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A Health Needs Assessment of Women's Health in Lincolnshire

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Executive summary

The national "Women's Health – Let's talk about it" survey received over 100,000 responses. In Lincolnshire, around 1,500 women participated in surveys and engagement on women's health (Lincolnshire ICB, 2024; Healthwatch, 2024). Locally and nationally, women consistently report the same poor experiences of the healthcare system. They feel dismissed and ignored by unknowledgeable and uninterested healthcare professionals (HCPs), and report long waits for diagnosis and specialist care.

As Lincolnshire Integrated Care Board's (ICB's) women's health engagement report concluded, a more inclusive, supportive and effective healthcare system is needed that addresses the specific needs of women.

Women in Lincolnshire have lost almost 5 years of healthy life expectancy in the last 10 years, likely due to an increase in unhealthy life among working-age women. This is over twice as many years lost as the national average. Addressing this must be a priority of the local system. The goal of the 10 Year Health Plan for England of halving the gap in healthy life expectancy between the richest and poorest regions will not be achieved without a focus on the specific needs and experiences of women.

The scale of reproductive ill health in the population is greater than previously thought. A recent survey of over 60,000 women found that almost 75% reported experiencing some form of reproductive health problem related to menstruation, menopause, pregnancy and disease. More than a quarter of women (28%) are living with at least one reproductive morbidity (Palmer et al, 2025).

The current models for abortion and contraception provision in Lincolnshire do not offer women and girls sufficient reproductive autonomy. Women are experiencing delays in either seeking or receiving abortion services, forcing them out of the county, to pay for private care, or to take their pregnancy to term. They have difficulty in accessing contraceptive services and advice at crucial times of their life, such as following an abortion or a birth. This is having a significant, detrimental impact on women's health outcomes and health inequalities.

In primary care, disbelief, dismissal and delay in diagnosis are common unless a woman happens to reach a practitioner with a special interest. Primary care services are also inequitable. Our analysis shows considerable variation in women's health services offered and the performance of those services, including disparities in contraception provision, cervical screening coverage, HRT prescription rates and blood testing for menopause.

The issues with primary care are compounded by a lack of specialist care and capacity. Women report having to travel out of the county for specialist endometriosis care, a lack of capacity in specialist menopause care, long waits for gynaecology, and a lack of access and choice in specialist abortion services.

The total cost to the local economy of missed workdays for female employees due to insufficient access to menstrual products, education and sanitation facilities is calculated to be £35 million each year.

All of this is having an impact on the mental health of women. Worsening healthy life expectancy in Lincolnshire women is due in part to worsening mental health. Despite evidence

of the relationship between reproductive health and mental health disorders, there is a lack of mental health support available for women. Similarly, despite menopause and perimenopause presenting a period of heightened vulnerability for mental health issues in women, these are frequently overlooked, and mental health screening is not consistently integrated with menopause care.

Experiences of the healthcare system are doing harm: women report worsening mental health when symptoms are ignored or normalised, and when experiencing long waiting times for diagnosis, tests and treatments with unmanaged symptoms.

This is the scale of the challenge. Women's voices are loud and clear. Action is needed.

Women's health advice and support hub

Recommendations are made throughout and summarised at the end of the document. The main recommendation is that the system develops a women's health advice and support hub to support GPs and other healthcare professionals (HCPs) with specialist women's health advice. This is based on models that have worked successfully in other areas at reducing gynaecology waiting lists, increasing access to services in primary and intermediate care, improving women's experiences of care, and improving knowledge and interest of women's health among GPs. It aligns with ambitions set out in the 10 Year Health Plan for England for a neighbourhood health service that revitalises access to general practice, brings care into local communities and convenes professionals into patient-centred teams.

Women's health advice and support hub

What the hub would do:

- Provide specialist women's health advice to GPs and HCPs to support women being treated in primary care when appropriate to do so. Getting It Right First Time (GIRFT) are publishing guidance and templates in support of this: [Customisable Advice & Guidance templates available for 14 common gynaecology conditions - Getting It Right First Time - GIRFT]
- Develop relationships and support communication between primary and secondary care to reduce unnecessary delays in care.
- Triage referrals between primary and secondary care to ensure patients are seen in the right place. See GIRFT guidance.
- Identify training needs (including through review of referrals) and develop a women's health training programme for primary care. The ICB Women's Health Engagement report has recommendations on training and development for healthcare providers that should form the basis of a training offer.
- Regularly review gynaecology patient lists to ensure women have been referred to the correct pathway, identify those with worsening symptoms, and expedite those experiencing the longest waits. See GIRFT guidance.
- Regularly review care pathways and develop community services or one-stop clinics, if needed.
- Facilitate a network of local HCPs with an interest in women's health.
- Support GPs or PCNs to adopt minimum standards for women's health services.
- Provide updates to HCPs on latest evidence and best practice and support participation in research.
- Prioritise gynaecology and ensure greater theatre and diagnostic capacity.

Women's health advice and support hub

How it would work:

- The hub would require a multidisciplinary team (MDT), likely to include senior clinicians such as a consultant gynaecologist, sexual and reproductive health consultant, GP with special interest (GPwSI) in women's health, data analyst and administrative support. Evidence shows that the more senior the clinicians involved in triage, the more referrals are diverted away from elective waiting lists, with more women having their needs met at a local hub or by their GP.
- The hub should consider digital solutions, such as services which allow GPs to directly contact a specialist consultant remotely from a pre-defined rota for expert advice.

Women's health advice and support hub

The hub will coordinate training to ensure HCPs are equipped to deliver high quality advice, support and treatment. Based upon feedback from local women regarding their experience when seeking support for health issues, the following training options have been suggested for HCPs in Lincolnshire (Lincolnshire ICB WH Engagement Survey 2024):

- **Ongoing training:** continuous training for clinicians on women's health issues to keep them updated on the latest knowledge and practices.
- **Specialised knowledge:** focus on areas such as menopause, endometriosis, menstrual health and mental health to ensure healthcare providers can offer specialised care.
- **HRT prescription:** training needed so doctors can prescribe hormone replacement therapy (HRT).
- **Nurse training:** nurses should receive training as they are more likely to spend time with patients and can provide detailed care and support.
- **Compassionate care:** training to improve empathy and understanding of women's health issues, ensuring that healthcare providers can offer compassionate and supportive care.
- **Communication skills:** enhance communication skills to ensure that healthcare providers can effectively discuss sensitive issues with patients.

Seizing opportunities

There are activities happening locally and nationally in the women's health space that we can build on.

National surveys and local reports from Healthwatch and Lincolnshire ICB provide a good picture of what women think about the care they receive in Lincolnshire. This provides a strong starting point for implementing changes that will address the issues women face locally.

Following new research, we now have the data on the extent of reproductive ill health in the population. This helps us to understand the scale of the problem and to plan how to meet women's needs.

New NHS priorities align with the women's health goals. Priorities on moving care to communities, using technology and focusing on prevention should provide an impetus for transforming women's healthcare. Objectives on reducing the time people wait for elective care, and improving access to and experience of general practice, align with the objectives of women's health hubs. The Tower Hamlets Women's Hub (see page 48) is used as a best practice example Neighbourhood Health Service design in the 10 Year Health Plan for England.

Lincolnshire has a women's health champion, advocating for women in the county.

Recent focus on menopause has normalised conversations, improved awareness and increased access to treatment. Though there is still work to do, this is a great example of how taboos and barriers to treatments around women's health can be broken down.

Development of the NHS Pharmacy Contraception Service and recent NHS abortion guidelines will improve access to contraception and hold local systems accountable for their abortion provision. NHS targets on eliminating cervical cancer by 2040 will provide momentum for improving HPV vaccination and cervical screening uptake.

Lincolnshire has the foundations from which to build local women's health services. There is good coverage of GP LARC services in the county, with 55 contracted practices. Evidence shows that women's health care models often start with an initial service offer which is then expanded over time, with LARC services often the first building block.

Co-commissioning arrangements between LCC and Lincolnshire ICB shows that fragmentation of commissioning arrangements can be overcome through collaboration. Lincolnshire women can access LARC for non-contraceptive purposes via primary care due to an agreement between LCC and Lincolnshire ICB. This a great example of moving care out into the community.

Training in women's health topics is now mandatory in undergraduate healthcare professionals and forms part of the General Medical Council examination. This means that HCPs entering the workforce will be more equipped to address women's health issues.

A note on women's health hubs

Following publication of the Women's Health Strategy for England (DHSC, 2021), funding was made available for women's health hubs to be developed across England. The hubs aim to improve access to and experiences of care, improve health outcomes and reduce inequalities by bringing together HCPs and integrating women's health services in the community. A core specification was published by DHSC to support hub development.

The funding allowed for a three-month pilot of women's health hubs to be carried out in Lincolnshire, between December 2024 and March 2025. The hubs were required to deliver the core services as outlined in the national specification. As no additional funding was allocated from April 2025, the pilot has now ended and there are currently no plans for the hubs to continue. The pilot is being evaluated. The results of the evaluation were not available at the time of writing this report.

This paper does not explicitly recommend the establishment of women's health hubs. Rather, the paper recommends that models of care are established to meet local needs, in line with NHS priorities around community care, prevention, reducing waiting times and improving experiences of primary care. Evidence shows that the most successful versions of women's health hubs are those that respond directly to a local need or priority. There is a risk that hub models could widen health inequalities if they are based on where there are existing interests and services, or on a nationally prescribed specification, rather than responding to local needs.

Background and introduction

Misconceptions surrounding women's health stem from a long history of female exclusion from research and clinical trials. Misunderstanding, misconception, and stigma still exist today and have a strong impact on the care women receive. To tackle the inequalities faced by women in healthcare, the government launched the first Women's Health Strategy (WHS) in 2021, informed by a large-scale Call for Evidence survey of nearly 100,000 people in England. The survey found that women felt that the system was failing them. Women repeatedly emphasised that they did not feel listened to or taken seriously by healthcare professionals. The WHS therefore placed a strong focus on ensuring that women's voices are heard. The strategy also highlighted the lack of research on women's health issues, recommending female-oriented research be used to develop services that address the concerns and needs of women. Empowerment and inclusion were also emphasised within the strategy, as well as addressing the difficulties women have with navigating health and care systems.

In November 2024, Lincolnshire ICB hosted Lincolnshire's first Women's Health Conference, where stakeholders from across the health and care sector were invited to address the unique health challenges women face, and contribute towards creating better, more accessible healthcare services for the future. As part of the event, the Lincolnshire County Council (LCC) Public Health team presented evidence on women's health needs locally, based on a rapid review of local data. The presentation focused on the decrease in female healthy life expectancy in Lincolnshire over the last 10 years, difficulties in accessing contraceptive and abortion services, the mental health impact on menstrual and menopausal health, women's experiences of and disparities in care.

Aim

The aim of this paper is to assess potential reasons for inequalities within healthy life expectancy for women and bring together the evidence base for women's health needs in Lincolnshire, making the case for a change in approach towards women's health. The paper aims to demonstrate to local policy makers that successfully addressing women's health needs is fundamental to realising improvements in healthy life expectancy and reducing health inequalities.

Objectives

- To provide an overview of Lincolnshire's population and demographics, including health inclusion groups.
- To understand the influences on female healthy life expectancy (HLE) and the possible causes of declining female HLE in Lincolnshire.
- To estimate the burden of poor reproductive health in Lincolnshire and assess the extent to which women in Lincolnshire can fulfil reproductive choice.
- To explore and describe the relationship between reductive health, including menopause, and mental health.
- To make evidence-based and achievable recommendations on improving the outcomes of women in Lincolnshire.

Outline

The needs assessment was undertaken in 2025 by the Public Health Division at Lincolnshire County Council (LCC). It brings together relevant data and literature, as well as incorporating views from women taken from local ICB and Healthwatch engagement reports, and recent national large-scale surveys on reproductive health. It looks at the population and demography of women in the county, declining female health life expectancy, reproductive health and choice, and has a particular focus on menopause and reproductive health related mental health needs. It also seeks to propose solutions, looking at models of care that have been successful in improving women's health outcomes and services.

Recommendations are made throughout and summarised at the end of the document. The primary recommendation is that a women's health advice and support hub is established to support GPs and other healthcare professionals (HCPs) with specialist women's health advice, as detailed above.

Methodology

Population and demography data is taken primarily from the Office for National Statistics (ONS), alongside evidence searches into the needs of women in health inclusion groups.

Headline figures on female healthy life expectancy are taken from the Office for Health Improvements and Disparities (OHID) Fingertips tool. Understanding of influences on HLE is based primarily on analysis of Lincolnshire Population Health Management (PHM) and Global Burden of Disease (GBD) data, and an evidence search on influences on female HLE.

Estimates on the reproductive ill health burden in Lincolnshire are based on findings from the national Reproductive Health Survey for England 2023. Evidence searches were undertaken on the mental health needs of women experiencing reproductive ill health and menopause/perimenopause. The chapter references local engagement reports on women's experiences of healthcare produced by Lincolnshire ICB and Lincolnshire Healthwatch. The chapter also references separate reports undertaken by the Public Health Division on cervical cancer elimination, abortion commissioning and women's health needs, all of which have fed into this analysis.

Recommendations are informed by an evidence search on women's health hub models and approaches to the management of gynaecology waiting lists.

Lincolnshire population and demographics

Population by sex and age

The Women's Health Strategy defines the three stages of the life course as adolescents and young adults (puberty to 24), middle years (25 to 50) and later years (51+). Lincolnshire has a total population of 782,808 individuals, of whom 398,714 are female (NOMIS, 2023). The table below (Fig.1) illustrates age demographics in each district, based on 2023 mid-year data from the latest Census.

	Proportion of female residents in area who are in this age group (%)							
	Lincolnshire	Boston	EL	Lincoln	NK	SH	SK	WL
11-24	14.69	14.85	12.15	24.26	13.65	13.19	13.73	12.62
15-24	10.27	9.88	8.12	20.27	9.08	8.70	9.00	8.35
15-44	33.16	34.39	26.46	47.72	32.22	32.04	32.30	30.72
25-50	29.63	31.97	24.44	33.41	29.99	30.47	30.54	29.08
45-55	13.90	14.62	13.54	11.42	14.63	14.35	14.65	14.00
51+	45.24	41.13	54.69	31.60	45.80	45.44	44.95	47.88

	Number of female residents in area who are in this age group							
	Lincolnshire	Boston	EL	Lincoln	NK	SH	SK	WL
11-24	58,557	5,341	9,022	12,571	8,420	6,575	10,333	6,295
15-24	40,951	3,553	6,026	10,502	5,597	4,336	6,771	4,166
15-44	132,220	12,372	19,645	24,729	19,867	15,974	24,310	15,323
25-50	118,143	11,502	18,146	17,316	18,496	15,191	22,986	14,506
45-55	55,416	5,259	10,053	5,919	9,023	7,155	11,025	6,982
51+	180,394	14,797	40,607	16,376	28,246	22,652	33,834	23,882

Figure 1. Females residents by age in Lincolnshire and its constituent districts (ONS, 2023).
EL, East Lindsey; NK, North Kesteven; SH, South Holland; SK, South Kesteven; WL, West Lindsey.

Population by ethnicity

The table below (Fig.2) shows Lincolnshire's population by ethnicity for females. The overall population is predominantly white, followed by white (other). Lincoln has a higher proportion of female residents who are Asian, Black or Mixed or multiple ethnic groups compared to the other districts.

	Proportion of female residents in this area who are of this ethnicity (%)							
	Lincolnshire	Boston	EL	Lincoln	NK	SH	SK	WL
Asian, Asian British or Asian Welsh	1.58	2.05	0.83	3.09	1.08	1.29	1.80	1.26
Black, Black British, Black Welsh, Caribbean or African	0.55	0.62	0.20	1.40	0.32	0.53	0.59	0.33
Mixed or multiple ethnic groups	1.30	1.35	1.06	1.87	1.19	1.28	1.33	1.16
White (English, Welsh, Scottish, Northern Irish or British)	89.08	74.39	95.47	82.85	93.90	84.17	90.20	94.7
White Other (Irish, Gypsy or Irish Traveller,	6.98	20.51	2.28	9.67	3.18	12.17	5.66	2.64

Roma, Other White)								
Other	0.52	1.83	0.16	1.11	0.33	0.56	0.42	0.33

	Number of female residents in this area who are of this ethnicity							
	Lincoln -shire	Boston	EL	Lincoln	NK	SH	SK	WL
Asian, Asian British or Asian Welsh	6,182	733	605	1,620	649	626	1,332	611
Black, Black British, Black Welsh, Caribbean or African	2,153	222	143	736	190	256	437	162
Mixed or multiple ethnic groups	5,093	482	772	979	717	617	984	561
White (English, Welsh, Scottish, Northern Irish or British)	349,134	26,640	69,469	43,428	56,548	40,713	66,659	45,677
White Other (Irish, Gypsy or Irish Traveller, Roma, Other White)	27,339	7,346	1,659	5,069	1,915	5,884	4,186	1,281
Other	2,034	388	120	584	200	272	307	162

Figure 2. Female population by ethnicity in Lincolnshire and its constituent districts (ONS, 2021).

The table below (Fig.3) illustrates the percentage of the population in Lincolnshire and its constituent districts who speak English as a main language. Boston and South Holland are the only districts in which less than 90% of the population speak English as a main language.

	English (or Welsh in Wales) as a main language
Lincolnshire	93.8%
Boston	79.3%
East Lindsey	98.5%
Lincoln	90.2%
North Kesteven	98%
South Holland	88.7%
South Kesteven	95.7%
West Lindsey	98.4%

Figure 3. People (all genders) who speak English as a main language in Lincolnshire (ONS, 2021).

Deprivation

Dimensions of deprivation are used to classify households as deprived based on four characteristics (ONS, 2021):

- Education: a household is classified as deprived in the education dimension if no one has at least level 2 education and no one aged 16 to 18 years is a full-time student.
- Employment: a household is classified as deprived in the employment dimension if any member, not a full-time student, is either unemployed or economically inactive due to long-term sickness or disability.
- Health: a household is classified as deprived in the health dimension if any person in the household has general health that is bad or very bad or is identified as disabled.
- Housing: a household is classified as deprived in the housing dimension if the household's accommodation is either overcrowded, in a shared dwelling, or has no central heating.

The 2021 Census used these dimensions as a variable to illustrate the proportion of households that experience the different levels of deprivation. The table below (Fig.4) shows how many households are not deprived in any dimension compared to how many households are deprived in one or more dimension. North Kesteven and South Kesteven are the only two districts in Lincolnshire that have a higher proportion of households not deprived in any dimension than households who experience one or more level of dimension. All other districts and Lincolnshire as a whole have more households that are deprived in terms of education, employment, health and/or housing than those that are not.

	Not deprived in any dimension	Deprived in one or more dimension
Lincolnshire	46.4%	53.60%
Boston	40.9%	59.10%
East Lindsey	39.8%	60.30%
Lincoln	45.2%	54.90%
North Kesteven	52.3%	47.80%
South Holland	44.0%	55.90%
South Kesteven	51.7%	48.30%
West Lindsey	49.2%	50.70%

Figure 4. Households by deprivation dimension in Lincolnshire (ONS, 2021).

By classifying deprivation based on stratified characteristics, deprivation dimensions illustrate a broader picture that provides a useful supplement to the Indices of Multiple Deprivation (IMD). IMD measures deprivation on a smaller, more local scale, classifying areas based on relative disadvantage, with Quintile 1 being the most deprived and Quintile 5 being the least deprived. Levels of deprivation vary across Lincolnshire, with coastal areas experiencing especially high levels (see Fig.5). The classification that is most prevalent across Lincolnshire is Quintile 2, which 23.1% of the county can be categorised into. Quintile 1 is the least prevalent, with 15.2%, but is highly concentrated around the coast. Quintile 5 sits slightly below the median, at 19.2%.

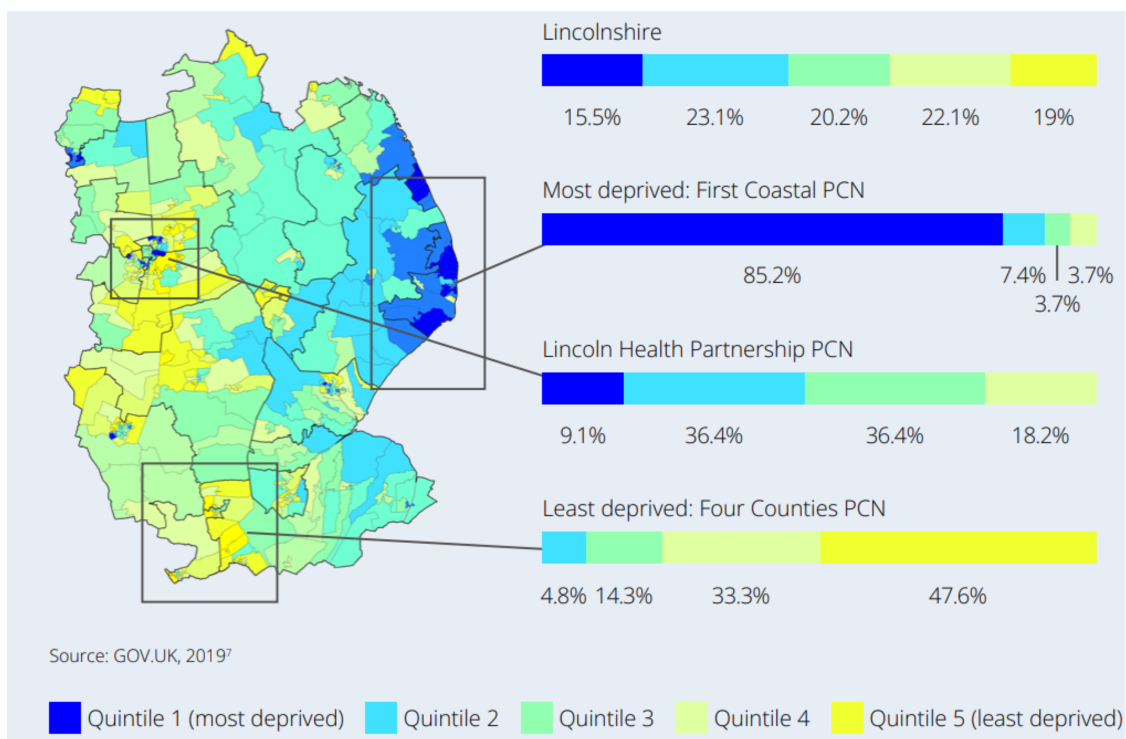


Figure 5. Deprivation across Lincolnshire (DPH Annual Report, 2024).

Population projections

In Lincolnshire overall, the age group projected to have the greatest population increase is the 15-24 age group, which is predicted to rise by 8.68% by 2030 (see Appendix 1). Lincoln and South Holland are projected the greatest increases in 11-24 year olds. The 51+ and 11-24 age groups are also projected to rise, by 7.29% and 6.20%, respectively. These age groups are expected to increase in all districts. This indicates a need to plan for pressure on services across the county that people within these age groups typically frequently utilise.

	Population change between 2023 and 2030 (%)							
	Lincolnshire	Boston	EL	Lincoln	NK	SH	SK	WL
11-24	+6.20	+8.24	+2.04	+11.22	+5.76	+11.19	+0.61	+4.99
15-24	+8.68	+11.06	+2.54	+15.61	+6.24	+15.38	+0.25	+8.11
15-44	-1.43	+2.83	-0.72	-7.96	+4.98	+1.87	-5.57	-6.63
25-50	-2.39	+1.36	+1.28	-21.15	+6.88	+0.01	-2.43	-1.85
45-55	-4.96	-3.80	-6.23	-10.58	-6.68	-2.49	-1.43	-5.14
51+	+7.29	+8.90	+8.29	+5.62	+4.98	+6.14	+10.75	+4.69

Figure 6. Female population projections for 2030 (ONS).

Health inclusion populations

Women with learning disabilities

More than 14,000 adults are estimated to live in Lincolnshire with a learning disability (Lincolnshire JSNA). There is no data on the proportion of these individuals within the county who are female. Women with learning disabilities (WwLDs) are often overlooked in healthcare settings when it comes to reproductive and sexual health matters. **There is an incorrect assumption that individuals with LDs are not sexually active and are therefore unlikely to have children, which means they do not need to be educated on sexual health**. This is a harmful assumption that can lead to women being underprepared for sex and at risk of

exploitation, as well as causing feelings of fear when experiencing changes like menstruation. WwLDs are four times less likely to undergo cervical screening than the general population, which again, has been attributed to the belief that WwLDs are less likely to be sexually active, so less likely to develop cervical cancer (Langan et al, 1994). Similar findings apply to breast examinations, with WwLDs less likely to access a mammogram (Sykes et al, 2024).

Despite the stereotype that WwLD do not require sexual education or screening, the national survey of adults with LDs found that of young women who were sexually active, those with LDs were more likely to have a child than other women. Pregnant women with LDs were found to be less likely to seek or attend regular antenatal care and few healthcare services were equipped to provide it in an appropriate manner. Reasonable adjustments, such as extended appointment times, are not common practice for pregnant WwLDs.

Women in the criminal justice system

It has been recognised for some time that a different approach is needed to improve outcomes for women in the criminal justice system. The impact of the criminal justice system on women is different to the impact on men. The criminal justice system also tends to have a greater impact on dependent children when a mother is imprisoned, as opposed to a father; between 24% and 31% of all women in prison have one or more child dependents (Ministry of Justice, 2015). As women are more likely to be primary carers, the disruption of the lives of dependent children increases the risk that they will also offend (CLINKS, 2016).

The peak age for women offending is 15 years old, which is 8 years younger than the peak age for men offending (Lincolnshire's Women's Strategy). Around 77% of women who are imprisoned receive sentences of under 12 months. HM Peterborough (where Lincolnshire women first go when remanded or sentenced to imprisonment) reported that the average length of stay for a woman was 21 days, which is significantly disruptive to a person's life, health, relationships and family but not a sufficient amount of time for rehabilitative work.

Evidence suggests that women and girls at risk of entering the criminal justice system typically present with two or more needs affecting their physical, mental, social or financial wellbeing (complex needs) (Lincolnshire's Women's Strategy). In 2017, **females were 135% more likely to self-harm in prison compared to males**. Despite this, women report a failure to adopt mental health informed and trauma informed approaches.

Considerations around female safety is also a concern, with **nearly two thirds of women in prison having a history that suggests brain injury, often as a result of domestic abuse**. An estimated 53% of women in prison report having experienced emotional, physical, or sexual abuse as a child, with 79% of women who use the Women in Prison charity's services reporting domestic violence and/or sexual abuse. The situation surrounding female imprisonment is often highly complex and requires services that take this into account when considering support.

Migrants and refugees

Women and girls make up approximately 40% of people seeking asylum worldwide. The table below shows migrant indicators for all persons in Lincolnshire. Boston and Lincoln see the highest migration from outside the UK, at 1.1% and 1.2%, respectively. Lincoln sees the highest migration from within the UK, which is likely linked to the presence of two universities.

	Migrant from within the UK	Migrant from outside the UK
Lincolnshire	9.9%	0.6%
Boston	9.4%	1.1%
East Lindsey	9.0%	0.4%
Lincoln	15.0%	1.2%
North Kesteven	9.4%	0.5%
South Holland	9.5%	0.5%
South Kesteven	8.6%	0.4%
West Lindsey	9.0%	0.4%

Figure 7. Population with migrant indicators in Lincolnshire (ONS, 2021).
The migration indicator classifies people based on the difference between their current address and their address one year ago. Migrant from within the UK refers to individuals whose address one year ago was in the UK. Migrant from outside the UK refers to individuals whose address one year ago was outside the UK.

Studies show that gender is the greatest factor in terms of outcomes, rather than migrant status differences. Despite this, migration research largely focuses on men, so services have been designed for men.

Sexual violence is an example of an area where female migrants may struggle to find support, further exacerbating the challenges of resettlement. **The lifetime prevalence of sexual violence in women over 15 years of age in the general population was 11% in 2022. In migrants and refugees, it was 69.3%** (Daou, 2022). Research has found that, of women forced to flee their homes due to conflict or disasters, as many as 50% have experienced sexual and gender-based violence (Red Cross).

Women face additional challenges such as predatory caseworkers, harassment in the workplace and unsafe housing. Several studies have found that women fear deportation should they disclose abuse or additional challenges, a fear that also interferes with seeking pregnancy support. This is of particular concern as female migrants are disproportionally at risk of perinatal and prenatal depression, with the burden of these disorders appearing to affect forced migrants to a greater degree than economic migrants (Nyikavaranda et al, 2023). It is therefore imperative that sensitive, specialist care is available for female migrants and refugees, in a manner that is accessible to the individuals who will be seeking it.

Evidence indicates that pregnancy support and mental health services are key areas that are not easily accessible to migrant women, with a lack of specialised services. Services need to address the issue of difficulty navigating the healthcare system in host countries, as well as the complex background faced by female migrants, and provide a safe environment in which fear of deportation does not prevent attendance. Displacement, resettlement, and migration can exacerbate health inequalities, and with the current services implemented for migrants predominantly rooted in male research findings, further work needs to be done to address the needs of women.

Homelessness

In 2021, Shelter reported that **60% of all homeless adults living in temporary accommodation in England were women, despite women only making up 51% of the general population**. This may be because women are more likely to be accepted into temporary

accommodation than single men. Nationally, the average age of death for a homeless woman is 43 (JSNA). Over the past decade, the number of homeless women living in temporary accommodation has almost doubled. The Housing Act 1996 defines a person as homeless if they:

- Have no accommodation available to occupy
- Are at risk of violence or domestic abuse
- Have accommodation but it is not reasonable for them to continue to occupy it
- Have accommodation but cannot secure entry to it
- Have no legal right to occupy their accommodation
- Live in a mobile home or houseboat but have no place to put it or live in it

Rough sleeping is considered the most dangerous form of homelessness. This refers to people who are homeless and sleeping on the streets or in places not meant for people to live, including cars, doorways, parks, bus shelters and abandoned buildings (The House of Commons Library, 2025). The 'invisibility' of women who are homeless or sleeping rough is particularly dangerous. Many reports describe women dressing up as men, moving continuously throughout the night, sleeping on buses and exchanging sex for accommodation; all indicators of the extreme measures women take to avoid the dangers of being visibly without a place to sleep. Providing female-only accommodation and ensuring that there are safe spaces to rest is key to allowing women the space to seek additional support; something that is likely not a priority with the other life-threatening challenges that they are facing each day.

Trauma often underpins homelessness, and with women this commonly stems from sexual and domestic abuse, with the University of York reporting that these are near universal experiences for women who are homeless - and often their reason for not having accommodation (University of York, 2021). 1 in 5 young women had experienced sexual assault once or more while they were homeless and there were five times as many young women aged between 16 and 24 who lost their last settled accommodation due to domestic violence in 2020/21 compared to men (Centrepoint, 2022). While domestic abuse was an almost universal experience, few women access existing specialist domestic abuse services (Crisis, 2023). Many factors could contribute to not accessing services, ranging from misinformation to fear of predatory caseworkers, but it is commonly agreed upon that female-only services are more desirable and therefore more likely to be utilised.

Gypsy, Roma and Traveller

Gypsy, Roma and Traveller (GRT) are terms used to describe a range of ethnic groups or people with nomadic ways of life who are not from a specific ethnicity (GOV.UK, 2022). In UK data collection, Gypsy and Travellers are often classed together, while Roma is a distinct group. The term Traveller can mean groups that travel, but Irish Traveller refers to individuals with specific Irish roots. The table below (Fig.8) shows female Roma, Gypsy and Traveller ethnic groups on a county and district level. In Lincolnshire, Boston has the highest female Roma population while West Lindsey has the highest female Gypsy or Traveller population. South Holland has the second highest population for both ethnic groups.

	Ethnicity	
	White: Gypsy or Irish Traveller	White: Roma
Lincolnshire	487	323
Boston	69	94
East Lindsey	66	28
Lincoln	66	62
North Kesteven	34	14
South Holland	74	82
South Kesteven	55	34
West Lindsey	122	8

Figure 8. Gypsy, Traveller and Roma female populations in Lincolnshire's districts (ONS, 2021).

Community is important to Gypsy and Traveller women, with the significance of relationships within a community strongly linked to patterns of domestic abuse and the subsequent seeking of support. **The fear of isolation from a community** hinders the reporting of abusive behaviours. Similarly, there is a common fear that if a mother were to approach social services, she would risk having her children taken into care.

A lack of awareness of consent culture and healthy relationships has been identified to contribute to domestic abuse behaviours in GRT communities, suggesting that young boys and girls need to be taught what abuse is and how to challenge it (Women and Equalities Committee, 2017-2019). Groups that promote positive mental health, such as 'Well Woman' groups, are an example of how local authorities can use their community development plans to support engagement with GRT, including educating women on consent.

GRT communities face different health risks to the general population, with GRT mothers being 20 times more likely to experience the death of a child (Davies, 2021). Several studies have found gaining access to doctors is very difficult for Traveller communities, despite there being no regulatory requirement to provide proof of address of identification to register at a GP registration. A study by Sweeney and March (2019) involved mystery shoppers calling 50 doctor's surgeries to request registration as they needed support with a 'woman's problem' but were from the Traveller community so did not have a fixed address or proof of identity. 24 out of 50 practices would not register the mystery shopper, despite every GP practice being rated as 'good' or 'outstanding' for their work with 'People whose circumstances may make them vulnerable'.

Difficulty with accessing healthcare services links to the issue of screening inequalities, with the lack of regular access to correspondence meaning that women may not receive screening invites. They may also not be near to the service they were invited to. There need to be simple processes for women to make or change their appointment, as well as reinforcement of the knowledge that proof of address is not a requirement when registering for a GP surgery.

Trans men and women

Based on 2021 data, there are 502 trans women and 500 trans men in Lincolnshire. Lincoln has the highest number of both trans women and trans men, likely due to the presence of two universities leading to an overall younger age demographic. Statistics from the 2021 Census found that people aged 16 to 24 years were the most likely age group to have said that their

gender identity was different from their sex registered at birth, with 1 in 100 people identifying as trans (ONS, 2023).

	Gender	
	Trans men	Trans women
Lincolnshire	500	502
Boston	50	56
East Lindsey	81	61
Lincoln	157	154
North Kesteven	48	44
South Holland	53	55
South Kesteven	69	85
West Lindsey	43	49

Figure 9. Trans women and trans men in Lincolnshire's districts (ONS, 2021).

Inequalities when accessing healthcare services has been identified as a significant issue for trans people. When attempting to access general healthcare services in the last year, **41% of trans people said healthcare staff lacked understanding of trans health needs** (Stonewall, 2018). 42% of trans individuals would like to undergo medical intervention as part of their transition but haven't yet done so for fear of the consequences it may have on their family life (Stonewall, 2018). 18% of trans respondents to the National LGBT survey (2018) had avoided treatment for fear of a negative reaction. These findings indicate a need for services that provide a safe environment for trans people. It is not acceptable that discriminatory attitudes towards trans people impact quality of care and accessibility of medical treatment.

A further issue is that GPs do not send cervical screening invites to patients registered as male, even if they have a cervix. The current requirement is for the individual to contact a GP and request an invite. With the identified barriers in healthcare systems and the lack of understanding of staff, this may be something some individuals are not comfortable doing and could be amended by categorising eligibility for invitations by presence of a cervix, rather than by gender identity.

While the WHS pledged to improve research on women's health issues, the lack of data on LGBTQIA+ in the strategy indicates that there is still a barrier for trans men and women that has not yet been targeted. While research and data surveillance are extended processes, training opportunities for healthcare staff should be explored and encouraged, with changes made to promote an environment in which trans people feel comfortable and understood. Language guides are an example of a resource that could be provided to staff, along with education to improve understanding of the medical needs of trans people.

Demographic summary

- Lincolnshire's female residents are predominantly made up of women classed as being in their later years (51+), with this age group comprising 45.24% of the total population. Reproductive age women (15-44) form the second highest number of residents with 33.16%. On a district level, Lincoln has the greatest proportion of 15-44 year old women (47.72%), while East Lindsey has the greatest number of women in their later years

(54.69%). The 15-24 age group is the lowest in the county but is notably higher in Lincoln compared to the other districts (20.27%).

- The age group projected to have the greatest population increase by 2030 is the 51+ age group, followed by the 15-24 age group. These age groups are expected to increase in all districts. The 11-24 age group is also projected to increase in all districts, but to a lesser extent. The 45-55 age group is projected to decrease in all districts, while the 15-44 and 25-50 age groups vary between districts but are anticipated to decrease overall.
- 89% of the female population in Lincolnshire are White (English, Welsh, Scottish, Northern Irish or British). The second highest ethnicity group is White Other (Irish, Gypsy or Irish Traveller, Roma or Other White). Lincoln has the most diversity in terms of ethnicity, however White is still the overwhelming majority.
- Boston and South Holland are the only two districts who have less than 90% of residents who speak English as a main language. Boston has the lowest percentage, at 79.3%, while South Holland has 88.7%.
- North Kesteven and South Kesteven are the only two districts in Lincolnshire that have a higher proportion of households not deprived in any dimension than households who experience one or more level of dimension. All other districts and Lincolnshire as a whole have more households that are deprived in terms of education, employment, health and/or housing than those that are not.
    - On average, women with learning disabilities die younger, peak offending age for women is younger and women who are homeless die younger.
- Lincoln has the greatest percentage of migrants from both within and outside the UK, with 15% and 1.2%, respectively. Boston has a similar percentage of migrants from outside the UK, with 1.1%.
- Boston has the highest female Roma population, with 94, while West Lindsey has the lowest, with 8. West Lindsey has the highest female Gypsy or Traveller population with 122, while North Kesteven has the lowest with 34.
- Lincoln has the greatest number of trans people, with 157 trans men and 154 trans women - significantly more than the other districts.

Female healthy life expectancy in Lincolnshire

The public health agenda aims to improve the health of our population to enable more years spent in good health. **However, over the last 10 years, Lincolnshire women have lost almost 5 years of healthy life expectancy** (HLE) – over twice as many years as the national average**.** Between 2013 and 2023, HLE at birth for females in Lincolnshire decreased from 65.1 years to 60.5 years, a loss of 4.6 years. By comparison, the average woman in England has lost 2 years of HLE in this period; the average woman in a statistical neighbour authority lost 2.4 years. In 2013, the average woman in Lincolnshire would have lived 1.2 years more healthy life than the average woman in England. By 2023, the average Lincolnshire woman was living 1.4 years less healthy life than the average woman in England (see Fig.10).

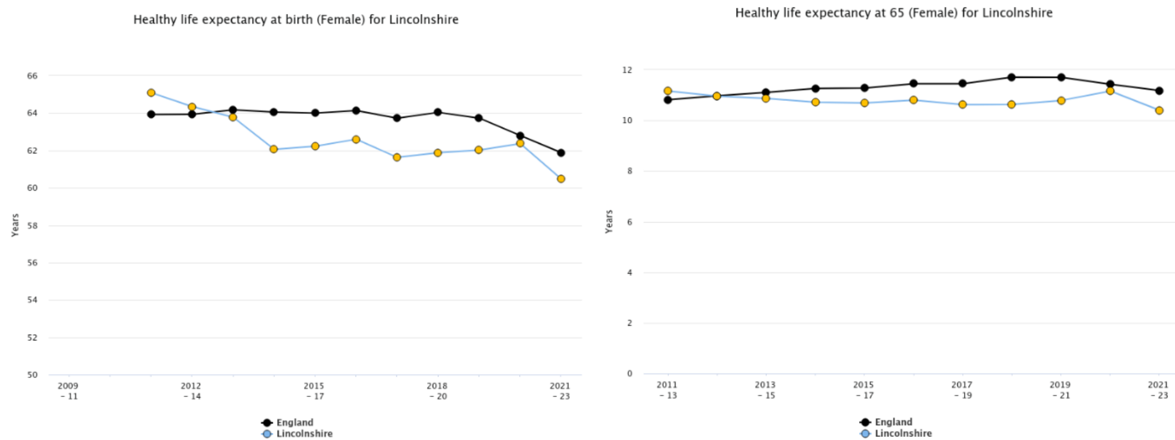


Figure 10. Healthy life expectancy in females (Fingertips).

Compared with statistical neighbours, Lincolnshire has the 2nd lowest female HLE, ranking 15th out of 16 local authorities. Women living in Shropshire, Wiltshire, Devon and North Yorkshire will live over 4 more years in good health than a woman in Lincolnshire.

Increase in unhealthy life in younger age groups

HLE is defined as a measure of the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health. Two outcome indicators on HLE are published by the DHSC: HLE at birth (the average number of years a person would expect to live in good health), and HLE at 65 (the average number of years a person aged 65 years would expect to live in good health).

As noted by the Office for Health Improvement and Disparities (OHID), changes in self-reported good health prevalence have a larger impact on HLE than changes in mortality rates (OHID, 2023). As how healthy or unhealthy people feel has the larger impact on HLE measures, this should be the focus.

A study into trends in life expectancy and healthy life expectancy found that the reduction in HLE at birth in the UK was mainly attributable to increases in unhealthy life in younger age groups (Walsh, 2021). This is reflected in Lincolnshire data, which shows that while HLE at birth has decreased over 10 years, HLE at 65 has remained stable, suggesting that self-reported ill health in the under 65s is driving the decrease in HLE (see Fig.10 above).

An analysis by the Lincolnshire Public Health Intelligence Team (LCC, 2025) found that Lincolnshire's working age adult (WAA) population are more likely to live in ill health as overall population health declines. It notes that:

- 24.8% of WAAs (aged 18-64) have between 2 and 4 long-term conditions. Almost 1 in 5 (19.1%) of Lincolnshire residents experience some level of limitation in their daily activities due to long term physical disabilities or mental health conditions.
- The percentage of WAA in Lincolnshire registering for disability benefits increased by 41% from 2014 to 2024.
- Economically inactive residents due to long term sickness increased from 26% in 2004/05 to 33% in 2024/2025, compared to a national increase of 23% to 27% over the same period. Economic activity due to long-term sickness is at its highest level.

- Overall demand on social care is increasing, driven by increasing disabilities, mental health conditions, physical disabilities and complex care needs among WAAs.
- Personal Independence Payments (PIP) in Lincolnshire have increased by 77% since 2019. Psychiatric disorders are most prevalent reason for those receiving PIP (a 103% increase since 2019), with MSK the second highest reason.
- Mental health conditions are becoming more common, and this is driving increasing demand on mental health services.

A Nuffield Trust analysis of disability-adjusted life years (DALYs) between 2011 and 2021 shows that working-aged women have seen a faster growth in health burdens than working-aged men, and women spend more of their working years living in ill health. Their analysis of Global Burden of Disease data shows the percentage increase in DALYs lost to all conditions (excluding Covid-19) between 2011 and 2021 was 4% for women aged 15 to 69, compared to 1% for men of the same age group. Working-aged women were more likely than men to suffer from conditions marked by ongoing pain, such as migraine, lower back pain, neck pain and other MSK conditions, and long-term mental health problems such as major depressive disorder, anxiety disorder and bipolar. By contrast, working-aged men were more prone to conditions with a higher risk of death.

Additionally, the burden of disease for sex-specific conditions, such as breast cancer and gynaecological diseases, falls more heavily on working-aged women. As Nuffield Trust note, gynaecological conditions often present at working age and most occurrences of breast cancer in women (65%) happen during working-age years. Working-aged men do not see the same level of burden for equivalent conditions such as testicular and prostate cancer.

Lincolnshire data

Data taken from the Lincolnshire Population Health Management (PHM) programme shows that Lincolnshire working-aged women (18-65) are more likely than men to suffer from MSK and mental health conditions. Also notable is the difference in obesity: 26.4% of women have an obesity flag compared to 18.6% of men.

Condition	Female	Male	Difference
MSK	48.10%	43.40%	4.70%
Cardiovascular disease	2.60%	4.70%	-2.10%
Chronic Pain	15.10%	7.80%	7.30%
Obesity	26.40%	18.60%	7.80%
Anxiety	29.40%	16.20%	13.20%
Depression	28.40%	16.70%	11.70%
Low Mood	20.10%	10.80%	9.30%
Mental Health Flag	43.90%	26.90%	17.00%

Figure 11. Lincolnshire Population Health Management dataset, April 2024 to March 2025 (NHS Lincolnshire ICB).

PHM data shows a relationship between female obesity and deprivation and mental health and deprivation, with females in the most deprived deciles more likely to report obesity and mental health conditions than females in the least deprived. MSK shows no relationship with deprivation (see Fig.12).

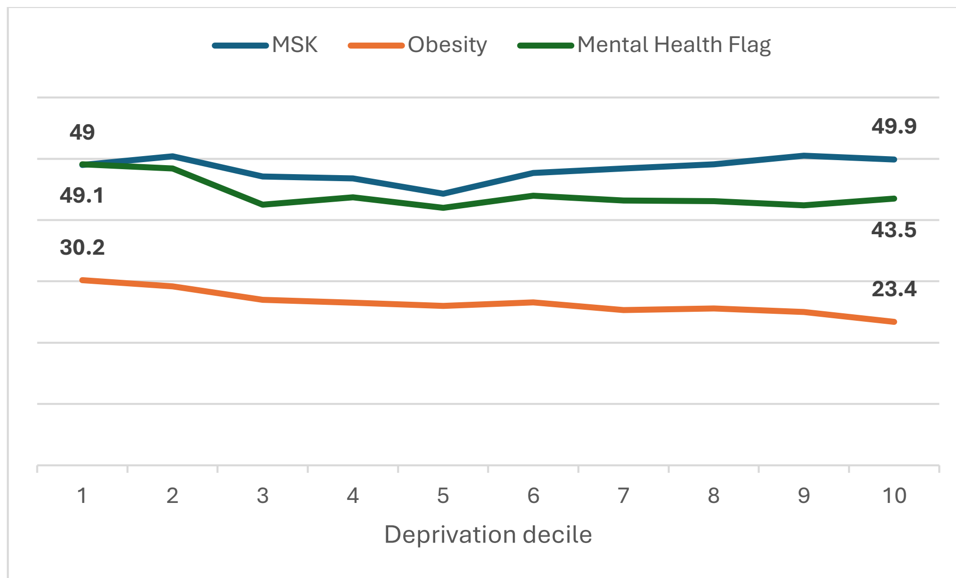


Figure 12. Lincolnshire PHM dataset, April 2024 to March 2025 (NHS Lincolnshire ICB).

Figure 13, taken from the Global Burden of Disease (GBD) data, shows where disease burden differs most by sex for people under the age of 70 in Lincolnshire. Excluding those disorders that are sex-specific, DALYs are higher for women for communicable diseases, MSK disorders, mental health disorders, neurological disorders and headache and migraine disorders. Men experience higher DALYs for respiratory, cardiovascular, substance misuses disorders and injuries.

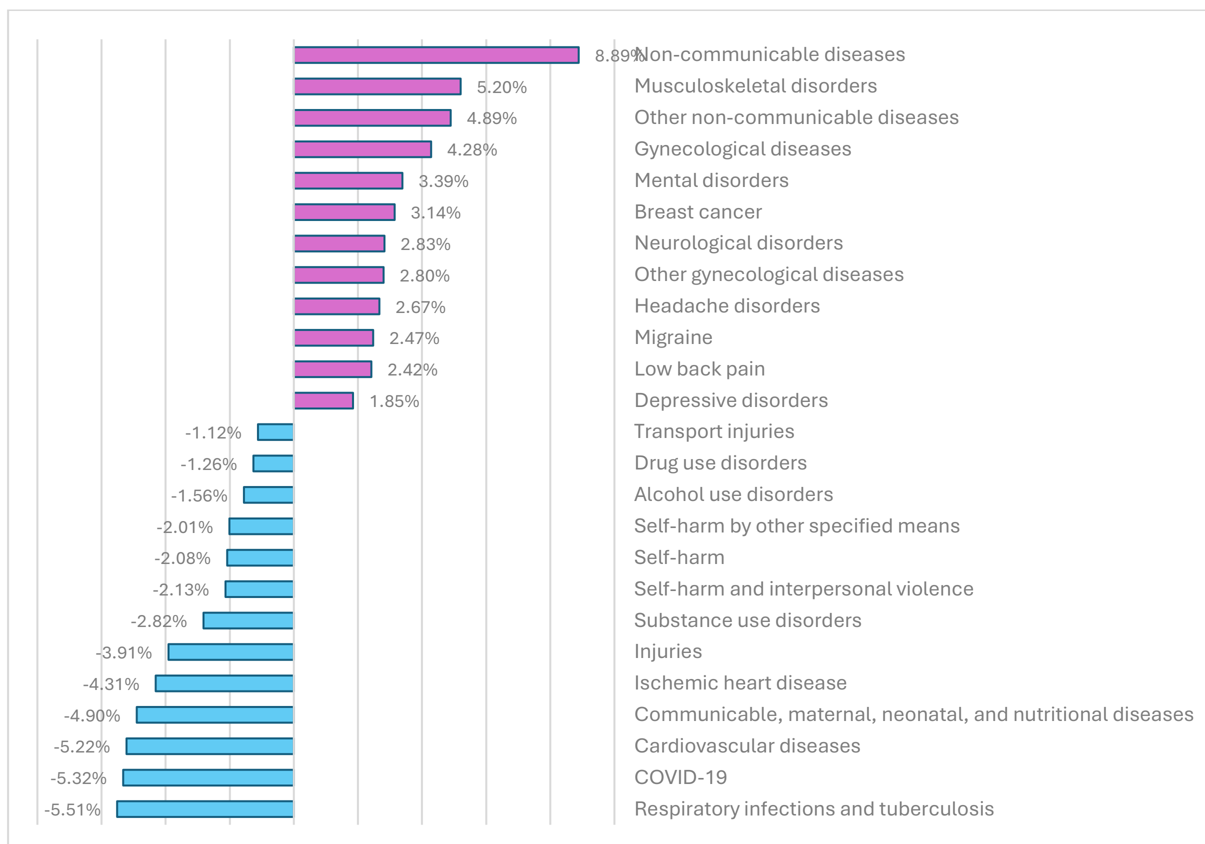


Figure 13. Disease burden by sex for people under the age of 70 in Lincolnshire (GBD).
Purple, women; blue, men.

As noted above, women are more likely than men to suffer from conditions marked by chronic ongoing pain. It should be noted that a Lincolnshire ICB survey found that dissatisfaction levels among women were high for services relating to living with long-term conditions, osteoporosis and bone health, and mental health and wellbeing (see Figure 19 below). This suggests that services for conditions that have a high impact on female HLE are not meeting the needs of women.

Lincolnshire's demography

Lincolnshire's ageing population may be contributing to worsening HLE. Lincolnshire has a higher proportion of older working age people (50+) and a lower proportion of younger working age people (under 50) than nationally and even among statistical neighbours (see Figure 14). Older working age people will be more likely to report ill health. While Lincolnshire men have also lost 3.4 years of HLE in the last 10 years, compared to an average 1.1 years nationally, demography alone does not explain why Lincolnshire women have experienced such a loss of HLE (4.6 years) in the last decade.

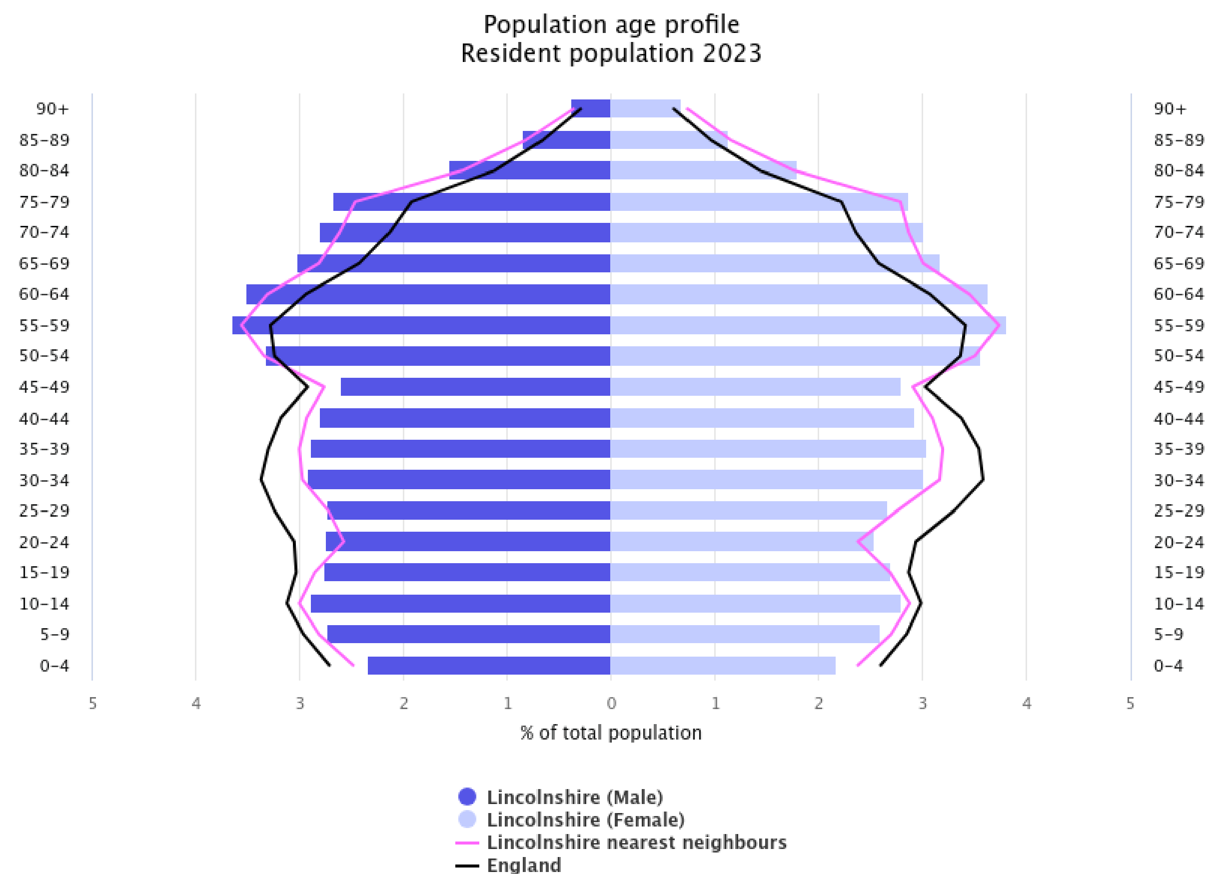


Figure 14. Population age profile. Resident population, 2023. DHSC.

The impact of Covid-19

The Covid-19 pandemic will have contributed to the fall in HLE, with delays in care for non-Covid conditions and an increase in long-term sickness following the pandemic being additional contributory factors.

In Lincolnshire, approximately 2 years of female HLE have been lost since the onset of the pandemic in 2020. This is similar to the years lost nationally. However, between 2013 and 2020, Lincolnshire females experienced a decrease in HLE of up to 2.6 years. Nationally, in the same period, the average woman in England experienced no change in HLE. This indicates that the decrease in female HLE in Lincolnshire began well before the pandemic and the decrease in HLE cannot be explained solely by Covid-19.

Widening inequalities

Life expectancy in England is significantly lower for people living in more deprived areas than for people living in less deprived areas, and socio-economic inequalities in health in England have been widening since 2010. The gap in healthy life expectancy between the highest and lowest ranked areas in England has also grown, by 22% for males and 17% for females since 2011–13 (Kings Fund, 2024).

The Institute of Health Equity (IHE) observe that inequalities in life expectancy are strongly related to the overall level of life expectancy, so the lower the life expectancy within a local authority area the greater the inequality in life expectancy within the area (IHE, 2024).

Data comparing HLE between different populations is limited. However, Lincolnshire's comparatively low and more steeply decreasing female HLE is likely an indicator that inequalities in HLE are widening within the county.

Unpaid carers

The steeper decline of female healthy life expectancy in Lincolnshire may in part be explained by the higher prevalence of female carers in Lincolnshire who are providing intense, unpaid care. ONS data shows Lincolnshire to have a higher proportion of unpaid carers than nationally, with the greatest difference showing in the number of unpaid carers who provide 50 hours or more of care each week (Nomis, 2021). Unpaid carers are much more likely to be female (67.5%), with an average age of 59 (Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB, 2024). ONS data shows that those who provide more hours of unpaid care are more likely to report that they are "not in good health", with females having worse outcomes than men overall (Census, 2021). Census data also shows that those living in the most deprived areas are more likely to be providing more hours of unpaid care (Census, 2021). This further contributes to widening health inequalities, particularly among women who bear most of the burden of unpaid caring roles.

Provision of unpaid care

Persons

	Lincolnshire Local Authority		East Midlands Region		England Country	
	count	%	count	%	count	%
All usual residents aged 5 and over	732,546	100.0	4,626,856	100.0	53,413,098	100.0
Provides no unpaid care	662,159	90.4	4,198,558	90.7	48,734,833	91.2
Provides 19 hours or less unpaid care a week	32,084	4.4	210,087	4.5	2,303,725	4.3
Provides 20 to 49 hours unpaid care a week	14,097	1.9	86,759	1.9	969,769	1.8
Provides 50 or more hours unpaid care a week	24,206	3.3	131,452	2.8	1,404,771	2.6

Figure 15. Provision of unpaid care. Office of National Statistics, Census 2021.

England

	Most deprived 1	2	3	4	5	6	7	8	9	Least deprived 10
9 hours or less	2.1	2.4	2.7	2.9	3.2	3.4	3.5	3.6	3.7	3.9
10 to 19 hours	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.1
20 to 34 hours	1.2	1.1	1.0	0.9	0.9	0.8	0.8	0.7	0.7	0.6
35 to 49 hours	1.6	1.3	1.2	1.0	0.9	0.9	0.8	0.7	0.7	0.6
50 or more hours	4.0	3.5	3.1	2.8	2.7	2.5	2.4	2.3	2.1	1.9

Age-standardised percentage (%)

Figure 16: Hours of care provided by deprivation decile. Office for National Statistics, Census 2021.

The burden of unpaid care on women in Lincolnshire is further evidence of the need for a healthcare system that addresses the specific needs of women. Unpaid carers make a major contribution to society, with estimates showing that the care provided by friends and family members to ill, frail or disabled relatives nationally is equivalent to £119 billion every year (NHSE). Improving women's health will benefit those they care for and the wider health and social care system.

Female life expectancy in Lincolnshire – summary

Women in Lincolnshire have lost almost 5 years of healthy life expectancy in the last 10 years, over twice as many years lost as the national average.

This is due to an increase in unhealthy life among working-age women. National evidence shows that women have seen a faster growth in health burdens than working-aged men, and women spend more of their working years living in ill health.

Data shows that women are more likely than men to suffer from musculoskeletal and mental health conditions, conditions marked by ongoing pain and distress. **Lincolnshire women report low satisfaction levels for services relating to these conditions.**

Further work is needed to understand why Lincolnshire women have suffered a disproportionate loss of healthy life. Addressing and monitoring this must be a priority of the local system. Many factors will influence this. Local data points towards the impact of non-communicable disease, obesity, and a higher prevalence of female carers in Lincolnshire who are providing intense unpaid care; a comparatively older working age population; and, as will be discussed later in this paper, delays to accessing care for menopause and reproductive health conditions.

The goal of the 10 Year Health Plan for England of halving the gap in healthy life expectancy between the richest and poorest regions will not be achieved without a focus on the specific needs and experiences of women. Improving the speed at which women can access diagnosis and treatment for conditions marked by ongoing pain and distress is key to reducing the disease burden carried by working-aged women, and therefore for improving overall healthy life expectancy.

Actions

- **Local plans to improve healthy life expectancy should focus on the specific needs and experiences of women. This must include improving women's access to and satisfaction levels for services relating to chronic, long-term conditions, menopause and reproductive health conditions.**

Reproductive health

This chapter examines the state of women's reproductive health in Lincolnshire by looking at progress towards three ambitions of reproductive health set out by Public Health England (PHE) in their 2021 reproductive health programme. These ambitions are to:

1. **Improve reproductive health-related quality of life**
2. **Fulfil reproductive choice**
3. **Early identification of reproductive morbidity**

Regarding ambition 1, the chapter explores the timeliness and quality of care received by women with reproductive health care needs, and the degree to which people experience difficulties in their life due to reproductive morbidity.

For ambition 2, the chapter explores the domains of contraception, unplanned pregnancy and abortion that underpin reproductive choice.

For ambition 3, analyses progress towards the goal to eliminate cervical cancer and relationship, sex and health education (RSHE) provision.

Background

The Reproductive Health Survey for England 2023 was the first population-based survey carried out in Britain with the aim of quantifying the burden of poor reproductive health at a population level. Findings show there to be is a substantial burden of poor reproductive health in the population:

- Almost 75% of participants aged 16 to 55 had recently experienced at least one of the following: heavy and severely painful periods, menopausal symptoms, reproductive conditions like endometriosis and polycystic ovary syndrome (PCOS), infertility and pregnancy loss.
- More than 1 in 4 participants reported having a reproductive condition, such as endometriosis, polycystic ovary syndrome, uterine fibroids, pelvic organ prolapse, or cervical, ovarian, uterine, or breast cancer.
- Women from minority ethnic groups, particularly black women, were more likely to report reproductive conditions, menstrual issues, and pregnancy-related adverse experiences.
- There was a strong association between financial status and reproductive health, with those who were struggling financially having poorer reproductive health.

We can use these findings to estimate how many women in Lincolnshire are affected by reproductive health disorders (see Appendix 2):

- Around 135,000 women aged 16 to 55 in Lincolnshire have recently experienced a reproductive health problem, and around 51,000 are living with a serious reproductive health issue.
- Reproductive morbidities affect 28% of the female population in Lincolnshire. The age group most affected are those aged 50-55, followed by those aged 40-44. 18,723 people in Lincolnshire are affected by PCOS and 15,879 are affected by endometriosis.
- Severe period pain, heavy menstrual bleeding, and/or hot flushes or night sweats affect 63% of the female population in Lincolnshire. Severe period pain and heavy menstrual bleeding is worse in younger age groups.
- Adverse pregnancy related experiences affect 5% of the female population in Lincolnshire. 4,584 women in Lincolnshire experienced pregnancy loss in the last year. 1,697 experienced unplanned pregnancy, with most of these people being aged 20-24.
- Reproductive, menstrual or pregnancy issues affect almost 75% of the female population in Lincolnshire. 16% of these women are aged 50-55, however all age groups are affected.

These figures may be an underestimate due to the poor diagnosis rates for reproductive health disorders. For example, nationally, people with endometriosis typically wait around 10 years for a diagnosis, while PCOS takes an average of 2 years and visiting more than 3 doctors (Gibson-Helm et al, 2017). A Healthwatch survey on Lincolnshire women found that the journey to an endometriosis diagnosis often takes more than 10 years, with some women waiting over 15 years.

Reproductive health disorders are associated with mental health disorders, and vice versa. Diagnosis of a reproductive system disorder is associated with two-to-three-fold increased odds of having a psychiatric disorder, with the perimenopausal period being particularly linked to increased risk of bipolar and major depressive disorder (Zaks et al, 2023). Equally, women with mental illness are more likely to experience reproductive health issues such as gynaecological diseases, STIs, reproductive cancers, contraception and emergency contraception, termination and recurrent miscarriage than women without mental illness (Hope et al, 2022).

Figure 17 summarises the burden of mental health morbidities experienced by women with different reproductive health conditions. While the menopause is not a medical condition or an illness, it is a period of heightened vulnerability for mental health issues in women.

Cohort of women	Mental health impact	Women affected
Infertile	Suicidal thoughts	42%[1]
	Depression	90%[3]
	Anxiety	15%-76%[7]
Heavy menstrual bleeding	Depression	67%[4]
(Peri)menopausal	Suicidal thoughts	7.80%[2]
	Depression	Risk doubles[5]
	Anxiety	24.54%[8]
	Bipolar disorder	112% increase in incidence[9]

	Major Depressive Disorder (MDD) onset	30% increase in incidence[9]
	Risk taking behaviour: increased alcohol consumption	One in three[10]
	Risk taking behaviour: gambling	5%[10]
Postnatal (under 25)	Depression	One in three[6]

Figure 17. The proportion of women with various reproductive health conditions who experience different mental health conditions.

[1] *PHE, 2021*

[2] *The Menopause Charity, 2023*

[3] *PHE, 2021*

[4] *RCOG*

[5] *The Menopause Charity, 2023*

[6] *PHE, 2018*

[7] *Hillcoat et al, 2023*

[8] *Huang et al, 2023*

[9] *Shitomi-Jones et al, 2024*

[10] *Reisel et al, 2024*

There is also emerging research on the complex relationships between reproductive health conditions and other aspects of health. Recent studies have explored links between endometriosis and immunological disease (Shigesi et al, 2025), highlighting the disproportionate burden of autoimmune disease on women (Angum et al, 2020) and the subsequent impact on mental health (Sloan et al, 2024). While these connections are still in the early stages of being explored, they signify how important it is to take women seriously about their reproductive health concerns. Practitioners need to be aware of the complexity of women's reproductive health issues and conscious of the evidence as it emerges.

Improved reproductive health-related quality of life

Dismissal, disbelief and delays in care

Healthwatch published findings from a 2024 survey on menstrual health, which included views from 450 service users and 18 professionals in Lincolnshire. Many commonalities were identified regarding the experience of diagnosis, irrespective of whether it was for PCOS, endometriosis, perimenopause or Premenstrual Dysphoric Disorder (PMDD). By far the biggest issues highlighted by respondents were not being listened to, not being taken seriously and a lack of interest and knowledge around menstrual health conditions and menopause. Figure 18 below shows a summary of the issues raised.

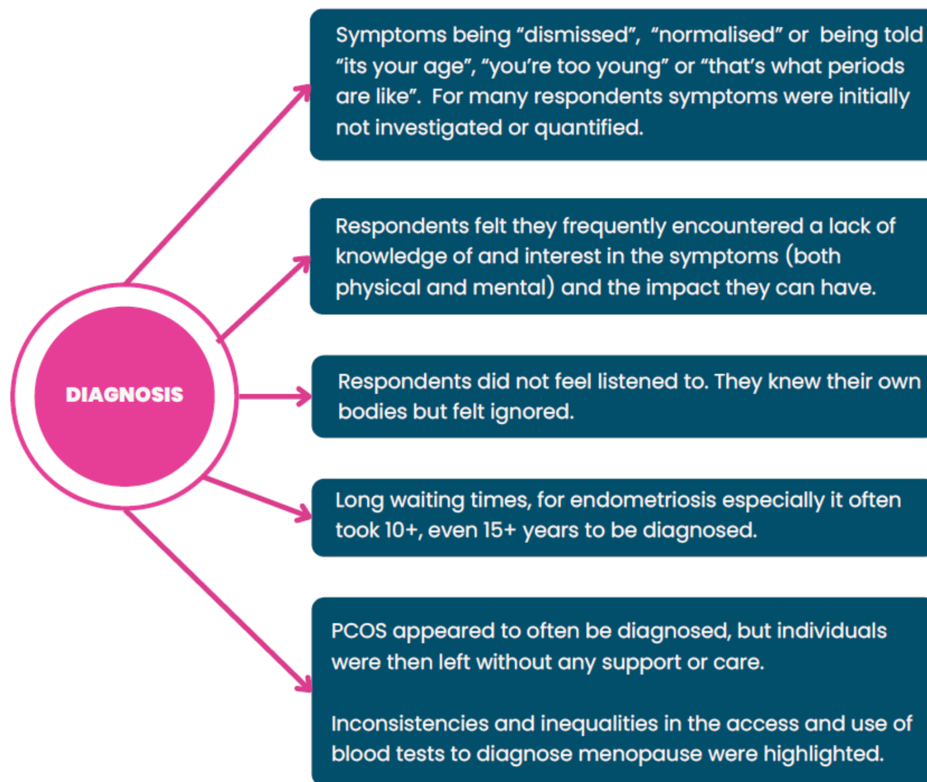


Figure 18. Summary of issues regarding diagnosis of reproductive health conditions identified by women in Lincolnshire (Healthwatch, 2024).

As part of the research, focus groups were conducted with health and care professionals to gain insight into their experiences of supporting patients. One of these focus groups highlighted the culture of blaming women, reiterating the thoughts of other respondents that they were at fault for not being able to cope with symptoms. Regarding going to the doctors, a conversation in the focus group discussed the presumption from some HCPs that women are '*expected to be in immense pain once a month*'. Another survey respondent wrote: '*After years of this treatment and attitudes you learn how to cope with your symptoms and give up on looking for help as it feels like there isn't any and* ***you begin to blame yourself for not being brave or strong enough'***.

Many women reported feeling that they had been 'gaslighted' about their symptoms. Several respondents said that the misdiagnoses, extensive waiting times and dismissal of their symptoms led to infertility. One reported that: '*It took 13 years and six hospitals; multiple misdiagnoses and gaslighting [...] because of this I am now infertile, am too high risk for egg freezing, have now issues with my existing condition and surgical intervention due to endometriosis now growing on a man-made organ, will be having major surgery which would not have been necessary. Due to no Lincolnshire specialists having the skillset to treat me I travel three and a half hours for care and have been in chemical menopause throughout this creating spinal issues and bone density loss.* ***No emotional, social or practical support has ever been offered***'.

Other reports from women living in Lincolnshire included:

- '*Had I been taken seriously sooner I may not be having fertility struggles*'.
- '*A large cyst was missed and killed my ovary*'.

- *‘That’s the bit. It’s the lack of curiosity’.*
- *‘Unless you have a GP who is particularly interested in women’s health it just doesn’t get done’.*

As part of the local Women’s Health system wide work and needs analysis, the Lincolnshire ICB (LICB) carried out an engagement survey on local women, asking respondents to rate their satisfaction on services they had recently used or accessed. As shown in Figure 19, the survey found high dissatisfaction levels for menstrual health services, with over half (51%) of women dissatisfied with the service they received. Satisfaction levels are higher for gynaecological services, though 43% of women using this service were dissatisfied with their experience.

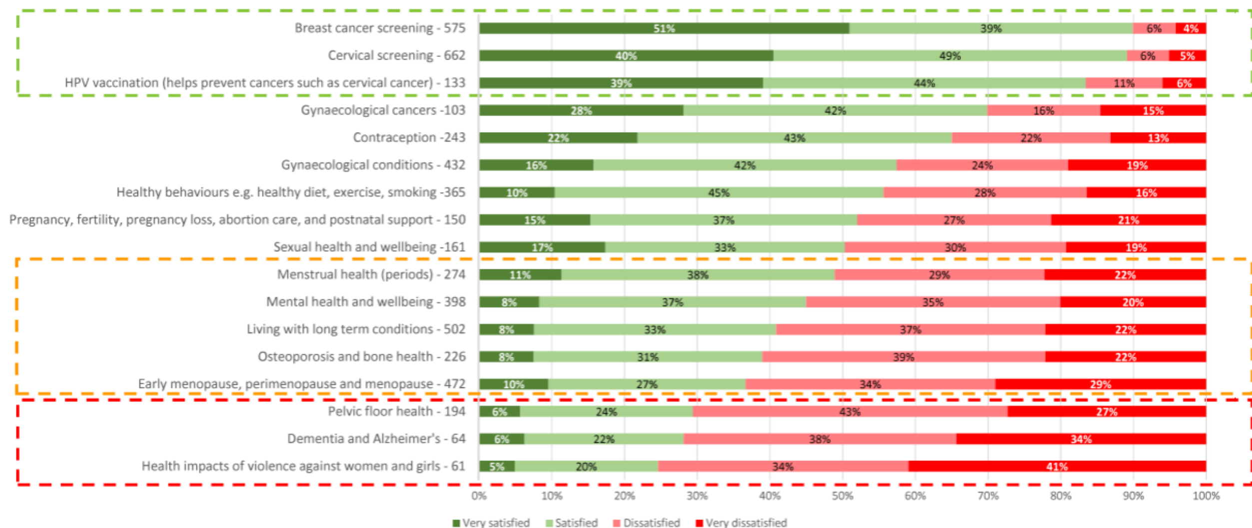


Figure 19. Satisfaction rates of services recently used.
The section highlighted in orange indicates where dissatisfaction levels were high among a significant number of responses (LICB).

These are the accounts of women who have sought help. However, there is national evidence that less than half of women with severe menstrual health conditions seek support due to feelings of stigma and shame. While stigma around menstruation and gynaecological conditions is widespread, there is evidence that this is particularly acute among young women (particularly under 21 years), and among women from certain cultural, religious or ethnic backgrounds (Women and Equalities Committee, 2024; Plan international UK, 2018). This further contributes to delays in accessing care and drives inequalities in access.

As noted above, diagnosis rates for reproductive health disorders are poor. Nationally, people with endometriosis typically wait around 10 years for a diagnosis, while PCOS takes an average of 2 years and visiting more than 3 doctors (Gibson-Helm et al, 2017). A Healthwatch survey on Lincolnshire women found that the journey to an endometriosis diagnosis often takes more than 10 years, with some women waiting over 15 years.

Regarding waiting times, the gynaecology specialty waiting list grew by 275% between April 2011 and April 2025, compared to an average 199% increase in waiting list size across all specialties (Nuffield Trust, 2025). As of October 2024, the number of people waiting over the 18-week target for gynaecology increased by 482% compared to before the pandemic (Women’s Reproductive Health Conditions Inquiry). In Lincolnshire, data from May 2025 shows that the

median number of weeks waited for a patient's first outpatient appointment with gynaecology was 40 weeks, 95% of patients were seen within 59 weeks.

A 2023 Lincolnshire needs assessment on women's health reported a 12 to14 month waiting list for specialist menopause care in the county (LCC, 2023). Healthwatch Lincolnshire note that there is no specialist endometriosis centre in Lincolnshire, leading patients to travel out of county for specialist support (Healthwatch, 2024).

The Royal College of Obstetricians and Gynaecologists (RCOG) argue that there needs to be a shift in the way gynaecology is prioritised as a specialty across the health service, including action to move away from using the term 'benign' to describe gynaecological conditions. They note that the term 'benign' is often used in healthcare settings to refer to non-cancerous gynaecological conditions, and that this misconstrues both the progressive nature of many of these conditions, and the severity of the symptoms experienced by the many women and people living with them (RCOG, 2022). This framing leads to deprioritisation of women's health services, with long waiting times resulting in far more advanced conditions for patients, including organ prolapse, sepsis, kidney failure, and cancers left undiagnosed, resulting in more complex, labour-intensive and thereby costly interventions (NHS Confederation, 2024).

Reproductive health and mental health

The Lincolnshire Healthwatch survey found that, although not directly asked about mental health, a recurring theme throughout responses was the impact of menstrual health conditions on mental health.

The link between reproductive health conditions and mental illness is well evidenced. However, as Healthwatch note, among HCPs this is poorly understood and rarely acknowledged and there is a lack of appropriate support available for women. In addition, poor experiences of care contribute negatively to mental health: women report worsening mental health when symptoms are ignored or normalised, and when experiencing long waiting times for diagnosis, tests and treatments with symptoms left unmanaged (Healthwatch, 2024). Nationally, RCOG report that 76% of women waiting for gynaecological care reported worsening mental health (2024). This should be considered in the context of gynaecology waiting lists which are increasing at a faster rate than any other specialty.

Mental health support provision should be integrated into treatment for reproductive ill health, yet support is only available in a handful of areas and is often too generic. There is not appropriate understanding of the mental health impacts of reproductive ill health, both in HCPs and in the environment in which women seek diagnosis and treatment. For example, hospital waiting areas and wards for endometriosis diagnosis are often shared with general gynaecology and obstetrics, which can be distressing as endometriosis is linked to infertility (Griffith et al, 2023). Moreover, much of the discourse surrounding reproductive health centres around pregnancy, whether that be achieving or preventing pregnancy. While pregnancy can have significant impact on mental health, it is important not to forget that reproductive health does not solely focus on conception, and support should thus be provided that is specific to the needs of the individual.

The impact on quality of life

Reproductive problems can cause considerable psychological malaise, with women describing 'an inner war' or being 'snapped in two' (Inhorn and Whittle, 2001; McGowan et al, 2007; Verdonk et al, 2009; Osborn et al, 2020). The pain experienced can impact work and careers, with women reporting having changed careers or stopped working altogether to manage pain, symptoms and mental health by avoiding commuting or unsupportive workplaces. Miscarriage, abortion and menopause are stressful life events that can have both biological and psychosocial impact, contributing to ill mental health (Lolak et al, 2005).

Delays in accessing treatment exacerbates both mental and physical ill health as it leads to women not being appropriately supported or treated for their condition. This contributes to a reduced quality of life, with a plethora of evidence suggesting that women with PMDD, endometriosis and infertility have a lower quality of life than other women (El-Masry and Abdelfatah, 2012; Facchin et al, 2015; Kitchen et al., 2017). Not treating menstrual disorders can also have a profound impact on fertility, sometimes causing infertility. Around one in seven couples in the UK struggle conceiving, and one in four couples' infertility is unexplained (NHS, NHS).

Looking at the impact on education and careers, a 2024 review by In Kind Direct reported that £3.25 billion's worth of workdays are lost to period inequity each year in the UK. Period inequity (or period poverty) refers to insufficient access to menstrual products, education and sanitation facilities (Jaafar et al, 2023). Based on the formula used by In Kind Direct, it was determined that **in Lincolnshire, the total cost of missed workdays due to period inequity for female employees each year is £35 million** (see Fig.20).

	Full time	Part time
People missing work with most or every period[1]	18%	17%
Average days missed each month[1]	2.4	2.6
Women who currently experience periods[2]	44%	44%
Women in employment[3]	102,984	53,439
Median daily pay[3]	£119.14	£52.60[4]
Average weekly hours worked[5]	35	16.4
Female workforce missing days due to period in Lincolnshire[6]	8,156.33	4,232.37
Total workdays missed per month[7]	19,575.19	11,004.16
Cost of missed workdays per month[8]	£2,332,188.437	£578,818.90
Cost of missed workdays per year[9]	£27,986,260.50	£6,946,355.25
Total cost of missed workdays per year[10]	**£34,932,615.75**	

Figure 20. Cost of missed workdays per year for female employees in Lincolnshire.

The above calculations are based on In Kind Direct's formula for calculating the total cost of missed workdays per year for full time and part time employees who are currently experiencing periods. Data for Lincolnshire employees is based on 2024 data (NOMIS*)*.

[1] *Survey of 2,926 UK adults 16+ who experience periods.*

[2] *Women selecting "Yes, I currently menstruate / bleed" in response to "do you, or have you ever had a period". Survey of 2,138 UK adults 16+, weighted to be representative of UK population 16+.*

[3] *NOMIS Labour Market Profile – Lincolnshire*

[4] *Data for pay for parttime employees was not available for Lincolnshire residents, so this figure was based on median weekly earnings in the UK for parttime employees, as of April 2024 (ONS, 2024).*

[5] *ONS. (2023). Average actual weekly hours of work for part-time workers (seasonally adjusted); for full-time assumed 35-hour FTE.*

[6] *Female workforce missing days due to period = (women in employment * women who currently experience periods) * people missing work with most or every period*
[7] *Total workdays missed per month = female workforce missing days due to period * average days missed each month*
[8] *Cost of missed workdays per month = total workdays missed per month * median daily pay*
[9] *Cost of missed workdays per year = cost of missed workdays per month * 12*
[10] *Total cost of missed workdays per year[10] = full time cost + part time cost*

Of those surveyed by In Kind Direct, 19% said that they miss work with most or every period due to symptoms affecting physical and mental health and lack of access to products or facilities at work. The report also identified that concerns about leaking and feeling embarrassed to ask for help kept people away from education and work. These findings highlight the impact that periods have on the workplace and how a lack of access to sanitary products can act as a barrier to education and work.

These findings are supported by Bloody Good Period's (BGP) research on periods and menstrual wellbeing in the workplace (2021). BGP found that 'a concentric cycle of silence' surrounds periods in UK workplaces (BGP, 2021). This phrase stemmed from a statement that issues surrounding menstruation 'can't be talked about, because they're not talked about'. Their research found that a quarter of women felt that taking time off work due to menstrual health issues had impacted their career progression; a quarter of women never talk openly about periods at work, and a third of women felt it was more professional not to mention menstrual health; a quarter of women reporting that they never feel supported, with the youngest respondents feeling the least supported. Only 1 in 10 respondents had not experienced anxiety or stress in the workplace due to their period.

Achieving good menstrual health

Hennegan et al. (2021) identified the requirements for achieving good menstrual health, including information about the menstrual cycle and self-care; materials, facilities and services to care for the body during menstruation; diagnosis, care, and treatment for menstrual discomforts and disorders; a positive and respectful environment which minimises psychological distress; and freedom to participate in all spheres of life.

Since 2022, the prices of own-label period products have increased by up to 57% (The Grocer, 2022). Action Aid published the results of a poll in 2023 which found that the number of people who were struggling to afford period products had risen from 12% in 2022 to 21% in 2023 (Action Aid, 2023). Of those affected by period poverty:

- 41% kept sanitary pads or tampons in for longer
- 8% re-used disposable pads
- 37% said they had used tissues or cotton wool instead of sanitary products in the last 12 months. 13% used socks or other clothing and 9% used paper or newspaper.

Reusing used products or using items that are not intended as period products can lead to infection, while keeping tampons in for longer than recommended risks severe health complications, such as toxic shock syndrome. Das et al (2015) found that higher-income women with personal hygiene spaces at home were more protected against bacterial vaginosis

than lower-income women with a lack of sanitary facilities, demonstrating the impact period poverty can have on an individual's health.

Other everyday products can often be prioritised over period products, with 60% of those affected by period poverty prioritising food, 48% prioritising gas or electricity and 24% sacrificing period products for themselves so they could afford them for their dependent (Action Aid, 2023). Those aged 18-24 were most likely to struggle to afford period products with more than a quarter (27%) of people surveyed in this age group saying they were affected, potentially due to a lack of financial independence or limited income. Water Aid conducted a similar survey and found that 61% of people in the UK said that if period products were cheaper or more free products were available, it would improve their mental health or wellbeing (Water Aid, 2022). Water Aid's survey also found that 61% of respondents wanted more support for schools to educate students on cost-effective ways to manage periods. Products available through public schemes can often be unsuitable for menstrual health conditions such as heavy bleeding.

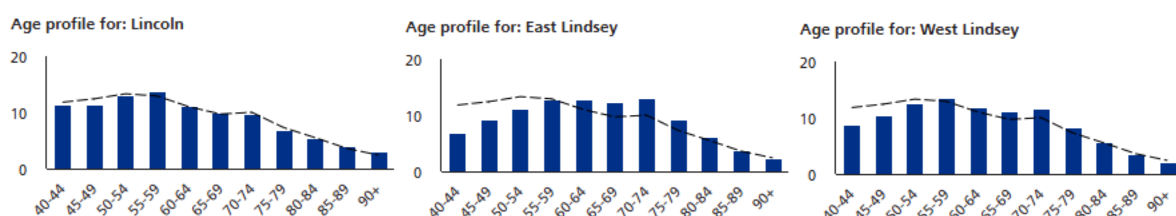
Menopause health

Menopause signals the end of the reproductive years, occurring once no menstrual periods have occurred for 12 consecutive months due to declining hormone levels. It typically occurs between the ages of 45 and 55 but can happen earlier. Perimenopause describes the transitional period before menopause. The perimenopause can cause a range of symptoms due to changing hormone levels. As with menstrual health, by far the biggest issues highlighted by Lincolnshire women around menopause were not being listened to, not being taken seriously and a lack of interest and knowledge (Healthwatch, 2024). This is reflected in the low levels of satisfaction reported by local women for menopause services, with 63% of women dissatisfied with the service they received (see Fig. 18).

Inequalities in HRT prescribing

Locally, women report inconsistencies and inequities in the access and use of blood tests to diagnose menopause (Healthwatch, 2024). Local data also shows that HRT prescription rates also vary between GP practices across Lincolnshire.

HRT replaces hormones that are at a lower level during menopause and is often recommended as treatment. Nationally, the estimated number of women aged 40 and over receiving HRT for menopause has more than doubled since 2020/21. The increase is seen across all age groups, with the highest increase in the 45 to 59 age group. HRT prescribing peaks at 50 to 54 years (NHSBSA). In Lincolnshire, the age profile for HRT prescribing in women aged 40 and over varies between districts. In Lincoln, West Lindsey, South Kesteven, South Holland and Boston, the age profile with the highest rate of prescribing is 55-59, while in North Kesteven, the highest rate of prescribing is in the 50-54 year age group. In East Lindsey, the age group with the highest rate of prescribing is older, at 70-74.



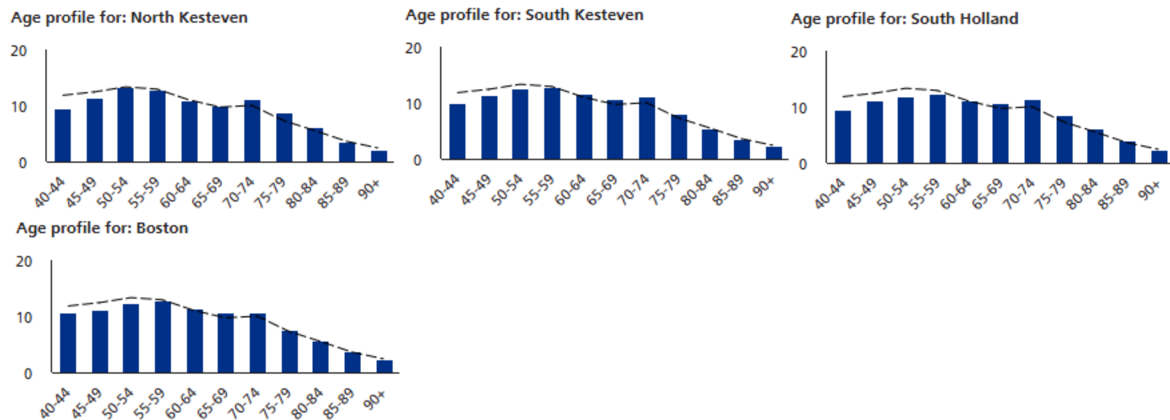


Figure 21. Age profile of women receiving HRT prescribing in Lincolnshire districts (NHSBSA).
Dotted line shows national population proportions.

Evidence suggests that more deprived areas experience a lower number of patients receiving HRT, a finding that has been consistent over recent years (see Fig.22). The least deprived areas in England have more than twice as many identified patients receiving HRT prescribing compared to the most deprived areas (NHSBSA).

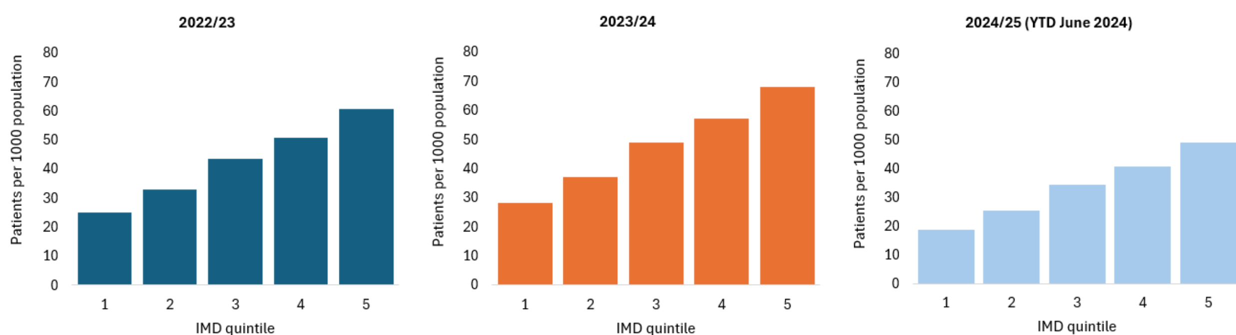


Figure 22. HRT totals by IMD quintile 2023-2025 (NHSBSA).
Over all years, patients increased with IMD quintile, with quintile 5 (least deprived) having the most patients and 1 (most deprived) having the least. Patients per 1000 population increased from 2022/23 to 2023/24 in all quintiles but decreased from 2023/24 to 2024/25. Patients per 1000 population in 2024/25 were lower than in 2022/23 and 2023/24 in all quintiles.

Figure 23 below shows the percentage of women in Lincolnshire with a menopause flag by deprivation decile, according to PHM data. A far lower percentage of women are recorded as experiencing menopause in the most deprived decile (11.7% in decile 1) compared to the least deprived decile (21.8% in decile 10). This is despite the age profile of each decile being similar. This suggests that women in the most deprived areas are not coming forward for support for menopause or are not being diagnosed as needing support for menopause.

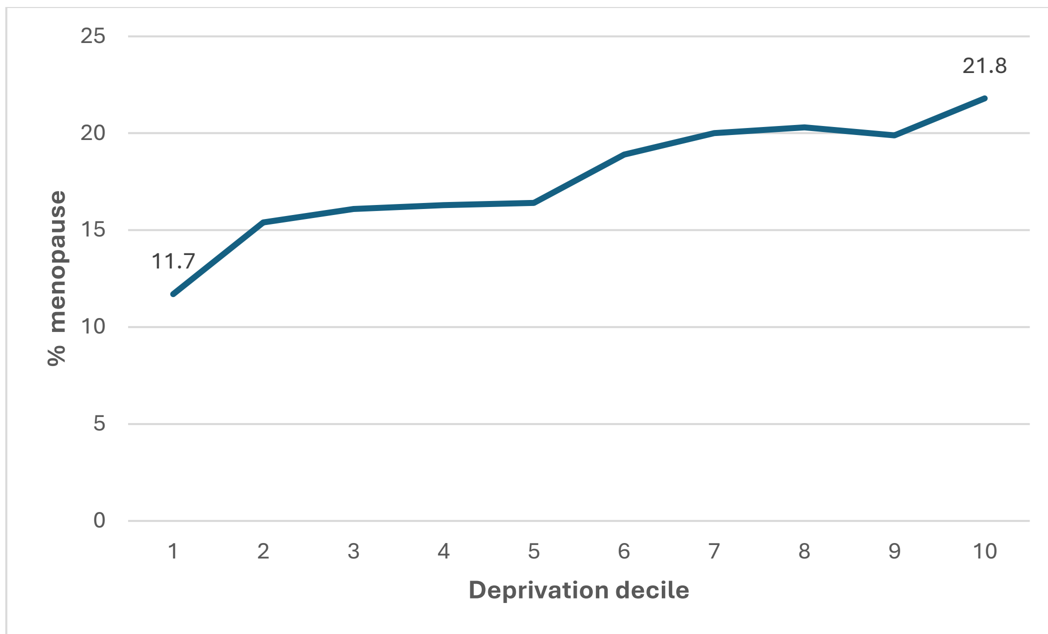


Figure 23: Percentage of women flagged as 'menopause' by deprivation decile, with 1 being the most and 10 being the least deprived, according to PHM data.

Rates of prescribing varies greatly across Lincolnshire's PCNs (see Fig.24). The prescription rate in South Lincoln PCN is almost double that of First Coastal and Rural PCN. Two PCNs, Boston and First Coastal and Rural, have prescription rates that are well below the Lincolnshire average.

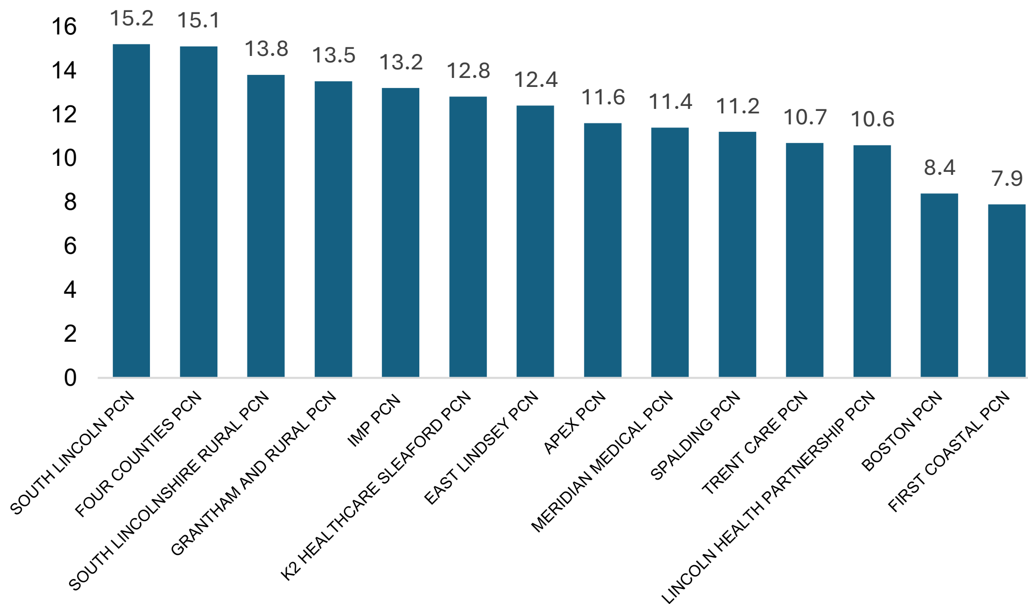


Figure 24. HRT prescribing per 100 women with any prescribing in Lincolnshire's PCNs (NHSBSA, 2024). Women aged 40 and over receiving HRT prescribing for menopause per 100 women, per PCN.

Finally, though the data is positive with regards to increasing HRT prescription rates in Lincolnshire, a 2023 review found a 12-14 month waiting list for the menopause clinic resulting in many women having to wait long periods of time before they receive advice/treatment (LCC, 2023).

Mental health needs of menopausal and perimenopausal women

The menopause and perimenopause present a period of heightened vulnerability for mental health issues in women. Despite their prevalence, mental health symptoms during the menopause are frequently overlooked by HCPs and mental health screening is not consistently integrated with menopausal health care (Martin-Key et al, 2023). Several studies have found that diagnosis of psychiatric disorders increases during the perimenopausal period, suggesting that there is an association between this stage of life and mental illness. Contrarily, it could indicate that menopausal symptoms are frequently misdiagnosed as mental illness and thus are incorrectly responded to by HCPs.

A survey of over 5,000 perimenopausal women found that 40% of respondents were offered antidepressants rather than HRT, despite NICE guidance stating that there is no evidence to support the efficacy of conventional antidepressants in perimenopausal women (The Menopause Charity, 2023). There is a clear need for less generic and more accessible support for mental health during the menopause and improved knowledge for HCPs.

A Healthwatch report in 2024 investigating menstrual health in Lincolnshire included a statement from a nurse working at LPFT regarding the link between onset of mental health issues in women of typical menopausal age:
'*What I really noticed was the strong link between people with first-episode psychosis hitting menopause.* ***I think probably having a vested interest in that has made me pick up on that.*** *There's not that link in with your GPs and that it's not something people are giving consideration to when people are becoming unwell at a certain age, mid to late 40s and into early 50s that first episode. You get presentations coming through and they don't know where this is coming from (with no mental health history).* ***They've never had any kind of mental health issues and background and then we're getting this first episode and people are ending up hospitalised.*** *There's not enough going on around early intervention for people to prevent this then ending up in hospital. The problem is, once you get into hospital, you're then medicated, then you think about the side effects for the medication, your weight gain. People going through menopause struggle anyway with weight gain and losing weight. We then start them on an antipsychotic or something like that it impacts on other factors in terms of their motivation, their mobility.*'

Key themes in evidence regarding the association between menopause and mental health are as follows:

Poor HCP knowledge and subsequent misdiagnosis or lack of effective treatment.
Women seeking support for perimenopausal or menopausal symptoms frequently visit their GP multiple times before being prescribed appropriate medication or help (Mumsnet, 2020). 86.76% of respondents to a survey by Martin-Key et al (2023) stated that their menopausal symptoms had negatively affected their mental health, however only 28.49% of those who visited a HCP to discuss their mental health symptoms felt that the HCP was aware of the peri(menopause) impact on mental health. Women report being misdiagnosed with depression or anxiety, rather than menopause, and incorrectly diverted to mental health services (Mumsnet, 2020).

Negative impact on work and career progression.
The Women and Equalities Committee (2022) conducted a survey on menopause and the workplace. Most respondents to the survey stated that their symptoms affected them at work, reporting a loss of ability to concentrate, increased stress and a loss of confidence, with 31% of respondents reporting that they took time off work due to symptoms. The Fawcett Society estimated that 1 in 10 women aged between 40 and 55 have left a job due to menopause symptoms and an additional 13% have considered leaving.14% of women reported reducing their hours and a further 14% had changed to part-time (The Fawcett Society). Research has found a myriad of reasons for women leaving their jobs due to the mental health implications of the menopause, including avoiding commuting and unsupportive workplaces.

Increased risk of psychiatric disorders.
Of the 1.2 billion women over the age of 45 (globally), 70% develop neurological and psychiatric symptoms during the perimenopause (Florio et al, 2024). Research suggests that perimenopausal women are at a higher risk of developing major depression, schizophrenia or bipolar disorder, while women who already have a diagnosis will experience a worsening of symptoms. Shitomi-Jones et al (2024) found that incidence rates of psychiatric disorders significantly increased during the perimenopause before decreasing back down to the premenopausal rates in the post-menopause. The rates were primarily driven by increased rate of major depressive disorder, however the largest effect size at perimenopause was observed for mania. Additionally, schizophrenia is more likely to present in young adulthood but there is a second, smaller peak in first admission rates for schizophrenia during the perimenopause (The Menopause Charity, 2023).

Increased risk of common mental health disorders (CMHD).
The menopause and perimenopause present a time of increased vulnerability to mental health issues. Interestingly, perimenopausal women tend to report different symptoms of depression compared to premenopausal women, such as increased anger and irritability, sleep disturbances, fatigue, as well as a range of non-specific somatic complaints. In 2023, a SAMH report found that 94% of women reported a change in mood due to menopause, such as low mood, anxiety, mood swings or low self-esteem. Pre-existing mental illness often gets worse and the risk of developing new-onset depression doubles in women aged 40-50 (The Menopause Charity, 2023). Female suicide rates peak in middle age and suicidal thoughts are up to 8 times more prevalent in perimenopausal women (The Menopause Charity, 2023).

Fulfilment of reproductive choice

Throughout their reproductive lives, women must navigate avoiding pregnancy when and if they do not wish to have children and becoming pregnant if and at a time they choose to. This section looks specifically at access to contraception and abortion in Lincolnshire to assess the degree to which women locally have choice and control over their reproductive system.

Contraception

The ability to access contraception and decide whether and when to have children is a human right and fundamental to a woman's health. With women becoming sexually active younger and having children later in life when compared with previous generations, most women are trying to prevent pregnancy for most of their reproductive life.

The provision of contraception is a highly cost-effective public health intervention because it reduces the number of unplanned pregnancies that bear high financial costs to individuals, the health service and to the state. Contraception is frequently used as a first-line treatment for menstrual problems.

Despite this, women are experiencing increasing difficulties in accessing contraceptive services and the full range of contraceptive methods, as well as struggling to access high-quality information and advice about the right form of contraception for them (APPG SRH, 2020; Women's Health Strategy, 2022). **Women have particular difficulty in accessing contraceptive services and advice at crucial times of their life**, such as following an abortion or a birth. There is evidence that women under 25, black women, and women from socially disadvantaged backgrounds are more likely to have abortions than other populations, suggesting an unmet need for contraception among these groups (All Party Parliamentary Group on Sexual and Reproductive Health [APPG SRH], 2020).

It is widely recognised that the division of responsibility for reproductive healthcare across three separate groups – the NHS, Local Authorities and Integrated Care Boards (ICBs) – has fragmented the commissioning landscape and created a lack of accountability.

As noted by Public Health England (2020), there are no commissioning mechanisms for the provision of contraception in maternity services either through the maternity contract (ICB) or the local authority. This means contraception is not routinely offered to women in maternity services, despite women presenting at maternity and abortion services with unplanned pregnancies shortly after giving birth and poorer pregnancy outcomes associated with short inter-pregnancy intervals (FRSH, 2020; DHSC, 2022).

By contrast, the commissioning mechanism for contraception as part of the abortion care pathway is more clearly located within the ICB, as set out recently in the NHSE Abortion Commissioning Guidance (2025). Women in Lincolnshire are routinely offered contraception following abortion; however, this offer does not currently include subdermal implants (SDI), which is one of the most effective and acceptable forms of contraception for women. Figure 25 below shows the impact on abortion rates where there is a routine contraception offer (abortion services, left) compared to where there is not a routine contraception offer (maternity services, right):

Figure 25. Under 25s abortion rates in Lincolnshire (DHSC).

Within primary care, GPs provide all methods of contraception as an "essential service" under the GP contract, funded by NHSE. However, this excludes the most effective long-acting reversible contraceptive (LARC) methods, SDI and intrauterine contraception (IUC). To provide these methods, GPs must have a locally enhanced service (LES) contract with the local authority commissioner. This naturally creates a postcode lottery, where some GPs provide LARC and others do not.

Hormonal IUCs can have additional gynaecological benefits including management of heavy menstrual bleeding (HMB), dysmenorrhoea and endometrial protection as part of HRT. Commissioning IUC for gynaecological or non-contraceptive purposes is the responsibility of the ICB, whereas commissioning of IUC for contraception is the responsibility of local authorities. This creates a situation where GPs with a LES contract for IUC with the local authority will provide IUC for contraception but refuse an IUC for non-contraceptive purposes, even though the device and procedure are the same.

The fragmented commissioning landscape inhibits innovation in digital contraceptive services as commissioners do not want to take on the financial risk of providing online services which may divert demand from another part of the system funded by another commissioner. There are currently no nationally commissioned online contraceptive services. The Reproductive Health Survey for England 2023 found that 29% of women would prefer to access contraception online but that less than 1% do, suggesting demand for online contraception services.

Co-commissioning works for women

Lincolnshire County Council (LCC) and Lincolnshire ICB are working together so that women can access LARC for all purposes via their GP.

Between August 2024 and July 2025, Lincolnshire GPs fitted 319 LARC devices for non-contraceptive, or gynaecological, purposes. By meeting these needs in primary rather than secondary care, women can be seen quicker and closer to home. It's more cost effective too, with a local system saving estimated to be over £56,616.12 so far.

Pharmacy services will improve access to contraception

Oral contraception – Combined Oral Contraceptive (COC) and Progestogen Only Pill (POP) – is now available at participating pharmacies via the NHS funded Pharmacy Contraception Service. Emergency hormonal contraception (EHC) has been included in this service since October 2025. EHC is currently commissioned by local authorities.

Unplanned pregnancy and teenage pregnancy

45% of pregnancies and one third of births in England are unplanned or associated with feelings of ambivalence (PHE, 2018). However, there is evidence that rates of unplanned pregnancies are likely to be higher among socially disadvantaged women. RCOG note that unplanned pregnancies are more likely to occur in women living in disadvantaged areas with lower educational attainment and poor dietary intake (RCOG, 2019). As an example, a

Gloucestershire intervention offering postpartum contraception to vulnerable women found that, among their target cohort, 75% of pregnancies were unplanned pregnancies (Local Government Association, 2019). Although pregnancies continuing to term mostly lead to positive outcomes, some unplanned pregnancies can have adverse health impacts for mother, baby and children into later life (PHE, 2018).

Despite the declining number of teenage pregnancies, teenagers remain the group at highest risk of unplanned pregnancy. Reducing teenage pregnancy requires high quality relationships and sex education, combined with the use of effective contraception, provided through accessible, youth friendly services (PHE, 2018).

For many teenagers, bringing up a child is extremely difficult and often results in poor outcomes for both the teenage parent and the child, in terms of the baby's health, the mother's emotional health and well-being and the likelihood of both the parent and child living in long-term poverty. Studies show that teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty and have a higher risk of poor mental health than older mothers. Infant mortality rates for babies born to teenage mothers are around 60% higher than for babies born to older mothers. The children of teenage mothers have an increased risk of living in poverty and poor-quality housing and are more likely to have accidents and behavioural problems.

Nationally and locally, the conception rate in women aged under 18 per 1,000 females aged 15-17 has decreased significantly over the last 20 years and continues to decrease. The most recent available published data (2021) shows Lincolnshire's under 18 conception rate to be 12.5/1,000, similar to the regional (13.2) and national rate (13.1) (DHSC).

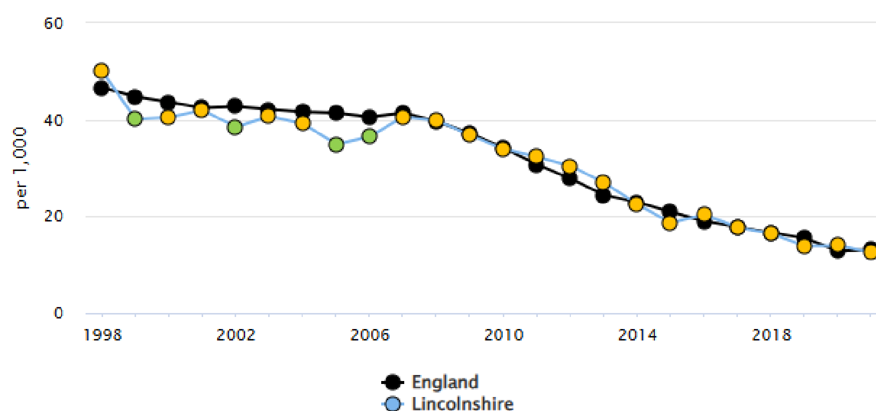


Figure 26. Under 18s conception rate (DHSC).

ONS provide under 18 conception data at middle super output area (MSOA) level to support identification of local hotspots and service planning. Figure 25 shows a map of under 18 conception rates by MSOA in Lincolnshire, and Figure 26 lists the neighbourhoods with the 10 highest conception rates in the county. The darker shaded areas have the highest conception rate. Rates are calculated based on conceptions between 2020-2022 and the low numbers per MSOA lend this data a degree of uncertainty.

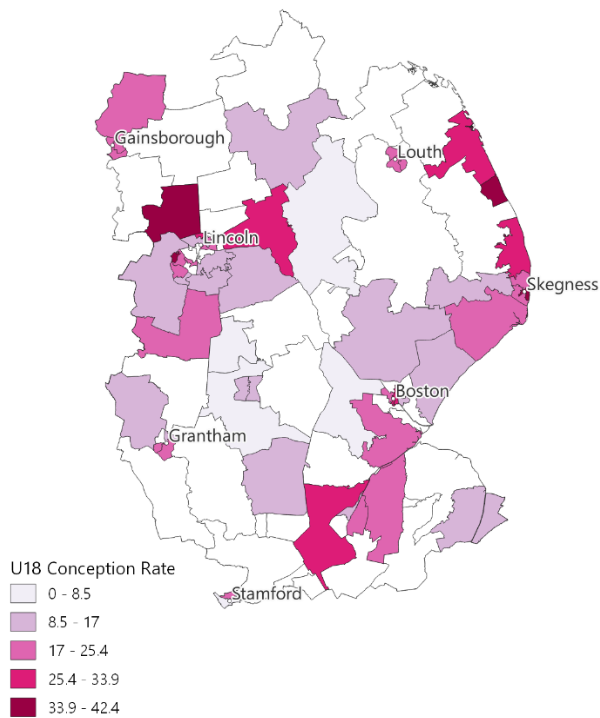


Figure 27. Under 18s conception rate by MSOA in Lincolnshire (ONS).

District	Neighbourhood	U18 conception rate
East Lindsey	Sutton-on-Sea	42.4
Lincoln	Birchwood West	40.5
East Lindsey	Skegness Town	36.1
West Lindsey	Saxilby & Scampton	34.7
Lincoln	Lincoln Ermine	33.9
East Lindsey	Ingoldmells & Chapel St Leonards	33.2
South Holland	Pinchbeck & Deeping St Nicholas	29.9
East Lindsey	Mablethorpe	27.2
Boston	Boston Central & North	27.0
West Lindsey	Cherry Willingham & Bardney	25.6

Figure 28. Neighbourhoods with the 10 highest under 18 conception rates in the county, 2020-2022 (ONS).

Wallace (2023) summarises the evidence on groups over-represented in teenage conceptions. Teenage pregnancy is more common in girls who have grown up in poverty, girls who are disengaged from education and girls who lack access to sex education and contraception. In the UK:

- Teenage conceptions and births are more common in deprived areas.
- Eligibility for free school meals has been found to be independently associated with teenage pregnancy.
- There is an association between school absenteeism and teenage pregnancy. Some studies also suggest connections with exclusion from school.

- Dislike of school is strongly associated with early sexual activity, unprotected sex, and pregnancy.
- Declining attainment during school years is associated with teenage conception and birth, as is expecting or wanting to leave school at the first opportunity.
- Adverse childhood experiences (ACEs) are also associated with higher prevalence of teenage pregnancy.

Recent ONS data for October to December 2024 shows that more young people (age 16-24) in England were not in education, employment or training (NEET) than at any point in the last eleven years. The Teenage Pregnancy Prevention Framework notes that most conceptions to under-18s are among 16–17-year-olds with NEET as an associated risk factor.

Abortion

Abortion care is an essential service and a common procedure, with ONS reporting that more than one in four conceptions resulted in an abortion in 2021 (NHSE, 2025). Nationally, there are a number of issues with abortion services, such as patients experiencing limitations on choice of procedure and location and surgical capacity not meeting patient needs (NHSE, 2025).

In 2024, a Lincolnshire Women's Sexual and Reproductive Health Needs Profile indicated several challenges in abortion care and access in the county:

- Women are experiencing a delay in either seeking or receiving abortion services in the first 9 weeks of pregnancy. In 2022, a significantly higher proportion of abortions took place at 10+ weeks gestation in Lincolnshire at 20.5%, compared to 12% on average in England. Lincolnshire is an outlier here, with the 2nd worst (highest) proportion out of 149 upper tier local authorities.
- There is a lack of patient choice on abortion method. In 2022, only 8.5% of abortions were provided using surgical methods, in comparison to 13.8% on average for England. In addition, there is no full telemedicine option and women with a pregnancy gestation of >12 weeks must go out of the county for abortion care.
- A lack of available and accessible NHS abortion services is leading women to pay for their own care privately. In 2022, compared to an average of 1.7% for England, 5.8% of patients in Lincolnshire privately funded abortion care, the third highest proportion in England.

The current model for abortion in Lincolnshire does not offer women and girls sufficient reproductive autonomy. The process of accessing an abortion is difficult. Travelling out of county and paying for private services is simply not an option for many people. Long waiting times for getting an initial appointment contribute to this problem by delaying the overall process, leading to women being forced to have a surgical abortion as they are at a later stage of pregnancy. These challenges have physical implications, with surgical abortion posing a higher risk than medical abortion, as well as mental implications, with poor abortion care potentially being a traumatic event in an individual's life.

In this context, it could be argued that Lincolnshire's comparatively low abortion rate is an indicator that many women in the county have no choice but to carry an unwanted pregnancy to term due to lack of access. Lincolnshire's abortion rate is significantly lower than the national rate (13.2 vs 19.2) and is the 7th lowest out of 149 upper tier local authorities. The rate also shows no significant change over the last 10 years, while the national abortion rate has

increased (see Fig.29). The indicator could be interpreted as evidence of low need and demand for abortion services in Lincolnshire, with the potential effect of deprioritising this essential service. However, with evidence of delays in access, lack of choice and high use of private abortion care, Lincolnshire's low abortion rate may be an indication that some women in our area are simply not able to access abortion services.

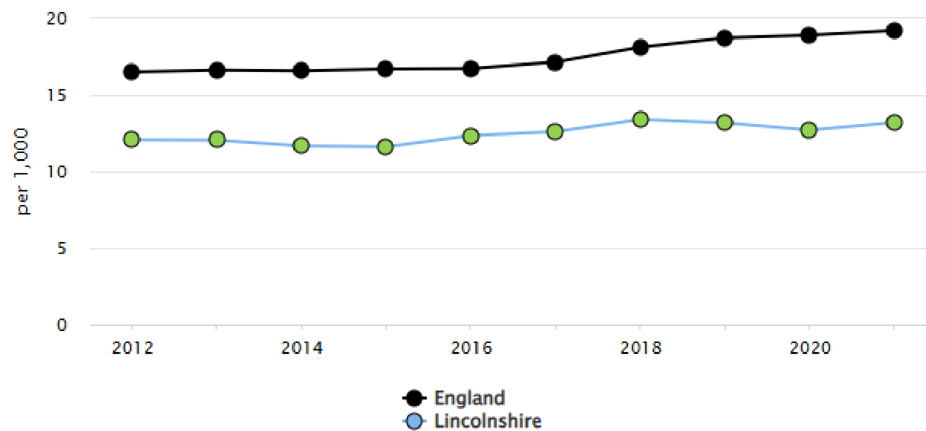


Figure 29. Abortion rates in Lincolnshire and England (DHSC).

New NHSE abortion commissioning guidance will hold ICBs accountable for local abortion services

NHS England have recently published guidance setting out expectations about how ICBs should commission abortion services. This includes bringing waiting times in line with NICE's two-week standards and increasing surgical capacity in both trust and independent providers. The ICB will be expected to provide a progress report to NHSE in early 2026 and must document their reasons for not following the guidance if they choose not to adhere to it.

Early identification of reproductive morbidity

Cervical cancer elimination

The Public Health Division's paper, 'Elimination of cervical cancer: Lincolnshire progress report' analyses data and evidence on HPV vaccination uptake and cervical screening and the progress made towards elimination of cervical cancer in Lincolnshire. A summary of this report is below.

NHSE has pledged to eliminate cervical cancer in England by 2040. The WHO considers cervical cancer to be eliminated when there is an incidence rate lower than 4 per 100,000 women. Lincolnshire's incidence rate in 2022 was 10.9/100,000, with rates highest in the most deprived areas.

To achieve elimination, 90% of girls will need to be fully vaccinated with the HPV vaccine by age 15 years, with 80% of women attending for cervical screening. Lincolnshire is behind the 90% target for HPV vaccination, with 74.1% having received 1 dose by year 10 (age 15). Lincolnshire is also behind the 80% target for cervical screening coverage, with 71.2% coverage among 25-49-year-olds and 76.5% coverage among 50-64-year-olds.

There are disparities in vaccination and screening coverage within Lincolnshire. Lincoln, Boston and the coastal areas have the lowest HPV vaccination uptake and also the lowest cervical screening coverage, putting women in these areas at higher risk of cancer, later diagnoses and worse outcomes.

Coverage of both HPV vaccination and cervical screening are lower among ethnic minority groups and people living in areas of high deprivation. Cervical screening coverage is lower among younger people (aged 25-29).

It should be noted that local cervical screening and HPV services have high satisfaction rates, according to feedback from women (see Fig. 18 above).

A feature of the cervical screening data coverage is the variation in screening coverage between GPs. Data shows a 38-percentage point difference between the highest and lowest coverage rates for 25-49-year-olds (from 46.03% to 84.08%), and a 29-percentage point difference in the 50-64 cohort (57.66% to 86.36%).

While it is difficult to model future cervical cancer incidence based on current HPV vaccination and cervical screening rates, the data shows that inequalities in cervical cancer incidence will widen and incidence rates will likely increase among women in the most deprived areas of the county.

Relationship, sex and health education (RSHE)

A woman's knowledge of her reproductive health influences management of unwanted reproductive health symptoms. It also affects whether a woman has a voice in making positive reproductive choices. Women of all ages cited school as the place where they had gained most of their knowledge on reproductive health but stated that information was often too basic and did not align with lived experience (PHE, 2018). Indeed, less than 15% of Lincolnshire respondents to the national reproductive health survey rated the quality of the relationship, sex and health education (RSHE) they received at school as good or very good (WRHS, 2024). This leads to a lack of understanding about what to expect regarding one's own reproductive health and how to manage it. This is particularly noticeable in terms of conception, with women often assuming that having children is easily achievable and feeling bewildered when difficulties are experienced (PHE, 2018). Poor menstrual health knowledge is particularly high among young women and girls, with one in seven reporting that they didn't know what was happening when they started their period and half unaware of what the cervix was. Young women describe not knowing what was 'normal' or 'what to expect' making it difficult to know when to seek help with regards to menstrual health (Women's reproductive health conditions).

RSHE became compulsory in 2020, along with a statutory curriculum that aimed to support young people with understanding what healthy relationships look like and how to navigate their personal lives in a positive, safe and healthy way (DFE, 2021). The guidance was updated in July 2025 for the first time since its initial publication in 2019. The new guidance introduces several changes, including emphasising that children should be taught how to develop skills to put knowledge into practice, for example around coping with frustration. There is also new content on social media, misogyny, deepfakes, AI and pornography, reflective of changes in technology and society.

Evidence suggests that school-based sex education delays the onset of sexual activity and increases contraceptive use among sexually active young people. Citing school as the main source of information also has a significant association with older age at first sex (Wallace, 2023). A recent study based on a survey of 1,105 university students found that, while most students felt that the curriculum prepared them well, only 38% were 'ready for life and ready for work' (HEPI, 2025). 28% of students did not feel well prepared for sex and relationships in higher education (HEPI, 2025).

A recent Young People's poll found that in 2024, only 50% of young people rated their RSE as 'good' or 'very good' (Sex Education Forum, 2024). Survey respondents to the WHS's Call for Evidence who were teachers reported that they were not always adequately equipped to teach certain topics, which appears to be a recurring theme in RSHE feedback; while RSHE is mandatory, training for those teaching it is often not sufficient. The new RSHE guidance announced a training grant for schools to support staff, however details on how much funding will be available have not yet been shared.

Reproductive health – summary

The scale of reproductive ill health in the population is greater than previously thought. Based on a recent reproductive health survey, we estimate there to be around 135,000 women aged 16 to 55 in Lincolnshire who have recently experienced a reproductive health problem, and around 51,000 living with a serious reproductive health issue.

The effect of reproductive ill-health on a person's quality of life can be significant. Despite the prevalence of reproductive health issues, and the fact that most women will experience menopause, women consistently report a lack of interest and knowledge around menstrual health conditions and menopause among HCPs. This is causing delays to diagnosis, treatment and care, with poor diagnosis rates for reproductive health disorders. In Lincolnshire, women report waiting more than 10 years for an endometriosis diagnosis, with some women waiting over 15 years. Women feel ignored, dismissed, and expected to live with chronic pain.

In addition to long waits for gynaecology, Lincolnshire women report having to travel out of the county for specialist endometriosis care, a lack of capacity in specialist menopause care, and a lack of access and choice in specialist abortion services.

In primary care, women experience inequitable and inconsistent access to services. Our analysis shows considerable variation in women's health services offered and the performance of those services across the county, including disparities in contraception provision, cervical screening coverage, HRT prescription rates and blood testing for menopause.

Delays in access to treatment exacerbates both mental and physical ill health as it leads to women not being appropriately supported or treated for their condition. This contributes to a reduced quality of life, with evidence showing that women with PMDD, endometriosis and infertility have a lower quality of life than other women. Women report worsening mental health when symptoms are ignored or normalised, and when experiencing long waiting times for diagnosis, tests and treatments with unmanaged symptoms.

The scale of reproductive ill health in the population suggests that the scale of mental health morbidity among women in the population may also have been underestimated. Despite

evidence of the relationship between reproductive health and mental health disorders, there is a lack of mental health support available for women. Similarly, despite menopause and perimenopause presenting a period of heightened vulnerability for mental health issues in women, these are frequently overlooked, and mental health screening is not consistently integrated with menopausal care.

Pain experienced through reproductive health issues can impact work and careers, with women reporting having changed careers or stopped working altogether to manage pain. Almost 1 in 5 women surveyed said that they miss work with most or every period due to symptoms affecting physical and mental health and lack of access to products or facilities at work. Difficulties in affording and accessing sanitary products is having an impact on the mental health and wellbeing of women.

There is strong association between financial status and reproductive health, with those struggling financially having poorer reproductive health. Feelings of stigma and shame around reproductive health prevents women from seeking help. This is particularly acute among young women and among women from certain cultural, religious or ethnic backgrounds, and this further contributes to delays in accessing care and drives inequalities in access.

Regarding fulfilment of reproductive choice, the current models for abortion and contraception provision in Lincolnshire do not offer women and girls sufficient reproductive autonomy. Women are experiencing delays in either seeking or receiving abortion services, forcing them out of the county, to pay for private care, or to take their pregnancy to term. They have difficulty in accessing contraceptive services and advice at crucial times of their life, such as following an abortion or a birth. This is having a significant, detrimental impact on women's health outcomes and health inequalities.

Finally, on early identification of reproductive morbidity, Lincolnshire is behind target in its pursuit of the 2040 goal to eliminate cervical cancer. Early identification is inhibited by poor knowledge among women and girls of their own reproductive system. While women of all ages cite school as the place where they gained most of their knowledge on reproductive health, less than 15% of Lincolnshire women rated the quality of the RSHE they received at school as good or very good. Teachers reported that they are not always adequately equipped to teach certain topics, including on women's health.

Recommendations

- **An MDT is established within the ICB, made up of senior clinicians and administrative and analyst support, with the primary objectives of reducing gynaecology waiting lists, increasing access to services in primary and intermediate care, improving women's experiences of care, and improving knowledge and interest of women's health among GPs.**
- **Put reproductive autonomy at the centre of plans to address health inequalities. To improve access to contraception and abortion, commissioners should adhere to the recently published NHSE abortion commissioning guidance bringing waiting times in line with NICE's two-week standards and increasing surgical capacity. A working group on contraception should be established, involving all contraception**

commissioners, to fund and commission contraception for women at key stages in their life and online contraception.

- **Integrate mental health support provision into treatment for reproductive ill health. Support should also not only focus on pregnancy, as reproductive health encompasses more than this. Women experiencing mental illness or with diagnosed mental health conditions should be offered additional support with their reproductive health including family planning and access to screening.**
- **Improve HCP knowledge of the menopause and its impacts on mental health. Misdiagnosis of menopausal symptoms leads to patients being provided ineffective treatment and increases use of mental health services that are not required. Reduce inequalities in access to menopause care and HRT.**
- **Support women and girls on low incomes with the cost of period products.**
- **RSE. High-quality, evidence-based education on menstrual and gynaecological health from an early age.**

Addressing gynaecology waiting lists

The Getting It Right First Time (GIRFT) and Outpatient Recovery and Transformation Programme (OPRT) teams have produced Clinically-led Gynaecology Outpatient Guidance which outlines actions services can take to tackle escalating demand for outpatient appointments. It provides practical, condition-specific advice for services to focus on which are safe and clinically appropriate for specialities with the highest number of +78 week waits. **Services should evaluate their offer against the guidance and work towards implementing any gaps.**

Below is a summary of recommendations taken from the above guidance, as well as examples from other areas and recommendations from bodies such as RCOG.

1. **Prioritise gynaecology**

Elective recovery should address the unequal growth of gynaecology waiting lists when compared to other specialties. Gynaecology should be prioritised, with a focus on the wider impacts on patients waiting for care and a move away from using the term “benign” to describe gynaecological conditions. Ensuring greater theatre and diagnostic capacity for gynaecology.

2. **Triage referrals**

Triage provides an opportunity to ensure that patients are seen in the right place, including:

- Referring patients to diagnostics if required prior to their first appointment
- Return patient to their GP with specialist advice (see Increasing access to gynaecology services in primary and intermediate care)
- Redirect to other specialties or return inappropriate referrals
- Decide on whether a face-to-face or remote clinic is most appropriate.

Evidence from women’s health hub models shows that the more senior the clinicians involved in triage, the more referrals are diverted away from elective waiting lists, with more women having their needs met at a local hub or by their GP. In Tower Hamlets, advice and triage are

provided by a multidisciplinary team (MDT) including a consultant gynaecologist, sexual and reproductive health consultant, GP with special interest (GPwSI) in women's health, and an administrator. This model has reduced the proportion of gynaecology referrals seen in secondary care from 85% to 25%, with the remainder of women either being seen in a women's health hub or by their GP with specialist advice and guidance support from the MDT.

Triage of referrals is also an opportunity to identify trends and training needs within primary care. A Yorkshire project involved joint reviews of 100 menopause referrals to secondary care, of which 62% of referrals were found to be unnecessary and could be managed in primary care with tailored advice. This review process, with resulting education and case discussion with primary care, has enhanced the confidence and competence of GPs in managing menopause cases.

3. **Regularly review the entire patient list**

Waiting lists should be regularly reviewed with administrative teams and clinicians to prevent duplication, ensure women have been referred to the correct pathway and identify those with worsening symptoms.

Review and validation of waiting lists should be included in clinician job plans, if not already.

The Clinically-led Gynaecology Outpatient Guidance recommends that the following patients are identified, with appropriate standard operating procedures (SOPs) in place:

- Patients waiting more than 12 weeks for a first appointment. Clarify if they still have symptoms and wish to be seen.
- Patients suitable for discharge without follow up.
- Patients suitable for Patient Initiated Follow-up (PIFU). PIFU enables patients to contact the team if they feel they need a follow-up appointment up to one year after being seen. The guidance includes a list of conditions suitable for PIFU.
- Patients that require a follow-up, and whether a face-to-face or remote clinic is appropriate.

Reviewing waiting lists is also an opportunity to expedite those patients who have been waiting longest. In Leeds, they chose to focus on conditions where women were waiting the longest; for example, reducing the wait for a first endometriosis appointment by swapping a general gynaecology appointment with an endometriosis-only appointment. This has reduced wait times for a first endometriosis appointment by nine weeks.

4. **Increase access to gynaecology services in primary and intermediate care**

This can be done through provision of specialist advice and training to primary care, and the establishment of community gynaecological services or one-stop clinics. Building relationships, networks and partnerships between secondary and primary care should be a key focus of this.

GRIFT guidance discusses the provision of specialist advice pre- and post-referral to improve and support the management of patient care. Several women's health hub models have a specialist advice function to improve referrals and increase the numbers of women that can be

seen by their GP. There are examples of services, such as Consultant Connect, which allow GPs to directly contact a specialist consultant from a pre-defined rota for expert advice.

A joint position statement on women's health hubs by the RCOG, RCGP, FSRH and BMS recommends the establishment of services which act as a bridge between primary and secondary care for the management of gynaecological conditions and menstrual health. These intermediate services should focus on identifying where care traditionally delivered in secondary care could be moved into community settings or co-located within primary care or SRH services.

There are examples of primary care gynaecology services, such as in Coventry and Warwickshire and the Modality service in Birmingham, which offer diagnostic tests, consultation and treatment for a range of women's health conditions. These services have had a significant role in shifting gynaecological services from acute hospitals to community settings and in reducing waiting times.

"Gynaecology Super Clinics" in Warrington are one-stop clinics held at weekends that provide simultaneous clinics offering consultation, diagnostic scans and minor gynaecology procedures. This approach has delivered shorter waiting times, with same-day scans and treatment, improved convenience and easier accessibility. GIRFT guidance includes a list of patient conditions which would benefit from one-stop clinics, along with diagnostics and treatments that could be available and a staffing list.

Several established women's health hubs and community gynaecology services have a core training and education function to build confidence in GPs seeing patients independently which contributes to reduced hospital waiting times.

5. **Communicate with women waiting for care and treatment, and signpost to support**

Services should prioritise improving communication with women waiting for gynaecology care and treatment, including giving women clarity on how long they should expect to wait.

RCOG recommends that women have access to easy-to-read, accessible bespoke summaries of what local networks and resources are available to women waiting on gynaecology lists so they can access additional support. Professional guidance should be available on how to support women on waiting lists.

Conclusion

Over the past few years, the dire state of women's healthcare has begun to be recognised across the UK. This paper describes how Lincolnshire's health system is not meeting, nor is equipped to meet women's needs in Lincolnshire. While acknowledging this is an important step towards improvement, it is now time to take actions which address these shortcomings.

As Lincolnshire ICB's women's health engagement report concludes, we need a more inclusive, supportive and effective healthcare system that addresses the specific needs of women.

As a first step, this paper recommends that an MDT is established within the ICB, made up of senior clinicians and administrative and analyst support. The MDT would have the primary objectives of reducing gynaecology waiting lists, increasing access to services in primary and intermediate care, improving women's experiences of care, and improving knowledge and

interest of women's health among GPs. We refer to this as a Women's Health Advice and Support Hub. Similar models have been successful in other parts of England and are referred to as best practice in the 10 Year Health Plan for England.

This cannot be a transient programme; it needs to be a central pillar of the system going forward. With the recent publication of the 10 Year Health Plan for England, we are in a time of great potential for the health and care system. Priorities on moving care to communities, using technology and focusing on prevention should provide an impetus for transforming women's healthcare. Objectives on reducing the time people wait for elective care and improving access to and experience of general practice align with the objectives of the national Women's Health Strategy.

However, continued poor care for women will impede the 10 Year Plan from successfully meeting its goals. The goal of halving the gap in healthy life expectancy between the richest and poorest areas will not be achieved without a focus on the specific needs and experiences of women. The local system must focus on understanding why Lincolnshire women have suffered a disproportionate loss of healthy life in the last 10 years, and on improving women's satisfaction levels for services relating to chronic and long-term conditions.

A recurring theme throughout local engagement on menstrual health and menopause was the impact on mental health. However, among HCPs this is poorly understood and rarely acknowledged and there is a lack of appropriate support available for women. This paper recommends that mental health support provision is integrated into treatment for reproductive ill health and menopause. Likewise, misdiagnosis of menopausal symptoms leads to patients being provided ineffective treatment and increases use of mental health services that are not required. Training for HCPs is essential for ensuring women are correctly diagnosed, treated and supported.

The current models for abortion and contraception provision in Lincolnshire do not offer women and girls sufficient reproductive autonomy. This is having a significant, detrimental impact on women's health outcomes and health inequalities. If we are serious about addressing health inequalities, then we must prioritise access to good quality abortion and contraceptive services.

Women represent 51% of the population and that population is not shrinking. This paper lays bare the state of women's health in Lincolnshire alongside clear recommendations for action across the local system.

Recommendations

1. An MDT is established within the ICB, made up of senior clinicians and administrative and analyst support, with the primary objectives of reducing gynaecology waiting lists, increasing access to services in primary and intermediate care, improving women's experiences of care, and improving knowledge and interest of women's health among GPs.
2. Local plans to improve healthy life expectancy should focus on the specific needs and experiences of women. This must include improving women's access to and satisfaction levels for services relating to chronic, long-term conditions, menopause and reproductive health conditions.
3. Put reproductive autonomy at the centre of plans to address health inequalities. To improve access to contraception and abortion, commissioners should adhere to the recently published NHSE abortion commissioning guidance bringing waiting times in line with NICE's

two-week standards and increasing surgical capacity. A working group on contraception should be established, involving all contraception commissioners, to fund and commission contraception for women at key stages in their life and online contraception.

4. Integrate mental health support provision into treatment for reproductive ill health. Support should also not only focus on pregnancy, as reproductive health encompasses more than this. Women experiencing mental illness or with diagnosed mental health conditions should be offered additional support with their reproductive health including family planning and access to screening.

5. Improve HCP knowledge of the menopause and its impacts on mental health. Misdiagnosis of menopausal symptoms leads to patients being provided ineffective treatment and increases use of mental health services that are not required. Reduce inequalities in access to menopause care and HRT.

6. Support women and girls on low incomes with the cost of period products.

7. RSE. High-quality, evidence-based education on menstrual and gynaecological health from an early age.

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