Dorset Women CIC E6_mixdown v1

Tue, Oct 28, 2025 3:25PM 55:42

SUMMARY KEYWORDS

Sexual health, HIV services, Dorset HealthCare, contraception, psychosexual service, innovation adoption, women's health, pelvic health, menopause, long-acting reversible contraception, primary care, gynaecology services, health inequalities, online resource.

SPEAKERS

Anjali Mavi, Marianne Storey, Rebecca Jones, Nicky Smith

Marianne Storey 00:22

Good Okay, so should we Do a little round of introductions? Rebecca, do you want to just say who you are? If you just say your name and what your role is, and maybe a bit about what that means to people who might not have any clue what any of that

Rebecca Jones 00:52

means. So hello. My name is Rebecca Jones. I'm the service manager for sexual health and HIV service. So we're part of Dorset HealthCare Foundation Trust, and we provide sexual health and HIV services to anybody who lives in Dorset, as it says, it's all aspects of sexual health and HIV. So within that, we've got extra specialist services for young people. So young people from 13 years upwards, we've got parts of our service that link with working women. So we've got our with sex workers. We've got parts of our service that you reach into prisons. We've got a psychosexual service. So we've got lots of different parts, as well as the parts that most people associate with sexual health, which is the contraception, genitarian services. So that's a little bit about me. We based in former but we, as I say, We're across the whole of Dorset. That's me and

Marianne Storey 01:46

Nikki, you had a very specific role in this. Okay,

N

Nicky Smith 01:50

so I'm Nicky Smith. I am a innovation adoption programme manager, and what does that mean? So with regards to the women's health programme, I supported with project management support, so I led on four of the six sub projects which sat underneath the women's Dorset health programme, and by that, I would lead and manage each project support the teams ensure that the aims and objectives from the project proposals were met, were delivered, if not. You know how we could mitigate certain barriers or challenges along the way, and it was around supporting the team to enable those sort of activities and making sure that budgets and resources were on track. And most importantly, at the heart of everything, obviously, was the women of Dorset. But how I could support the teams to enable that to make a difference for Dorset. I work for an organisation called Health Innovation Wessex, who worked in collaboration with NHS Dorset. We were asked to come on board and support NHS Dorset with regards to the project management, but we had much wider support in this as well. And we are one of 15 Health Innovation networks across the country, and we are partly funded by the Office for life of sciences and the NHS. So we support NHS services, academia, industry, all kinds of different sort of voluntary organisations and stakeholders to improve patient outcomes and economic growth. But for our role, and my role specifically, were to lead the projects with the very specific objectives and timelines and resources that we had. Somehow,

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Marianne Storey 03:30

you've made our project seem very important. Nicky, well, they were, they were national innovation sounds very impressive.

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Nicky Smith 03:37

It was a massive joint effort, massive and the teams were incredible. And I think the fact that it was driven by women, led by women, and is still continued by the voice of the women, and I think that's what made it and still makes it today, and will still continue to make it that special, because we're all women as well, aren't we?

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Marianne Storey 03:58

So Well today, we're obviously here to talk about sexual health, and I just wanted to talk a little bit about what that means, because we've had an episode on women's health and gynaecology. We've got an episode coming up on pelvic health, and we're always talking about the website and that talks about menstrual health and other types of areas of women's health that might all seem like they're the same thing to you know, you're a lay person. I mean, even to me, sometimes I wonder what the difference is. So if we could just clarify, I mean, probably you're the best person to answer this, Rebecca first, and then Nicky, maybe you could just talk about what your role was in terms of the project. But what do we mean by sexual health? That's different to gynaecology, for example, or menstrual health,

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Rebecca Jones 04:38

Rebecca. So again, it is a broad so many areas. I mean, even sexual health itself is quite big, isn't it? Yeah, so in terms of what is sexual health, it is all encompassing, but it is about having healthy genital healthy reproductive organs, having a healthy sex life that feels right for you, feels safe for you. Making you feel that you've got the information that you need. In terms of the sexual health services that we provide. We do have the contraceptive element, contraception part of our service. So again, we can give advice to women all the different types of contraception, whether that's all contraception, implants, patches, coils, where there's such a wealth of different types of contraception. There's the natural family planning method. So there's lots of different ways of different types of contraception that we can support with if women aren't sure, because again, there's so many and there's lots of information on the websites. But if people really aren't sure what is right for them, people can make an appointment with us. If you can go to the GP as well, but if you're not sure, you can speak to one of our nurses who can help talk you through the different choices that there are. So that's really important. So you do have choice. You know, some have hormones, some don't have hormones. So again, it's important people do understand that there isn't just one size fits all the people might say, Oh, the brain, it's brilliant, but it might not be the right thing for you. So that's important in terms of us, what we provide. So we've got our sort of main sexual health service, in terms of people who've got problems that they think, well, have I got an STI a sexually transmitted infection? You can come in for your testing, and we can have some see one of our clinicians who can help do the testing within our clinics, give you treatment, any advice and support you can do that equally, very importantly, we've got, at the moment, we've got a partnership with sh 24 which is for our Digital STI testing. So again, if we're asymptomatic, so asymptomatic means you haven't got any known symptoms. But again, we encourage people to get themselves tested as well. So you you can use sh 24 and that's free to anybody who lives within Dorset. And then you go online, and then they'll send you the test kits through the post, do the swabs wherever I ask you to do, post them back, and then you get your results texted to you. And then if yes, if it's all negative, that's fine. If there's anything you do need treatment for, sometimes you can get through the post. Other times they might direct you to come into clinic. So that's really something that's really been very effective, and we get good results in terms of a lot of patient experience. People find that really helpful. So you can, if you Google sh 24 and then you put in from Dorset, you can get direct access to that as well. So amazing. So that's, yeah, so that's good. So that, and that's obviously, then you don't have to ring up to try and make an appointment. And obviously, if you do want to come into clinic, you can do and equally, if you're not quite sure what it is that you feel something's not quite right down below, we're not sure what, then again, you can come into clinic, and then you can be seen by somebody who can help, give a diagnosis, associated treatment, or refer you on elsewhere. So again, sometimes we say, if you're not sure, come in, we'll might just see you the once and then refer you on elsewhere. So again, that's important. So that's really a bit about sexual health.

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Marianne Storey 08:09

I mean, what I've learned about that today Rebecca is why it's a slightly separate thing to other health, which, yeah, is interesting on its own, but it seems to me to be a part of the NHS actually running really well.

R

Rebecca Jones 08:21

Yeah, it's good. I mean, it's a brilliant service. And I find, even now, I don't know how long I've been here, now six years, I'm still learning things most days. But certainly Lucas, we've got an integrated service. The idea is that, you know, someone could, a woman may come in, and potentially, then she could come in, she could get her contracept, she could have a smear done, she could have her contraception sorted out for her, and then if she's got an STI or anything else, you could have be tested for that and have treatment. And it can all be done at once, because that's the thing. Is a big thing people coming in, isn't it? And so it is. We recognise that is anxiety provoking. So I think one of the feedback that we get from of our patients is about how all our staff are so welcoming, non judgmental, so friendly and just understanding and appreciate that. Actually, it's a big deal to come in, you know, take some of your clothes off and, you know, have to have an examination. So I think the more that we can do in one appointment. And again, we try and make our settings as sort of non clinical feeling, you know, to as as we can so, but yeah, I mean, it's a vast service in terms of the different aspects, and we're really proud of the services that we were we offer to sex workers. So we do a lot of outreach work for, you know, for that's a really vulnerable group of women in reach into the prisons and working lot of the young work with, can we do with young people? So the same, some of the young people go into schools, but we also do one to one work with young people. A lot of that is linked around sort of self esteem. Seen generally as well in terms of people's high risk taking behaviour, or, again, just their own personal journey and learning about themselves. You know how they keep them safe and supporting them with their sort of sexual health safety, potentially looking at what options for contraception. So again, it's there's lots of different parts to it, but then they all interlink, which is good enough. So we've got close seats with Guy knee, because we see a lot of women who come to us who probably need to go on to guide it. But we have got our own consultant, reproductive consultant, Shruti back then, who's amazing. And so that means that we can now see a lot of women who may have coil problems. So again, that's a good part of the service. They can have scan guided consultation to determine if they've got a problem. Is it with the coil? Is it seated in the, you know, in the right place? But again, you can go to gynae or ultrasound scans for that as well. So again, it just depends which way you come in. So some people may go for different routes. It's just so

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Marianne Storey 11:04

good to hear about a service that's like, really well delivered, really well organised and really great feedback. It can work.

R Rebecca Jones 11:11

I mean, there's still some people who still waiting and again, sorry, you have to, you have to ring back again, because however many appointments you put on, there's always more people coming through wanting to be seen. So, yeah, so again, yeah, no, but it's a great service, no doubt, largely down to you. Rebecca, no, we have got, we've got a fantastic team. We've got brilliant nurses, doctors, we've got pharmacists, our healthcare assistants, admin and the health advisors, again, we've got a real breadth of team members, which I think all adds to, you know, enriching the level of service that we can bring. So team effort is indeed what makes the dream work.

M Marianne Storey 11:54

Yeah, in this day and age, being able to just self refer or walk in, it's really quite an unusual situation. And yeah, why is it that sexual health services, someone could literally just walk into your clinics,

R Rebecca Jones 12:07

mainly because of the confidentiality that surrounds sexual health so so I think that's because if anyone comes to our service, it is completely confidential. If someone doesn't want us to contact their GP about why they've been to us again. We will always respect the request for patient confidentiality. That's paramount. So I think that's primarily why so people don't to get to us. You don't have to go through another service. Some people do come that way to us. But from our perspective, that's crucial, that people know when they come to us, whatever they want to say to us is held in confidence. I mean, obviously safeguarding is always the one exception, but that is the same for all of us. But if people come to us, our records are completely closed. They're completely separate. So again, nobody outside our service can see those records. They're completely held separately. We've got our own separate system, and that's part of the venereal diseases act that they have to be held separately. So So again, some of that's historical, but again, that's the idea behind that was, again, to encourage people to come forward. Because if people think, Oh, someone might know I've got x, y, z, I'm not going to come forward, just in case. And then, of course, it's if people don't come forward and they don't get treatment, then of course, things are more likely to be transmitted. So that's where, where it comes from. So I would say probably 95 plus percent of people we see are self referral, so they ring up for our phone line. So what we're trying to do at the moment, we're just trying to get the permission to move to a personal health record, which would mean that patients would have their own record once they're in our service, which they hold, but then it's they can book online. So at the moment, we've only got online booking for contraception in the May, where we'd like to move so that more people can use online booking, because we know that that's for lots of people. That's how they like to book things. It's linked with the NHS digital plan.

M Marianne Storey 14:08

Do you find that people it's going to say abuse that system is the wrong words. That's very negative. But because it's so unusual to be able to do that, do people come with things that perhaps aren't sexual health, and you forward them on to somebody

R Rebecca Jones 14:20

else? Yeah. So women's health, we do see increasingly, that we've got people who are coming to us because they've got nowhere else to go. Yeah,

M Marianne Storey 14:28

but you put that in a much better way than I did, yeah,

R Rebecca Jones 14:31

and, and that's the thing. Sometimes people come to us because they're not sure what it is they've got. So sometimes we can see them and then we can refer them on or revise where they need to go. Other people really shouldn't have come to us, but, you know, depending what they say on the phone, will depend on how they get into be seen, and then, of course, with all the contracting commissioning, so that's how what we're paid to deliver. Again, that can add additional challenges as well, in terms of people, we could. Technically say we've got the skills to do it, but we're not paid to do it, so we're not supposed to be doing it. So, but, I mean, you'll always get some, I mean, again, you do get some worried. Well, who will keep coming back round? Again, it's trying to offer reassurance to those people.

M Marianne Storey 15:15

So you had a question, actually, I interrupted it.

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Anjali Mavi 15:18

I mean, that's really good. You have the system of self referral, and which I can see, taken away, some more layers between GP and all, which is great, actually. So when we talk about your department, I agree you have people coming with a maybe some medical problem in with the sexual health and all. But what about the sex education? Because when we talk about the sex education, we just talk about, okay, it's happening in school and all college, but coming up from the background. I from, you know, I'm from India, but then Asian community, like India, Pakistan, Sri Lanka, Nepal, Bangladesh, there are still a misunderstanding about the sex you know. And I feel like this topic need to be discussed very openly, because still, people don't know the basic things about having sex. I'll be honest, and we assume internet, technology, social media, give all the information. I'm sorry. I've got to use the word, maybe porn videos people see, and this is the way. But there are women who still struggling to make their husband partners, to understand about the sex and how they perceive again, you know, and it's related to mental health also. So is anywhere you can signpost, or your department can entertain or take these people also on board or promote. We are there to talk about sex education for these people who are not very much exposed to the system,

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Rebecca Jones 16:44

yeah, so I guess in terms of young people, in terms of sex education, so RSE relationships and sex education, that's we've got a team, our shios team, we call them now that's the sexual health education outreach team. They rebranded this year because they wanted education to be the key part, and that's their primary focus. So in terms of that team, they're working with the 13 plus age group. But a part of that team, we've got two of our almost tutors who go in to do the RSC within school. So we've got two really great members of our team who are great talking to young people. They're great educators, and they we've developed an RSE package, which we go in and teach to other teachers, to teach to their pupils. But what we find you more often than not, is that saying, Oh, will you come in and teach it yourselves? Because, again, they're saying the young people do value that having someone separate coming in. So that's something that we do feel is really important to teach people about. You know, healthy relationships. You know, how they protect themselves. You know, in terms of mentally, you know, physically, emotionally, so consent, you know, preventing STIs, preventing pregnancy, and a lot of that is all link linked as well, all about wrapped around self esteem as well being very important to make sure that young people feel empowered to take control of their own sexual health and feel confident.

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Anjali Mavi 18:13

So this self fulfilled form which you have, is it available to share, because I might need to share within our group.

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Rebecca Jones 18:21

So basically it's just our phone line number, so I can share all that, so people just ring up the phone line and then you'll get booked in for an appointment. So we're 13 years plus service. If we have anyone younger than that, we have links with through paediatrician, but generally as a service, we're very non judgmental, so anybody can come to our service any age, and depending on who's the best person to see you, we would the admin team there would point you in the right the right direction. So that's for young people, and as you say, for older groups. That's a good question in terms of, how do we make sure we keep people informed in terms of the appointments that we give to people as part of the session. It is very much looking at that individual person in terms of, you know, testing where they feel safe in their relationship. What's if there's anything in terms of their relationships that they want to discuss. And we do have a psychosexual service as well. So we do have some people who come to us through that route, if they've got psychosexual problems. So that's sort of sexual problems which are physical. So if you almost tested that they're not physical. So it's sort of so they've got a psychological aspect behind them, which is why someone might be experiencing problems. But as you say, in terms of how, for some people, if they come from different cultures, as you say, how we would, I don't necessarily know that we do something for that group, so I suppose it's for that's something we could give some more thought to. Certainly, we do go and give outreach, say to asylum seekers. So we have been asked to give information to groups such as asylum seekers. So again, where culturally they may have. Not had access to the same types of information? Yeah,

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Anjali Mavi 20:04

I raise this concern because I have, I've discussed this in past with many women in different, diverse community, and they have shared their, you know, thought about it for this is it just for the men pleasure, and we're doing it, and they might don't know how to and, you know, from that point of view. And having said that. Now you have said the number is there. There are some children who might be taking information from school, but some children's are very shy. They don't want to talk about their friends, and they even don't want to talk about their parents. So some some Indian parents discuss that on the table, actually, who we can refer so they can be openly talk about it, you know? So I think that's a good way of signposting you your team.

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Marianne Storey 20:44

I feel like a project coming on.

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Rebecca Jones 20:46

Yeah, yes. And certainly, if there's any groups that you're that you're involved with, Anthony that we could then link to. So our she asked team would be happy to link with them, or again, from there, they can do outreach with other groups as well with adult groups. So again, as you say, It depends on if people feel that they want to speak to their children about things but they don't know the best way to do it, then potentially, there's other things that we can look to support, especially in more of our sort of ethnic minorities or marginalised communities. We that that's something that we're keen to do, because I think that's where we always feel that we're struggling to reach some groups still, because we know in Dorset we have the ethnic minorities are smaller groups, but again, some ways, that makes it even harder for us to reach them. So I think if we could do some No,

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Anjali Mavi 21:31

please do share the number, because I love in our groups, and I know there will be many people who wanted to talk, but they're not open to talk. Maybe I give them a platform. Maybe they will say, oh, there is someone who I can talk so it would be great. Yeah, that's good.

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Marianne Storey 21:46

Let's move to you Nicky, because I think we will be interested to hear why we chose this subject as a work stream in the first place for the big women's health programme. Did you want to talk a little bit about how this came about and what the focus was of what the work you were doing?

N Nicky Smith 22:01

Yeah, so if you cast your mind back to 2022 the women's health strategy, and through the Department of Health and Social Care, a call to evidence was undertaken and trying to capture women's views pan England about how they felt issues were for them around women's health, and about 100,000 women responded to this call to evidence, and this amalgamated in to national funding in 2023 for 25 million pounds for ICBS integrated care boards to support their local systems with creation of a Women's Health Hub, or if they already had one, to expand on that hub to other geographical areas within their patch. And there were obviously other recommendations within the national women's health strategy about how we could support our women locally and what that would look like. And I know Marianne, you were on board long before I was and you were part of what was called, I think, a Dorset Women's Health Task Force, and how you could unpick some of the recommendations at that Dorset level. And then a lot of engagement with Dorset women happened, whether that was through focus groups, face to face engagement, and this was all sort of CO produced by a task force which included health innovation, Wessex, MHS, Dorset. Dorset women's CIC so Marion and lots of other partners who were involved in this task force listening to what women in Dorset were specifically saying, what their barriers were, the challenges were, what were the areas that they needed help most with, and alongside a digital women's survey and all of the face to face engagement, it helped to identify and concentrate on six aspects of care to support women in Dorset. So they were a Dorset Women's Health online resource. So women across Dorset said they felt an online resource would be more suitable for them. So in terms of access, that was one of the biggest barriers accessing appointments, and we felt that having an online resource would help health inequalities around that, and especially people who were having problems accessing transport and who might be carers, and it would help alleviate having to take time off to access support by having this central sort of one place of evidence and self help and self care for women. And that was managed by Dorset women's CIC so the lovely Mariam. And then there was pelvic health disorders, pelvic health dysfunction. Yes, we've got that episode coming up. So watch this space. More women than you think have problems with. Pelvic health dysfunction, but we know we're going to come onto that for a different podcast, but it's how we could support women with that and then long acting reversible contraception, so that all ties into sexual health. Menopause was huge, and we know menopause itself is a massive topic. And then we had a specific sub project supporting minoritized groups and mobile support all goes back on that no brilliant, and then you have a really important one I think, which I think encapsulates everything, probably your young women's physical and mental health sub project. So we had six. I led on four. My colleague, Patrick Arnold, led on a young women's physical and mental health. But you can see just what we've been talking about, sexual health can just overlap into all of these different sub projects. Sexual Health is huge, but by unpicking some of these priorities that Dorset women told us they were then, they helped establish our focus underneath the Dorset women's health programme, and that's where the projects came from.

M Marianne Storey 26:04

What was it about? I mean, we got used to calling it lark, but for Angeles sake, and everybody else's larks is L, A, R, C, which stands for long acting reversible contraception. Do you want to just tell us? Tell us what that means, and why was that picked as a workstream in particular.

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Nicky Smith 26:21

So I'm sure Rebecca can do more justice with regards to the clinical aspect. But this is things like the coil your contraception implant or injection. So the contraception typically lasts longer and needs to be not necessarily by, say, a contraceptive pill, which for some pills, you need to take every day. So it mitigates this sort of, oh, gosh, I forgot to take my pill. Once the coils in, the implants in or the injections been administered, then you can go about your life and not have that sort of stress and worry, because many people forget to take the contraception. Understandably, it's reversible, so you can remove the coil, you can remove the implant, and then you just don't have those future injections.

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Marianne Storey 27:03

Why that subject? Why did that get special attention? So that came about. We

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Nicky Smith 27:07

know in Dorset there is no community pathway for non contraception.

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Marianne Storey 27:14

What does it mean? Community pathway?

N Nicky Smith 27:17

So that would be typically me if I typically had really heavy menstrual bleeding, say, or I was on hormone replacement therapy, etc, etc, I went along to my GP and settle it on really, really struggling with heavy bleeding. It's really having an impact on my life. I'm in pain. It's this whole sort of holistic physical and mental health, well being aspect, it's really having a detrimental effect. Can you someone in your surgery, say, practice nurse or whoever, assess me, and then if I'm if I meet the criteria to have that coil fitted in primary care rather than secondary care. So that would be sort of your hospital environment, which would then need to be triggered by a referral from your GP, typically, to the hospital. And so that means the woman's having to wait longer, she's in pain longer, and it's going to have an effect on her life, but not also her sort of physical, mental well being, but also her capacity to work. So we have to not forget that as well. So this would speed things up hugely for women and have a huge impact on their physical and mental well being, but also it would reduce pressures on secondary care. We know that there are currently workforces in primary care who can fit coils, but it's just about having the appropriate trained workforce, the contingency, the capacity, the sustainability, and how we can develop a pathway that could enable that and reduce those health inequalities to make sure that women have the equitable access and improve their health outcomes as well,

A Anjali Mavi 28:59

makes sense to you. Anjali, definitely. And thank you. Well, I'll be honest, because I know when men sent the question the morning I was reading, I was like, blank when I read the first word, l, a, r, c, I like what this mean. And then later on, I Googled it. And then that's what actually, when we are doing this podcast, which is not just going to people who understand the medical language. This podcast is going to old, normal woman whom I don't understand this language. So when Marion said coil, my mind was clear. And Marion had her own experience, which was for me, it was like, oh. It was painful. What she was saying, Oh, dear, because I know my my some of my friends had the coil and they discussed because they had a heavy bleeding and everything. But having said that, I have a very important question for all of you. I myself want to say it is me who used to think that. But then, of course, because I've been exposed to so many intelligent and knowledgeable people in NHS, so my myth was gone. But I can still see that myth, that mindset is still there in our culture and in many areas, coil will spoil your sex life. We discussed that during covid time. We had a zoom call with lot of people, and we were discussing something, and they said one of the men actually said that, in a fun way, my sex life is ruined since my mom, my wife, had this coil, and she's always scared if something happened, and we try something different, so it will be difficult to make her understand. And we were just laughing, actually, because it was a joke that time. But today, in this scenario, I could see that it is a mental problem for many women, and that's why maybe some women don't choose that path to go for coil. So I think I don't know how we can put forward this information in a way, coil is good. It's not gonna ruin your sex life. So I don't know what you're gonna say on this,

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Nicky Smith 30:57

and that's a really good point. You raise it is a myth, but it's understandable that people, when they don't know something, they instantly think maybe this is worst case scenario. And I think it goes back to very much, the education, the raising the awareness piece is having, and starting those conversations as well. And I think that loops back to the Dorset Women's Health online resource, which does have a long acting, reversible contraception, web page dedicated to giving women that evidence based information. And also it goes back to people like Rebecca providing that information in a very confidential environment. And it's also, what does a coil look like? Where does it go? What's it supposed to do? How is it put in? What's the process? I think it's unpicking it all. And I think some of it would be and could be, and I completely understand, will it hurt? What happens? What happens afterwards? And I think it comes back to, let's talk about it. And there are other forms that can support, generally, from a contraception point of view. But with regards to the non contraception pathway, this would benefit so many, many women. I mean, Rebecca, I don't know if you want to jump on on the back of

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Rebecca Jones 32:10

that, you heard that myth before, Rebecca, I mean, all different things come forward, don't they? You've probably heard it all, yes, but I think, I think the reality is, some people, you know, get because scared it's going to fall out, or it's going to, you know, they're going to be able to reach it. But I think, as one of our nurses said, he said, no penis is ever going to be large enough it will get anywhere near the coil ever. So because it's that high up,

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Marianne Storey 32:36

I like this answer. There's your answer. Anytime anyone else asks,

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Rebecca Jones 32:41

yeah, it would be a, it would be a first. So I think, but I think it is down to the education. Is to say, in terms of understanding, is to say where the coil sits. You know, it isn't in a way that anywhere is going to be able to touch. And obviously, you have your threads that you have to encourage you to go in and just to feel that it said that the threads are on the end of a long you know that they're beside you, but you can only just reach there, but the coil is much higher up than that. So you you say, in that sense, you don't have to worry. But it's like all these things, once you have a seed is sown, I suppose then people do. That's where the myths come from. But it

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Marianne Storey 33:18

doesn't help. You know, you almost get this double problem, then Haven't you? You've got these kind of myths flying around, and people's concerns about the coil and will it hurt, and all those things you talked about Nikki, but then when they find that actually, I've got to wait two years for a referral into secondary care because my GP can't insert it, then you've got a double problem. That's not great for women. So that's why it became a subject for the programme. And obviously you working very hard together, the pair of you, to try and sort this challenge out.

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Rebecca Jones 33:48

So I think the key thing to stress is that if women need a coil fitted for contraceptive reasons, they can get those readily through their GP, well, through if the GP, if they do fit the lots, or through sexual health, so that where we've had the more delays is where women need the coil fitted for non contraceptive reasons, I'd say, as in link to heavy periods in menorrhaging, or linked to HRT. So it's for women over a certain age, and they don't need the coil, or the coil has different periods. It has different it's licenced for different periods. It's licenced. The licence periods keep changing, but they're licenced for contraception for longer, often than the licence for contraception and the HRT aspects, which is why there was sometimes we get into this position where women have, you know that she needed it for the non contraceptive reasons. They need it for heavy bleeds. You want to help their with their HRT, and then we can't give them in primary care. We can't give them in sexual health. So this is the key part of the work stream that we were looking at for women's health, for this group of women who were actually being really disadvantaged and. You know, really, because of their age bracket that they were in, and the only pathway that we have for those women is through gyne services, and the gynaecology services have got very long waits. So that's something that we all felt really passionate about, that it actually is very wrong that there's people out there when we've got clinicians out there who can fit the coils and are keen to fit the coils, but that we're not able to because they're not funded to do. So

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Marianne Storey 35:27

what did the work look like? I mean, when you try and change something like this in your lines of work and your project management role, Nicky, you know, and you I know, the two of you work together, what's trying to fix that look

Rebecca Jones 35:37

like? So Jen Spencer, she leads from public health. So she leads on the contract with GPS for for Lark. And so she's been really involved and been was really proactive as well in supporting this piece of work, again, because obviously public health can fund coil fits for contraception reasons, but not for non contraception. So again, again, she's been really committed to driving high quality services forward for women. So she was really active in the group in terms of, let's look at scoping, what numbers of women that we're aware of within Dorset who fit that group. So we've got people we know who come to us with sexual health it was trying to try and get a sense. We had some input from primary care to say about what they were seeing in primary care as well. And then it was pulling together a paper, which, again, Jim was very instrumental in, which was then taken to the ICB, that's integrated care board. So they are our commissioners for all NHS services in Dorset. So a paper was pulled together, which was then shared with them, and then having Paul Johnson as the Chief Medical Officer for the ICB and also for the Women's Health Strategy Group, in this sense, was useful, because then it pushed it up their agenda. It's something that's been there. It's not actually new. It's something that we've been trying to talk about for a long time, but actually the having it as one of the projects within the women's health strategy, I think then gave it that elevated status and more of a push behind it. So again, we're still waiting on formal confirmation that we can move ahead with the pilot, but we've certainly got a lot further forward than we have done ever before. So I think that is in part to Jen's involvement, but also the group, because it just shone a light on that group of women. And key for people who work in the services, it's so frustrating because we have women who come to us, they ring up so they go, come through the phone line, then they get booked in for their pre call consultation, and then when they go through why they need it, it's like, oh, I'm very sorry we can't provide it. Yeah, that's Yeah. And it's so hard then for the clinician, because then it's like, oh, you're having to say no to somebody, when actually there might be somebody who really is sort of in desperate need to have their coil fitted, just because it's impacting on their daily life. So, so from our perspective, we were something that we feel is really important, because, again, it's, you know, women are 50% of the population, and over 50% of the population endorse it. So this is a group of, a group that just deserve to have appropriate care. And the feeling is it could be resolved in quite straightforward way. There was an easy solution in terms of, you know, GPS in primary care, wanting to fit us, wanting to fit, if there's more complex, slightly more complex, they could come to us. So, yeah, so we we're edging there. Still don't want to get excited. It

Marianne Storey 38:44

sounds an incredibly frustrating situation. I know how hard the two of you and other people worked on this project to really try and move this forward, which sounds to me like it was a question of just getting it paid for. Because, as you said, there was no lack of people willing and able to do it, and you even have the women in your clinic

39:03

with the legs ready I can't

R

Rebecca Jones 39:07

do it. That's an incredibly frustrating so, I mean, yeah, you know, I think it's really important that women know that people like you are working so hard to really change things for them, but also to understand that it's not easy. You know, you've talked about an incredibly long and frustrating process, and you're still not there yet, but at least this project has inched it forwards. Yeah, exactly. And then it's been linked in as well to the sort of linked in with the work they do for guy knee, yes, as well. So on you go, yeah. So which is what, yeah, what you've said about all the all the different work streams all overlapping again. Some of it's teasing it out and saying what, you can move it from that work stream, move it there and then. But that feels like just kind of bumping it around, and not actually exactly, whereas we felt for non contraceptive coils, if they can get done, if they're undertaking it primary care or in the. Sexual Health that's almost like at a lower level, which then frees up gynae services for the more complex things that they need to see. Otherwise, everything gets put on the gynae list, and actually it's just too much for them to manage. Well,

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Marianne Storey 40:14

particularly when women are coming to primary care settings for other kind of gynaecological type procedures, even if it's just a smear test or they're coming to see a physio, you know, a woman's health, you know, if there's something going on, vagina wise, for women, it does make sense if that clinician can also put a coil in by and I know, I know we've been talking about this for years, but to women, I don't know about you, Anjali, but to women, that just makes so much sense while you're up there, can you just do more than one thing? Because we were talking earlier, weren't we, Angela, about how traumatic it is to go and even just have a smear test, right? And you know, women don't want to go and do that. We're all women here. We've all been every single one of us knows what that's like, and I'm sure every single woman who's listening would know and empathise with you know, it's not, hasn't it's

A

Anjali Mavi 41:03

not only about the physical thing. It's about it's all connected mentally. Actually, I I myself when I have a semester, I have to prepare myself for a week, okay, until you have to go there, they're gonna put this, they're gonna do this, they're gonna do that. So it is one thing we need to prepare ourselves. As Marin said, if this can happen during that time only, why not? Why we need to wait, as she said, two years waiting list. So I think we need to make it compulsory, some rules.

R

Rebecca Jones 41:34

Yes, definitely, definitely,

N

Nicky Smith 41:36

just a quick point on the back of what Rebecca was talking about the lark project, you're quite right. Marianne, what this project did was provide a vehicle to address some of these challenges and to try to be a voice for some of those women, for a lot of women, quite frankly, that are suffering and often suffering in silence as well, an annual audit had historically been done, but not for some time. So that is something that we completed as well. So we were looking at the landscape of trained staff, as it were in primary care, who was trained to do, what the capacity, etc, etc, if there was appetite to do more, how we could go about that and that kind of stuff. And we also did a scoping exercise in what the current and what the existing training is to staff, what are the gaps? What needs to be done to make that more efficient? If there are gaps? And it was also around hearing the voices, hearing more voices, those continued voices from women. And we can continue to do that through your good work, Marianne, through the Dorset women's CIC and the online health resource, because women can leave feedback on the online resource, and I know that they can contact you in other ways, and you're continuing to do that engagement as well outside of the online resource. But also, as I alluded to, it links back to the lark web page. So there is a lot of work being done with this stream of work. There are conversations being held. This is something that through the development of the pathway that we created, and through that proposal and options paper, will then give that vehicle to make that pathway, that community pathway happen. So watch this space. Health Innovation. Wessex, on behalf of NHS Dorset, will be producing an impact report as well on all the good work of the Dorset women's health programme. So yes, we'll be looking back to see what's happened since the end of the live project, 31st of March. 2025 so it didn't just stop there. I want women to be reassured that there's so much work carrying on in the background, and that will continue to be carried on. But we need to keep hearing your voices. We need your feedback. We need to keep seeing what are still the problems, because we know we can't solve this overnight. We need you to tell us what are your experiences. We know that two of the top reasons in the digital Women's Health Survey in 2024 was availability of appointments and not feeling listened to. So I think through all of our programmes of work, we've helped to influence some of that, but we can only go so far. We can only do it with with the women of Dorset. Well,

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Marianne Storey 44:27

of course, this carries on in your day job, Rebecca, doesn't it? This doesn't go

R Rebecca Jones 44:30

away Exactly. Yeah. I mean, that's the thing. We're always looking at what we can do differently. But at the moment, we're currently working with public health to undertake a health needs assessment. And what that means we're actually looking at all our data from the last five years in terms of who we've seen, by age, ethnicity, where they live, and trying to then we'll be matching that against the public health of national data in terms of because that's always what we wanted to sense. We know we've you. Seeing lots of people. We know demand always outstrips capacity, but we still don't know if we're seeing the key people we need to see. So you know, are we reaching the marginalised groups? Are we reaching the vulnerable? So we do lots of work. So from sexual health perspective, our feeling is there lots of people they can can go to their GP for contraception and other support, but for other more vulnerable groups, they're the ones that we be looking at trying to reach. But again, you want to do this Health Needs Assessment just to get a sense of who have we reached and who have we not got have we not reached yet? So

M Marianne Storey 45:38

that's me. Like Angela might be a useful person to the dragons that she's always looking for new projects, aren't you? Absolutely.

A Anjali Mavi 45:46

And I wanted to add live the when we are talking about this, giving information and telling people this is this, is that. But I feel is we are talking about women health. Agree, we want to pass this information to the woman. But I always says in all the podcasts is not only about the woman. I feel like in our culture, the more information should go to the men's actually in the house, because they are the one who can, if they are not supporting the women's will not come forward and talk about it, either it's menopause or anything any woman health. I feel like GP should have one kind of compulsory workshop for the men's every like, we get that NHS message, you are due to this vaccination, due to this. You know, I think that this kind of message should come. You should be eligible to attend this. You should come for a workshop to talk about women's health so they can support their partner, wives, daughters, sisters, mothers. Because I am seeing every day, I'm telling you, and sometime in my house, don't judge my husband. He's amazing person. But because of the lack of information, because of lack of understanding, he asked me, I think I'm going for pre menopausal, menopause. He literally asked me when this is gonna be finished.

M Marianne Storey 47:08

He's got a shocker coming.

A

Anjali Mavi 47:12

And I loved him. I said, I even don't know when he started. Oh, you're asking for the finish. How can I answer this question? And I was like thinking that day, I said, I'm gonna raise this on the podcast, the understanding the educated people still don't understand about women's problem, the Harmon change and everything. I think we should definitely signpost them rather than women. Definitely they are our first audience, but then they are the also right people. I mean,

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Marianne Storey 47:38

this is what you're saying, Anjali, is so much of what we heard when we did our first kind of surveying and engagement with women about what should we be looking at. And we heard that over and over and over again, which is why, as Nikki said, that the website was really such a huge priority for the whole programme, because if we did nothing else, we needed to give women and and their men and their children information that they could go and look at and look at and learn and understand and educate themselves about all sorts of things. But as you know, you know, what's come out of many episodes of these podcasts we've recorded is this issue of reaching women from marginalised communities and different cultures and ethnic backgrounds, because there are these misconceptions and these cultural barriers and additional things that women and families have to overcome in order to get to Rebecca's service in the first place. You know, we're just running a really lovely set of perinatal classes for Afghan refugee women who have literally got brand new babies so cute, but they are so enjoying and welcoming the opportunity to talk about their sexual health and their their gynae problems, that they've never talked about it before ever. And we've got a really safe space and a translator, and they're really lapping it up, asking so many questions. You just think there's such a community that we this huge is that we're not reaching, you know, and you know, ever since I've known you, know, you've educated me about what everyday people don't understand and the barriers that they experience to accessing women's health. We make so many assumptions about or we'll just run a clinic and they'll come actually, it's just not that straight forward. It's not and one size doesn't fit all, as we know, and different culturals will have different experiences. Some just don't talk about it. Like you said, if you deliver a service treating everyone the same, potentially with the same need, it's not going to be equitable, and it's it's going to widen the health inequalities. People come with different health conditions, different backgrounds, different needs, different priorities. And like you were saying earlier, Nikki, you know, if you if you don't address the health concerns, you know, the ripple effect of women being able to work, to being able to engage with their communities, to be able to be at a really good parent, do the school, you know, it's like you're tackling these things like heavy bleeding. I often use that as an example, as it leads to so many other things. Yes, yeah. And if women can't get help with heavy bleeding, it's really quite difficult to function. And we don't talk about

Nicky Smith 50:05

that enough. No, we don't, and that's for some women who don't understand what's happening. They often think, gosh, well, I'm just going to have to give up work, or this is what's going to happen, or what's wrong with me. I'm frightened. I'm scared.

50:18

No, agree. So

Marianne Storey 50:19

just to wrap up, then quickly, what do you what's what's what's next for you both? What are you currently what's your current priorities? What does today look like for you?

Rebecca Jones 50:27

So as I said before, we're focusing on our health needs assessment with public health. So that's huge in terms of pulling all our data for the last five years. We'll keep you busy for a while. And yeah, but what are you hoping that will come as a result of that? What will that information tell you? We're hoping that that will tell us, you know, where we're on track, where we're seeing the right types of people that we need to be seeing, where perhaps we're off track, and where the groups are that we are missing, and where we need to perhaps look at different approaches to make sure we do meet the needs of those marginalised, vulnerable groups, because that's where we feel is where we should be trying to target our energy as more of a specialist service. So that's a massive piece of work that we're doing at the moment, and we're just waiting for the last sign off for our which I mentioned with about getting obtaining a personal health record within our EPR system. So for our electronic patient record, it's a standalone system, so it's completely separate. But we want to move that forward so that it's been like, you know, you have your NHS app you can have once you've got your touchdown service, you've got your own record that you can access to make the bookings, keep your records on you've got your what have you results on there, and blood test, all those types of things, anything that you need. It's all there which you can access. So that's good. So again, we're not just trying to get through the various sign off,

Marianne Storey 51:55

yeah, grass hoops that you have to jump. Yeah,

R

Rebecca Jones 51:57

we've got a few more that have emerged. We don't have that. You won't be kept busy again. No, exactly so, but no, but that'll be good once we get through all the hoops so we can get it going. That will be brilliant, because that's something we know that will make a big difference for patients, because it will make it more easy for people to access our service. So that'd be great. So that's what's going to be Yeah, I'm going to be working on with the

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Marianne Storey 52:21

team, aren't you? Nicky,

N

Nicky Smith 52:22

oh yes. So health innovation, Wessex, as I said, I'll be creating an impact report from say, by the time it's produced, it will be circa 12 months on since the end of the Dorset women's health programme. So I will be pulling together that now and over the next several months, and the digital Women's Health Survey that went out last year will be revisited, and that will be going out next week. I think it's, yeah, I think next week. So NHS Dorset will be pumping out a load of comms around that, getting women to sign up. And it's around the online resource. Has it worked? Has it been effective, that kind of thing, but also not just because of the online resource for all the other sort of project groups, this is what's kind of happened, and then what's the impact been? Sort of the outcomes for you. And we can then amalgamate the analysis of that survey which health innovation in West we'll be supporting with, again, that will all go into the Impact Report, and then we can identify more future recommendations based on the women of Dorset. So yes, we'll be busy over the next few months.

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Marianne Storey 53:34

Yeah, well, I mean, thank you so much both of you for coming on today. It's been such a fascinating conversation, and I feel like, I also want to say to you both, thank you for all the work that you're doing. Because I just, I think I've said it already, but, you know, people don't get to see how hard people like you work on their behalf. So, you know, on the behalf of women, you know, thanks

R

Rebecca Jones 53:53

for everything. Thank you, Marion, I would say, for actually sort of spearheading the start of this big project. Because actually it's the work that you did with women initially that got this all going really, and really the women's health strategy work sort of piggy backed onto what you'd already started. So I think that's really important, that we recognise that actually it already started at a grassroots level, which is, I think, is what was important. And again, it did get all the other layers of does always get a bit more complicated when we have to put all the statutory organisations in. But I hope that, in a way, we can just move things forward, and it gets moves it back a bit more so it is, feels like it is more grassroots. Again, it's the women who are leading what we need to do next. And as you said, we've got the other work that's going alongside it, but I think that's what's really important, because that's where you sort of get all the passion and the enthusiasm. I think that's what we all need to keep us going. Because sometimes it can just feel as though you just get can get ground down in all the bureaucracy sometimes. But I think that's what everyone who. Has been really committed to moving things forward. For women, I think we've still got a way to go, haven't we, but I feel at least we've got it on the the agenda. And things are we have moved some things have moved forward a lot more than others, but it is heading in the right direction. Well, we will certainly keep it on the agenda, and Angela and I will be we'll be a string from the sidelines. So thank you again, and it's been such a pleasure to talk to you.