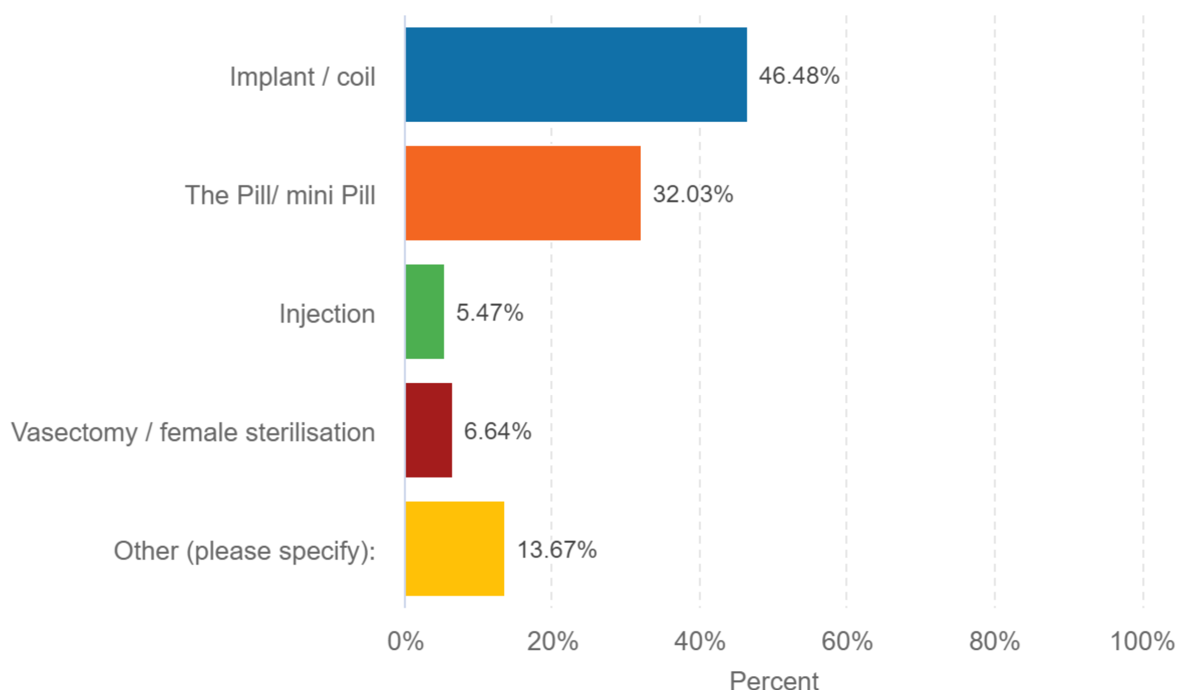


Figure 2: Responses to Question 3: Which contraception do you use? Choose all that apply.

Of 70 respondents who chose 'other', eight stated they use a contraceptive patch which was not offered as a response option here. Condoms were used by 24 respondents, seven respondents used no contraception, and seven respondents gave answers which appeared

in the poll already e.g. the Mirena coil, the implant. Intriguingly, one respondent stated she prays to a higher power!

Question 4: Why do you use contraception?

Responses: 508 comments: 38

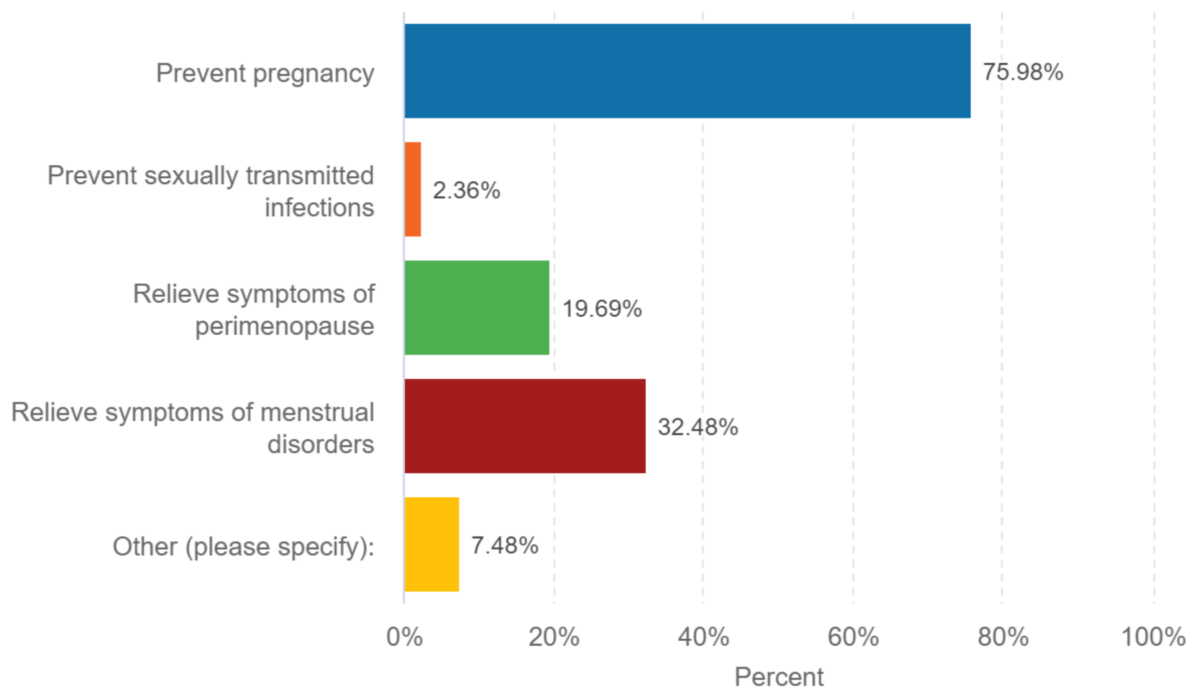


Figure 3: Responses to Question 4: Why do you use contraception? Choose all that apply.

Of 38 respondents who chose ‘other’, 24 respondents mentioned specific conditions e.g. endometriosis, painful periods, low mood. 13 respondents stated that they don’t use contraception, which may demonstrate a misunderstanding of the question. Six respondents stated they use contraception to prevent pregnancy, with one respondent sharing some strongly-worded views about the present government and her decision to not have children- this was one of the listed options, but it appears that people had other issues they wanted to share in addition.

Question 5: Have you ever struggled to get contraception?

Responses: 1484

Comments: 256

Yes, please comment below: 12.06%

No: 87.94%

Question number	Themes	Number of mentions
5	Contraceptive types	164
	Appointments/ waiting time/ access	135
	Services	79
	Issues/ difficulties	71
	Length of wait	67
	Menopause/ conditions	26

The majority of comments on this question described the type of contraceptives women have struggled to access or would prefer to use. Unsurprisingly, the next highest number of comments were around difficulties getting appointments, waiting times and access to services especially for those living rurally; respondents highlighted delays with appointments, long waiting times, and demand is often far greater than provision. Many respondents noted issues with services and issues more generally; poor local services, services that are not young person friendly, lack of expert knowledge- one respondent was told that her coil would dissolve on its own.

Respondents also noted that contraception is not seen as shared responsibility in a relationship so the onus is on woman to take hormones, that weight is frequently a barrier to accessing hormonal contraceptives, and GPs can refuse to refer for sterilisation based on their own opinion rather than the patient's request.

The last word on this question must go to the woman who stated, "It takes such a long time [to access services]. I was booked to have the coil and by the time the appointment came up I was pregnant (we used condoms)".

Question 6: Please tell us about your experiences of accessing contraception/sexual health services.

Responses: 785

Question number	Theme	Number of mentions
6	Contraception	376
	Appointments/ access	312
	Sexual health services	205
	Problems/ issues	181
	Health	143
	Good/ easy access	113
	Prescriptions	33

Responses to this question mainly focused on issues with appointments and access to services; many respondents were not aware of any stand-alone sexual health services in their area, and were under the impression that the only route in was via GP. Those who were aware of local sexual services (~15%) had found that the services were good/ easy to access.

Question 7: Do you know what Long-Acting Reversible Contraceptives (LARC) are?

Responses: 1466

Yes: 676 46.11%

No: 790 53.89%

Question 8: Have you ever been advised by a health care professional to use the implant, injection or coil (LARC)?

Responses: 1468

Yes: 707 48.16%

No: 761 51.84%

Question 9: Do you know about any additional benefits of having LARC?

Responses: 1448

Comments: 288

Yes: 303 20.93%

No:1145 79.07%

Question number	Themes	Number of mentions
9	Contraceptive types	400
	Menstruation	193
	Ease of use	67
	Menopause/ perimenopause	56
	Benefits/ protection	36
	Pregnancy	12

Respondents predominantly mentioned the types of contraceptives they were aware of or had used; they spoke about how using contraceptives had improved their menstrual symptoms, alleviated pain and menopause symptoms and prevented pregnancy. Many spoke of how easy using LARC is as it means they will not forget to take it, compared with taking the Pill.

Respondents spoke about the benefits and protection offered by hormonal contraceptives, especially those experiencing perimenopause who noted the protection against various cancers and heart conditions.

Question 10: How could contraceptive/ sexual health services be improved?

Responses: 664

Question number	Themes	Number of mentions
10	Appointments/ services	406
	Venue/ accessibility	255
	Service provision	148
	Education/ advice	157

Overwhelmingly, respondents were concerned with access to services- many were unaware of services in their local area (some stated this was due to age and having no need for contraceptives) and did not know how they might find out about provision. Some respondents were under the impression that sexual health services were provided by GPs whilst others were aware of stand-alone sexual health services in their area.

Question 11: Do you know what perimenopause is?

Responses: 1514

Yes:1390 91.81%

No: 124 8.19%

Question 12: Are you experiencing any perimenopause/menopause symptoms?

Responses: 1150

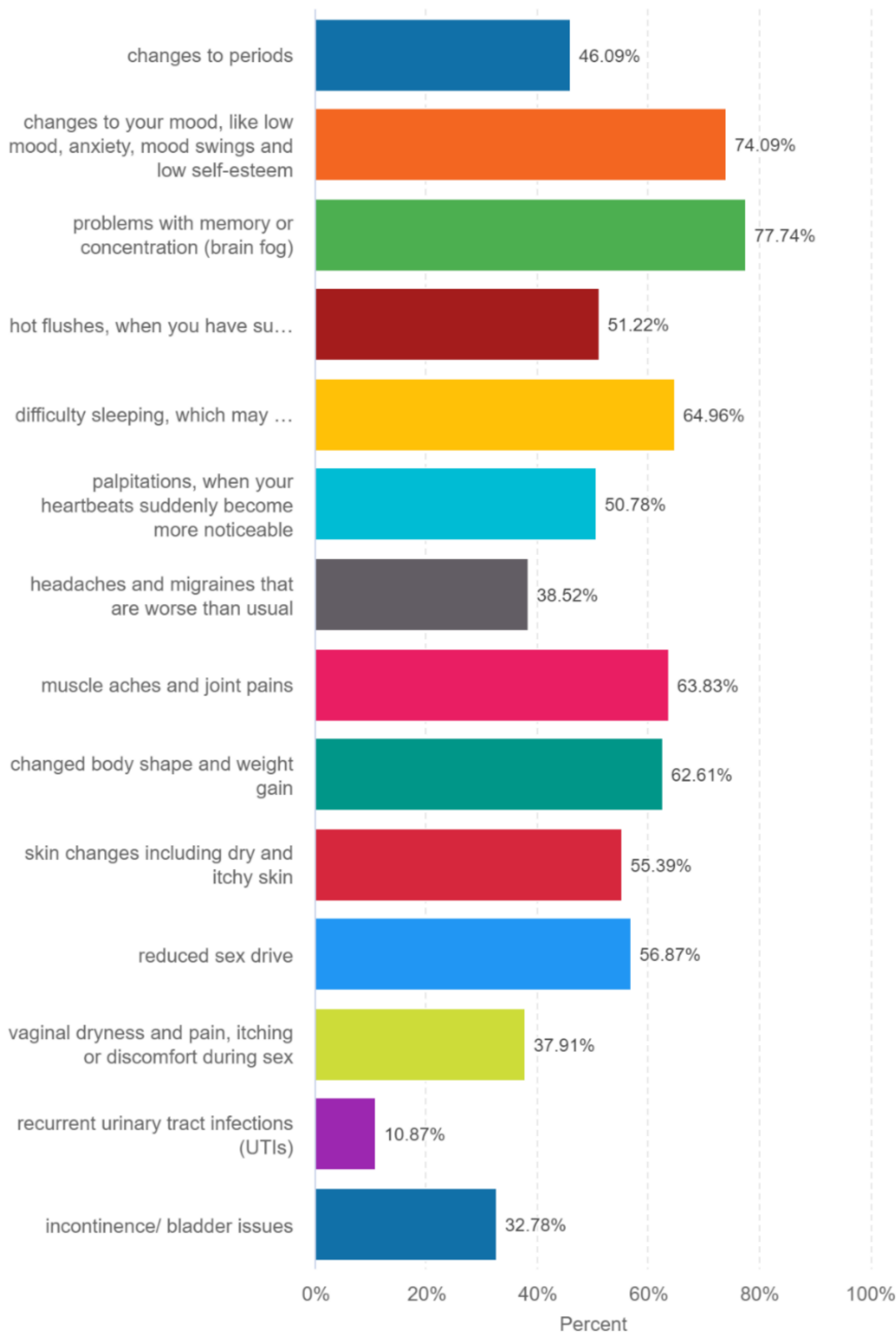


Figure 4: Responses to Question 12: Are you experiencing any perimenopause/menopause symptoms?

The symptoms the greatest number of respondents experience are problems with memory/ brain fog (77.7%) and changes in mood (74%). The symptoms with the highest number of responses are often symptoms of other conditions such as depression, anxiety and thyroid problems. Respondents flagged in other comments sections that GPs are often dismissive of cognitive symptoms, and will refer to mental health services without checking hormone levels which would indicate peri- and menopause symptoms.

Question 13: Are you having any treatment for your menopause symptoms?

Responses: 1448

Comments: 630

Question number	Themes	Number of mentions
13	Types of hormonal therapy	408
	HRT	311
	Medication	29

The responses to this question focused mainly on the types of treatment women were using to manage their peri- and menopause symptoms, with a significant number just stating HRT. Interestingly, many of the comments referred to the resistance they had encountered from GPs and primary care providers in accessing hormonal therapy for menopause, including the respondent who "privately funded testosterone gel… as my GP said she wasn't 'clinically competent to prescribe'" and the respondent who mentioned their menopause symptoms at a thyroid check-up and was told that the GP did not have time to discuss them.

A number of respondents mentioned that their GP was reluctant to prescribe where there were previous conditions or concerns about weight, with one respondent stating "I was always told the issues I had were about being fat and nothing to do with menopause at all". Several respondents mentioned that their symptoms were dismissed as mental health problems or another issue due to their age.

As with other questions, many respondents mentioned issues in accessing appointments with GPs and primary care services in terms of waiting times, referrals on to other services and lack of knowledge when they finally saw someone.

Question 14: How could menopause services be improved?

Responses: 913

Question number	Themes	Number of mentions
14	Access/services	736
	Specialist training	356
	Treatment options	144
	Awareness/education	115

As with other questions, comments overwhelmingly referred to the need for improvement in access to services- suggestions were mostly to have dedicated and specific menopause clinics, with knowledgeable and well-trained staff who have the time to spend discussing symptoms and potential treatments. Other suggested alternatives were menopause specialists in each surgery, either specialist nurse or GP, and menopause navigators/champions at each GP Practice. A respondent suggested adverts and information so people "know menopause is normal".

Were menopause clinics to be a part of the core primary care offer, respondents stated a need for continuity with GPs all following guidance and best practice, taking a holistic approach to all symptoms and actually listening to women, rather than being dismissive. A respondent said she didn't know enough about menopause herself to know what she needed to ask for, but didn't trust GPs enough to believe they would help. One respondent stated her belief that specialist menopause clinics "[should be] 24/7 available and paying the angels that work there 400 pounds per hour", which was certainly a vote of confidence in the care provided by NHS staff.

The final word goes to the respondent who said of her experience asking for perimenopause support: "It was a pretty cold, clinical experience with an undertone of 'you're exaggerating, it can't really be that bad'- how different it could have been to see someone who was well-informed about menopause, who understood and cared that I'm itchy, angry, sweaty and a bit demented!"

What we have learned

What survey respondents have told us- highlights

Respondents told us:

- They would like to see stand-alone women's health services/ hubs, that can be accessed without needing a referral from a GP or primary care provider
- Medicalised language is a barrier for people who don't have health service knowledge- using plain English makes services more accessible
- Making services more digitally accessible must be balanced with consideration for people who need 'analogue' ways to access health care
- They would like to see health staff across the board trained in women's health so that treatment of a variety of conditions can be holistic
- LGBTQ+ service users need to be treated sensitively and without making assumptions
- Services need to be much better about providing information in a range of formats and languages

Limitations

There are approximately 917,000 girls and women between birth and 90 years old across Lancashire and South Cumbria, with approximately 800,000 falling within the scope of this research. The response rate of 1549 represents approximately 0.2% of the eligible

population. Limitations with the research design need to be considered in the analysis to give context and recommendations for the future.

Reach

The research was restricted to an online survey only; no paper copies were made available, and the survey was only available in English. Having an online-only research tool excluded those who do not have access to digital equipment; this may go some way to explaining the low response rate from women aged 66 and over, as older adults are less likely to be digitally active. Digital-only research also excluded those who may have not have access to digital devices, are unable to afford internet connection at home, or are unable to afford to travel to a location with free internet access. The survey was shared with around 350 individuals via email, and more broadly on ICB social media channels, and given the number of contacts from second- and third-hand recipients we can surmise that it was shared widely. However, the low response rate suggests that the survey did not penetrate deeply into all communities.

An interesting consideration is the number of partially completed surveys, totalling 1343. Smart Survey does capture information from partial surveys, so it is possible to access these surveys and potentially understand why they have been abandoned. However, consent to use the information is not given until the respondent submits their survey so we are unable to use any information provided. It is possible to speculate why so many surveys were started but left incomplete, which could be people realising how long it would take to complete, being put off by the number of questions, not understanding the questions and possibly men who were curious about a survey aimed at women and AFAB people.

Accessibility

The survey was offered as an online-only exercise using the Smart Survey platform. This platform is not compatible with all screen readers so may not have been accessible to visually impaired respondents. Due to time constraints and lack of resources we were unable to offer an easy-read version of the survey, which may have been a barrier to gathering responses from neurodivergent women and women with learning disabilities. This method also excluded communities and individuals who may have low literacy levels as it is reliant on written language alone.

Language

Several organisations contacted the team to request that the survey be offered in languages other than English, so it was accessible to women from ethnic minority communities. Due to the time constraints and lack of resources it was not possible to offer the survey in other languages. This would have required translation from an outside agency, or sourcing and buying in a digital platform capable of offering different languages. This is a barrier to understanding the needs of women from ethnic minority communities who are unable to read English-language material.

Focus

While the survey was intended to scope out interest in women's hubs, the team did start with a number of assumptions; that women between 16 and 66+ years old in Lancashire and South Cumbria would be mainly interested in contraception or menopause care, so the

questions focused mainly on these two areas. The team were challenged by organisations and respondents who felt this was a narrow view of the kind of services women/AFAB people need.

Recommendations

From these results, it is possible to understand how wider NHS services are impacted by the lack of a holistic 'women's health' service.

Many respondents were unsure of what was available to them in terms of sexual health services, women's health services and primary care more broadly. Many respondents felt that waiting times for initial appointments in primary care were too long, and that waiting times following referrals into secondary care were prohibitive. The question was raised repeatedly around why there was no stand-alone women's health service that didn't necessitate a visit to a GP or a referral to sit on a lengthy waiting list. Many respondents commented that there is a distinct lack of knowledge and expertise in primary care services around sexual health, contraception, peri- and menopause, which contributes to the reluctance of many to approach services in the first place.

Overall, many respondents commented that male GPs were especially disinterested and unsympathetic but primary care providers generally seemed to lack knowledge about women's health, contraception and hormonal treatments for peri- and menopause symptoms across the board. A strong sense of disillusionment came across, with many respondents commenting that they were not heard or listened to, had their concerns and fears dismissed, were told that they could only discuss one concern per appointment, and felt that no one in the health system really seemed to care that they were in pain or suffering.

LGBTQ+ respondents repeatedly highlighted the heteronormative nature of 'women's health'- not all biological women are in heterosexual relationships and so do not need contraception to prevent pregnancy but still benefit from hormonal treatment. Not all people accessing 'women's health' services will identify as women, but continue to need a reproductive health service e.g. non-binary people and trans men.

LARC is not a broadly understood term outside of healthcare services, reflected in the responses to the survey. However, many respondents spoke about their preference for contraception such as implants, injections, coils etc. A concern raised by respondents was that they did not know enough about or understand the (sometimes incorrect) information staff gave them, and that accessing sexual health services very much depends on where a person lives.

Common symptoms of menopause (mood changes, memory difficulties, difficulty sleeping) are often misunderstood as mental health issues resulting in inappropriate referrals to mental health services- which are already under unprecedented strain due to demand. Similarly, women experiencing common peri- and menopause symptoms are frequently referred to gynaecology services for symptoms such as changes to periods, vaginal dryness, and bladder/continence issues. This impacts on waiting times, service provision, staff and patient well-being, staff retention and ultimately, patient satisfaction and faith in the healthcare system.

From the 1549 responses and analysis of themes, the following recommendations have been developed:

- Address unwanted variance in primary care- issues around services provided, accessibility, knowledge and specialism of staff.
- Education around availability of sexual health services- highlight local provision, consider targeted comms campaigns.
- Greater provision of specialist/focused clinics staffed by well-trained, compassionate, and knowledgeable staff.
- Provide services locally at Place rather than centrally- consider issues such as transport, deprivation, rurality when planning service delivery.
- Utilise primary care/community spaces as people are already familiar with them- no need to build additional clinical spaces.
- Education around LARC- avoid medicalised language, ensure women understand benefits and risks.
- Be mindful of LGBTQ+ service users; avoid gender-stereotypes in comms materials, use inclusive terms.
- Address menopause as holistic condition- does not always require referral to gynaecology or mental health services.
- Improve accessibility- language/ location/ estates e.g. disabled access.
- Provide literature in multiple languages and formats e.g. non-English community languages, easy-read formats, braille etc.