

Women and Equalities Committee

Oral evidence: Women's reproductive health, HC 133

Wednesday 29 November 2023

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Members present: Caroline Nokes (Chair); Dr Lisa Cameron; Lia Nici; Kate Osbourne and Kirsten Oswald.

Questions 109 - 171

Witnesses

[I](#): Professor Hilary Critchley FMedSci, Fellow at Academy of Medical Sciences; Dr Robin Buckle, Chief Science Officer at Medical Research Council; Dr Judith Richardson, Programme Director at National Institute for Health and Care Excellence (NICE) and Professor Lucy Chappell FMedSci Chief Executive Officer at National Institute of Health and Care Research.

[II](#): Maria Caulfield MP, Parliamentary Under-Secretary of State (Minister for Mental Health and Women's Health Strategy) at Department of Health and Social Care; Charlotte McArdle, Deputy Chief Nursing Officer at NHS England and Professor Dame Lesley Regan, Women's Health Ambassador.

Written evidence from witnesses:

Department for Health and Social Care [[WRH0057](#)]

Examination of witnesses

Witnesses: Professor Hilary Critchley, Dr Robin Buckle, Dr Judith Richardson, and Professor Lucy Chappell.

Q109 Chair: Good morning. Welcome to this session of the Women and Equalities Committee and our third evidence session into women's reproductive health. Can I thank Dr Robin Buckle for joining us via Zoom, Professor Lucy Chappell, Professor Hilary Critchley, and Dr Judith Richardson? Thank you very much for the evidence you are going to give this morning. As is usual, Committee members will ask you questions in turn. If at any point a question has not been directed to you but you wish to come in then please do indicate and I will do my best to bring you in at an appropriate moment.

I will go to you all in order but start with Lucy. We have heard from previous witnesses that they do not think women's reproductive health is sufficiently prioritised when it comes to research, when looking at NICE guidelines: why do you think that is?

Professor Chappell: We need to consider this in the round from the point of view of research that is specific to women's health specialty areas, but also, equally and just as importantly, to make sure that women are properly represented in all research, such as that into cardiovascular disease or dementia, and particularly where there is a sex disproportionate burden of disease.

Research into women's health can be broadly divided into two buckets: research for maternity and research into other areas. I am chief executive at the National Institute for Health and Care Research and, working closely with our colleagues in the Medical Research Council like Rob Buckle, we have an active and thriving portfolio across all women's health areas.

Since 2016, NIHR has invested £222 million on research related to pregnancy, £80 million on research of gynaecological conditions and £52 million specifically on research related to women's mental health. We ask ourselves if that portfolio is equitably distributed and what more we could do to ensure that we learn from the industry, colleagues that we work with such as the Medical Research Council, and, crucially, what we think about the pipeline in practice, policy and guidelines. That is why we work closely with colleagues, such as Judith in NICE, but also with our colleagues across policy and NHS England to make sure that women really see the benefit.

At NIHR we have a very clear policy to make sure that women are involved in research: from prioritisation and conceptualisation, to design, delivery, and dissemination, through to, "What next?" So, with this very strong focus on the involvement of women and their families, we are trying to say, "Let's research what's important to them, not just what's important to the researchers."



Our priority setting partnerships with James Lind Alliance have shown that research prioritising women's perspectives rather than our own has been highly successful, and we have commissioned calls, sometimes topic-specific, against those James Lind Alliance priority setting partnerships by women. I am sure there is more we can do to ensure we see the impact of our research really reaching women at the clinical interface.

We are also continually examining our portfolio to say, "Are we putting enough towards this?" We are one government funder but we are not the only funder and we obviously work closely with the other research councils and charities to constantly ask, "Where are the gaps in our portfolio and where could we go further, faster?"

Q110 **Chair:** When questioning where the gaps are, have you identified any?

Professor Chappell: Yes. We have a couple of ways of doing this: one is to look at how we map our research against disability-adjusted life years, known as DALYs. We have many groups arguing—and in fact there have been a couple of reports this week—that we are not investing enough in cancer or dementia, for example. So we could say, "Well, what is the burden of disease?" That is one approach and, according to disability adjusted life years, we are certainly matching the DALYs.

The Women's Health Strategy published last year was extraordinarily powerful in making sure that we had much stronger women's voices and that we understood what they are saying. One of the areas is certainly around menstrual health and endometriosis, but we are also hearing about menopause, for example, which is why we have just released a commissioned call about the role of testosterone in management of the menopause. This came directly from work by NICE identifying a gap in evidence that left women uncertain: they were going to their health care practitioner and they were not sure, so we have responded to that.

We are also seeing gaps around representation of subgroups. One particular area of focus, for example, is around research inclusion of those from a variety of different ethnic groups, particularly recognising that women from Asian or black African Caribbean heritage may have different experiences of clinical care and may have different needs that we should adequately address and research. Through that we have done a few things at the NIHR: we have launched a race equality framework, and launched a research inclusion strategy which says that if you want to do high-quality scientific research that makes an impact, you must ensure you are recruiting participants that are representative. It is not good enough to say, "That was too difficult" or, "We didn't have the funds." NIHR is very clear that that is what we expect and that you may need to adapt your methods to ensure you have a representative population.

We are also launching some calls that focus specifically on the needs of under-represented populations, across both maternity and other women's health areas.



Q111 **Chair:** When did you make it a requirement that research participants should come from diverse backgrounds?

Professor Chappell: We have always had that as an expectation, but it is a question of how you enact it. One critical aspect is that you need the data. For example, I am a researcher in pregnancy hypertension. If you wanted to ask, "What is the burden of disease?", we actually know that it would not be appropriate to recruit participants on a population basis because black African Caribbean heritage women are overrepresented in pregnancy hypertension. We are trying to improve our data collection and curation so the very question of, "Are you recruiting a representative population?" needs the data and the data integrity to be able to do that.

Since the Women's Health Strategy was published, we have been working on multifaceted approaches to put the tools in place for both researchers and participants. I have heard from groups that women do not want to feel exploited or taken on tokenistically, they want to be involved. We are looking at a whole package of tools, resources, and incentives that will continue to be rolled out and monitored, not just at the end of a study but in real time during a study, to say, "Do you know what representative would look like, and what are you doing to ensure that?"

Q112 **Chair:** How long have you known that there is a gap there?

Professor Chappell: We published our first data diversity report in November 2021, in common with many other funders, and that is where we looked at two aspects. One was, "How representative are our participants?" Overall that first report where we looked specifically at trials showed that if you just look at sex and ethnicity, we are recruiting a representative population against the UK population. So, as a headline, it looks as if we are doing fine but if you actually start digging into the details—and this is what needs far more nuanced analysis and data capture analysis—there are areas where in certain diseases, women, or particularly women from certain ethnicity groups, are under-represented. The headlines that we are representative hide some disaggregation in the data that might show otherwise.

It has taken a greater effort to do that, but we are also looking, I think importantly, at the representativeness of our researchers. There should be a virtuous circle and again, although in some areas we are representative, we know from our earlier phase work—Discovery Science and our Invention for Innovation programmes—that we could do more to support women in innovation and entrepreneurship, for example. So we have launched some programmes specifically to support FemTech: women in tech.

Q113 **Chair:** When did you launch them?

Professor Chappell: Those have been going in our Invention for Innovation programme for about the last 12 months. We are currently evaluating them to see how to extend further and the impact of those interventions: where do we do more of what works well, and where do we refit where we think we could do better?



Q114 **Chair:** How long have you known that there is a problem with women not being sufficiently represented in doing the research, and why did it take until 2022 to start having a specific programme to make sure they were?

Professor Chappell: I came into post in August 2021, as we were coming out of the pandemic, and we very much recognised some gaps in covid research. As the national pregnancy lead for the RECOVERY Trial, we worked extremely hard to ensure that pregnant women were included in the covid treatments. We have certainly been aware of some gaps and there have been many researchers, both in the pregnancy world, which is my academic base, and in Professor Critchley's world, which is gynaecology and other women's health conditions.

One issue is that we need to build in strategies that relate to exposure to women's health and women's health research in education that start at undergraduate level. We need to ensure we work with the universities—which are sometimes the owners of clinical academic pathways along with funders, none of us have owned those areas solely—to say, "How do we ensure that our fellowships are open and available?" For example, we do a joint funding scheme with the very highly regarded charity, Wellbeing of Women, to pull into this area because we cannot look at gaps late in the pipeline and then say, "Well why do we not have anyone?" We must ensure we are putting in strategies earlier on.

We are currently in the middle of launching an internship and undergraduate programme. Not just for medical schools and medical students, but for many other undergraduates—in nursing, midwifery, allied health professionals—recognising that women's health is a truly multidisciplinary specialty and that we need representation of all those specialties in our research pathway. It is about both building capacity and ensuring that we have an offer across all those areas across our infrastructure and our programme funding.

Q115 **Chair:** Do you understand the frustration expressed by previous witnesses that here we are, in 2023, still talking about how we build capacity and introducing pathways and launching programmes?

Professor Chappell: We should recognise that we all have a part to play and that one single actor is never going to enact all the change. I have grown up in academic obs and gynae, and I have seen the many areas where we are making progress, but we should never say that we are nearly there; we are not. I see it in women's health, I see it in other areas, and I see a real hunger.

I would say there is as much of a need to ensure women are adequately represented in non-specialty areas too. Why has it, for example, taken this long to ensure that we do not just have experiments in male mice? I think women being put at the back of the queue reflects many wider societal issues, and I think we want to see how to ensure there are not cliff edges. I have had three children—my career did continue—but how do we ensure we do not see those cliff edges mid-career? How do we ensure we pull



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women in but also retain them? My view is that if you have representative researcher groups, that will absolutely drive representativeness of research participants so that we can get better treatments and management to women, not just across the country but a global reach.

Q116 Chair: Thank you. Robin can I turn to you? We have a wonderful case here of where the women are in the room and the men are on Zoom. Can I just ask you the same question: is women's reproductive health sufficiently prioritised when it comes to research? Is enough money being spent on it?

Dr Buckle: Yes. Certainly, the importance of women's health has long been recognised. The portfolio that we have—and Lucy has described NIHR's portfolio— you would probably say is smaller than ideal. The reasons for that are multifaceted. If I can just provide a small bit of context: as Lucy identified, MRC works very closely with NIHR. To some extent, our focus is more on the discovery and mechanism that underlies the creation of new interventions, or new routes to prevention, and so on. In that respect, we spend about £25 million per annum on the women's health portfolio that is the interest of this Committee. That has been fairly constant over the last five years and has increased slightly from the previous five years.

Again, just to put in context, when we talk about defining what we spend in a particular area, the majority of MRC's work is into generic research. We funded the discovery of DNA, lots of genetics, lots of data science. These will, of course, underpin much of what could be done in reproductive health. The amount I have said for reproductive health is on a par with what MRC spends on cardiovascular research specifically, for example. You can dice the portfolio in many, many ways and be worried about what is being spent, but what I would say is that our approach here is to fund in what we call, "Response mode." The community comes to us with the questions, with the proposals, and we make sure we have a fair and objective process to fund those. In truth, we are regularly asked why we do not put particular efforts or ringfences around certain areas. Our experience over many years is that the higher quality outputs are supported generally through an open system, whereby we might want to stimulate the community to come to us, but we assess things across the piece and fund the best science.

There will be occasions where we have set up particular activities. I would just cite, for example, the Million Women Study, which we set up in the early '90s with Cancer Research UK. That is the world's largest longitudinal study looking at women's health. As you will probably know, that has influenced the HRT guidelines for prescription on the NHS, among other things. Similarly, activities such as UK Biobank are clearly informative of women's health issues.

Coming back to the issue of the capacity of the community and the representation of women in science, there is potentially an ability to conflate issues here. I would like to split it into three areas. The first is, what is the strength of the applicant community? We have provided



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evidence to support the BBC interviews on Tuesday, just to say that when we look at the applications that come to us in this area, they are less than what we would like. But they do better than average in terms of their award rate, having gone through peer review. To some extent, we would like to encourage the applicants to come to us with these questions, and there are ways to do that. There is the issue of what is the capacity in the sector—

Q117 **Chair:** Can I just ask a question on that? That was quite a glib, “We would like to encourage the applicants to come to us.” How do you actively encourage them to come to you?

Dr Buckle: That can be done in a number of ways. All I was going to say, there are wider, more generic issues about clinical science, and the attractiveness of clinical science, and the under-representation of certain groups within that. But if we think there is, to some extent, an orphan area which is under-represented, we would have potential to run meetings, set up networks, advertise explicitly on our websites around opportunities, and to encourage. There are multiple examples that can be done, and at this point in time we have not targeted women’s health in particular.

Q118 **Chair:** Why not?

Dr Buckle: Because it has not proven to be a priority area for us, above and beyond other priority areas. There are very few areas that we prioritise—

Q119 **Chair:** Why has it not proven to be a priority area?

Dr Buckle: Well, it is balancing other priorities that we have to deliver. We are delivering research across the entire health spectrum.

Q120 **Chair:** Can I ask a very specific question? Women’s health has not proven to be a priority for you. How much is men’s erectile dysfunction a priority for you?

Dr Buckle: It is exactly the same. We do not prioritise that. If applications come in to us, they would be reviewed. I do not know what we spend in that area—

Q121 **Chair:** Did you know that five times more research is conducted on erectile dysfunction than on women’s menstrual health? Five times.

Dr Buckle: That may be true, but that would not be true in our portfolio. I think you have to be careful where you look. You can imagine that there is probably a lot more commercially-related activity, because of the market and the history around that area. But in terms of what we receive and what we fund, there is not that discordance.

Q122 **Chair:** No. But you have been very clear, women’s health is not a priority, I think we heard from you. Can I turn to Hilary please, and the same question: is women’s reproductive health sufficiently prioritised, and if not, why not?



Professor Critchley: Thank you for the opportunity to contribute to the conversation. I was very pleased that the Academy of Medical Sciences was able to offer evidence to this Committee, and I am speaking for the Academy in the answer to the question. But might I just preface by saying that when I started my career 40 years ago as a medical student, menstruation, bleeding problems, were a taboo area. Twenty years on from that, it was highlighted, and there is an excellent editorial in *The Lancet* about how the impacts on half the society are not prioritised by policymakers and funders, and here we are 20 years later having this conversation.

There is no doubt at all that menstruation, bleeding disorders, incontinence, menopause, these are all areas not spoken about, they are hidden. That probably is a start of why they are not prioritised. But I think that the conversations going on now have really raised the level of needing to now invest. We need to enhance education, not just in clinicians, in funders, in the public, but particularly in research. I think we do need to have a focus on reproductive health research. My conflict of interest is I am an academic gynaecologist. I have been privileged to be well funded over my academic career, and with declaring a conflict of interest, much of that has come from the Medical Research Council.

Q123 **Chair:** Can I just ask that? We just heard from the Medical Research Council that some proposals that came forward in this area were not of the highest quality. Why do you think you were funded? Do you think you had to put in additional effort to make sure that your research projects were funded?

Professor Critchley: You are now asking me to speak personally, I am not speaking on behalf of the—

Chair: Go on, go on.

Professor Critchley: First, I worked in a centre of reproductive health. It was the University of Edinburgh Centre for Reproductive Biology, Reproductive Health, and then later the MRC Centre for Reproductive Health. I was very privileged to be in an environment where reproductive health, menstruation, and many other taboo areas were highlighted. I worked cross-discipline with other colleagues, that was absolutely critical. By working in those teams, having an identification—as our previous speaker said about the new technologies, and whether they were technologies 20 years ago or technologies today—we could bring to the crucial discovery science that would then move to the translational NIHR. I was supported in that clinical academic career and opportunity to do research.

There is no doubt that as individuals, being a female in that pathway, you have to be supported, but you also have to be very vocal about what you feel is important. Having the advocacy of one's colleagues and of the clinical community is important.



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I want to return to the area of menstrual bleeding, abnormal bleeding. Where the Academy has been able to bring evidence is that it has been able to through its own meetings, its own contributions to the Women's Health Strategy, its contribution to your current Committee for evidence. We are talking about a problem that people say affects one in three women, but there was an excellent study in the Netherlands in 2019. It was an online survey of over 40,000 women between 15 and 45, so across the reproductive age span, highlighting that probably over 50% had menstrual problems. So that could actually be as high as one in two.

The research is confounded by the fact that bleeding is too often considered a symptom rather than a diagnosis. If we take endometriosis, we have a diagnosis, it affects one in 10. If we take bleeding, this affects one in three, perhaps it could be as many as one in two. It affects absenteeism from work. There are good surveys: 13% absenteeism, perhaps 60% presenteeism. That means you may be at work, but you are not working to your full potential. We have to have at the heart that we want a healthy workforce working to its full potential, but we are not going to answer the big questions unless we understand the cause.

We have heard a lot in the last two sessions. I read the transcript, I listened to the two previous Committees, so I know about the conversations around adenomyosis. The big questions for the basic scientists are: if you have a uterus, why is it heavier if you have adenomyosis? Another cause we have hardly heard anything about is uterine fibroids: 70% of white women and 80% of black women will have fibroids by the age of 50. They are the single biggest cause of bleeding. Bleeding causes iron deficiency, it causes anaemia. These are major cross-health issues, they can affect pregnancy outcomes, they are completely under-recognised.

There is huge opportunity for the discovery science, but we just have to raise the awareness that it is important and people want to work in the field. We can apply all the new technologies, the organoids on the bench, the sequencing, the big data, we can go to the UK Biobank, but we have to be sure we have phenotyped our patients correctly and we begin to understand cause.

In the NHS budget, drugs are the second-largest cost. We know 90% of drugs do not work in 30% to 50% of those that use them. If we do not get the right drug, at the right time, to the right person, for the right reason, we are not going to have precision of care. In the field of gynaecological disorders and treatments, we have a one-size-fits-all approach. It treats a symptom, not a cause. Where our funders can help us is targeting those basic mechanisms, and then taking them to the translational opportunities.

Q124 **Chair:** Thank you. I am very conscious that we are going to run out of time. Can I turn to Judith, please, with the same question about funding for women's reproductive health? Is it enough, and if not, why not?

Dr Richardson: Yes. Perhaps if I talk about how NICE prioritises, and the extent to which women's and reproductive health is being prioritised by



NICE. We have a fairly comprehensive suite of guidance that supports women and reproductive health. But acknowledging that it is an area that we need to put on the same footing as, for example, cancer and cardiovascular disease, we are currently coalescing all our guidance to look at five key priorities for where we develop guidance. Women's and reproductive health will be one of those moving forward. We know that there are some gaps in the guidance that we have produced, but we are very reliant also on the evidence base that is generated. We know that there are particular gaps in certain themes, in certain areas. For example, if we take the menopause or endometriosis, we know there are still questions to be answered. In terms of filling the gaps at a more macro level, I also know from reading the transcripts that PCOS was identified as a question, and we know that is a gap for us that we are looking to fill at the moment.

In terms of particular groups within the population, we also know that there is not enough research to answer all the questions we would like to be able to answer with our guidance, so we make research recommendations as we develop every piece of guidance, as we become aware of those evidence gaps. For example, in the menopause guideline that we have recently updated and is out for consultation at the moment, we have made recommendations about subgroups in the population and women from particular ethnic groups, and the outcomes for them from HRT.

Q125 Kirsten Oswald: I want to go to Robin first. What I am interested in is how research gets commissioned. Particularly the process for research into women's reproductive health, and whether that process allows for women's reproductive health conditions and for female researchers to be considered in an equitable way. I wonder if you can carry on where you left off, Robin, and tell us about that.

Dr Buckle: Yes, absolutely. If I may, respectfully, just clarify what I said. We treat women's health as an area of importance, for sure. All I am saying is we have a very limited number of explicit priorities, of which this is not listed as one. In terms of the research process, as I say, we work in response mode, which means we do not commission ideas, we let the community come to us with its best ideas. There is a process of peer review, which is a well-established process, all the funders run it, by which you then send the application out to experts for their opinion. There is a process of a response to that critique, proposals are then ranked, and we fund the very best.

There was no comment that I made about the quality of submissions to us. I was saying the award rates generally for applications that come to MRC is one in five. We reject 80%. That is not because they are bad proposals, it is because they are not the best proposals. That 20% we fund is lower than what we perceive as internationally competitive research. We do not have the budget to fund all the internationally leading-edge research we receive. When we have looked at our portfolio in terms of women's reproductive health, the award rate on average, the numbers are smaller.



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We are talking about 400 or 500 applications over the last few years. The award rate there has been 33%.

I mentioned there is the issue of the size of the community and therefore the number of applications you get, or the readiness of that community to submit to MRC or other funders. The issue then is, are our systems fair and objective in how we review these? All I can say is, we aim to be as objective as possible in every funding decision we take. Our committees are drawn from experts across academia, industry, and internationally.

If you want to ask about women's representation on those committees, we currently have on average 42% representation of women on those committees. The target, of course, is 50% and we change those committees on a yearly basis with turnover. We are targeting more female applications to sit on our boards explicitly, and to chair our boards and so on. I would argue that in terms of representation of sex on the committee, in terms of male and female and the processes that we have, they are objective. Applications coming in this space have as fair a hearing as any other, and in fact the evidence is they do better than the average coming to us.

Q126 Kirsten Oswald: I appreciate your answer, but you have said to me that women's reproductive health is not a priority. I am interested, in the context of the conversation we are having today, how we are going to up the game if that remains the case. Do you think that there is further action required? Briefly, if you do not mind.

Dr Buckle: Yes, absolutely. Sorry, I need to clarify about what I mean by priorities. We do not set out priorities. We say, "We fund medical research, please make applications to us." When we target specific areas that will be because we perceive a need to build, for example, an infrastructure, or a centre and—

Q127 Kirsten Oswald: Sorry to cut across you, but you do not perceive such a need in this area?

Dr Buckle: In my view, the need is to make sure the applicant community is stronger and more active researchers are able to apply to us; that needs to be addressed through capacity building schemes in general. We have done a lot of work to represent more women in research career pathways and take account of the pandemic issues that have hit that community. We need to understand if there are particular research infrastructures that might be needed to support this area of work. At present, we have not identified any specific targeted investment in that respect, so the priorities are about capacity and capability in the community.

As Lucy mentioned, there are a number of approaches, and we are at the front edge of making sure the utility of research funded in this space and that comes to us is methodologically robust in being representative of both genders in terms of design and sex, and that the utility of the outcomes is for the wider community. The basic tenets of what we do in response



mode—we do not ringfence and we do not target in certain areas—mean this community can come to us and feel they will get a fair hearing for their research proposals. We need to stimulate that community.

Q128 Kirsten Oswald: I wonder if I can go to Lucy with the same question. How is research commissioned, particularly in relation to women's reproductive health, and does that allow for women and their health conditions to be properly represented?

Professor Chappell: The National Institute for Health and Care Research commissions on a different basis to the MRC; we have a very explicit commissioning stream across all our programmes. We take the drive from a whole number of places, for example policy needs. We take the NICE recommendations directly from NICE where they identify the evidence, and we commission against that evidence so that we iteratively improve the guidance. I mentioned the James Lind Alliance, which is driven by patient need, and we also take direct patient suggestions.

In a parallel way, we also look at our clinical research network and how we enable supporting women's research from the delivery point of view. Within the CRN, our Reproductive Health and Childbirth specialty is usually one of the top three recruiting specialties. Around 95,000 participants a year take part, directly supported by the NIHR Clinical Research Delivery Network. For example, we commissioned an evaluation of the women's health hubs, which you have heard about from the Women's Health Strategy. We knew that was a policy need if we wanted to help commissioners have the evidence so they could continue and grow the scheme.

As an example of capacity building, we have just put out a highlight notice for under-represented disciplines and specialisms targeting nurses and midwives, again to pull that community in. We may also include other areas we have heard are important, for example prevention of male violence against women and girls, domestic abuse prevention, and testosterone for menopause. We will take all these ideas—including those that Hilary has mentioned—and issue a commissioned call, and we expect to fund.

Typically, when it goes out to the community, we encourage our researchers to work together. Rather than not just being directly competitive, we often try to say, "Take the best from this centre and that centre, bring on new centres where you might want to be growing so there is a stronger pipeline, and try to work in a collaborative way for our commissioned calls." We find that works.

We are currently commissioning against the Core20PLUS5, which issued care for women from black and Asian ethnicity groups as its number one inequality. That is another example of where we are responding to NHS England as to how we can improve the evidence which feeds into NICE and onwards into provision of care.

Q129 Kirsten Oswald: Hilary, the same question to you.



Professor Critchley: This clinical academic pipeline has been raised a number of times. They are going to be critical because they are our future generation. We are having a discussion now, but it is really important that what we talk about now impacts in the years ahead.

From the academy's point of view, it has been able to support the clinical academic pipeline. I would like to use the example of the academy's starter grant. These are very small pots of money that young researchers can achieve success with, which can give a step up, because they then have the data to go to other funders—such as NIHR and MRC—to get other career support opportunities. Here I talk about the fellowships.

Wellbeing of Women is another funder that also provides small pots of money to help career academics in the pipeline, with those small awards that are then leverage for the bigger awards: either going to the MRC or another funder with a highly competitive project grant, or going to one of the funders for the fellowships that is going to support them through their careers.

There are opportunities, but those opportunities need to have the applications coming from the pipeline who are interested in women's reproductive health. We have to separate those who are doing the research and those for whom the research benefits; we need both to have the impacts we want.

Q130 Kirsten Oswald: Judith, I want to put a different question to you about how NICE decides which guidelines to commission. I wonder if that allows for women's reproductive health conditions to be considered in an equitable way. You mentioned earlier that you knew PCOS was a gap; I am particularly interested in that. We heard NICE had decided there was no need for PCOS guidance because there is international guidance, so it would be good to know if that is right. If that is the case, how can you be confident that is the right guidance, and that it is even being followed?

Dr Richardson: I will start with how we prioritise our guidance. We work with a whole range of stakeholders across the health and care system to understand from them what would best support delivery of care in the areas that matters most, and where not only NICE can do the work to develop guidance; there are lots of other guidance producers out there.

At the moment, we are trying to ensure we work in a more collaborative way. There is only one pot of money, and we must use that as wisely as we can, both nationally and internationally, and not duplicate effort. It is really important that we hear women's voices, or the voices of patients and the public, and that all comes into play as we prioritise.

We also need to make sure we are addressing the conditions that have the greatest impact in terms of health in society, and where people have the greatest ability to benefit, but also where there is the biggest variation in care. Lucy has talked about how important Core20PLUS5 and health



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inequalities are; health inequalities is another area that influences our decision to prioritise guidance.

Specifically looking at PCOS, there is a very good international guideline developed by Monash University in Australia. We have looked at the quality of that guideline; by accepted standards of guideline development, it is excellent. There are differences in some recommendations in that guideline between Australia and what we might say in this country.

Rather than starting de novo with a guideline on PCOS, we are looking at what we can take from the Monash guideline that we could use in this country, which aspects we might need to develop ourselves, whether there are other ways of doing that, and whether we should be collaborating with the Royal College of Obstetrics and Gynaecology, who have also produced guidelines on PCOS.

We are having a look in the round to ensure we make the best use of resources but also support those making decisions about PCOS, and, fundamentally, GPs and others working in primary care to be able to do their jobs to the best of their ability.

It will take us a little time, but probably not as much time as if we had started afresh developing a guideline on PCOS. We hope to be able to signpost people to other guidance if we decide that is good enough and if we can make the right arrangements with other guideline producers. If we cannot do that or if there are elements of that guidance that would not be fit for purpose in this country, we will look at how we fill those gaps.

Q131 Kirsten Oswald: Does it surprise you that we are at this point in terms of guidance for a condition that affects so many women and has such a profound effect on so many women's lives?

Dr Richardson: It is surprising that no guidance has been developed to date by NICE. We are reliant on hearing from the system what they wish us to prioritise, and we have heard today how certain aspects of women's health are not prioritised as they should be.

Q132 Dr Cameron: My first question is briefly to Lucy and then Judith. Are you confident that the research or NICE guidance sufficiently considers different groups of women to ensure all women's needs and experiences are taken into account, for example from different ethnic minority groups, teenagers across the lifespan, and perhaps women with disabilities, as well?

Professor Chappell: What you are naming is absolutely crucially important, and we are seeing steps on that pathway, but, at NIHR we are committed to going further.

We have a number of different pillars of our research inclusion strategy that looks at all the various ways, but we need to make sure we move from strategy to delivery and to actions. This is about scientific excellence for impact for real people. If you take that approach, it is of benefit to all, whether you are a researcher, a participant, or an end-user. That gets



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away from the view that it is difficult. It is not; you just need to think about a much wider group of strategies. We have talked about the need to tackle this from ways of working in research.

I was in Bradford a few months ago, and was really struck by the steps they are taking in one of their institutes to have researchers from the community and to look at how they supported them. You suddenly open doors to making that inclusion happen, rather than it being done from the centre to people. Its research is done with colleagues across the community, and that needs to go back a step to the prioritisation and design stage.

We need to look at it through a number of approaches, even things such as how we pay those who help us design; we have patient participant and involvement in many aspects of our research, and look at how to approach them or pay them, right through to the strategies we use.

From covid, we saw a move away from a secondary care-centric model of research delivery into a much more decentralised, primary care-based, community-based model, where we were looking at research working within clinical pathways, but actually going beyond that and saying, "What if those clinical pathways in themselves can still exclude some people?" So really asking how you weave in ways that tackle the inequalities from the start, for example using much more remote monitoring, but again thinking about digital inclusion.

It is a very multifaceted approach. As a funder, we need to keep evaluating what works and show our enduring commitment. One of the messages I have been absolutely clear about is this is not a flash in the pan; I am completely committed. Every talk I give has a slide or six that says we are doing this because it matters, and because you should want it too; because it is the way to have impact.

Dr Richardson: Lucy has talked about the research and the need to strengthen the research base. As an organisation, we are very reliant on that research making its way through to us, for us to be able to synthesise that and turn it into recommendations for how services should be delivered. We are a little behind the research community in terms of what we are able to say, but we are very well aware of the need for us to be making recommendations wherever possible to address equality and health inequalities.

Particularly since covid, we have been looking very critically at how we approach health inequalities and equalities within our guidance development processes. We have also looked at the extent to which our committees were equipped to address some questions. We have been doing a lot to strengthen our methodology, but we also need to work with the system to understand the impact of our guidance, and whether that has a differential impact on different groups of people in communities, for example on different ethnic groups. We need to be able to feed that back in so we are part of a learning system, develop better research in time,



and turn that into better guidance that addresses all people's needs on a more inclusive base.

- Q133 **Dr Cameron:** Hilary, I was interested in what you said about the taboos and stigma; how far we have come, but how far we still have to go. How should the research landscape for women's reproductive health be improved, and do you also think it is holistic enough in terms of mental health, as well as taking account of physical health aspects?

Professor Critchley: We all acknowledge the importance of women's reproductive health, and we need to understand, if you have a menstrual health problem, how does that then impact on your later health outcomes? Is it a signal that could identify a later cardiovascular health problem? How do those menstrual health issues impact your mental health? These are areas that are crucially important when we are talking about what needs to be on our research agendas.

Can you go back to the first question? I jumped to the second one because it is an important issue to raise when we are thinking about the bigger picture of our topic.

- Q134 **Dr Cameron:** The first question was about improving inclusion for women from ethnic minority backgrounds and disabled women.

Professor Critchley: It will depend on the type of research you are doing. There is fundamental discovery science at the bench. If we are doing that sort of research, recruiting patients is very important, and a huge thank you again to the altruism of the patients who help us with our research; they are amazing. We need to be sure, when we are looking for participants, they know about the research and they can be involved in it. There are opportunities when they are approaching healthcare and they come for their appointments, whether in primary or secondary care, because everybody comes to that. If everybody knows about the research, they can be potential participants in it.

It is about having advocacy for those projects and really being proactive about reaching all communities; that might include teenagers—if there is a study that involves that end of the reproductive age—right through to the perimenopause and menopause, which is again another point where these problems become so much more evident. It is about education and making clear the research is for all, not just selected groups.

- Q135 **Dr Cameron:** Robin, how do we improve the research landscape for women's reproductive health, overcoming the stigma that we have spoken of? I am also quite interested in the mental health aspect alongside the physical health aspect.

Dr Buckle: There is a growing understanding of what we would term the multi-morbidity of a number of conditions. Mental health is a priority for us and NIHR because of its breadth of impact, and it is one area where there is active research in both the UK and Africa, where we have a research unit



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that is explicitly looking at this in African populations in terms of applying for local health.

On the issue of improving the research base, I have already touched on the issue of capacity, which we need to address holistically. There are also opportunities to join up the various investments, and I have mentioned some population research efforts. We are creating a new adolescent health study that will involve 100,000 children and teenagers recruited across the ages of eight to 18. It will be explicitly looking at the issues around puberty and the health impacts, which will then be followed for decades. That will be a different type of study to UK Biobank but of similar impact.

Having those capabilities advertised to the community will encourage other applicants to come in, because they will see the possibility. We need some case studies showing where we have been successful, as well, to stimulate the community.

The other aspect—which has not been mentioned directly, apart from the comment on erectile dysfunction—is to engage industry more to address the research opportunities in this space. That will come from insight into the mechanisms underlying the various disorders we are discussing, which needs to come from the research that MRC funds. It needs to be advertised and discussed with industry partners so they can see routes to therapeutic development in this space, which are probably under-represented in their own portfolios at the moment.

Q136 **Dr Cameron:** Lucy and Judith, what improvements would you like to see?

Professor Chappell: To the taboo and stigma, it is our job to commission into those areas and to not accept any areas are off-limits. For example, we have commissioned for interventions to support women in prison, to support the mental health of birth mothers at risk of recurrent care proceedings, and mental health outcomes for women and partners who have experienced a stillbirth. Those are areas that would typically not get so much spotlight; we have heard how research into stillbirths has had less attention. If we can do a poll, it is quite powerful to highlight that we think these are important areas.

On the mental health area, it is crucial that we constantly ask about the integration of physical and mental health. As Rob mentioned, that is highlighted by our work on multiple long-term conditions and really recognising what Hilary said about the impact of one on the other in a bidirectional way.

We funded an extensive portfolio on multiple long-term conditions looking at clustering because they do not happen by chance. We are using artificial intelligence as an approach to look at clustering, and then to say what interventions would be effective. It should not be automatic that you progress from one physical to one mental health condition, or, if you have a mental health condition, that that negatively impacts your physical health



condition. It is about recognising them as important in their own right, but crucially looking at the interaction between them.

Dr Richardson: As I have said before, we are reliant on the research evidence coming through. But we do recognise, as an organisation, that interplay of physical and mental health is incredibly important and that people need help in determining the best strategies for supporting women to not only deal with their physical health, but also with any associated mental health problems, and sometimes vice versa, as well. We look forward to hearing more from the research communities and being able to use that evidence base to develop recommendations.

Chair: Thank you very much for your evidence this morning. If you wish to add something in writing, please do not hesitate to do so. Apologies for the fairly abrupt end, but we wish to get the minister, the women's health ambassador and, indeed, the deputy chief nursing officer in.

Examination of witnesses

Witnesses: Maria Caulfield, Charlotte McArdle and Professor Dame Lesley Regan.

Q137 **Chair:** Good morning. Can I welcome Dame Lesley Regan, Women's Health Ambassador; Maria Caulfield, Parliamentary Under-Secretary of State for Women, and Parliamentary Under-Secretary of State for Mental Health and Women's Health Strategy; and Charlotte McArdle, deputy chief nursing officer for NHS England?

Thank you very much for coming this morning. Maria, can I start with you, please? We heard from Naga Munchetty and Vicky Pattison about their feeling there is a lack of education about what young women should expect when it comes to periods. We heard from the previous panel that menstrual health remains a bit of a taboo. Can you tell us what more is being done across both Government and the NHS to make sure that women's life course is better understood and better taught both to young women and medical professionals?

Maria Caulfield: You are absolutely right. In our call for evidence for the Women's Health Strategy we picked up that, very often, women struggle to find information, and were sometimes unaware of—the menopause is a classic example—many of the varied symptoms. This is why we sometimes find it takes a long time and multiple visits, for young women in particular, to be diagnosed with endometriosis or other menstrual conditions.

We have done a couple of things in the first year of the strategy: first, we have added a dedicated portal on women's health to the NHS website because, very often, when we have done roundtables with women from across the country facing different problems, they find it very difficult to get reliable information. They would often go to Google or read magazines, and they were not sure how accurate that information was.

The women's health area is now live on the NHS website: it covers over 100 different conditions in terms of women's health—things like the



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menopause, menstrual health, and endometriosis—and it gives signs and symptoms and what to expect in terms of assessment, treatment and management. That is helpful, and long term we would like to get that on the app, but it is only on the website for the moment.

Lesley has been doing a huge amount of work with DfE because, you are right, young women in particular often learn in school how not to get pregnant, but very little else about menstrual health. It is not just about ensuring young women get that information, but young boys and men too because we have also had feedback, particularly around the menopause, that men would find that information equally helpful. If you are going to be supporting a partner, sister, mother, or anyone that you know, it is important that young men are aware of the signs and symptoms too.

We are doing a lot of work with DfE in terms of the curriculum and how that will look, but also about education for healthcare professionals because one of the big pieces of feedback we had from women is that, when they have maybe gone to the website because they are concerned about some signs and symptoms they are having, when they ask for help, they are very often not listened to or have a negative experience. The GMC, for example, is making sure that in doctors' training there are now assessments on women's health that trainees need to pass. The Royal College of GPs has a women's health module as well. So, in all, it is about raising the profile and ensuring that everyone is as up to speed as they can be on some signs and symptoms.

Q138 **Chair:** I am really pleased to hear about the engagement with the DfE. Can I ask if you have had any formal role in feeding into the RSHE review?

Maria Caulfield: I have not, but Lesley has, and—because of Lesley's clinical experience as the Women's Health Ambassador—she is taking an active part in that.

Q139 **Chair:** Thank you, and I am going to turn to you straightaway then, Lesley. We heard from previous witnesses that it had been difficult to get their concerns taken seriously. They felt that they were effectively being told to suck it up. Why is that? Why is that still happening, and what are you doing as the Women's Health Ambassador, as our champion, to change it?

Dame Lesley Regan: We are doing quite a lot of things. I have been very busy for the last 18 months. I have been very committed to looking at women's health across the life course, as opposed to picking up a disorder or a problem and just focusing on that. That includes the importance of teaching young people—girls and boys—about menstrual health, sex, reproduction, contraception, and fertility. Then, in younger women, ensuring that they understand what is a normal period and what is not a normal period, and that is the bit that has been missing.

As women move into their reproductive years, they need to know much more about what they can do to ensure their pregnancy is as problem free as possible, and what they can do to ensure the baby they are carrying has



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the best chances of a good start in life because disadvantage starts before birth and accumulates through life.

I feel very passionate about the women in their latter years, in the post-reproductive group, because, I suppose, I am in that group. I am also very conscious of the fact that my mum and my grandma did not spend much time in their post-reproductive years. When I came out of medical school 40-plus years ago—I am exactly the same vintage as Hilary Critchley, by the way—women just disappeared from view when they became menopausal because they were no longer reproductive vessels. I do not say that as a challenging or antagonistic thing, but what has happened in the past is that women have been viewed as pregnancies. The Women's Health Strategy and Better for Women—the previous report that I authored when I was President at the RCOG—have really drawn a focus on the fact that women have an awful lot more to their lives than being pregnant.

The vast majority of the women in this room, if they have chosen to become pregnant, will be pregnant for two or three years of their life. Yet, the life expectancy in this room is now 85, so there are an awful lot more years we have to be looking for. That is why I am particularly pleased that this is not a one-year or a two-year strategy: this is something that is going to go on for 10 years, so it is really going to be embedded. I hope in that way, people like Hilary Critchley and I will be able to ensure that the people following after us will always prioritise these things, but particularly menstrual health.

Q140 **Chair:** What do you want to see out of the Government's RSHE review?

Dame Lesley Regan: I chaired the review panel because I was a clinician, and I should say it is a review: it is not changing the statutory guidelines. It was greatly welcomed that this became a compulsory topic but, if you like, it is an amendment or an addendum which has looked specifically at the age appropriateness of sex and relationship education in schools.

What I am hoping is going to come out of the review is that we teach children from a very young age the things they need to understand so that they do not find they are exposed to things that frighten them or are dangerous because ignorance makes you very vulnerable.

Q141 **Chair:** Conversations with the Children's Commissioner revealed that we have seen an escalation in sexually-transmitted infections in children—specifically gonorrhoea and syphilis—in some cases recorded in 13-year-olds. Should the RSHE curriculum include information for those children who are at risk?

Dame Lesley Regan: It needs to include information about how, if you are going to have a sexual relationship, you can do so safely.

Q142 **Chair:** Should we expect that to be age appropriate for teenagers as young as 13?



Dame Lesley Regan: If those are the statistics then, yes, there needs to be an ability to ensure that children have the right information to make decisions and that they are not, as I say, ignorant because then they become very vulnerable.

Q143 **Kirsten Oswald:** Maria, what do you think is being done to make it easier for women to have quicker and less invasive testing?

Maria Caulfield: There are a few things, actually. First, about raising awareness—as Lesley is doing around the school curriculum—so that women are more aware of the signs and symptoms of potential conditions they may be experiencing, so they come forward and get help quicker. Then, the work we are doing in terms of improving education for medical teams, so they recognise those symptoms and take women seriously when they come forward.

In terms of getting things done more easily, the Women's Health Hubs is one of those areas where we are going to be transforming women's healthcare. Every ICB is now in the process of receiving funding, on average about £600,000 per ICB, so that there will be access in every part of England. For Women's Health Hubs, we have set out our expectations of some core services, so it will be around cervical screening, contraception, preconception advice, and advice on the menopause. Local areas are either setting up new Women's Health Hubs or they are already in place and they are expanding them and, depending on their local population, will provide additional services to those.

For example, I have been to one in Hackney where they have secondary care consultants working with local GPs—Lesley has been a big advocate for these—and they are a kind of one-stop shop. Instead of having to go and see your GP, who may have to refer you to a consultant, who may then send you on for tests, the Women's Health Hubs have those experts in women's health there in one place, usually in the local area to the women.

When you build that on top of the 100 rapid diagnostic centres across England, then the new surgical hubs, where gynae is one of the six priority areas for tests and investigations, not only are we opening up access points to make it easier for women to try to get healthcare, particularly when they are busy juggling multiple roles, from work to childcare, to maybe looking after elderly parents, we are then focusing on, okay, if there is a problem, how can we more quickly get access to tests, treatments, investigations, and management of any conditions they may have.

Q144 **Kirsten Oswald:** We have heard that there is a new diagnostic blood test for PCOS, but there are concerns that it will not be used by the NHS. What are the Government and the NHS doing to make sure that that test does become available?

Maria Caulfield: Obviously, we will look at the evidence for that, and that will be something that NHSE necessarily decides on in terms of how that is



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rolled out, but they are the sorts of things that we can be doing at Women's Health Hubs and making that as accessible as possible. Once that decision is made, and the decision around funding for that, then we have the infrastructure to make that as accessible as possible for women.

Q145 Kirsten Oswald: Charlotte, can I put the same couple of points to you about the ease of access to quicker and less invasive testing, and that point about testing for PCOS and whether that will actually be made available?

Charlotte McArdle: As the Minister said, the key to this is the roll out of the Women's Health Hubs because they will have almost a co-ordinating function for women so that they can get treatment for many parts of their reproductive health and wider women's health issues in a one-stop shop. Obviously, treatment has changed over time in terms of availability of new, easily accessible, and less invasive treatments, which can now be carried out outside of a hospital environment in primary and community care.

Many of the health hubs have an integrated function so, as the Minister said, we have one in each ICB working towards full establishment of an ICB health hub as a proof of concept. They have taken on, if you like, many different formulae, so many of them have virtual and digital, which makes it easier for women to access the service they need, and they can get better information in a more timely fashion.

They have both primary care GPs, secondary care physicians, and the whole multidisciplinary team available to them regardless of their location. If they are in primary and community care, they are supported by secondary care. For example, I have been to Liverpool secondary care, but was very much involved in primary care in all the sessions there, so they have access to all the necessary tests, investigation and staff they need to make that journey simpler and more straightforward for them.

Q146 Kirsten Oswald: Can I just press you on the new diagnostic blood test that we have heard about for PCOS? Is this something you think is likely to be used by the NHS? That is not clear to us.

Charlotte McArdle: We have to review the evidence. We would have to look at that very closely, and we would have to consider what roll out of that would mean. It would have to be financially viable and costed, and the money available to the NHS to do so. All those things need to be in place but, certainly, if it is a better service, provides good access, is a quality tool, and improves the health and wellbeing of women, that is something that the NHS would want to support.

Q147 Lia Nici: Lesley, do you think that women and healthcare professionals understand what treatment options exist, and do you think women have equal access to them? Whose responsibility is it to ensure that it does not become a postcode lottery?

Dame Lesley Regan: There are several questions there. Do I think that women and girls know what is available? The answer is no. One of the factors that we are putting into the strategy and that I particularly hope



will come to fruition with the health hubs is that we get girls and women to understand a lot more about what is normal and abnormal, and then prompt them with the information so they can then seek access.

Most women of reproductive age will have 12 periods a year for 40 years of their life. My ideal would be that every time you or I as females see any form of healthcare professional, whatever the topic, it should be part of the routine questions. If you go and see a doctor, even if it is a foot doctor or a liver doctor, they will ask you, "Have you had any surgery in the past? Have you had any operations?" I would like them to say, "Well, how are your periods?" They do not have to be an expert, but if they were to say that and the woman said, "Well, I think they're okay." "Well, did they ever stop you going to school or going to work because they were too heavy or they were too painful?" That is such a step forward because many girls and women do not realise that being incapacitated by their periods is not normal and that they can come and see someone like myself or Hilary Critchley and within half an hour we can sort solutions for them.

Q148 Lia Nici: You are talking about the healthcare professionals there; do you think the healthcare professionals are fully equipped to be able to offer that as well?

Dame Lesley Regan: No, and that is why, looking at this, with curricula, training and the websites and, as Maria was saying, the GP women's health module, which is obviously my particular specialty because I am an obstetrician and gynaecologist, it is all focused on that. You would be surprised at how many very senior and highly specialist gynaecologists in a particular surgical field will not know an awful lot about how you can prevent women having painful, heavy periods. We can never be complacent that we have it right, and we have to keep pushing it. By making period problems or menstrual problems something that everybody talks about, and every clinician or healthcare professional, not just doctors, asks women about, that would be an enormous step forward.

Q149 Lia Nici: What you talk about is huge. How long do you think it will take us to get to that point?

Dame Lesley Regan: It does not need to take very long at all; we just need to get people to understand two things. If it is a woman, it is likely that she is having periods up to the age of 50 or so, and all they have to ask is, "Do your periods ever prevent you going about your job or going to school?" Then, you forward them on.

In response to the comment about polycystic ovaries, people do not go to a doctor or a nurse and say, "I've got polycystic ovaries." They say, "I've got irregular periods," or "I can't get pregnant," or "I've got hair growth on my chin." It would be so much better if we were to focus on menstrual irregularities and problems, and then we would get to those diagnoses so much more quickly.

Q150 Lia Nici: Whose responsibility do you think it is to make sure that this does



not become a postcode lottery?

Dame Lesley Regan: It is everybody's responsibility. I have visited all 42 ICBs in the last 18 months. I am very conscious of the fact that many of the leaders in the ICBs are very worried about disadvantaged groups and many of them are focusing their hub, or their pilot hubs, on disadvantaged groups which I, obviously, want to encourage.

Q151 **Lia Nici:** Charlotte, women are reporting that pain is not being taken seriously. Can you set out how women's pain is actually going to be taken seriously as far as it is a symptom, but also as part of a diagnosis or treatment? How do we make sure women get the effective and appropriate pain relief they are asking for?

Charlotte McArdle: It is true to say that in the 100,000 women's voices that influenced the development of the strategy, those issues were very much to the fore and that conversation has continued. It is really important that this strategy begins to raise awareness of those issues and that it highlights the need for us to be constantly listening to and working in partnership with women and local communities around these issues about pain thresholds.

Different ethnic groups and different cultural beliefs affect how we think about pain and how we manage pain. There is a huge awareness issue here, and it is really good that the strategy is focusing on that now. As a nurse and as a clinical healthcare professional in the NHS, we are taught from the beginning of our training about talking to the person in front of us about what is important to them, about understanding holistic care, and how we work with that individual to develop a care plan that takes into account what is really core for them. If pain is at the centre of that, then my expectation is that any healthcare professional will be talking about that and the management of that pain will be central to the treatment plan and the woman's experience.

In NHS England, we have done quite a bit of work around surveys, and we have a very engaged patient experience and engagement team that is picking up these issues. We have put a lot of advice on the women's section of our website that the Minister has already spoken about. For example, just a couple of weeks ago, we produced what I think is very good, detailed information around heavy periods and, of course, pain usually comes with that. There is a lot of good advice there for women and girls about how to manage that, when to seek professional help, what they can do in the meantime, and what procedures might be necessary to carry out.

So, that comes to the point around the management of pain for certain procedures and, again, there are more opportunities now to do less invasive procedures for women. The guidance from the royal colleges around this is important and that has just been issued about how to manage those conversations, engaging the woman in the conversation, giving her choice, making sure she understands what the issues are, how the pain can be managed, and then offering, for those who maybe have a



perception that this will be more painful for them or want to have more opportunity for pain relief, that that is provided in an appropriate setting. For example, local anaesthetic is provided in some healthcare facilities, but it is not appropriate for all. Raising awareness, having the conversation, and then a detailed plan for that woman to get her to the right place is core to what we are doing in the Women's Health Strategy.

Q152 Lia Nici: This is a question to both Maria and Lesley: the Department for Health is putting a lot of faith in the Women's Health Hubs. How can we ensure they are going to work effectively for women? Maria, earlier, you suggested that women could go there and services are there, but will women have to be referred by their GP? Can they just go? Is that for new symptoms, or is that for ongoing conditions? How can we make sure those health hubs are going to be in the right place, and that it is not going to make it more complicated for women to actually travel to those hubs?

Maria Caulfield: For the Women's Health Hubs there are a variety of models, and there will be the core services that we have suggested that should run in every one of them. However, there will be additional services or different services depending on the local population. Some services they can drop in for, perhaps for something like contraception; others they will need to book appointments. GPs will be based in some, so it is an easy way to see your GP. Others will be based in hospitals, and it is a different route.

There is no fixed model: it depends what works for the local area but, also, for the local population as well. Lesley has done some work on this already. I think for every £1 you invest, you get £5 worth out of it. In the previous session, Lucy Chappell identified that we are evaluating these. We are providing a significant amount of funding, but it is only £600 000 per ICB. What we want to show is proof of concept, that by having a Women's Health Hub you get to women who sometimes struggle to access healthcare because you are just making it more accessible for them, and you become a trusted source. If you had a good experience accessing contraception, you may well go back there for your smear test. You may well go back there if you were thinking of getting pregnant and want some preconception advice.

So, they become a trusted source in the local area and then you save on appointments for people either holding back and needing secondary care or more assessments. That is why we are evaluating them so that if they show they are value for money and improve outcomes for women that they then become a more sustainable part of healthcare going forward.

Q153 Lia Nici: Is it too early to say whether there is enough funding to ensure there is a proper, effective roll-out?

Maria Caulfield: Certainly, we have been clear that the funding we have made available, while it is a significant sum, is only enough as proof of concept and to start the ball rolling. We are not suggesting it will enable as many Women's Health Hubs as we would ideally like but, because we are evaluating it, we will be able to make the case. I am confident of why we



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need to roll these out more widely across the board and support the NHS in terms of enabling that to happen. So, this is really a proof of concept, the pump-priming funding, that we would see it as, rather than we are funding the model as a whole.

Dame Lesley Regan: I would like to emphasise that it is not one size fits all, and that it does not have to be a place-based hub: it can be a virtual hub. They will probably be the cornerstone to signposting girls and women to where they need to go. I am sure you have been to umpteen different appointments and halfway through the consultation, usually about an intimate topic, someone says, "Well, I'm sorry, I can't do that. You can't have that here."

I would like you to be able to come and see me or one of my colleagues, virtually, on a platform, and then, for example, if you need a prescription for something, then I could send an email prescription to your pharmacy, if that was what you wanted. If you needed to be examined because we were concerned about something, then I would need to make you an appointment to come and see somebody in a simple place that had examination facilities. If we worked out in this conversation, this triage, if you like, that you needed to have a certain blood test or some imaging or, possibly, you needed a procedure done, then we would direct you straight to it.

The virtual triage is going to be crucial for actually rolling this out and scaling it up because it is going to quickly become very evident to the ICB leads that this saves an enormous number of wasted appointments.

Q154 **Lia Nici:** Is it the ICB's responsibility to ensure that the roll-out of health hubs is effective or, if not, whose responsibility is it, and what should the timetable for roll-out be?

Dame Lesley Regan: I think all the 42 ICBs have put forward or submitted an overview of what they are planning to do, and they are very varied, which is exactly what we wanted because the different populations will need different things. The responsibility will have to be with the ICBs, and we asked each ICB to nominate a women's health champion with whom I meet every month.

I am really encouraged by that because, usually, 90 or more turn up on this platform, so that means there are at least two per ICB. There has been a lot of enthusiasm, and I hope that with the pump priming that Maria Caulfield was just mentioning, that that will give them all an opportunity to have proof of concept. It will then be very evident that, first, the women think it is a much better deal because they are getting sorted out swiftly.

In visiting many of the successful hubs around the country—because there are some models that were going before the Women's Health Strategy started—what is very evident to me is that this is also a very important tool in workforce retention. For example, there is a hub in Manchester run by a really inspirational woman and, every time I go there, it is quite



evident that everybody is really proud to be part of this service because they can see that they are doing a really good job.

- Q155 **Chair:** Lesley, can I just take you back to the question of virtual hubs? You will probably be aware that there is a report out from the University of Oxford today talking about the number of people who have died or suffered serious harm because of the switch away from face-to-face appointments including, I think, one woman who died of a blood clot at home six weeks after giving birth. Is there a danger that virtual hubs make women's health a second class service?

Dame Lesley Regan: I have not seen the report, Caroline, but I heard Radio 4's take on it this morning on the "Today" programme. If they are not used judiciously, of course there is a risk. For those of us who have been doing virtual consultations since lockdown in March 2020, we have developed a sense of when you need to bring people in to talk to them.

Obviously, I am not omnipotent: I am not always going to get it right, and I probably would not be the best person to be giving advice about cardiovascular problems, for example. I mention that because women do very badly with cardiovascular disease for all sorts of complicated but gendered reasons. Yesterday, I did a clinic at St Mary's: I saw seven women on a video platform, and I saw two women in person because I had already identified that I thought that they needed something.

One of them did not have a physical problem, but I picked up that there was something else going on, and I think she thought it was worthwhile coming in to talk about it because we were able to point her to some services that she did not know about.

- Q156 **Chair:** You spoke of the ICBs deciding how they would target their services and where they might focus. Is there a danger that we are going to see that the new disadvantaged group will be women living in rural areas who, almost inevitably, unless it is virtual, will find it harder to access hubs?

Dame Lesley Regan: I suppose it is a possibility, but my conversations with the ICB leaders and the Women's Health Champions have reassured me that they are very conscious of what they need to do to try to reach their populations. Catering for a rural community is very different from an urban one, and it is very different from the seaside deprived.

- Q157 **Kate Osborne:** Good morning, everybody. My first question is for the Minister. Minister, you will remember that we had a Westminster Hall debate on equal access to IVF ahead of National Fertility Awareness Week last month and that debate touched upon a postcode lottery for treatment—which we have also touched on today—unnecessary delays, bias in diagnosis, women not knowing their options, discrimination, and unnecessary testing. A lot of these issues, as I say, have been highlighted again today.

In that debate, you gave a commitment to continue the discussions and urgently publish guidance to ICBs to remove all financial barriers that



same-sex couples face. Following that debate, I wrote to you on 2 November but I am yet to receive a response from you. Can I ask you to briefly tell me where you are in terms of publishing that guidance, and when I might get a response from you?

Maria Caulfield: I will certainly look at that when I get back. Access to IVF was one of the first priorities in the first year of the Women's Health Strategy, so we take this really seriously, and there has been some work that is making a difference. First, on the GOV.UK website we now have a list of every single ICB and the number of cycles they fund, the criteria for being able to access those cycles, and their criteria for same-sex couples. One of the big problems we had before the ICBs were created was that there were so many CCGs, it was almost impossible to identify on a national map what was being offered where.

What we have seen with the creation of the ICBs that had multiple CCGs within them, is that they tended to have levelled up the service provision. If, on average, most CCGs in an ICB area were offering three cycles, but a few were offering one or two, the ICB has tended to go for the three. That is not 100%, but that tends to be the direction of travel. So, we have seen a small increase in the number of cycles offered, and we can now see—and it is regularly updated—which ICB is offering what so we can have discussions with those that are maybe offering fewer than others.

Our next challenge is to try to level that up, and that is a discussion we are having with NHS England. That does require funding, and that is something we will be having active discussions about. That surrounds the guidance as well because we want to make sure that if we are asking ICBs to reach a certain level, they actually have the funding to be able to do that. We are also doing work on add-ons. For those couples having IVF treatment and paying for it, we know—and this has been raised in the Chamber as well—that the information about how much each add-on treatment impacts on the chances of becoming pregnant is very hit-and-miss. We are providing information so that couples can make those decisions and they can pay extra if they want to, but they are aware of the chances of success for each of those.

Our final piece is around same-sex couples who have had a significant disadvantage in terms of being able to access IVF and you will know that we announced in the Westminster Hall debate that we would be passing two SIs, one around the additional testing that same-sex women have to go through to be able to access IVF, and one to those who are HIV around the use of gametes in particular, and removing that obstacle. We expect those two SIs to be coming forward probably end of January, beginning of February, and we are absolutely committed to passing those statutory instruments to even that out.

It was a priority in the first year and it will continue to be a priority going into our second year because we are not quite where we want to be. It is about having discussions with NHS England and ICBs about the infrastructure and the funding to be able to level up that access and have



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a consistent offer across England. So, it is a work in progress. We have good progress, but there is still a lot to do.

Q158 **Kate Osborne:** Thanks very much for that. Yes, it was obviously very welcome when you announced the two SIs in the debate, but you are absolutely right, it is great to have the information that people can access in terms of who is offering what, but the levelling up is the key part.

Maria Caulfield: No, and I absolutely accept that.

Q159 **Kate Osborne:** Maria, in every area of reproductive health women have told us of the bias and discrimination that they experience in their diagnosis and treatment. Can you tell me whose responsibility it is to ensure that healthcare professionals and policymakers are not discriminating against women or different groups of women?

Maria Caulfield: You are right, and this is why we have the Women's Health Strategy because the Government take responsibility for making sure that there is equity of access to services. Whether it is maternity, or any other services that women are trying to access, we know there are certain groups that do not feel able to access services or have a poor experience when they do access them.

This is a wider piece of work. For example, in our maternity work with the Maternity Disparities Taskforce, we find that those disparities happen long before a woman actually gets pregnant, and it is almost too late to try to mitigate some during pregnancy and birth. That is why we are looking at preconception advice. This is a big area for the Women's Health Hubs, but also for post-natal care in terms of subsequent births and making sure that women have that preconception advice up front. We take this very seriously, and we fully recognise that there are groups of women who have struggled to access help and support and who maybe have had a bad experience that prevents them or deters them from coming forward the next time.

But, as Lesley said, it is also everyone's responsibility and the Women's Health Strategy is a cross-government piece of work so that, yes, from a clinical point of view, health and social care can have an input in that. It is also about how employers support their workers. Do they give them time off to go for appointments? Do they take these issues seriously? That is why we have things like the Menopause Workplace Champions, with Mims Davies as the responsible DWP Minister, who is really working hard with employers so that they recognise how important health is to their employees.

The DfE is raising awareness about what good health at a young age looks like and when to seek help. We know there is a group of women in the criminal justice system who struggle to access healthcare and support. So, it is everyone's responsibility but, in terms of practical healthcare, the Government are taking responsibility, rolling out the strategy, and



providing funding and policy guidance in terms of how we address those issues.

Q160 **Kate Osborne:** You say the Government take responsibility. If I can ask you and Charlotte: are the NHS and the Government doing enough? I will ask you, Charlotte, first, please.

Charlotte McArdle: I think it is fair to say we can never do enough on these issues, but there is plenty of work being done. It is at the forefront of my mind and other healthcare professionals and, indeed, the NHS system at a national level to ensure that women are not discriminated against. The workforce in my own profession is 89% female. We are a diverse population; we have many healthcare professionals in the NHS from black, Asian, and ethnic minorities. We are using things like the WRES data, which has been in place since 2015, to ensure that discrimination is not happening. We are monitoring progress with that which, thankfully, has improved, but there is still much more to do in that space.

We have worked with the NMC and NHS employers around new guidelines for dealing with and tackling racism in the NHS. We have the Core20PLUS5, which, obviously, is looking directly at health inequalities, but we know that many of those health inequalities affect women, and they affect women from different backgrounds. I would want to reassure you that we are doing quite a lot to ensure that women are not disadvantaged in any way and, again, I go back to the strategy: the voices of over 100,000 women have been heard, and we need to continue that conversation. We need to work in partnership and provide opportunities for shared decision making with women and their care.

Q161 **Kate Osborne:** Minister, did you want to say anything else?

Maria Caulfield: Just to touch on Lesley's earlier point that for too long women's health issues have just been seen as something that naturally happened to women and that there is no help or intervention needed: women naturally start their periods, women naturally get pregnant, women naturally go through the menopause. But actually we know there are health issues around those areas and we are knocking down those stereotypes that these are natural parts of a woman's life course and that there is no difference we can make to those.

For example, the perinatal pelvic health model that NHS England is rolling out now: you can reduce birth trauma and tears during birth by about 20% by having the OASI care bundle. Traditionally, that has just been seen as something that happens during a tough labour. There are things that you can proactively do that will make a difference, and that is not just for the actual birth. We heard from Theo Clarke in the recent debate that the lifelong consequences of maybe incontinence, painful sex, or reluctance to have a second child, have long-term consequences for those women and by being proactive you can reduce a lot of that up front.



They are the stereotypes we are trying to change, and I think the NHSE is doing some great work in that. One of the issues we have is, sometimes, our databases, particularly for maternity, are often quite old. We are working on two-year-old data at the moment, which was the height of covid, and so we are not seeing, in terms of our outcomes, the benefits of those initiatives. We are moving to more real-time data early next year. You will see we are making huge inroads in some things that have not been challenged for years. It is about challenging that narrative that periods are just what happen to women, menopause is what happens to women, giving birth is what happens to women. Actually, you can improve outcomes across the whole life course of all women by looking at the challenges they face, and the signs and symptoms they have rather than individual diagnosis.

Q162 **Kate Osborne:** Charlotte, do you think the NHS is sexist?

Charlotte McArdle: The NHS is built upon the need to provide services and it has a workforce that is very well trained and skilled in dealing with the individual that presents with them. Obviously, as I said earlier, we are skilled in providing holistic individual care and thinking about what is important to that person, and those relationships are built on respect, honesty and understanding. That is the culture that we are developing and improving in the NHS as we go forward. We are going on an improvement journey. The chief executive of the NHS has developed NHS Impact, which is about quality improvement in all areas of our service, not just in women's health, and those principles are very much key to that improvement journey. I hope that that will address the issues you are alluding to around discrimination and sexism as we move forward.

Q163 **Kate Osborne:** Do you think that women's experiences, whether they be women working within the NHS or, indeed, patients, reflect the view that improvement is being sought?

Charlotte McArdle: It is fair to say we have had mixed views from women who have experienced care. Obviously, we have had women who have not had a good experience of care and that is regretful, and it is not something that I or anybody else would want to see. There are also women who have had very good experience of care and we need to work harder to make sure we get everybody to the right experience of care.

The survey data, the engagement with women, hearing and listening to them but, most importantly, working in and with local communities that have different needs and different concerns in relation to women's health is key to making a good experience for everyone. There are different ends of the spectrum, and we all have our individual experiences of using healthcare. What we need to do is hear those who have not had a good experience to make sure that we work towards improving that. The Quality Committee at NHSE always starts with the patient's story, usually of a poor experience of care, and then there is a dialogue and conversation. So, those voices are being heard and we understand that it is not a good



experience for everyone, but our aim and ambition is, obviously, to improve that.

Q164 **Kate Osborne:** Lesley, can I ask you the same question: do you think the NHS is sexist?

Dame Lesley Regan: To answer that, I have to remind you that I came out of medical school in 1980 when only one in 10 medical students were girls or women, and I have seen that change dramatically. I know a bit about this because one of my daughters has become a mature student and is just about to qualify. Two-thirds of the intake now are women. We know that the NHS is the largest employer in Europe and that nearly 80% of those employees are women. The NHS has a really good opportunity to demonstrate that the past is the past and if we want to retain that 80% of women in our workforce then we have to ensure that all the things we have been talking about—easy access to menstrual health to resolve menstrual problems, contraception, pregnancy, and menopause—are optimised.

Q165 **Kate Osborne:** Minister, what is the economic impact of women's reproductive health conditions and the failure to treat them swiftly? What consideration is being made to the benefits of early intervention as part of the Women's Health Strategy?

Maria Caulfield: There absolutely is an economic cost for not looking after women in a timely manner, and we can see this with the work that the Menopause Champions are doing in DWP. We know there is a significant percentage of women who are lost to the workforce because of the menopause, either because the women did not recognise the symptoms of the menopause and felt they could not cope with work any longer or, if they did recognise the symptoms, when they asked for help—whether for HRT or other interventions—they struggled to get that help and felt they had to leave the workforce because of it.

One of the initiatives that the new Secretary of State did when she was a Treasury Minister was to initiate the pilot study of endometriosis in the workplace because that is another group of women that we have met with—we know that on average it takes eight to nine years to get a diagnosis—who felt they could not cope in the workforce, or if they were retained in the workforce they were often overlooked for promotion because they were having to take time off work on a regular basis.

So, there is absolutely an economic cost to not being responsive to women's symptoms, conditions or timely intervention when they have a diagnosis, and that crosses all age ranges from young women who have menstrual problems right through to more mature women who are going through the menopause. We lose a lot of women throughout that because they feel they cannot get the help and support they need.

Q166 **Kate Osborne:** Thank you. We waited a very long time for a women's health strategy to tackle gender inequalities in healthcare, and now some recommendations are already failing to be implemented. If I can ask Lesley



first, and then, Minister, I will come back to you: what does success of the Women's Health Strategy look like with respect to women's reproductive health?

Dame Lesley Regan: I would say that if girls and women were able to control if, when, with whom and how many times they became pregnant because they had easy access to contraception, if women and girls were able to ensure they never had to have time off from school, college, workplace, or from their caring responsibilities because they did not suffer from painful, heavy periods, that would be good. If every woman who entered the menopause recognised that some symptoms could be something she needs to ask for help with, that would be a really good way forward.

As an obstetrician, I have collected myriads of data on pregnant women throughout their pregnancy, and then the moment the baby is delivered we just ignore it all. My other ask of this strategy in the long term, and this will take longer to implement, is that we take women who have had a complication during pregnancy, and we make sure that they are flagged because we know that that will predict some problems they are going to have in later life.

For example, if you get gestational diabetes, you are definitely going to become a type 2 diabetic, or even an insulin-dependent one. It also gives us a particularly good handle on how we could improve women's mental health because one in five women is going to have some degree of post-natal depression after their baby is born or during that first year of life, and we know that that is almost pathognomonic of them probably requiring mental health services later.

Rather than waiting for them to present with a problem, let us try to prevent them. The reproductive things I see, because of my background, are the easy wins, and then we can concentrate on improving the things that really do kill women, which are cardiovascular disease, the complications of osteoporosis, and frailty and dementia, and probably a combination of all three.

Q167 **Kate Osborne:** Minister, if I can ask you the same question: what does success of the strategy look like, and if we had you back here in five years what could we expect to be different?

Maria Caulfield: Success for me is twofold. First, that women feel that when they are accessing healthcare, they are being listened to and they are being taken seriously, and they are not having to navigate a complicated system of hospital appointments or go back to the GP or another investigation, that they actually feel that the health system is responsive to their needs. Second, that we are actually improving outcomes and improving the care for women in the first place.

We have done a huge amount in the first 18 months. If you look at the access points that we are opening up for women, whether that is the new



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pharmacy initiatives so that contraception can be accessed through pharmacy services, the Women's Health Hubs that we are rolling out, the fact that we have made gynae procedures one of the six priority areas for the new surgical hubs to try to get on top of some waiting lists, the fact that, if you look at some priority areas, we have had over 400,000 women access that prepayment HRT scheme in 18 months, that is saving a lot of women a lot of money in being able to take their HRT.

Tommy's is taking on the recommendations from the Independent Pregnancy Loss Review so that women from a first miscarriage will be getting assessed and supported rather than the three miscarriage rule which existed before. The pregnancy loss certificate for babies lost before 24 weeks' gestation will be coming forward in the new year. That will impact a lot of women who have been asking for that for a while. Then, we have our work around the Perinatal Pelvic Health Initiative to try to reduce the number of birth traumas happening in the first place by rolling out the OASI care bundle. Inevitably, there will be some women who do have birth trauma, but they will get better support and help with long-term management of those symptoms.

We have done a huge amount of work in the first 18 months, so I am confident that, say, in five years' time—our 2024 priorities will be announced shortly after Christmas—that we will see, for every part of a woman's life course, there will be something there that women will be able to say, "Yes, it was easier to get contraception," or "I was able to go and see my GP who identified I was going through the menopause and I wasn't having a nervous breakdown," or "Actually, I was really supported during my pregnancy. I had a small tear, but I was very well supported throughout it." We are hearing some positive stories.

Also, as Lesley touched on, this does help staff recruitment. If nurses, doctors and physios feel they are giving a better service of care, they are much more likely to get that job satisfaction which they struggle with at moment, saying no to women, whereas they will be able to be proactive and say yes. We have to develop that policy and then support it financially to make it a reality. We are starting to see that within the first year, and I am confident that, after a number of years, we will see a real game changer in terms of how women experience health services.

Kate Osborne: I hope so, thank you.

Q168 **Chair:** Can I just interject with a question? You have all been really reticent about wanting to say that there are problems with sexism in the NHS. I am going to hit you with some evidence this Committee has taken over the course of the last three years. First, BAME nurses telling us during covid that all the PPE was designed for American men with big Desperate Dan type square jaws. Second, Surviving in Scrubs came in front of this Committee and talked about the sexual harassment they had faced in surgery. Third, we had witnesses tell us they were effectively told to suck up their menstrual conditions and to just get on with it.



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Lesley has quite rightly indicated that the feminisation of the profession is happening, but my question is: what role do diversity and inclusion officers in the NHS have in solving these incidents of sexism and discrimination in the health service? I will start with Charlotte.

Charlotte McArdle: Clearly, those officers have a role to play, but if you take that back a step, staff and people who use our services need to feel able to raise their concerns, and some people do not.

Q169 **Chair:** Specifically, if I was a member of staff who had been sexually assaulted in surgery, would a diversity and inclusion officer have any role to play in me having a voice to articulate what had happened to me?

Charlotte McArdle: A diversity and inclusion officer can offer support, can triage, can point you in the right direction, can help you to articulate your voice and have it heard in the right place in order to deal with the concern. I think there are other mechanisms for staff to use as well. I do not think it is all about diversity and inclusion. Staff need to be able to raise their voice with someone they feel comfortable with and who they trust. We have professional nurse advocates right across the NHS now who deal with a number of issues. They are not related to diversity inclusion or uniforms or clinical care: they are there to support the staff to help them articulate whatever that concern is. For me, the most important cultural shift we can make is that people feel it is acceptable to raise their concerns, that they are not pilloried for doing that, and that that concern is treated with and dealt with the respect it deserves.

Maria Caulfield: We are putting a huge effort into reducing the number of incidents of harassment in the health service. We have a lead in every trust now, and we are working across the board. The figures show that the higher number of incidents are actually patients on staff, and patients on other patients. We are encouraging staff to report that so we have a better handle on the types of incidents that are happening.

In terms of the diversity and inclusion officers, my big concern about them is that they have been in post for many years and yet we are still seeing instances. Very often, when you have an individual in post, it almost abdicates the responsibility on everyone else because they think, "Well, it's the responsibility of the diversity and inclusion officer. We don't need to change, or we don't need to implement these policies." I really want it to be everyone's business, so that if you are seeing harassment or if you experience harassment yourself and you report it to your line manager, to one of the speak up guardians, whoever it is within your organisation, that it will be taken seriously, and that everyone sees it as their responsibility and not just something for the diversity and inclusion person in that trust.

Q170 **Chair:** What if I am a nurse who cannot access fitting PPE?

Maria Caulfield: We are looking at our PPE at the moment. I cover pandemic preparedness as well, so that is something we are looking at. For covid, the type of PPE we had in reserve for a pandemic was not the type of PPE that we actually needed for covid: it was much more flu related.



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Some was procured because it was the only PPE we could get at that time, so we are absolutely looking at that at the moment going forward.

Charlotte McArdle: Could I add to that? Just to say that we are launching a new uniform in the NHS which has been tested, trialled, and developed by staff from all backgrounds. We have tried to accommodate that in the shape and the style of the uniform and the wearability. We have also checked it against the quality of the cotton, particularly thinking about menopause and how that suits. Some learning has been taken on board in relation to going forward with the new uniform.

Q171 **Chair:** Will it be a uniform that fits everyone as opposed to one size fits all?

Charlotte McArdle: Obviously, there will be variations on the one size fits all in terms of size, but also in length and shape but, essentially, there cannot be an individual uniform for everybody working in the NHS.

Chair: I am really sorry; it is time for PMQs. I have kept Members here too long. We did not get to our final section of questions. Is it okay if we send them to you in writing? Apologies to Lia who did not get to ask them. Can I thank you for your evidence this morning? It has been very helpful.