



Resolution

Primary care webinar – Women's health

30 September 2026



Agenda

13:30	Introduction	Ellen Nicholson, RN, QN, Safety and Learning Lead (General Practice), NHS Resolution
13:35	Scene setting: Disparities and issues seen in women's health within primary care	Dr Paula Cowan, GP, National Women's Health Speciality Adviser, NHS England
13:50	Venous thromboembolism in obstetrics	Victoria Wilkins, RM, Associate Safety and Learning Lead (North), NHS Resolution
14:00	ELSGP cancer report – focus on women's health disparities	Samantha Thomas, RSCN, Safety and Learning Lead (Midlands and East), NHS Resolution
14:10	Gynaecological cancers	Dr Julie Oliver, GP, Chair, Primary Care Women's Health Society
14:25	Panel questions	All speakers
14:30	Close	

Disparities in Women's Health: Primary Care

30th September 2026

*Dr Paula Cowan MBChB LRCSPI DFFP DRCOG MRCGP
Regional MD Primary Care, Community & Neighbourhood –
North West
NSA Gynaecology
GP Partner Eastham Group Practice*

Introduction.....

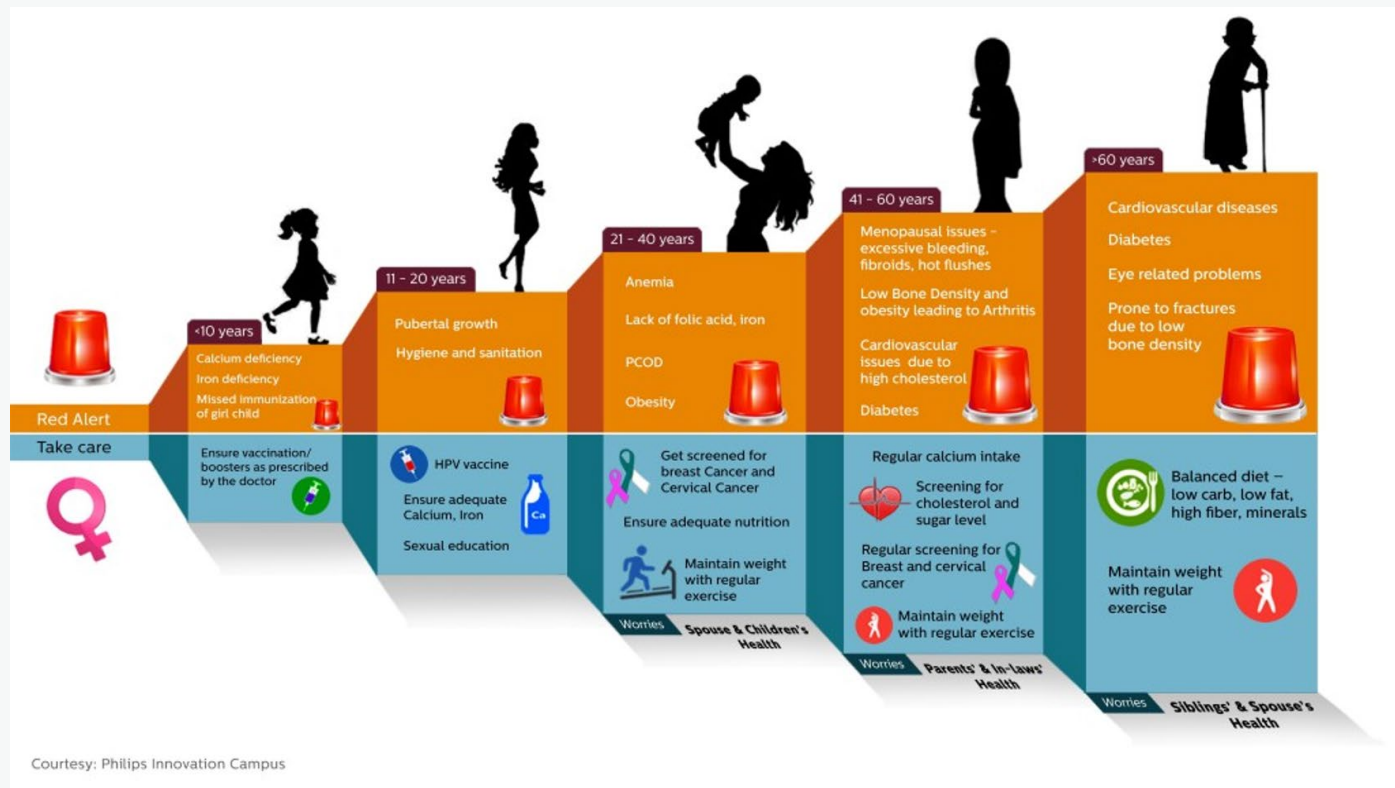
RCSI	1995
Eastham Group Practice	2003-date
Wirral LMC: 2 Terms Vice Chair	2006-2015
<u>NHS Wirral CCG</u>	2012-2022
➤ Clinical Lead Urgent Care	2015-2016
➤ Medical Director	2016-2019
➤ Clinical Chair	2019-2022
NW Joint Clinical Lead NHS@home Programme	2021-2022
NW Region Medial Director Primary Care	2022 -date
NW Region Interim Medical Director Commissioning	2023-2024
National Primary Care Medical Directorate lead for Women's Programme	2024- date
National Primary Care Medical Directorate lead for Prevention Programme	2024-date
National Specialist Adviser Gynaecology	2025-date

80%
**Decisions in a
household
made by.....
Women**



**WOMEN MAKE UP
51%
OF THE WORLD'S
POPULATION**

Women's Health in Primary Care: a lifecourse



Why this matters

THE CASE FOR CHANGE

Three gaps shape women's health. Primary care can close them.

PRIMARY CARE IS THE LEVER

The front door—and the place to listen earlier, connect care and close the gaps.

01

HEALTH GAP

LONGER LIFE ≠ HEALTHIER LIFE

More years can be spent in poor health and disability.

02

ACCESS GAP

NEED IS NOT MET EQUALLY

Deprivation • ethnicity • disability •
place • language • age

03

SYSTEM GAP

FRICTION CREATES DELAY

Short consultations • fragmented
pathways • limited specialist advice

THE IMPACT SPREADS

Education • work • income • caring roles • trust

National Direction

A 10-YEAR AMBITION

From women's voice to joined-up delivery.

Renewed Women's Health Strategy for England + NHS 10 Year Health Plan

01

VOICE + CHOICE

02

BETTER
PERFORMANCE

03

HEALTHIER LIVES

04

EVIDENCE FOR
WOMEN

WHAT PRIMARY CARE MUST DO

LISTEN + ACT

Improve first-contact
assessment

REVIEW + RETHINK

➤ Respond when symptoms
persist or escalate

STREAMLINE CARE

➤ Referral • pain relief •
prevention

INTEGRATE LOCALLY

➤ Women's health hubs across
neighbourhoods

THE DELIVERY TEST

Can neighbourhood pathways remove barriers for women?

Listen earlier • reduce delay • connect services • improve equity

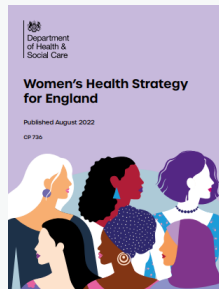
Policy Context of Women's Health

Elective Reform Plan

Single Point of Access

New OP Model

Gynaecology as a priority specialty

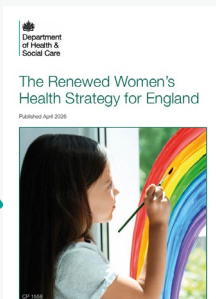


Neighbourhood Framework

Not one of the high priority cohorts but.....clear links with Reform agenda

- Improve routine care
- Improve proactive care
- Deliver better alternatives to hospital care

“ICBs will maintain and develop access to Women’s Health Services as part of neighbourhood care, and women’s health services will be aligned to new neighbourhood health pathways and structures~



Problems women are facing highlighted in the Renewed Women's Health Strategy for England

A healthcare system not designed for women

- Healthcare structurally fails women's needs
- "healthcare systems were just not designed with women in mind" (p. 4)

Women not listened to or believed

- "Being ignored, gaslit, humiliated and disrespected are all-too-common experiences for far too many women. More than eight in 10 say there have been times when healthcare professionals did not listen to them" (p. 2)

Pain normalised or dismissed

- Systematic issue of medical misogyny in the NHS, leading to delayed diagnosis
- "This academic evidence is supported by the abundant examples of women who report their pain being normalised or dismissed" (p. 18)

Long wait times

- "There are major challenges in gynaecology care - where average waits are 15 weeks, up from an average of 6.4 weeks in 2018." (p. 11)

Fragmented care and lack of clear, joined-up pathways

- Women face a "diagnostic odyssey" (p. 14) and are required to repeat their health story multiple times to different healthcare professionals

Inequalities based on location, affluence, and ethnicity

- "Working-class women and women from ethnic minority backgrounds are being failed most of all." (p. 11)

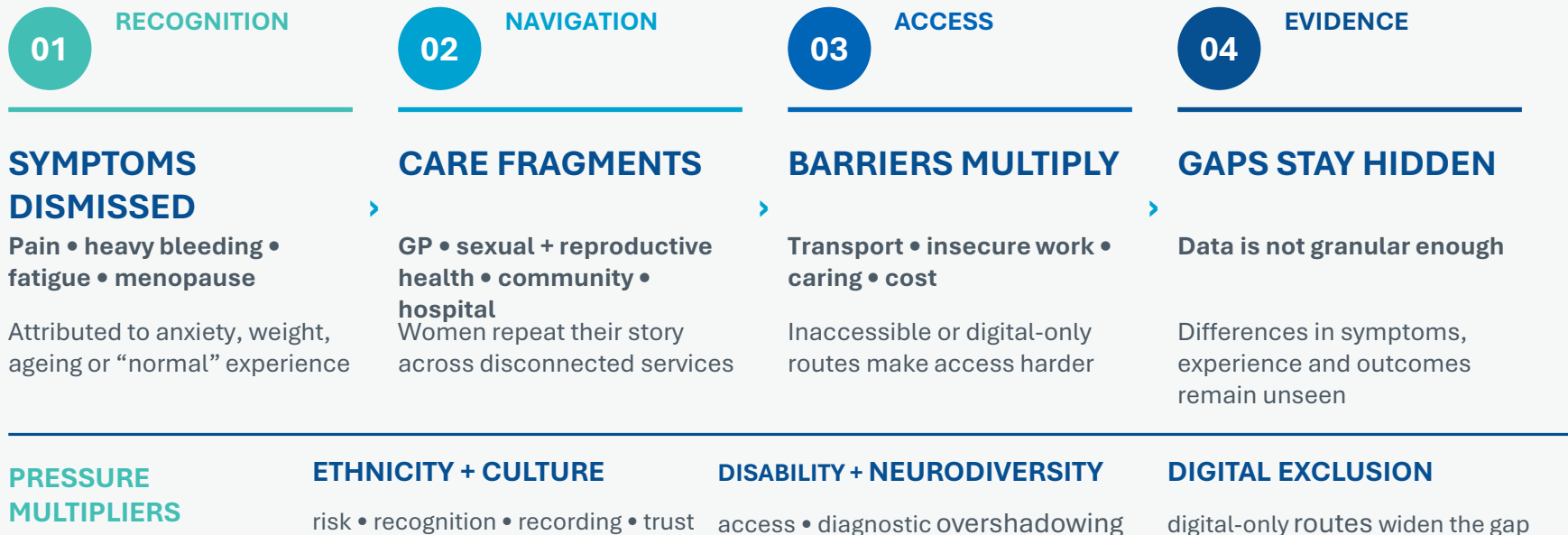
More years in poor health

- "Women in England spend more of their lives in poor health than men, while only the wealthiest third can expect to remain in good health until retirement." (p. 8)

Where inequity is created

INEQUITY ACROSS THE JOURNEY

Barriers compound—from first symptoms to visible outcomes.



Quality context

**84% women
report being
dismissed by
medical
professionals**

**22,000 women
waiting over a year
for treatment***

**Gynaecology waiting
list exceeds
750,000***

**Gynaecology waiting
list has the highest
% increase****

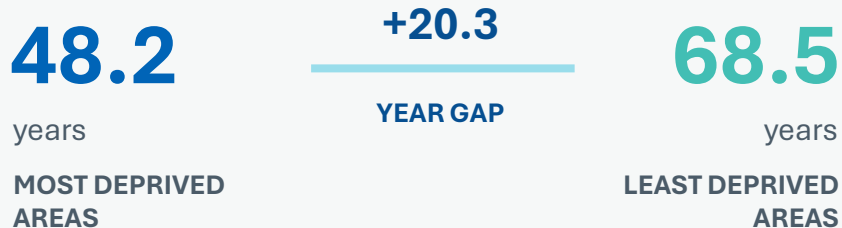
**60,000 women
unable to work
due to
menopause
symptoms****

*BBC.co.uk/news

**NHS Confederation. Women's health economics: investing in the 51 per cent. Oct 2014

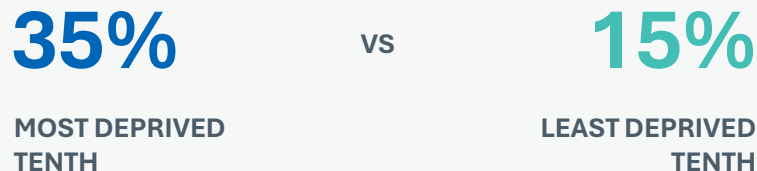
Deprivation: a powerful driver

WOMEN'S HEALTHY LIFE EXPECTANCY · ENGLAND, 2022–24



Women in the most deprived areas can expect two decades fewer in good health.

PHYSICAL INACTIVITY · 2023/24



More than twice as likely to be physically inactive

Measure the gap—not only the average.

Deprivation increases multimorbidity and barriers to planned, preventive and follow-up care.

Diabetes is a women's health issue

THE PATTERN SHIFTS

BEFORE

40

Women are more prominent among early-onset diagnoses

Early-onset T2D is more aggressive.

Women are disproportionately represented among diagnoses before 40.

INEQUALITY LENS

Young adults from deprived areas and minority ethnic backgrounds are over-represented—compounding gaps in access, treatment and pregnancy care.

TAILORED SUPPORT

T2Day

AGES 18–39

More intensive, tailored care

- Contraception + preconception care
- Folic acid + pregnancy planning
- Therapy choice + weight management

Women's health is built into diabetes care.

PREGNANCY + LIFETIME RISK

Gestational diabetes

Risk is higher in this cohort

Previous gestational diabetes is a major marker of future type 2 diabetes risk.

Plan pregnancy and review medicines proactively.

PRIMARY CARE

REPRODUCTIVE + METABOLIC + CARDIOVASCULAR

Recall · weight support ·
medicines review
Pregnancy planning



Obesity: beyond individual choice

ENGLAND · 2023/24

64.5%

OF ADULTS

Overweight or living
with obesity

WEIGHT IS SHAPED ACROSS LIFE

Not one choice—multiple forces.

LIFE STAGES

Puberty · pregnancy ·
menopause

HEALTH

Medicines · mental health
Sleep · pain

DAILY LIFE

Caring roles · income
Local environment

STIGMA BECOMES A BARRIER

Weight stigma can deter attendance

MISSED CARE

Diagnostic overshadowing

Symptoms risk being attributed
to weight rather than
investigated.

PRIMARY CARE RESPONSE

01 Ask permission

**02 Use respectful
language**

**03 Assess wider
determinants**

**04 Offer evidence-based
treatment**

Integrate obesity + diabetes + cardiovascular + reproductive + mental health care

Monitor access, continuation and outcomes
by sex, deprivation, ethnicity, disability and
digital access.

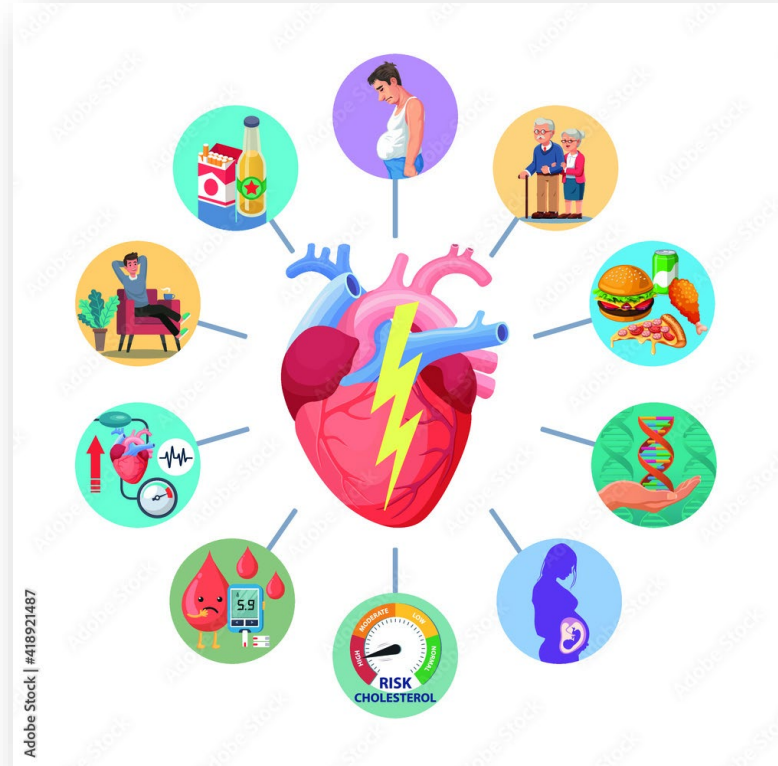
CVD Awareness

- Coronary heart disease **kills twice as many women as breast cancer in the UK**. However, there is a widespread misperception that it's a man's disease
- This lack of awareness of their risk could mean women are less likely to recognise they are having a heart attack, leading them to delay seeking help.
- Women **typically arrive at hospital later** than men when having a heart attack, contributing to delays in treatment. A heart attack is a medical emergency - delays in receiving treatment are putting women's lives at risk
- A stroke can happen to anyone at any age, but it's often thought of as happening more in men. Men do have slightly more strokes, but stroke is one of the four leading causes of death in women in the UK. **Women tend to have strokes at a later age than men, and nearly half of all strokes (45%) in women happen past the age of 80.**



Risk factors

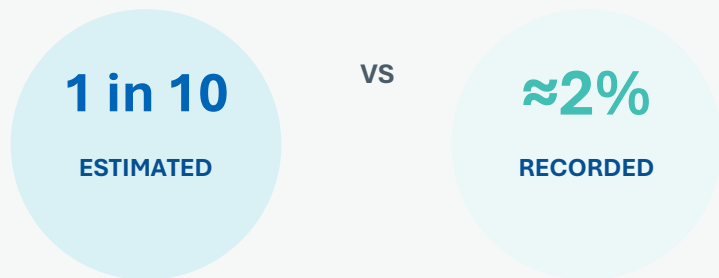
- The risk factors for heart attack are well established; **high blood pressure, high cholesterol levels, a family history of coronary heart disease, smoking, obesity and diabetes.**
- **Women who have similar risk factors to men may have a greater chance of developing coronary heart disease.**
- Women's lack of awareness of this so-called 'excess risk', combined with a low uptake of health checks, means that women may be **dramatically underestimating** their personal risk of heart attack.
- Women who have established coronary heart disease **are less likely than men to reduce the chances of a second heart attack by managing their risk factors**



Gynaecological conditions: common, often missed

HEAVY MENSTRUAL BLEEDING · ENDOMETRIOSIS · ADENOMYOSIS · FIBROIDS · PCOS · PELVIC PAIN · PROLAPSE · INCONTINENCE · MENOPAUSE

ENDOMETRIOSIS: THE RECOGNITION GAP



Estimated prevalence vs NHS hospital diagnosis recorded

Reproductive-age women · linked 2011–21 data

DIAGNOSTIC DELAY

**8 years
10 months**

average reported in a 2023 UK survey

ADOLESCENTS

37%

**estimated to
experience heavy
menstrual bleeding**

THE COST OF DELAY

● PAIN + ANAEMIA

● FERTILITY

● MENTAL HEALTH

● EDUCATION

● EMPLOYMENT

Delayed diagnosis compounds the harm

HOW DELAY BUILDS

- 01 REPEAT VISITS**
without a structured review
- 02 VARIABLE ACCESS**
examination · ultrasound ·
specialist advice · pain relief
- 03 LONG WAITS**
trust erodes while cost and
harm rise

THE IMPACT SPREADS

Wellbeing

Relationships

Fertility choices

Education

Employment

**Delay affects lives—not only
symptoms.**

ECONOMIC SIGNAL

£130

less per month

4–5 years after diagnosis

–2.7 pp

**probability of paid
employment**
same period

Earlier recognition is a quality, economic and equity imperative.

Endometriosis diagnosis cohort: women aged 25–54; comparison with the two years before diagnosis.

Lets talk about ... Menopause



Menopause symptoms can impact all aspects of a woman's quality of life

1/2

said menopause
had a **negative**
impact on
their home life

1/2

said menopause
had a **negative**
impact on
their sex life

4 in 10

said menopause
had a **negative**
impact on their
work life

3 in 10

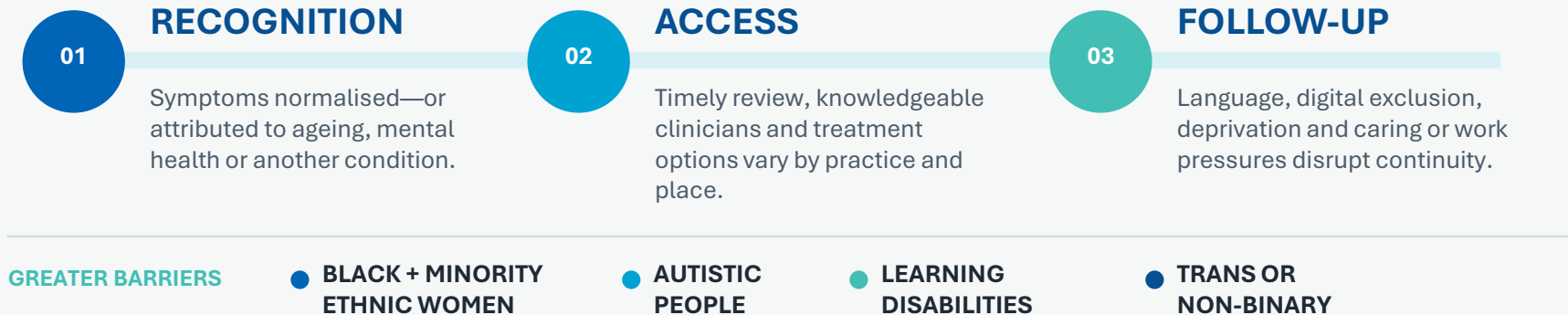
said menopause
had a **negative**
impact on their
social life

Menopause – Understanding the impact on women and their partners, Heather Currie, Sara J Moger; (based on three online surveys with women 45+ with menopause symptoms (currently/in previous 10 years; 2015/n=1,000; 2016/ n=1,000; 2017/n=650 women and n=350 partners)

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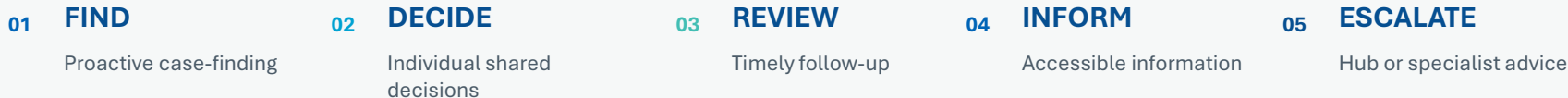
Menopause Disparities in Primary Care

INEQUITY CAN ENTER AT EVERY STAGE OF THE MENOPAUSE CARE JOURNEY



Less consistent care can reflect overlapping barriers—not individual choice or engagement.

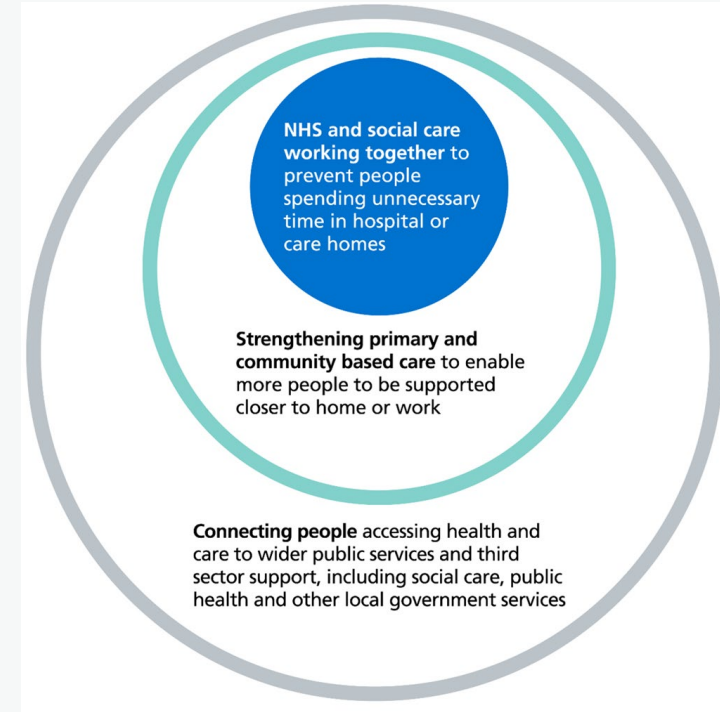
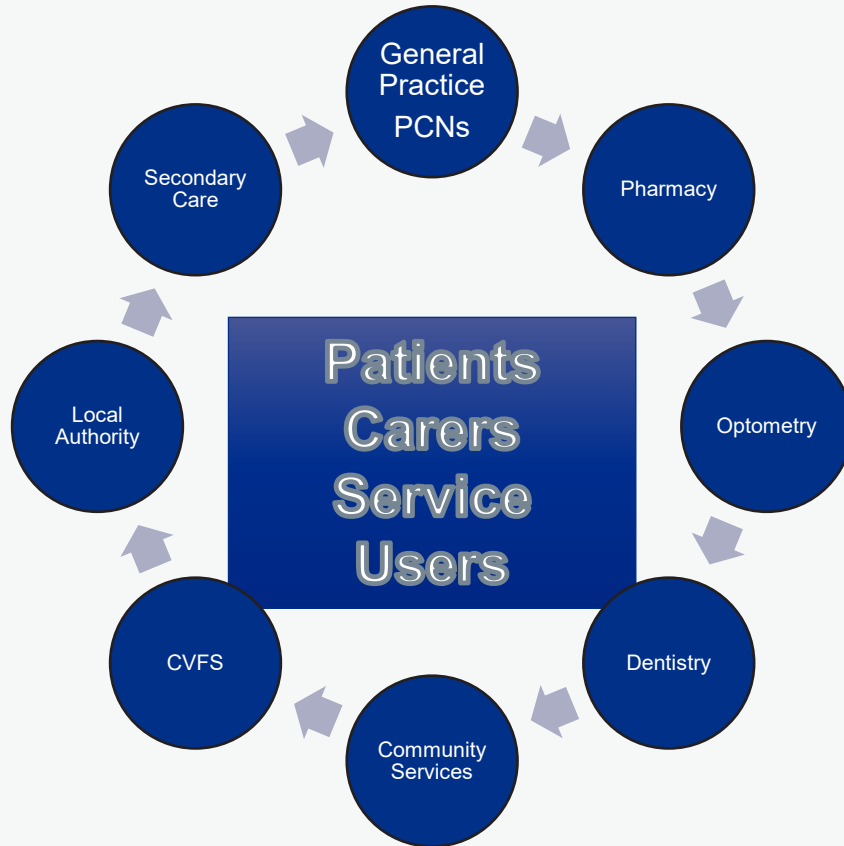
PRIMARY CARE CAN CLOSE THE GAP



■ **Consistent recognition + informed choice + reliable follow-up**



***Neighbourhood health
reinforces a new way of working
for the NHS, local government,
social care and their partners,
where integrated working is the
norm and not the exception.***



Neighbourhood delivery for women's health

ONE CONNECTED NEIGHBOURHOOD TEAM



DELIVER

RIGHT CARE

RIGHT TIME

RIGHT PLACE

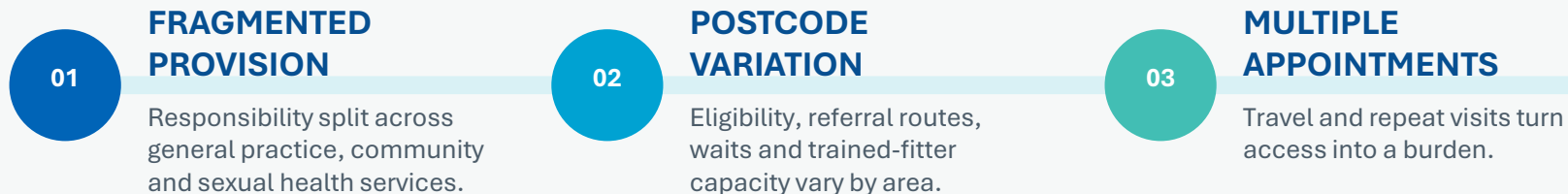
RIGHT PROFESSIONAL

MDTs upskill primary care and strengthen continuity · designed around local need · face-to-face + digital routes

- Use integrated models to improve access, reduce duplication and avoid unnecessary hospital referral.

Inequity in access to long-acting reversible contraception

THE SAME NEED — A DIFFERENT ROUTE, WAIT OR OUTCOME



DISCONNECTED
PATHWAYS

CONTRACEPTION

≠

**GYNAECOLOGICAL
INDICATIONS**

Access may differ for heavy menstrual bleeding—even when the intervention is the same.

WHO PAYS THE PRICE?

- YOUNGER WOMEN
- DEPRIVED COMMUNITIES
- DISABILITY
- LANGUAGE
- TRANSPORT

ONE SYSTEM PATHWAY Shared standards · self + inter-practice referral · sustainable workforce · equity monitoring

Simpler access. Less duplication. Fewer unnecessary hospital referrals.

LARC for all indications

What should primary care measure?

MEASURE THE JOURNEY — NOT JUST ACTIVITY

Are women heard, recognised, reached, treated, protected and connected?

01

EXPERIENCE

Feel heard + involved
in decisions

02

RECOGNITION

Repeat consultations +
time to diagnosis

03

ACCESS

Availability + uptake of
LARC, menopause + women's
care

04

CLINICAL CARE

Investigate · treat · review
· safety-net

05

PREVENTION

Diabetes · obesity · CVD
uptake + outcomes

06

INTERFACE

Advice + guidance · referral
quality
· avoidable urgent care

EQUITY

Compare every measure—not only the average.

Deprivation · ethnicity · disability · age · geography

CROSS-CUTTING

Priorities for Primary Care

THREE MOVES • SIX PRIORITIES

Turn every contact into earlier, fairer and more connected care.

1

LISTEN

Understand need

01

REVIEW + SAFETY-NET

Persistent symptoms •
continuity

04

TARGET INEQUITY

Practice + PCN data • proactive
follow-up

2

ACT

Intervene sooner

02

ACT EARLIER

Investigate + treat while waiting

03

USE EVERY CONTACT

Link contraception •
preconception • menopause •
prevention

3

CONNECT

Join up care

05

JOIN UP PATHWAYS

Advice + guidance • community
+ women's health hubs

06

BUILD CAPABILITY

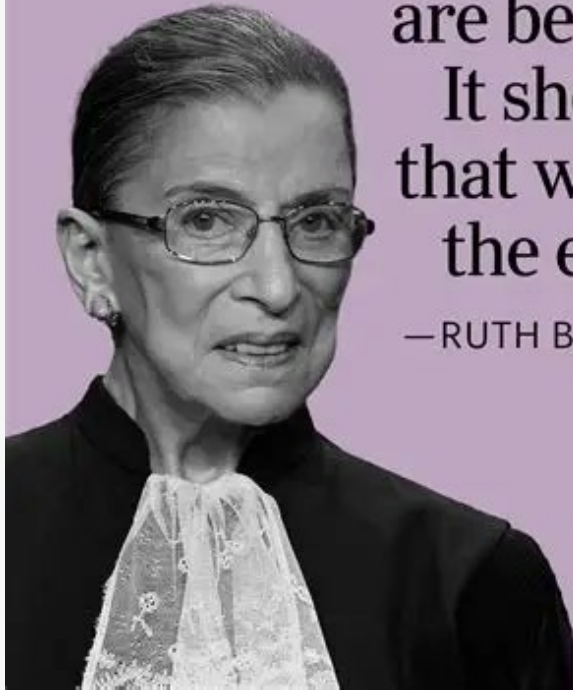
Whole-team skills • face-to-face
+ digital

OUTCOME

Earlier action • Fairer access • Fewer fragmented journeys

“Women belong in all
places where decisions
are being made.
It shouldn’t be
that women are
the exception.”

—RUTH BADER GINSBURG



Thank You



@nhsengland



company/nhsengland



england.nhs.uk

paulacowan@nhs.net

AIM: Reducing VTE (Venous Thrombosis Embolism) in pregnancy

Safety and Learning Directorate

Presented by: Victoria Wilkins, Associate
Safety and Learning Lead/Project Lead
victoria.wilkins3@nhs.net

Background

Pregnancy elevates venous thromboembolism (VTE) risk by a factor of 4 to 6 compared to the non-pregnant state.

It is associated with significant morbidity, mortality and psychological distress for families.

This poses a substantial financial burden onto the NHS.

National discussions on VTE in maternity have highlighted a potential disconnect between primary and secondary care, prompting action to improve prevention.

A retrospective thematic analysis of NHS Resolution claims related to VTE



Inclusion criteria (Total 51 claims):

Settled maternity claims with
damages paid

All VTE during pregnancy up until 6
weeks postnatal

Incidents occurring between April
2016 - March 2025



Themes from 43 open claims were identified but not analysed

Results

1 in 2
suffered with
a **Pulmonary
Embolism
(PE)**

3 in 4
developed a
VTE in the
**postnatal
period**, most
commonly
between 11-42
days.

3 in 5
delivered
vaginally



Results - Diagnosis

- **1 in 2** presented more than once before a diagnosis was made.
- For those who presented more than once, the average time from presentation to diagnosis was **9 days**
- The longest time from presentation to diagnosis was **102 days***
- **2 in 5** presented to **urgent care or emergency departments** between 24 weeks to 10 days postnatal
- **3 in 5** presented to a **GP** > 11 days postnatal



Results - Risk assessment

- Of the claims with no VTE risk assessment it was apparent from the letter of claim that risk factors were present
- **3 in 4** women had a completed VTE risk assessment, however only **1 in 3** were completed **correctly**
- **3 in 4** women had a **change** in risk factors from booking
- This led to VTE prophylaxis not being prescribed in several cases where it was required (58%)

Results - Risk assessment

Booking

- Maternal Age
- BMI 30-40
- Parity
- Family History
- Smoker

Antenatal

- Hospital Admission
- Current Systemic infection
- Immobility

Postnatal

- Caesarean Section
- Parity
- Maternal Age
- BMI
- VTE in antenatal period

Illustrative case story – Primary and secondary care

Situation

- Patient aware they were high risk for VTE in pregnancy, attended GP at 5/40 when pregnancy was confirmed
- GP referral to obstetrics as unclear on correct medication, dosage and duration to prescribe.
- Patient was booked but not seen by an obstetrician until 14/40 gestation due to limited appointments
- 3 days later, patient presented with collapse and PE was confirmed. The patient did not receive or administer medication as the hospital chemist been closed early on a Friday and on a weekend

Background

- G6 P5
- Previous VTE when on contraceptive pill
- BMI of 38
- Smoker
- Maternal age 34 at booking

Assessment

Breach of Duty

- Unable to access care early enough to receive prophylaxis
- Referral to obstetrician too late and not escalated from first contact with maternity services
- No prophylaxis given in the antenatal period prior to VTE occurring

Recommendations

Causation

- Had the GP or the obstetrician prescribed prophylaxis from the time of confirmed pregnancy the VTE is unlikely to have occurred on a balance of probabilities
- Communication and ability to bypass the standard process for women in this situation is key to ensuring they receive prophylaxis as early as possible.

Limitations

- **Assumptions made:**
 - Spontaneous vaginal delivery when no other type of delivery is noted
 - Low risk when no risk factors have been noted
- **Compliance to prophylaxis remains unknown throughout pregnancy and the postnatal period**
- **Retrospective – based on available documentation**
- **Health inequalities were not analysed with this data**

The influence of health inequalities on receiving care

Ethnicity – multifactorial

Social and economic deprivation – ability to attend appointments/hospital

Language – ability to understand information and provision of information in appropriate language

Working pregnant people – ability to attend appointments/hospital

Vulnerabilities – learning disabilities, migrants/asylum seekers, safeguarding concerns, teenagers- multifactorial

Rural communities – ability to attend appointments/hospital

Assess



ASSESS

Conduct a risk assessment at booking. Reassess when a change occurs during the antenatal and postnatal period to maintain up-to-date assessment of risk factors through a “fresh eyes” approach.

Inform



INFORM

Provide improved education for healthcare professionals, patients and their families regarding VTE risks, symptom identification, and prevention measures to enhance recognition and action.

Medicate



MEDICATE

Verify that the appropriate dosage and duration of prophylaxis are prescribed when required and given to the woman. Ensure a clear explanation of how to consistently administer the medication.

REASSESS

REINFORM

REVIEW MEDICATION

ASSESS

Conduct a risk assessment at booking. Reassess when a change occurs during the antenatal and postnatal period to maintain up-to-date assessment of risk factors through a “fresh eyes” approach.

INFORM

Provide improved education for healthcare professionals, patients and their families regarding VTE risks, symptom identification, and prevention measures to enhance recognition and action.

MEDICATE

Verify that the appropriate dosage and duration of prophylaxis are prescribed when required and given to the woman. Ensure a clear explanation of how to consistently administer the medication.

The cost of claims



The total cost of closed with damages paid claims was £3.5m

Other associated costs included increased medication needs for longer duration, increased inpatient stays, longer term ongoing follow up care



The average cost of a claim was £68,793



Other 'costs' to the patient are detriments to physical, emotional and mental health in the short, medium and long term

Key messages

VTE assessment is essential in pregnancy and the postnatal period

Risk should be reassessed with every change, using the correct maternity VTE assessment tool

This will allow for the correct prophylaxis at the right dosage for the right amount of time

Key messages – Primary care

Communicate	Communicate with obstetrics at any stage
Ensure	Ensure discharge paperwork is viewed and considered
Refer	If in doubt, refer
Think	Think VTE if pregnant or recently pregnant

Delayed diagnosis of cancer thematic report

Samantha Thomas

NHS Resolution

Samantha.thomas37@nhs.net



Key findings

Delayed diagnosis of cancer:
a thematic review of general
practice indemnity claims



Advise / Resolve / Learn

Published: October 2025

Analysed **105** closed, settled general practice indemnity (GPI) claims over a seven-year period to March 2023.

Key findings include:

- **65.7%** of patients were diagnosed with stage 3-4 cancer, compared to national early diagnosis rates of around **54%** for stages 1-2.
- **40%** of cancer diagnoses were made following routine referrals or emergency department attendance, rather than urgent suspected cancer referrals.
- Remote consultations featured in **53%** of claims, highlighting the increased importance of comprehensive history taking when physical examination is not possible.
- **73.5%** of claimants aged under 50 years were female, indicating potential gender disparities in early-onset cancer detection.

Background to the delayed diagnosis of cancer in general practice report

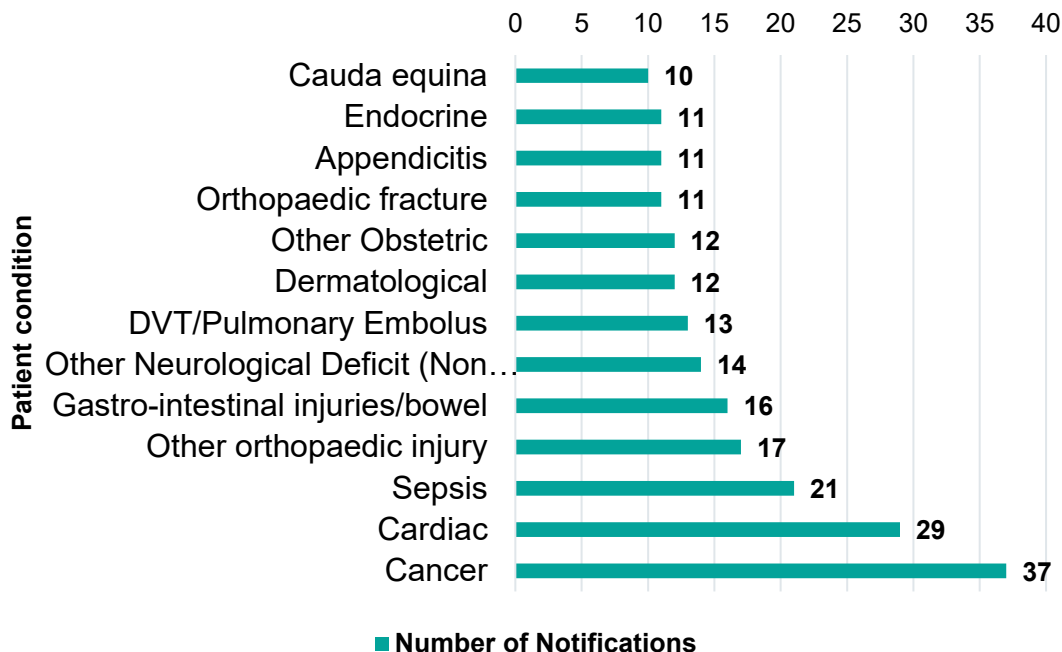
Failure to investigate, and/or
diagnose, and missed, wrong
and delayed diagnoses

Medication errors

Delays in care, including
speciality reviews and referrals

Problems with communication,
between primary and
secondary care

Most frequent notification by patient condition



Claims data

105

closed settled
claims with total cost
of **£6,135, 218**

Cancer with most
professionals seen
before referral

- lung cancer*
- head and neck cancer
- urological cancer
(excl prostate)
- other cancer*

Highest number of successful
claims

- colorectal cancer
- skin cancer
- breast cancer =
- prostate cancer =

Cancer with most visits before
referral

- other cancer*
- lung cancer
- urological cancer
(excl prostate)

Highest cost of
successful claims

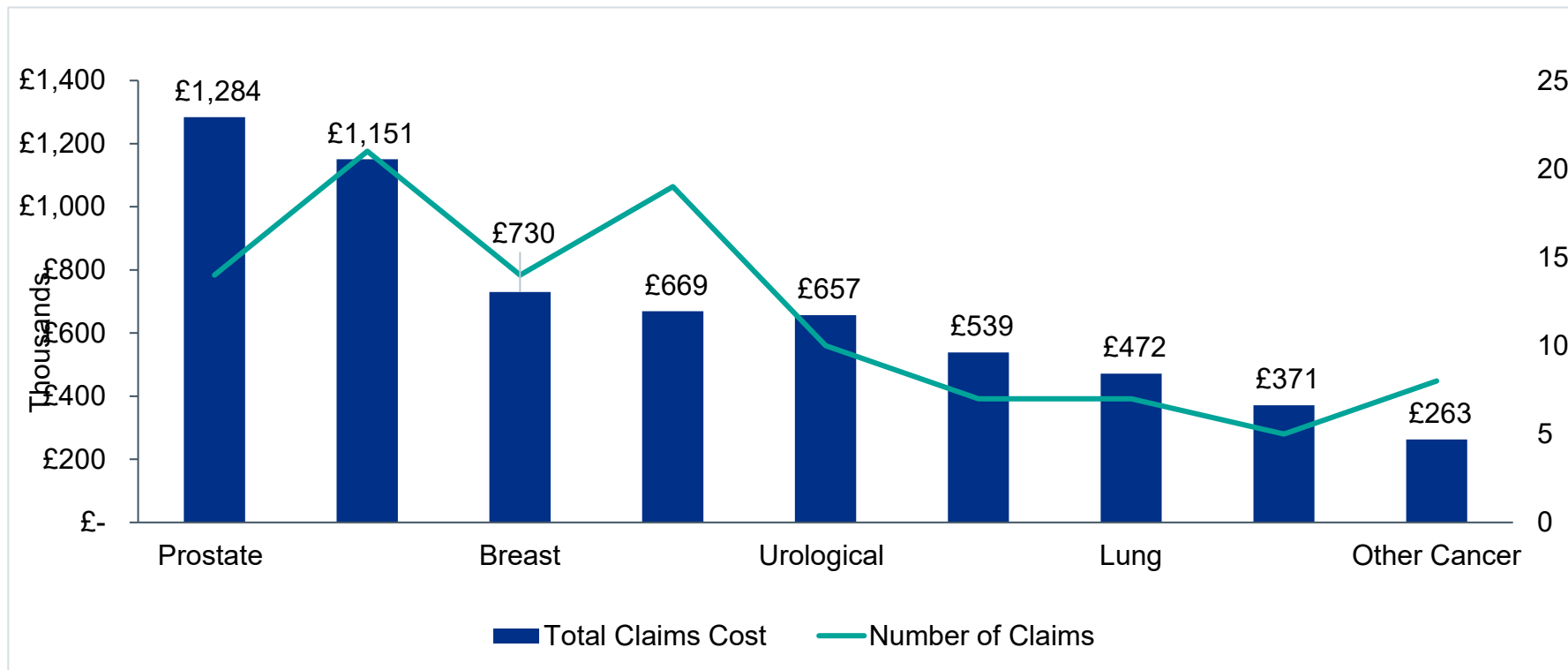
- prostate cancer
- colorectal cancer
- breast cancer

Cancer with longest
GP delay to referral

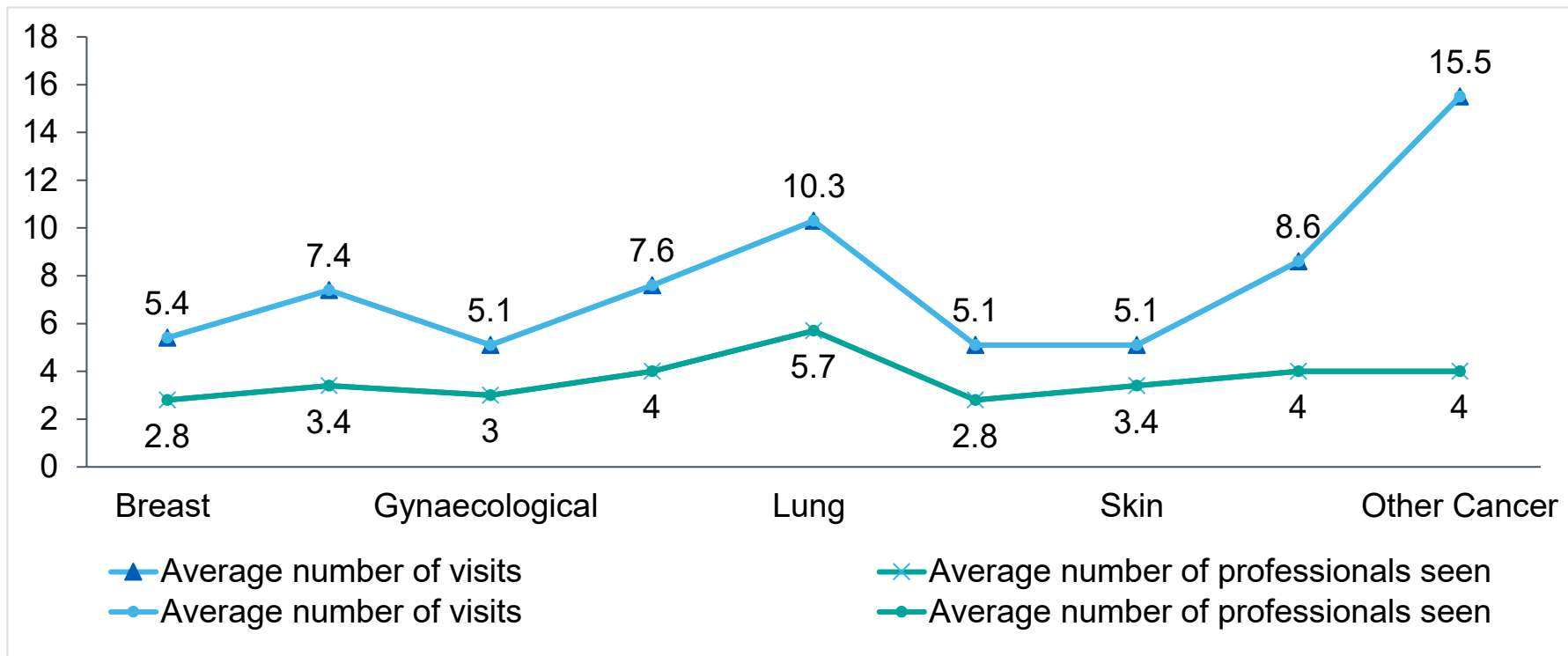
- prostate cancer
- skin cancer
- gynaecological cancer

*other = haematological,
pancreatic, liver cancers

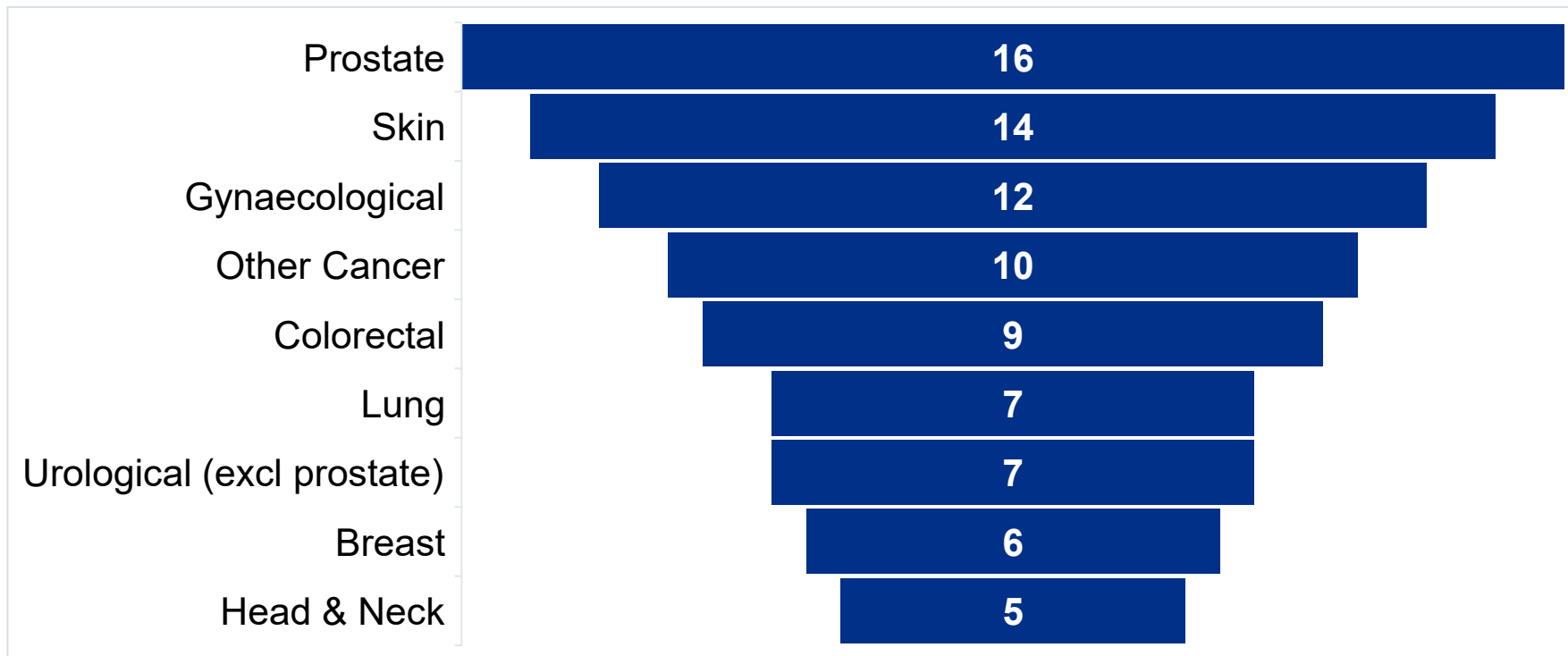
Cancer subspecialties by total claims number and cost (£)



Cancer subspecialties by average number of healthcare visits before referral



Cancer subspecialties by average General Practice professional delay to refer, in months





Main findings

- **7.6%** of claims showed the treatment of symptoms without a diagnosis or differential diagnosis.
- Fragmented systems obscure repeat attendance. There was an average of 7.4 primary care visits before referral and diagnosis.
- In **40%** claims, cancer was diagnosed following routine referral to specialties or emergency department attendance.
- **65.7%** of patients were diagnosed at stage 3-4 cancer and many had received multiple courses of antibiotics and treatments without improvement.

In the lead up to their eventual diagnosis with cancer, patients often had multiple points of contact with the health system – including calling NHS 111, calling an ambulance, attending out-of-hours centres and visiting emergency departments. Patients who spoke to NHS 111 and attended out-of-hours services experienced increased fragmentation of care, with these visits not always reflected in GP records.



Main findings cont'd

- Insufficient history taking and safety netting advice was a feature in both face to face and remote consultations. **53%** of claims contained remote consultations.
- **73.5%** of claimants under 50 years old were female and were noted to have higher rates of metastasis at diagnosis.
- Risk of cancer recurrence was not recognized in the **10.5%** claimants who had a prior history of cancer.
- Patients who had multiple morbidities, were under several specialties or who had recently seen a specialist experienced increased delays.

Patients have limited avenues to access secondary care without GP support. Patients who were initially reassured delayed return to their GP. Those who were unsatisfied sought escalation via NHS 111, ambulances or emergency departments.

Case example

Breast cancer | Case study

A patient in their 60s presented with a breast lump in their chest wall,

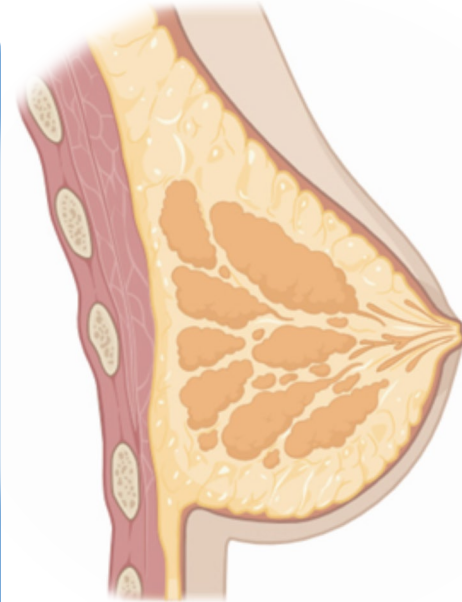
The GP was reported to find 'no palpable lump' and advised the patient to return if it increased in size. The patient returned over a year later. They were reviewed by the same GP who noted that the lump was reported to have increased in size, and an urgent ultrasound was ordered, which took place nearly six weeks later.

The scan identified a suspicious lump, and the patient was referred for suspected soft tissue cancer before being redirected to breast clinic.

The patient was subsequently diagnosed with an invasive stage 3 breast cancer.

The legal case highlighted that 'in order for the lump to have grown, it had to have been present in the first place' and 'a soft lump can also be cancerous'.

Allegations included substandard examination of the breast, failure to refer at the first appointment and failure to give adequate safety netting advice.



Positive practice example

Good practice

A practice carried out a Significant Event Analysis (SEA) following receipt of a complaint.

They realised that there had been a process issue with no pathway for urgent bone scan requests and liaised with the Trust. There were no contingency plans for administrative staff to clarify the type of bone scan required to make the request. The SEA also identified it was not optimal for the patient to receive further investigations in primary care, and it was necessary to refer back to a specialist team for appropriate investigations and to avoid delay. They also discussed with the Clinical Commissioning Group (CCG) cancer lead, demonstrating good integrated system involvement of stakeholders. A plan was then made with the Trust on steps for investigating patients with possible metastatic disease in the future.

They also considered sharing with the wider GP network and shared a reminder to consider the vague symptoms (non-specific symptoms) pathway for referrals.

Recommendations

01

Improving
diagnostic
processes

02

Strengthening
communication
within
consultations
and across the
system

03

Empowering
patients with
clearer
pathways for
self-referral
and escalation

**Read the
full report
online**



Areas of focus – pillar 1

The diagnostic process

- Optimise the use of diagnostic imaging support tools and transparency of diagnostic appointments and reporting times
- Optimise the use of non-specific symptom (NSS) pathways in primary care
- Review multidisciplinary training standards for remote consultation and triage.
- Explore increasing routes to enter the cancer pathway considering the multiple routes patients use to access services and utilising local contract agreements to aid system working.

Supportive policy

- NHS Faster Diagnosis Framework²²
- Best practice timed diagnostic pathways⁶⁴
- Faster diagnosis standard²²

Areas of focus – pillar 2

Communications within consultations and beyond

- Develop configuration of digital and telephony systems to detect and flag repeat attendance across multiple healthcare interfaces.
- Facilitate optimised onward referrals.
- Develop system-wide quality assurance of primary care consultations to monitor and measure the effectiveness of consultations and improve unwarranted variation.
- Engage with national and regional primary and secondary care interface groups to minimise patient risk caused by interface issues and promote wider system learning.
- Review multidisciplinary training standards for remote consultation and triage.
- Develop a programme of multidisciplinary training around remote triage, assessment and safety netting in general practice.

Supportive policy

- | | |
|---|--|
| — GPC primary secondary care interface guidance ⁶⁹ | — NHS general practice improvement programme ⁶² |
| — NHS England delivery plan to recover access to primary care (2024) ⁵ | — NHS patient safety strategy ³ |
| — NHS PIER Framework ⁶¹ | — NHS primary care patient safety strategy ⁴ |

Areas of focus – pillar 3

Patient voice and routes of escalation

- Increase self-referral pathways, particularly in symptomatic patients with a prior history of cancer or multiple morbidities.
- Enable patient escalation in primary care.
- Explore whether protected characteristics influence place-level patient outcomes in primary care.
- Implement the ‘three strikes and rethink’ process for patients/relatives/carers who do not feel heard with unresolved or deteriorating conditions.
- Consider increasing the options for self-referral and patient-initiated follow-up (PIFU) for symptomatic patients and those with past history of cancer.
- Facilitate the acceptance of private diagnostic tests and consultations in NHS secondary care were indicated as part of the cancer pathway to increase patient empowerment.

Supportive policy

- | | |
|---|--|
| — NHS England delivery plan to recover access to primary care (2024) ⁵ | — NHS personalised care ⁷¹ |
| — NHS Primary Care Patient Safety Strategy ³ | — The National Healthcare Inequalities Improvement Programme ⁷⁰ |

Jess's Rule - 3 strikes and we rethink

'reflect, review and rethink'



Jessica Brady had 20 consultations with her GP practice in the 5 months leading up to her death, and her cancer was not diagnosed. Jess was then admitted to hospital and found to have stage 4 adenocarcinoma. Jess passed away in December 2020 at the age of 27.

Reflect: Think back on what the patient has said and consider what has changed or been missed. Offer ongoing **episodic** continuity of care for future direct patient care. If previous consultations have been remote, see the patient face-to-face and conduct a physical examination

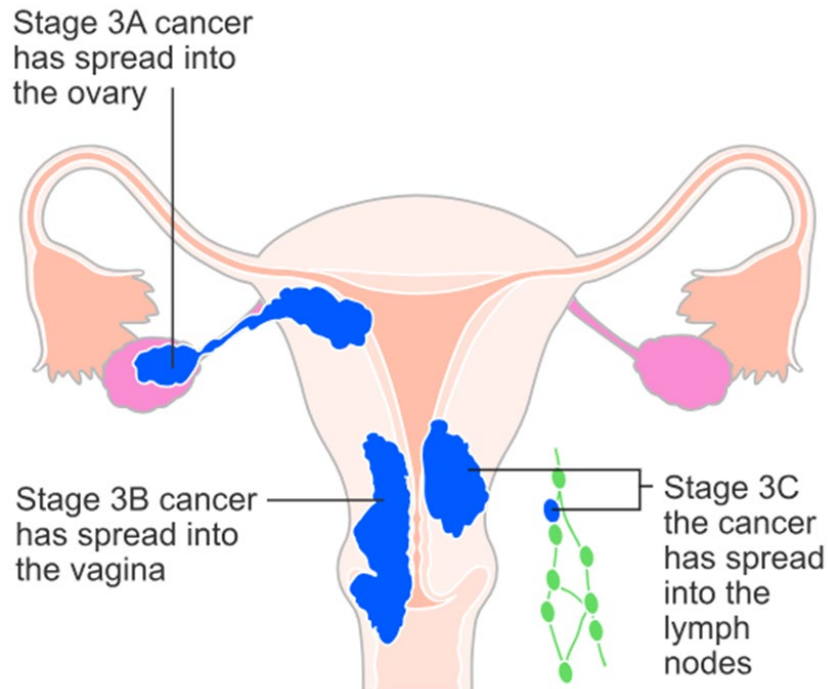
Review: Where underlying uncertainty exists, consider seeking a view from a peer and review any red flags that may suggest another diagnosis, regardless of the patient's age or demographic.

Rethink: If appropriate, refer onwards for further tests or for specialist input.

Local innovation

Somerset NHS Foundation Trust

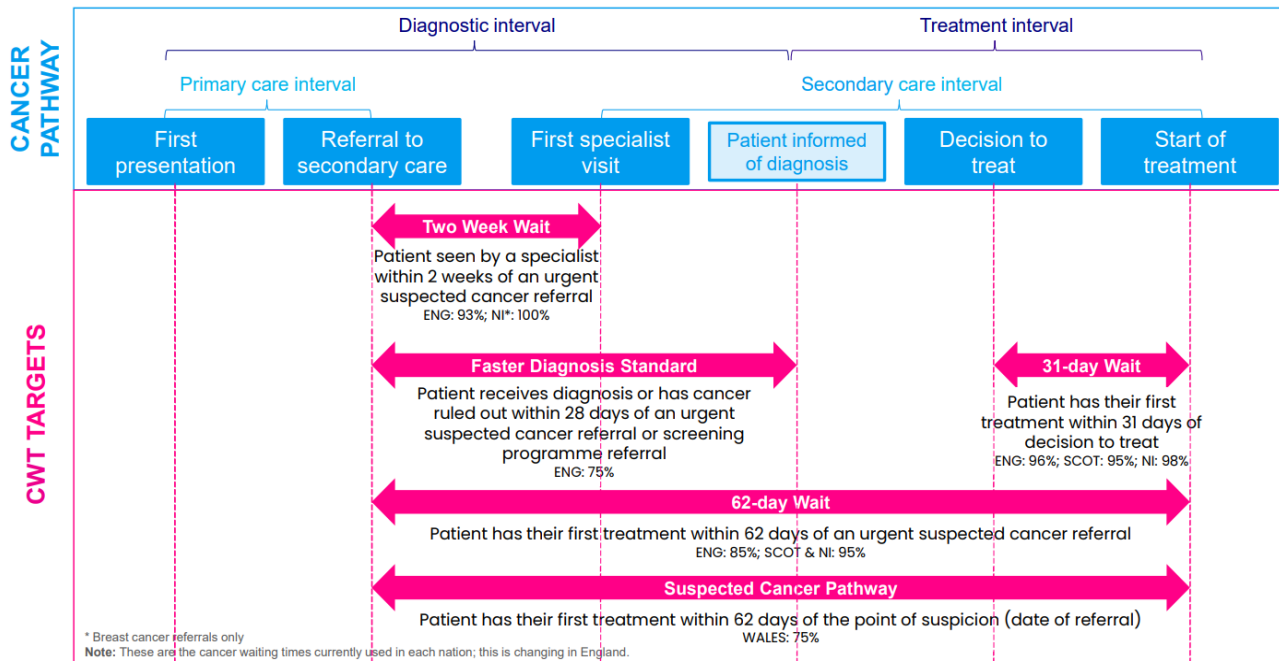
After noticing a year-on-year (30% in 2023) increase in the number of women with post-menopausal bleeding referred to its gynaecology service, Somerset NHS FT launched a 'first of its kind' service, allowing women who are experiencing vaginal bleeding or unusual discharge (after the menopause) to complete a self-referral (via the website or by telephone) to the gynaecology booking team in order to reduce avoidable delays.



Cancer Research UK

Summary

Cancer waiting times targets



The timeline between first presentation until referral to secondary care is a key point in the cancer pathway. This report highlights key themes contributing to delayed diagnosis of cancer in general practice claims.

Source: Cancer intelligence team, Cancer UK - Performance measures across the cancer pathway Key Stats (2023)

To err is human, to learn is to improve



“Human beings make mistakes because the systems, tasks and processes they work in are poorly designed.”

Professor Lucian Leape,
Harvard School of Public Health



Primary Care
Women's Health Society

GYNAECOLOGICAL CANCERS

Dr Julie Oliver



<https://www.pcwhs.co.uk>



Julieoliver1@nhs.net

DR JULIE OLIVER



Declarations

- Director of Durham Gynae and Retired Chair Primary Care Women's Health Society
- Training lead Sunderland WHH
- Clinical advisor – Clearblue
- Speaker Meeting – Gedeon Richter, MSD, Bayer, Theramex, Besin, Exeltis, Organon, Mylan
- Trainer – Bayer IUC
- Whopaysthisdoctor.co.uk



AGENDA

Clinical case – Emma
Reflective learning

Clinical case – Anne
Reflective learning

Clinical case – Joyce
Reflective learning

Clinical case – Yvonne
Reflective learning



EMMA

Aged 37

Postnatal check at 8 weeks

Para 4 – this last baby was a surprise.

Emma had attended her postnatal check.

Areas explored including, her pregnancy and delivery. Any trauma arising as a result.

Future plans for pregnancies

Current health

Bleeding issues both during and after the delivery – had some bleeding through her pregnancy and she was still bleeding at the 8 week check

Mental health – sleep, tiredness, bonding, feeding, support at home etc

Contraceptive plans – family now complete – wanted referral for sterilisation

Medication

Health promotion – Emma hadn't attended for any cytology due to her pregnancies.



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WHAT ARE YOUR PLANS?

Examine

- 1.Examine her today with a speculum
2. Consider 5Cs – conception, compliance, chlamydia, cervix & CANCER

Thoughts

- 1.Health promotion is not an after-thought
- 2.Examination is a vital skill – do not skip it
- 3.Promote LARC

Red Flags

- 1.Never had any cervical cytology
- 2.Prolonged bleeding pattern
- 3.Everyone assumed others had looked into this

01. Examine

02. Thoughts

03. Red Flags



STATISTICS

Cases

- 3.299 new cases of cervical cancer each year, 2019, 2021-2022, UK.

Deaths

- 880 deaths from cervical cancer, 2022-2024

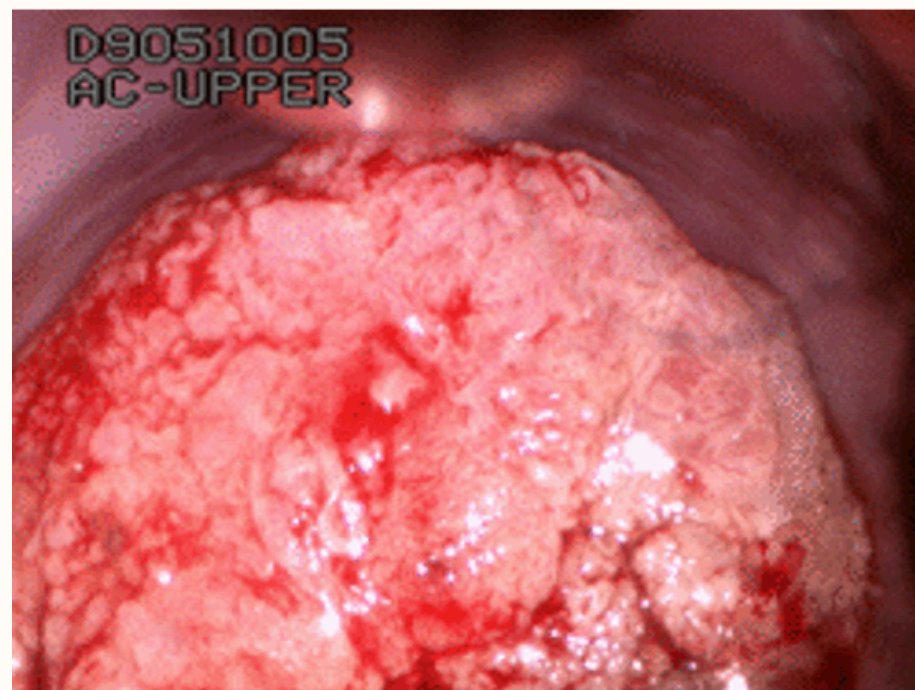
Survival

- 63.5% survive cervical cancer for 10 or more years, 2018, UK.

Preventable Cases

- 99.8% of cervical cancer cases are preventable, UK, 2015

EXAMINATION



Gynaecological examination findings

Symptom and signs	Possible cancer	Actions
Appearance of cervix consistent with cervical cancer	Cervical	Consider a suspected cancer pathway referral [1.5.16]

01

Appearance of Cervix consistent with cervical cancer

02

Possible cancer shows Cervical

03

Action to consider a suspected cancer pathway referral



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ANNE

AGED 75

Been attending weekly with UTI symptoms.
Had recurrent treatment from yourselves, and Urgent Care for UTI
Symptoms always seemed to improve for a day and then recurred.
Urine dipstick and testing was always positive for blood but never grew any bacteria
Started c/o pain all the time and her requirements for analgesics escalated and she
was on tramadol



REFLECTIVE LEARNING

Examine

The examination reveals a hard exquisitely painful lump in vagina
and you have some blood on your finger
The is not able to tolerate a speculum

Thoughts

- 1.Examination is a vital skill – do not skip it

Red Flags

1. She was not getting better
- 2.Persistent microscopic blood on urine sample with no bacteriuria
- 3.Escalating pain
- 4.Mass in the vagina

01. Examine

02. Thoughts

03. Red Flags



WHO GETS VULVAL CANCER AND HOW COMMON IS IT?

Who

Vulval cancer is a rare cancer. Around 1,500 people are diagnosed in the UK each year.

Risk

Your Risk of developing vulval cancer increases as you get older. On average each year more than 40 /100 (more than 40%) new cases are in women aged 75 and over

Vaginal mass (unexplained and palpable) in or at the entrance to the vagina	Vaginal	Consider a suspected cancer pathway referral [1.5.18]
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Vulval symptoms

Symptom and specific features	Possible cancer	Actions
Vulval bleeding (unexplained)	Vulval	Consider a suspected cancer pathway referral [1.5.17]
Vulval lump or ulceration (unexplained)	Vulval	Consider a suspected cancer pathway referral [1.5.17]



JOYCE – AGED 68

“Just don’t feel well” – but I know it isn’t my heart

No energy despite sleeping well, no joy for life, lost her appetite, mild abdominal pains, slight background nausea. No change in bowel habit, weight loss of 6 pounds.

PMH- IHD – MI 5 years ago –

BP well controlled

Pulse 72 regular

Abdo – slight bloating, no masses

Bloods showed

FBC – normal, UE normal, Bone chemistry – raised adjusted calcium, CRP raised 95, LFT normal, Ca125 27,

CXR, normal

FOB normal

Pelvic US – showed 10cm RIF mass



WHAT ARE YOUR PLANS?

Examine

1. Done

Thoughts

1. Vague history with mildly abnormal bloods
2. Think wide, think common conditions
3. Keep looking

Red Flags

1. Weight loss
2. Raised Calcium

01. Examine

02. Thoughts

03. Red Flags



NICE GUIDELINES NG12

Weight loss

Symptom and specific features	Possible cancer	Actions
Weight loss (unexplained)	Several, including colorectal, gastro-oesophageal, lung, prostate, pancreatic or urological cancer	Carry out an assessment for additional symptoms, signs or findings that may help to clarify which cancer is most likely Offer urgent investigation, or a suspected cancer pathway referral , or a non-specific symptoms pathway referral [1.13].
Weight loss (unexplained) with abdominal pain, 40 and over	Colorectal	Offer quantitative faecal immunochemical testing (FIT) [1.3.1]
Weight loss (unexplained) with rectal bleeding in adults under 50	Colorectal	Offer quantitative faecal immunochemical testing (FIT) [1.3.1]
Weight loss (unexplained), 50 and over	Colorectal	Offer quantitative faecal immunochemical testing (FIT) [1.3.1]
Weight loss (unexplained), 40 and over, ever smoked	Lung or mesothelioma	Offer an urgent, direct access chest X-ray [1.1.2] [1.1.5]



NICE GUIDELINES NG12

Weight loss with upper abdominal pain or reflux or dyspepsia, 55 and over	Oesophageal or stomach	Refer using a suspected cancer pathway referral [1.2.1] [1.2.7]
Weight loss (unexplained) in women, and trans men and non-binary people with female reproductive organs	Ovarian	Consider carrying out tests in primary care [1.5.3] See the section on primary care investigations for more information on tests for ovarian cancer
Weight loss with diarrhoea or back pain or abdominal pain or nausea or vomiting or constipation or new-onset diabetes, 60 and over	Pancreatic	Consider an urgent, direct access CT scan, or an urgent, direct access ultrasound scan if CT is not available [1.2.5]
Weight loss with raised platelet count or nausea or vomiting, 55 and over	Oesophageal or stomach	Consider non-urgent, direct access upper gastrointestinal endoscopy [1.2.3] [1.2.9]

Hypercalcaemia or leukopenia with persistent bone pain, particularly back pain, or unexplained fracture	Myeloma	Refer using a suspected cancer pathway referral [1.10.5]
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OVARIAN CANCER-THE SILENT KILLER



Cases

7,748 new cases of ovarian cancer, 2019, 2021-2022, UK.



Deaths

3,900 deaths from ovarian cancer, 2022-2024, UK.



Survival

39.3% survive ovarian cancer for 10 or more years, 2018, UK.



Preventable cases

Ovarian cancer cases are preventable, UK, 2015

YVONNE

AGED 59

Been on HRT since she was 50 years
Prescribed 100mcg oestradiol patch with 200mg micronized
progesterone capsules daily
BMI 40
Light bleeding on and off for 11 months
Doesn't want to come off her HRT

5CS

- 1 – CONCEPTION!
- 2 – COMPLIANCE
- 3 – CHLAMYDIA
- 4 – CERVIX
- 5 – CANCER

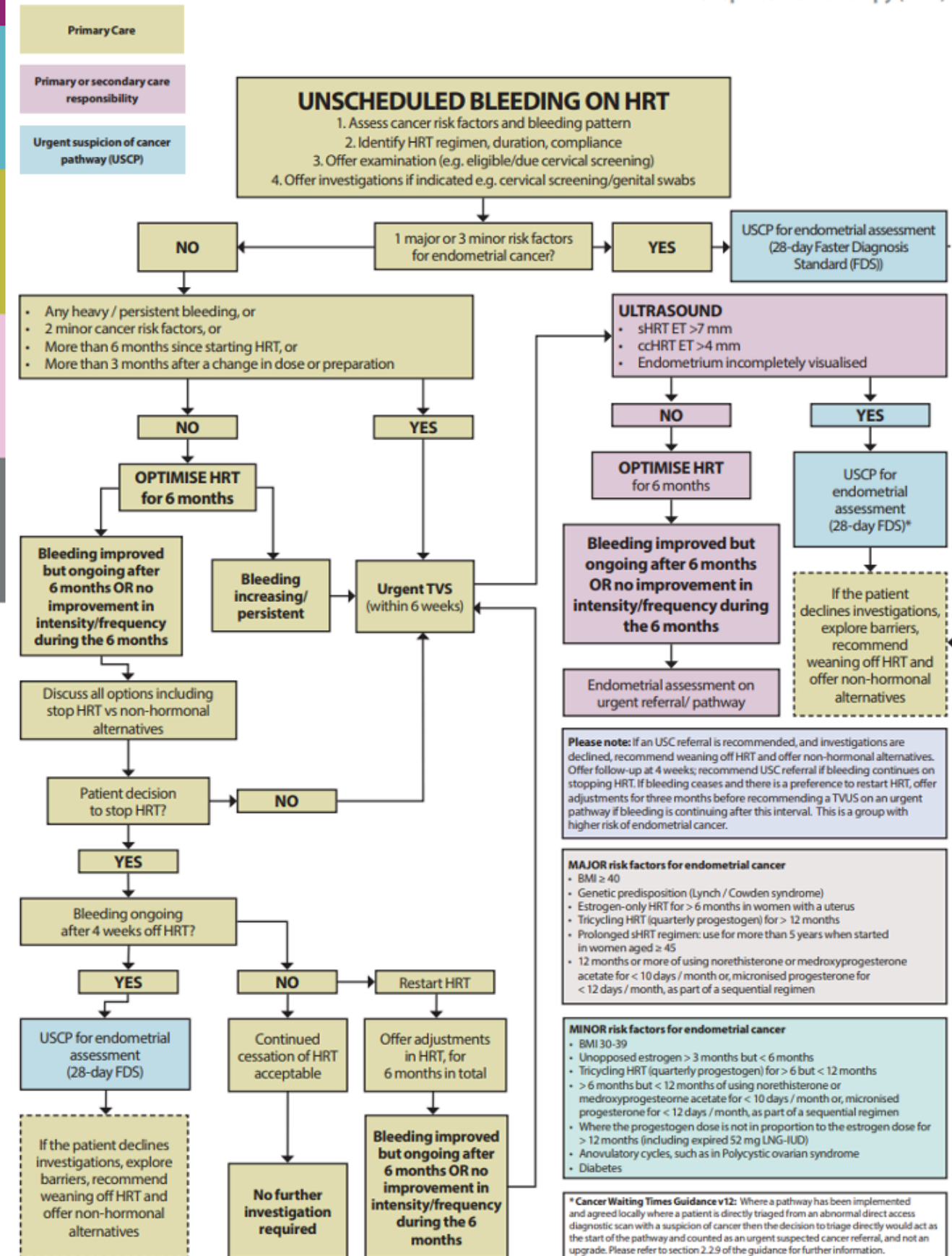


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REFLECTIVE LEARNING

6 of 46

BMS Guideline Management of unscheduled bleeding on hormone replacement therapy (HRT)



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NG12

Post-menopausal bleeding

Symptom and specific features	Possible cancer	Actions
Post-menopausal bleeding (unexplained post-menopausal bleeding that cannot be attributed to hormone replacement therapy (HRT)) in women, and trans men and non-binary people with female reproductive organs, 55 and over	Endometrial	Refer using a suspected cancer pathway referral [1.5.12]
Post-menopausal bleeding in women, and trans men and non-binary people with female reproductive organs, under 55	Endometrial	Consider a suspected cancer pathway referral [1.5.14]

Post-menopausal bleeding is unexplained vaginal bleeding more than 12 months after menstruation has stopped because of the menopause. [Unexplained post-menopausal bleeding](#) is vaginal bleeding that cannot be attributed to [HRT](#) timing, expected settling-in timing, or any identified benign cause, and therefore requires further assessment to exclude underlying pathology.

THANK YOU VERY MUCH!

References

British Menopause Society

<https://thebms.org.uk/publications/bms-guidelines/management-of-unscheduled-bleeding-on-hormone-replacement-therapy-hrt/>

NICE guidelines

• <https://www.nice.org.uk/guidance/ng12/chapter/recommended-actions-organised-by-symptom-and-findings-of-primary-care-investigations#bleeding>

Cancer Research UK

<https://www.cancerresearchuk.org>



<https://www.pcwhs.co.uk>



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Primary Care
Women's Health Society

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