HOUSE OF COMMONS

Women and Equalities Committee

Oral evidence: Reproductive health conditions: girls and young women, HC 1265

Wednesday 19 November 2025

Ordered by the House of Commons to be published on 19 November 2025.

Watch the meeting

Members present: Sarah Owen (Chair); Alex Brewer; David Burton-Sampson; Rosie Duffield; Dame Nia Griffith; Christine Jardine; Kim Leadbeater; Kevin McKenna; Rebecca Paul; Rachel Taylor; Nadia Whittome.

Questions 1 - 41

Witnesses

I: Emma Cox, Chief Executive, Endometriosis UK; Janet Lindsay, Chief Executive, Wellbeing of Women; Dr Nandi Simpson, Director of Implementation, NHS Race and Health Observatory; Katharine Gale, Co-chair, Menstrual Health Coalition.

Written evidence from witnesses:

Emma Cox, Endometriosis UK [RHW0061]

Janet Lindsay, Wellbeing of Women [RHW0079]

Examination of witnesses

Witnesses: Emma Cox, Janet Lindsay, Dr Nandi Simpson and Katharine Gale.

Chair: Good afternoon and welcome to the Women and Equalities Committee. Today we are holding our first evidence session on reproductive health conditions among girls and young women. I am delighted that we have such a fantastic panel before us. We will be hearing from Emma Cox, chief executive officer at Endometriosis UK; Katharine Gale, co-chair at the Menstrual Health Coalition; Janet Lindsay, chief executive of Wellbeing of Women; and Dr Nandi Simpson, director of implementation at the NHS Race and Health Observatory. Thank you very much to you all. We are really looking forward to hearing your evidence today.

Q1 **Kim Leadbeater:** Thank you, everyone, for joining us this afternoon. One of the key issues in reproductive health is the lack of knowledge and information that girls can have about their bodies, about what is a normal period and when to seek support. It was not great when I was at school, which is quite a while ago now, but from speaking to younger colleagues it does not necessarily seem to have got much better. Janet, is it your view that the new RSHE curriculum will deliver the education that is needed for girls when it is needed, so that we can prepare them for if, when and how they may need to seek help?

Janet Lindsay: It is a step forward, and a lot of people have really welcomed it, but the top line is that we have to do much more to support teachers and parents to deliver really good education around menstrual health in schools. We believe that we must deliver really good lesson support plans for the PSHE curriculum. It has to be concise information, and we have to remember that some people will not be able to deliver everything we want.

We have to make sure that we are delivering good education for the educators. That will be a lasting change for menstrual health education across the whole school system. We have to engage boys and girls—we must not leave boys out—and make sure that they have the knowledge and tools to feel that they can go and ask questions. That is why we believe that educating the educators is the start of this. If we can make sure that the educators have the information so that girls and boys can go and ask questions—and the new guidance includes emphasis on making sure that pupils understand how to access health services, the professionals and further information—that will really help.

We have surveyed over 2,000 young girls, and so many of them—more than half—have felt really shamed when it comes to the lack of knowledge that they have about their own periods and menstrual health. They have been shamed by teachers, actually. One in five—17%—feel that they have not been able to approach their teachers, or they have been shamed. That is not because teachers want to do that, but because of the lack of information for them.

For us, it is critical. We hosted some workshops last year with schools. We went to two or three, and it was obvious that the teachers who were going to be delivering the information were really keen to have something going forward. We are looking to launch something next spring. It is in the process of going through focus groups with schools, and hopefully, when we have had all the feedback, we will be able to update the PSHE lesson plans for key stages 3 and 4. That is ages 11 to 14 and 14 to 16.

Q2 **Kim Leadbeater:** That is really helpful, Janet; thank you. As someone who has many teachers in my family and many friends who are teachers, I sometimes get slightly nervous about saying, "The teachers can do it, the teachers can do it," because teachers have a lot to do as well as educating children and young people. I worry slightly about that, but you are absolutely right that we need to empower them and give them the tools to do the job properly. What actions do you think the DFE needs to take to ensure that those curriculum changes are implemented effectively?

Janet Lindsay: Obviously it needs to make sure that we get the funding. I mean "we" in the general sense; I know that Emma from Endo UK is also doing work in schools. It needs to make sure that there is funding there, and it needs to make sure that there is time in the curriculum to actually deliver this. We are going to be providing online training sessions so that teachers will be able to get the knowledge that they need to deliver these lessons, at a time that is convenient for them rather than for the person delivering it.

We are going to have resources for teachers and parents, because we believe that is also imperative, so that everybody in this ecosystem has enough information. We do not want to go into any more schools and hear the stories from girls that they just did not know what was happening when their period started, and they did not know where to go.

The other thing is to make sure that there are period products available to everybody, that they are easily available and not hidden away, and that whoever is looking after them is sympathetic to allow girls to go to the loo and have the products they need. That will make a huge difference.

Q3 **Kim Leadbeater:** Fantastic, thank you. I have a couple of final points. I have a background in sport and physical education, so I would be interested to know if you have any observations about the relationships that can be made between girls and physical activity and sport as a result of issues that we know can cause problems for them when their periods start, and the relationship that they have with sportswear, access to toilets and things like that.

Then, Nandi, do you think there is anything that we need to think about specifically in terms of ensuring that people from ethnic minority backgrounds and those with physical and learning disabilities have a

particularly tailored piece of education?

Emma Cox: I totally agree with what Janet has been saying. On the sport side, what is really interesting for me is that with certain conditions, like endometriosis, the physicality of the bloating, which can be very severe, if it is not managed properly can lead to more injuries and harm if you undertake sport because your muscles have literally changed. Certainly, with some elite sport and with young gymnasts and dancers, it can lead to damage. There is a lot more that we want to do to make sure that people are aware of that.

In schools, I am sure we have all had our own experiences over the decades of sport and periods. As Janet was saying, we must make sure that there is access to menstrual products, especially for those with heavy menstrual bleeding. One of the other things we hear an awful lot about, which is so sad, is girls and children who cannot access the toilets. I have friends who have teenage daughters, one of whom will not go to school on PE days because they are not always allowed to go to the toilets beforehand. If she is having a period, she says, "I can't go in." There is definitely something around sports about being able to do that.

Another thing—we have seen the England football team and the rugby teams doing some work on this—is recognising that because of the menstrual cycle, people might be at different stages hormonally, and that could impact how well they can do and so on. We need to educate in a really simple way some of those leading sports, so that if they have someone who is usually really good at hurdling and they are not doing well one week, they are not, if you like, told off for not trying hard enough. There is a whole range of things around there to support young girls with sport.

Dr Simpson: We welcome the updated RSHE statutory guidance, but beyond a statement that all RSHE subjects must be taught in a non-discriminatory way, there is no instruction to acknowledge racial inequity and cultural stigma around gynaecological health. The reason this is concerning is that common gynae conditions, like polycystic ovary syndrome and endometriosis, are more likely to impact black and south Asian women and have important implications on fertility. Primary care is often the first port of call for reproductive health, but we know from research commissioned by the NHS Race and Health Observatory that there are some really serious ethnic inequalities or ethnic disparities in trust in primary care.

It is really important that there is proactive action to address this. For example, effective and equitable teaching would rely on schools meaningfully engaging with children and their parents in ways that account for that racial inequity and mistrust in primary care and empower them in relation to their legal rights to good healthcare.

Q4 **Kim Leadbeater:** Brilliant, thank you. Katharine, This Committee's December 2024 report on women's reproductive health received a lot of

media attention, and coverage of issues around women's reproductive health has continued, thanks to the efforts of some very high-profile women, such as Naga Munchetty and Vicky Pattison, who sadly was off "Strictly" this week, but she did a brilliant job anyway. To what extent is that attention raising awareness among girls and young women, in your opinion?

Katharine Gale: First, I do not know of anything else that all girls experience during secondary school that is not covered within school and that not all teachers are aware of. Secondly, let me say as a registered nurse and expert here today that school nurses also have a role to play, yet they have not had the training in menstrual health. Any awareness is good awareness, but it can cause issues with trust; if we start to see only negative stories coming out, that will cause more distrust. The awareness is very good, but there is more that we need to be doing to help empower young people to advocate for their own health.

Q5 **Kim Leadbeater:** Is there anything the NHS could do to improve its communication with young women in this area?

Katharine Gale: Yes, absolutely. In my current role with Health Education and Improvement Wales, we are doing general awareness training for all health staff on women's health. I want every single health person to understand women's health. It is everybody's business. When we can communicate from that place, "This is what women are experiencing," we are not going to have the red flags and we can make sure that they get the care and attention they need promptly.

Q6 **Chair:** I am going to follow on from Kim's point—not about "Strictly", although I am really sad to see Vicky gone, but about communication with young women in this area. Have you seen any good examples of co-production for communicating menstrual health and wellbeing that we could flag?

Emma Cox: NHS Digital did some short videos and animations last year around menstrual health conditions—endometriosis and heavy menstrual bleeding. They were good, but I know they had challenges in getting them out. They used a range of people who do that. Janet, I know that various of your trustees are involved—

Janet Lindsay: Yes, I was just going to come on to that. It is really important that have more accurate health information that goes out on social media. I know that, ideally, everybody would like the NHS app and website to be able to do that, but we need to use things such as TikTok. The reason I feel that is so important is that there are some very well-intentioned but not very well-informed TikTok influencers out there who are filling the gap. Today we saw something where somebody was recommending nutmeg to use for particular menstrual health issues.

We really want evidence-based information out there, as I know Emma does—in fact, probably everybody on the panel does—but it has to be served up in a form in which we know young people are now getting their

information, whether it is education or just general information. We have to make sure that we join the TikTok age. If that means working with some influencers, then we should. As an ambassador and a trustee we have Dr Nighat Arif, who is brilliant, putting out information on her TikTok. There is also Dr Aziza Sesay, and I could list quite a lot of others. We really need to embrace the digital age and make sure that we are appealing to the audience that we need to appeal to.

Chair: Dr Nighat's information is incredibly informative but also very engaging. Yes, more of that please.

Q7 **Rachel Taylor:** This question is to you again, Janet; you have been put on the spot a little, but obviously there is a lot of good work that you have been doing, which we would like to get some more information on. Can you tell us a little more about your period symptom tracker: how it works, its impacts and whether there are plans for the NHS website to link up to it?

Janet Lindsay: The period symptom checker was launched in February this year. We developed it over a nine-month period with GPs, with gynaecologists, with the support of the Royal College of General Practitioners and the Royal College of Obstetricians and Gynaecologists, with pharmacists, with women's health researchers and most importantly—right at the centre—with women with lived experience. All women were represented, including women of colour and women from marginalised groups.

The purpose of the checker is to help shorten the time between when a woman or girl first experiences heavy bleeding or painful periods and when they seek medical help if they need it. We want to get more women to see their GPs and provide them with information; that was the real purpose of us launching it. Over 60,000 women and girls have completed the symptom checker, which is fantastic. We are amazed. We know that there is unmet need with the symptom checker, but not only do we have this immediate success, but we know that 62% of those women and girls went to see their GP.

With the symptom checker, you either get a response that says, "It sounds like you're managing your periods well," and they are probably using medications that they can buy over the counter if they need them. Then there is another group of women and girls who will receive a letter that lists the questions and their responses to them, for them to take to their GP. The real success of this is that it empowers women and girls to go and have a successful appointment. Some 62% said that they had been to see their GP when asked two weeks later in our follow-up survey, and 59% of those who went were happy with the appointment. That is a lot of women who are getting the help that they need.

Q8 **Rachel Taylor:** Do you have data on the age groups of the women accessing it?

Janet Lindsay: We will have, and we will send that through to you. We are doing that currently.

Q9 **Rachel Taylor:** Great, thank you. This question is to anyone who wants to pick it up. There are concerns about apps that allow women to track their menstrual cycle, both in terms of people using them instead of contraception, potentially trying to change things, and in terms of data privacy. Do you share those concerns, and what action do you think is required to address them?

Emma Cox: Yes, I have concerns about those. I am not a data expert, but the amount of data people are putting into commercially owned apps is interesting, and so is the management of that. In an ideal world, would it not be great if the NHS app enabled people of all ages to log their symptoms in a way that they could then, if they wished to, discuss them with their healthcare practitioner? Of course, a woman who is on contraception for whatever reason will be talking about their periods to their nurse. If they then have other risk symptoms, such as endometriosis or bowel symptoms, they will talk to their doctor. There is no cross-link.

If only there was a way of having something as simple as recording the main aspects of your periods on the NHS app. Again—I am sure you will hear more than one of us say this a number of times—51% of the population go through a menstrual cycle for a big chunk of their lives. It feels like an important aspect for the NHS to collect data on. I know that is probably a way down the road, but would that not be a great thing? It would not only enable people to manage that and do it safely, but, if it was managed properly, enable some great research to be undertaken. We could probably find some solutions about how people manage and things like that.

Q10 **Nadia Whittome:** Emma, our report identified unacceptably long delays in women receiving diagnoses, including for endometriosis. In your experience, are diagnosis waiting times improving? If not, what further steps are required?

Emma Cox: The average time to diagnosis for endometriosis has been about eight years for many years—over a decade—and it has gone up to eight years and 10 months because of covid. As you all know well, the gynae waiting lists went up by the highest percentage during covid. They are still high: 750,000 in the UK are waiting for gynae appointments and, worryingly, that number is going up. There is some interesting work being done by the Office for National Statistics, which will be looking at some data as well; hopefully, that will be out in spring-ish next year. That will be not just data, but really solid ONS data, and we will see what it comes up with.

We re-analysed some of the data we have for this submission. One issue is that it seems that the younger you are when you go in with symptoms, the longer your endometriosis diagnosis takes. That is because—I am

going to give you a very general, stereotypical answer here—you go in and you are not believed. We know that the majority of people are not believed. You are told, "You're too young," and put on the pill, with no discussion that you may have something that is a menstrual condition. That means that you are told for many years that it is in your head. You might try different contraception, and the hormonal treatment might work for managing your endometriosis, but 10 years later you come off because someone says you should come off the pill, and it is back with a vengeance. We find that it links back to the original question: how do we educate young people, but how do we educate healthcare practitioners too?

If I may just say so, I find the term "reproductive health", when linked to anything to do with menstrual health, really unhelpful. What is reproductive age? A doctor means first period to last period. Girls as young as seven are having periods, up to about 52 for the menopause average. But when the ONS was asked by NICE to work out the number of people who are of reproductive age, it used 16 to 43. Clearly, it is going to do that, because no one in society thinks reproductive age is under 16. Most people think it is 20 to 40-something.

We have done a real disservice by labelling these things "reproductive health", because not only does it put the focus on, "Well, you're there to have babies, aren't you?", but it rules out anybody who is not societally thought of as being reproductive. We know that the young people coming through—my niece's generation—will have far more periods than my grandmother did, just because of the early ages, menopause being later, and people not having as many children and not spending as long breastfeeding. So we have younger generations having many more periods, but they are not being considered whenever we talk about reproductive health. They are generally not considered by the public. I went slightly off topic there.

Q11 **Nadia Whittome:** That is really helpful, thank you. Are the November 2024 NICE endometriosis guidelines having a positive impact? If so, which elements are having the greatest effect on diagnosis times?

Emma Cox: The guideline was produced in 2017 and had a partial update in 2024. We asked for a full update, but the only section updated—well, other than one sentence—was on diagnosis. It is definitely an improvement, but I was on the committee—I did not get everything I wanted. The first thing I would say is that the guideline has not been implemented. There are bits of it that have been, but the new section on diagnosis has not been implemented. As of this point, I do not believe it has made a difference. I hope it will. I am an optimist, and I think it might, but there needs to be some pressure on the NHS to implement it.

Again, I would like to see a full review. To give an example of why, even though we have a NICE guideline on pain, it refers to the endometriosis guideline, and the only thing the NICE endometriosis guideline says on non-surgical pain management is one sentence, that says, "Chinese

herbs don't work." This is anything that is non-pharmacological. There is nothing about physio, CBT, or all the stuff that we know about; it just is not in there. Sorry, I will stop ranting about that. It is good, but it needs a full review, and then it also needs implementing.

Q12 **Nadia Whittome:** Nandi, we know from international evidence that black women, and I imagine other women of colour, are less likely than our white counterparts to receive a diagnosis for endometriosis. Is that pattern replicated in the UK? If so, what are the causes of that, and how do you think that disparity can be addressed?

Dr Simpson: That pattern is replicated in the UK. In terms of causes, there are a couple of things that I would highlight. One of them is structural. For the first time this year, the elective care waiting list dataset included demographic breakdown, and the longest waits were faced by black and ethnic minority people and people from deprived regions. It is really important to note that although people from ethnic minority backgrounds are more likely to be in poverty, the dataset indicated that there was inequity across all the regions. Therefore, there are specific interventions that are needed to address ethnic health inequity in the way that elective care waiting lists are managed.

The research that the RHO commissioned into trust in primary care showed that black participants cited being repeatedly dismissed, and that led to diagnoses for endometriosis later in life. There is a compounding effect. People's repeated experiences of not being listened to, being dismissed and so on affect people's health-seeking behaviour. That compounds waiting times but also poses risks to plans to shift care into the community.

There are a couple of ways that we think this could be addressed. One of them is about embedding a race equity lens into the implementation of the 2025 elective care reform plan and ensuring that community-based interventions are forefronted. There is also a point about ensuring that the Carr-Hill formula review is equity sensitive, so that funding for primary care services accounts for ethnic inequity as well as deprivation, because these two things are fundamentally interlinked.

Q13 **Nadia Whittome:** Janet, what progress has been made on research in relation to new diagnostic tests for reproductive and menstrual health conditions?

Janet Lindsay: Thank you for that question. For those who do not know, Wellbeing of Women is one of the only funders of early-career research into women's health. We are currently funding what I think is some really exciting research in this area. We are working with Dr Jackie Maybin and Dr Gemma Sharp, whose team is setting the top 10 research priorities for the future of abnormal uterine bleeding. That covers heavy bleeding and irregular or prolonged periods. Just to give you an idea, that affects approximately 4 million women in the UK, which is a lot of people we really need to help. We are also funding Dr Marianne Watters in

Edinburgh, who is looking at how menstrual fluid could be used to develop a diagnostic test in primary care. That will speed up the long waiting times that so many people experience. We also have somebody who is looking at endometriosis and blood clotting; again, that could pave the way for a blood test.

So there is some work going on, but it is small. We need more funding into research, into women's health, into these really common conditions—particularly things like fibroids, PCOS, endometriosis and adenomyosis, which is really only just becoming something that people are considering. We urge the Government to really invest in this area, because if we do not get a pipeline of early-career researchers, we are not going to be getting those tests and things later on. It takes on average 17 years to turn a new idea into a treatment or a medical procedure. For what we are doing now, it could be a long drag, although the femtech industry is speeding things along, and there are lots of exciting things going on in that area. Yes, we need to look at this positively, but we need more money for research into women's health.

Emma Cox: Obviously, a lot more research is needed. If we look globally—I am just talking about endometriosis here—there is a lot of effort going on. In fact, you can spend £1,000 and get a test that has not been proven to work, if you want to send it off to Switzerland. We need some form of test, but one of the things that I find really interesting is the potential of gynaecological ultrasound to help diagnose certain conditions.

Not all ultrasound is equal; Katharine can talk about that. You need to be trained in gynae ultrasound. Looking at babies is different from doing an internal vaginal investigation. However, with recent developments, one of the reasons we are hearing more about adenomyosis is that if you go to the right person, they can see adenomyosis on the ultrasound. Certainly, somebody trained should be able to see deep endometriosis, and then it can be backed up by MRI if necessary. Fibroids, of course, should be seen and so on.

There is a real potential to develop gynae ultrasound, especially in women's health hubs or wherever it might be. That would be a much more low-cost way of starting to diagnose some conditions and then, certainly for things like endometriosis and adenomyosis, plan if surgery is appropriate and, if so, who needs to be doing the surgery and what the outcomes are likely to be. I will just flag that a clear scan does not mean you do not have endometriosis, but for the deep disease, which is about 20% and quite often the most severe in terms of the extent of the disease, it can now be seen by people who know what they are doing.

Chair: Thank you, Nadia, and thank you, Emma, for raising that. That is exactly how I was diagnosed with adenomyosis. It was not what I went in for, but it was what the sonographer saw.

Q14 **David Burton-Sampson**: Having talked about diagnosis, we are now

going to look at care and treatment. Katharine, what recent developments have there been in effective treatments for reproductive health conditions—and, most importantly, are all girls and women able to access them?

Katharine Gale: One of the ideal places for them to receive care is in primary care. If we refer them to secondary care for treatment, there will be a long delay. We know that there are already 750,000 waiting for procedures or treatment. Ideally, it is primary care. Actually, when we go back to some treatments that can be very helpful early on—not for endometriosis but, say, for heavy menstrual bleeding—they have not even been offered in primary care. Quite often, young people are told that their symptoms are normal and will probably settle down, but of course by then they are moving through their education and missing more time off school. We have failed to give them some treatment that may well have helped.

Just like Emma was saying, diagnosis is key. If we are just saying it is heavy menstrual bleeding but in fact they have adenomyosis or endometriosis, then of course the treatment would be different, and the support would need to be different. It is that time from referral to diagnosis and treatment that we need to address. Not all ultrasound is the same and neither are all diagnostic laparoscopies. If it says it is normal it does not mean there is no disease, but we are not going to give the treatment.

Of course, there is no cure for endometriosis either, nor is there for adenomyosis, and we are recommending hysterectomies. We need more treatments, but if it is going to take 17 years to get a new treatment, we are going to be waiting a long time.

Q15 **David Burton-Sampson:** That is rather worrying. Our previous inquiry found a lack of shared decision making between patients and healthcare professionals, meaning patients were not getting the treatments they wanted or needed. How can we better empower women—particularly younger women, whom we have heard are often ignored or told just to go on the pill or whatever it might be—to be fully involved in the decisions about their treatment and care?

Katharine Gale: It is so important that we understand what is normal. That is the first thing. We want young people to understand their bodies and know what is normal for them, and then to know what is not normal and when to ask for help. We know that when they are dismissed early on by being told, "Things will settle down," they do not present for many months after that; it may be 22 months before they seek help again. It is really important that they have the language they need about their bodies, which means anatomical names as well, and that we use radically simplified information and talk to them about it in a way they will understand.

It is really important that they are given an opportunity to have informed consent. That means discussing all options, rather than just what we deem suitable. If we are saying that they are not sexually active so they should not have the contraceptive pill, then we are denying them the opportunity to be engaged in whether that is something they want to do. Again, early diagnosis is key; if they are 10 years on the oral contraceptive pill and then come off to try to conceive, and then find out they have disease, it is delayed diagnosis.

Q16 **David Burton-Sampson:** Nandi, I am interested in your views on this—women being involved in their treatment and care and being able to be part of that discussion—especially from a race perspective.

Dr Simpson: It comes back to the point about symptoms being dismissed and normalised. For example, the Caribbean and African Health Network compiled a report into uterine fibroids. One of its stark was that black women are more likely to undergo hysterectomies and less likely to be offered fertility-preserving treatments, because at the point by which they are diagnosed, the disease has progressed so far that their treatment options are radically reduced.

There is also a really important point about language. Language is a barrier. How can everybody be sure that people have understood conversations and the implications of the conversations they are having with healthcare practitioners if there are language barriers? There are some really important issues around the way that conversations happen and that decisions are made in healthcare.

Some ways around this can include co-production: co-designing and co-producing services with girls and their families from ethnic minority backgrounds and involving community-led organisations in that kind of work. But of course, training healthcare practitioners is not a silver bullet, so there has to be some kind of reinforcing accountability. We must frame inaction as a care quality and patient safety issue and think about how this can be incentivised and enforced through regulatory action.

Q17 **David Burton-Sampson:** Emma, you said that to an extent you welcome the NICE guidance that girls aged 17 and under who have suspected or diagnosed endometriosis should be referred to a paediatric and adolescent gynaecology service or a specialist endometriosis service. Is this actually happening across the country, and do you have any good examples of paediatric and adolescent gynaecology services that could be replicated elsewhere?

Emma Cox: In summary, yes to the last one and no to the first. It is very rarely happening; there are very few paediatric services. It was a very difficult discussion to get that into the NICE guideline, because the guideline says what should happen, rather than what can happen. However, there are a couple of really good examples, and the one I am going to talk about is Oxford. There is a great doctor in Oxford, Katy Vincent, who specialises in adolescent pelvic pain. Of course, it is really

important that we do not label people with a disease before they have a diagnosis and that we recognise that up to 50% of adolescents with severe pelvic pain will not actually have anything. We will not be able to ascribe a pathology to that, but they have that pain.

Katy tries to treat the whole person. She has joint clinics with herself as the gynaecologist, a physiotherapist and a psychologist, and they try to treat the individual. Of course, these young people are having to interact with the NHS and doctors very early on in their lives. It is not what they expect to be doing when they are 14, 15 or 16, is it? It really helps them understand the whole issue that people are facing. It is worth bearing in mind that for some people, endometriosis—I am going to take endometriosis because I know it, but it is not the only one—can cause pain, but if that pain is left untreated, it affects how pain is felt through the body. It becomes chronic pain and then impacts how you think and so on. If we are leaving people on average seven years before we manage their pain, there can be pain sensitisation.

What Katy has done in Oxford is a really great way of trying to support people so they understand and get the help they need at the age they need it. It is especially important with adolescents, because it might not always be appropriate to have surgery when you are young. It is a really key thing, and I would flag Oxford as one of the examples of where it can be done. That's the thing, isn't it? If it can be done somewhere, why is it being done hardly anywhere else? Katy was surprised when she set the service up a few years ago. She said, "I'll go see what everyone else is doing, and then I'll do what they're doing," and realised that she could not find anyone else doing it.

Katharine Gale: There is also a really great service in Bristol for PAGS, and it has involved nurses. I was working in that with Dr Naomi Crouch. One of the issues is that if things are not done in primary care, there is a long wait for young girls. There are 10 NHS-commissioned PAG services. They will all be different in what they offer, and it sounds like the Oxford one is great at focusing on pelvic pain. But unless the people in primary care can really advocate for the young people and are trained to listen, investigate and act on what they are saying—we cannot be referring all young people to PAG services.

PAGS are there for when management fails—when something has been tried in primary care and it fails. They will be wanting to see people with suspected bleeding disorders, for example, or at high risk of clots, or with development, neurodiversity or learning needs, or congenital gynaecology. But we often found that the young girls who were coming to our service had not had any treatment at all for their heavy menstrual bleeding in primary care.

Q18 **Chair:** Emma and Katharine, you mentioned Oxford and Bristol, which will have pockets of deep deprivation but are not among the most deprived areas in our country. What is it like accessing those sorts of

services in the most deprived parts of the country?

Emma Cox: It is very difficult in any area, but I would estimate that it is appalling in deprived areas, unless Katharine wants to tell me differently.

Katharine Gale: No. It is so specialist. That is why the NICE guidelines for endometriosis say a paediatric service or a specialist centre, but again, it is hard to get to those centres.

Chair: Thank you. I had an inkling, but I wanted confirmation; I will not just guess.

Q19 **Alex Brewer:** This is very interesting. Katharine, we are seeing widespread support for the women's health hub model as a local one-stop shop for female health, but what services should be included in the hubs and how could they be delivered most effectively?

Katharine Gale: We must not focus on the word "hub", because different areas will require different things. If we say, "Oh, one ICB has a hub," that ticks a box, but if it is a very large ICB, that is not going to be enough to make sure that women are getting the care they need. It is really important that the hubs have the eight core services, including menstrual problems; contraception counselling; LARC, or coil, fitting; pre-conception care; mental health and wellbeing—we think about pre-menstrual syndrome and PMDD—cervical screening; and sexual health disorders.

When we produced our document "What will It take? Investigating the Reality of Women's Health Hubs in England", we found that most issues were around sustainable funding. That was the No. 1 problem, and there was no consistency of services offered between one hub and another. Some were just focusing on menopause, some on menstrual health, and it was not a one-stop shop at all. We also know that each ICB received a one-off allocation of funding, but only 7% topped that up. Without sustainable ringfenced investment, these hubs cannot operate equally across England.

Q20 **Alex Brewer:** I am interested in exploring suitability of service a little more. It seems that in more rural areas, perhaps, where you do not have a big conurbation, there is a real risk that there is less financial incentive to put in a hub and so on. Particularly for younger women and girls who maybe cannot drive, that might be a real gap. More generally, are the hubs an appropriate model for adolescent girls' gynaecological care?

Katharine Gale: They can be. If staff are trained to talk to young people about contraception and sexual and menstrual health, then why not? But in terms of staff and staff training, we find that if there is no funding, we are not getting the right staff and the right variety of services being offered. Regarding one hub in one ICB, of course that is going to be an issue, so we have to look at the 10-year plan as well as the move towards digital, because some aspects can be done online and digitally,

and primary care has to be the first place for people to access initial investigations.

Q21 **Alex Brewer:** Is there a risk that focusing on women's health hubs means that that the primary care side might fall short?

Katharine Gale: No, I do not think so. Most people will go via their primary care, so it is really important that we focus on training all staff to be aware of women's health, not just on allowing specialists to get involved, because too many young girls will be waiting too long.

Q22 **Alex Brewer:** Nandi, the Race and Health Observatory has said that in implementing hubs, consideration has to be given to how race plays a role in shaping reproductive health outcomes, and you have talked about that a little already. What might that look like in terms of delivering the hub services?

Dr Simpson: If a model is to be based on local need, it is really important to understand what that local need looks like for the different people who make up the local population. At its core, this is about understanding what the population looks like and then working with communities to understand what their specific health needs are and how best those can be delivered. Ideally, it is about making sure that there is ringfenced funding that enables that kind of community participatory approach to designing or co-designing service and service delivery so that the hubs can be accessible by all.

Q23 **Rosie Duffield:** Emma, you were telling us earlier about your ideas of fertility. We found that women's reproductive health was too often seen primarily through the prism of fertility, even when women had decided they did not want to have children. Are you aware of any recent progress towards more inclusive co-decisions about treatment effects on fertility?

Emma Cox: I am a natural optimist, but I find it hard to say yes to that. There is still a lot to be done. At a strategic level, we are starting to hear that people understand that women are not just there to have babies. On the ground, however, we heard last month that people are being told, "Come back when you want children; put up with the pain until then." Your report on this was brilliant, but we are not seeing that come through on the ground yet.

One thing I find really worrying—I am afraid it might be a bit off topic—is that there is a draft NICE guideline on fertility problems out at the moment, and in the draft the decision has been made to split endometriosis into "mild" and "severe", which is not a recognised thing because you have moderate and other things. It has put mild endometriosis—whatever that is—in with people with unknown fertility and said that before they can have IVF, they need to practise unprotected sex for two years. You are literally saying to a group of people, "Stop your medication. You might be in too much pain to have sex; you might be having painful sex; but we're just lumping you with everybody else." To me, that is an incredibly backwards step.

Yet again, it seems that pain is ignored if you are put in the fertility bundle, if that makes sense. We are still hearing that. There are some positive steps coming through and there is much more in the press around fertility preservation. There is an understanding, although I am not sure if the funding will come through for people who, for example, are having their ovaries removed for whatever reason, that they should get help with fertility preservation, not just for certain conditions. We are starting to see a bit of movement in some top levels, but not on the ground. If that NICE guideline comes out, it will be a very big step backwards.

Q24 **Rosie Duffield:** You mentioned moving away from the use of the term "reproductive health" to describe all gynae and menstrual issues. What term do you think we should be using, or have you not got to that stage yet?

Emma Cox: Reproductive health is important, but it does not cover everything. Personally, I would split it into reproductive health, menstrual health and gynae cancers. Babies are important in the world and to many people; we must never negate that. It is a really important aspect, but when dealing with menstrual health as the focus, that should be a term in its own right. As you know, the Government have agreed to move away from the term "benign gynaecology". That is the medical term for non-cancer gynaecology. It implies there is absolutely nothing wrong with you and is perceived as meaning it does not matter. After your last report, the Government committed to not using that term, but we need to recognise menstrual health as an area in its own right.

One of the reasons for this is actually really practical. Quite a lot of hospitals do obs and gynae together. We say "obs and gynae". We all know babies do not wait, so if you have your obs and gynae lists in your operating theatre and you have five emergency caesareans, no gynae stuff happens, but it is not rescheduled because it was obs and gynae. However, if a knee surgery did not happen, it would be rescheduled, because they would realise it had been missed. Maybe it is time to move on from constantly linking obs and gynae. They are both obstetrically important—fertility and reproductive health are important—but it does not cover everything.

As I said earlier, it impacts how we see things, with the whole myth around, "You're too young to have these conditions; it doesn't matter," or, "Oh, well, they'll disappear at menopause," as if scarring and bladder damage magically disappear in a puff of smoke at menopause. I know a sad story—and it plays out on the ground—of someone who ended up having to have a hysterectomy. It does not happen for everybody with adenomyosis; it is case by case. As she was leaving the women's and reproductive health hospital, the nurse said, "We won't be seeing you here again then, will we?" She was 32 years old. It is just that, "Well, you're not part of us any more." We hear these stories all too often. I could go on, but I will stop at that.

Q25 **Rosie Duffield:** Katharine, you were nodding in agreement. Do you want to come in?

Katharine Gale: Absolutely. We find that when you have consultants doing dual obs and gynae roles, obs will always trump gynae. We also have lots of gynaecologists who are becoming very specialist, and when we get that specialism it becomes very difficult to help with waiting lists. Someone will say, "Well, I'm not a menopause specialist," or, "I'm not hysteroscopy trained." Even within a specialism, we have this issue that you become so super-specialised that the waiting lists are really long, because it will make a big difference if you are going to have, for example, endometriosis surgery that you have somebody who is really competent at diagnosis and treatment. We also know that if you have any emergency cases, a gynae case will be low priority against any other emergency in the hospital.

Emma Cox: One issue is the allocation of theatre time. The reason we do not have long waiting lists is not that there is suddenly as much theatre time as you want; it is that there are just hardly any done. We are going to do some freedom of information requests, but we do not really want to disturb the NHS at a busy time. What I am hearing on the ground is that pre-covid, a specialist endometriosis person might have had a full day and a half day of surgery in theatre; now, they might have two half days. They cannot schedule complex surgery because they do not have a full day. That can mean, we hear—it would be interesting if we could find this out through yourselves—that the very long waiting lists are for some of the most complex gynaecological surgery, because they just cannot get the theatre time to do that.

Katharine Gale: They cannot get the theatre time because they also might need somebody from urology or they might need someone from colorectal as well. You have complex teams coming together to deliver the care that these women need. If it gets cancelled, that means it needs to be rescheduled for all those people to be there.

Rosie Duffield: It sounds like women are at the bottom of the list.

Emma Cox: Yes. Totally.

Q26 **Rosie Duffield:** Yesterday, I was at a birth trauma conference, and it was all the same excuses about why we cannot have these things done.

To what extent do you think that women's fertility is sufficiently safeguarded? For example, should egg freezing be available on the NHS for people with certain conditions?

Emma Cox: One challenge with some of the menstrual conditions is that it is a spectrum. Someone can be very badly damaged internally, severely disabled, and someone else might not have those issues at all. We know that endometriosis is a leading cause of infertility in women. However, 70% of those with endometriosis should be able to get pregnant naturally. It is not an absolute black-and-white thing, but if

somebody has a medical reason for reduced fertility, then, just as they would for some cancer conditions, they should be offered fertility treatment.

I am very aware that it is very hard to make rules around that. It is very easy to say, but again, you have someone who might not need it and someone who might, and there needs to be a decision around how that is done. It goes back to the original point: if more effort was put into this, we would know these answers. There have been no really new developments in the contraceptive pill for, what, 50 years? There are some issues around how it is treated. I am sorry to say this, but look at erectile dysfunction medication and so on.

Dr Simpson: Just to go back to the point about what ethnic inequalities look like here, we know, for example, that black women are less likely than women from other ethnicities to have IVF cycles funded on the NHS, and that both black and Asian women have lower birth rates than white women. Everything has to be looked at through that equity lens as well.

Q27 **Chair:** You mentioned access to fertility treatment following illnesses other than cancer and that NICE is going to issue some guidelines. Do you know when that will be?

Emma Cox: There is a fertility problems guide—I love that title—which is due to come out on 19 March according to its website, but that is the one where we have concerns because it is talking about putting mild endometriosis in with infertility. I can send you some information on that.

Chair: That would be great; thank you very much.

Q28 **Christine Jardine:** Apologies for arriving late. We might have heard some of the answer to this question already, but, Janet, since the women's health strategy was published in 2022, are we any closer to understanding why women too often seem to be expected to endure chronic pain and painful investigative procedures for reproductive health conditions?

Janet Lindsay: Are we any closer to understanding it? I would say no, we are not. Our survey shows that period pain is routinely dismissed. We surveyed 3,000 women and girls aged 16 to 40 and found that 51% felt that the healthcare professional had failed to take their symptoms and pain seriously. It is a systemic dismissal; it is not individual. This dismissal means that women are experiencing delayed investigations. Not only is it just awful for the women, but it is a risk to safety. Many of them could be given timely treatments and care. We really need to tackle this pain dismissal and women and girls feeling that they are not being listened to.

Q29 **Christine Jardine:** Is workforce training in the NHS addressing this issue effectively, or is it falling short?

Emma Cox: It is falling short.

Janet Lindsay: Yes, it is falling short. We would all agree that it is falling short and we need to do something about it. I want to echo what Nandi said: it is much harder for those who really cannot advocate for themselves. We hear this time and again. We have a health collective, which is a collective of marginalised groups around the country, and it covers everything from disability to race, ethnicity, ADHD and sex workers. One of the main things that they say is that their pain and symptoms are dismissed; they are not taken seriously. We have to address this, finally, and that will involve real training and education for healthcare professionals.

Q30 **Chair:** Nandi, you raised your eyebrows as well; you have a game face as good as mine. We have heard in previous sessions, and in the Health and Social Care Committee's work on black maternal health, how black women's pain has been dismissed time and again, so I just want to bring you in.

Christine Jardine: It is depressing.

Dr Simpson: Absolutely. The perpetuation of tropes about angry black women or strong black women and "Mrs Begum" syndrome driving all these things is really unhelpful. I also want to add a point about research. Research about pain and its treatment is mostly based on a white male body as the norm, and as Janet points out, there are real funding gaps in relation to research and a real need for research that is fit for purpose by being representative of both ethnicity and gender. Addressing that research gap is really important as well.

Q31 **Christine Jardine:** That is important, because if you are only researching male pain, at least half of the population is excluded. We understand that NHS England was due to hold a stakeholder roundtable on managing women's pain in the spring of this year. Did it happen? If it did, are you aware of any actions arising from it?

Janet Lindsay: It was yesterday morning.

Christine Jardine: It took place yesterday? Better late than never.

Janet Lindsay: It took place yesterday morning as part of the women's health strategy refresh. It was a really positive session; there was really good inclusion from many different bodies.

Emma Cox: It was led by Baroness Merron, and it was NHS England, the Department of Health and Social Care and various stakeholders.

Janet Lindsay: And women with lived experience and obviously healthcare professionals. It was solutions based. It was a very good session and we look forward to what comes out from it.

Q32 **Christine Jardine:** This may be an unfair question, but how confident are you of what will come out of that session?

Janet Lindsay: I am confident that the intention is there. Certainly, I have great belief in Baroness Merron from the Department of Health and Social Care. We also have Lesley Regan, the women's health ambassador, and Sue Mann, who heads women's health at NHS England. They are all very impressive, and I am sure what will come out will be good. How it gets translated on the ground afterwards is always the question, and that is going to be very challenging for any health condition at the moment, but I am optimistic that there will be some good words coming out. It is about how we as charities and others support that to be implemented on the ground.

Q33 **Christine Jardine**: Finally, Nandi, I want to ask about discriminatory attitudes in the NHS around minority racial groups and tolerance for pain. Is there anything you want to add, because it sounds as if this should be a priority?

Dr Simpson: Absolutely. Obviously, there is a point about healthcare practitioner training, and the Race and Health Observatory has commissioned some work around decolonising curricula. We hope that there will be some recommendations and insights that can feed into better training for healthcare practitioners. But there is also a point about accountability and the need to see dismissal of pain or inequitable variations in the way that care is delivered as a quality and safety issue, and there is scope for accountability through regulation in relation to that.

Kevin McKenna: Before I start, I have to declare my interest and draw attention to my entry in the Register of Members' Financial Interests, because I worked at NHS England for seven years in the strategy team. This is quite personal to me anyway, for a whole set of reasons, but I want to look a bit more at the system-wide impacts, in particular of some reorganisations that are happening in healthcare in England at the moment. Are there risks to the delivery of services specifically for girls and young women in the plan to merge the functions of NHSE into the Department of Health and Social Care? Several eyes lit up there, but that is for Janet in the first instance.

Janet Lindsay: Without a doubt, there are risks with the merger, because it could lead to a loss of capacity, expertise and momentum for women's health. When you are making change there is always a period when there is disruption, and we have to be very careful. There could be a loss of operational focus. Obviously, DHSC is primarily the policy Department and NHS England is the delivery arm. We have to remember that there could be reduced bandwidth for women's health because civil servants are really concerned with the structural reorganisation. Obviously, that could cause a loss of continuity with the relationships with the ICBs, which have been reduced anyway, and local systems. We need to make sure that there is operational capacity and that regional delivery is not weakened. Again, when it comes to health equity, we must make sure that we are protecting those who are affected most and who are not able to protect themselves.

Emma Cox: I agree with everything that Janet said, but I will just put some of the other side as well. There is a real opportunity to get a smidgen more agility into the NHS processes. For example, some ICB directors have spent nine months trying to get something through on women's health that an independent women's health hub could change in three days just because they are funded differently. There is real potential to actually start looking at how we deliver on the ground in some circumstances rather than having as much bureaucracy. There are always two sides of the coin on that one.

Q34 **Kevin McKenna:** I have a lot of affection for NHS England and, because I have worked there, I have a lot of insight into what did not work well, so it is interesting that you said that. What could the Government do to reassure you all that this will work and can be made to work? What do you need to hear from the Government?

Janet Lindsay: We really need some kind of repository for best practice. Colleagues have highlighted Oxford and Bristol; there are great women's health hubs around the country. Yesterday, we heard about others in Sunderland and Birmingham. There is some fantastic work going on out there. You are absolutely right about agility; this is an opportunity as well as a concern. We know what works and what is good out there, so let us roll that out in different places.

Emma Cox: From my perspective, which is merely one, we need a commitment not to throw the baby out with the bathwater. It is great to see things being slimmed down and so on, but there are some exceptionally enthusiastic and talented people in NHS England who are doing great work. I suppose the question in terms of strategy is what is going to be kept and moved to DHSC, and what is not. When they are looking at things like severe service specifications and some top-level commissioning, I am sure that could be done in a different way but it would be good to get reassurance and commitment that the top-level roles will still be done, just, hopefully, a bit more agilely.

Q35 **Kevin McKenna:** Should roles like the women's health ambassador and the national clinical director for women's health be kept, or is this an opportunity to maybe change them?

Emma Cox: I am going to give a personal view. I think they are both amazing, and they seem to work really well together; it would be a real shame if either of them was not there. There is a big job to do. I am sure there is a job for both those roles, but again, when it comes down to it, what is the job that needs doing, and how is that going to be taken forward?

Katharine Gale: I would like to see the expert nurse also at that level. We often talk about GPs or consultants but there is a huge workforce of nurses in primary care, and then we have the expert gynae nurses at nurse consultant level or specialists. It is really important that we look

across the workforce to deliver the plan, so I would like to see a nurse representative.

Q36 **Kevin McKenna:** I am so glad that someone flew that flag. It is a constant battle to get nurses, AHPs and patients on to these and that is very important.

We are shifting from largely an NHS organisation, in NHS England, to a civil service organisation. Should these roles still somehow be in and of the NHS even if they are moving into the Department, or does that not matter?

Emma Cox: If you have just had eight years of suffering, not being able to go to school, dropping out of university and not being able to do the job you want, you just want it to work. I know that is a really naive answer in some ways, but the whole thing about it is: what are we trying to achieve and what is the best way to deliver that? If I think of the people I know with endometriosis and mental health conditions, it is about deciding what we are trying to achieve strategically, and then people deciding the best way forward at a strategic level so there is that driver to see these things through.

Katharine Gale: We cannot let these young girls suffer like their mothers did. If we can get it right for young people now, we will reap the benefits for decades to come. It has to work. It has to be timely and it has to be effective.

Q37 **Dame Nia Griffith:** You will be very aware that in the 10-year health strategy there is an emphasis on moving from hospital to community, and from sickness to prevention and early intervention. You have talked about waiting lists, the specialisms that gynaecologists now have which make them even rarer and make it more difficult to give access to everyone, and the difference in very deprived areas just in simple things like GP provision. Do you think the 10-year strategy is going to deliver well for reproductive healthcare for women and girls? Are there caveats we should raise with the Minister? Are there ways we could really make this work? We all like the idea that it is local and you get early diagnosis, but you have shared stories about how long it takes to be recognised as even having a problem. How is it going to work? How are we going to spread the expertise?

Emma Cox: We need to take a little step back, because there is a big workforce element to this and having the right people and the right training is important. One thing we have not touched on is that menstrual health training at medical school is, to be polite, lacking for all healthcare practitioners. We are talking to some current and recent medical students who get very little training indeed, so there is a whole workforce piece, which I know underpins the plan. Those with endometriosis and mental health conditions are younger; they are working, at school, at university and so on. They need something that fits in with them so they can go somewhere locally or can access the care in the way they need. Not all

but many of them are quite digitally literate. I know people who have not had smears who really know they should have smears but because they have to get one several miles away from where they work, they do not want to take a day off work and so on.

The focus is good. The caveat I would give is that some people will need to go to hospital for secondary and tertiary care, and how do we get waiting lists down by giving everyone the support they can have in primary and community care, as good as it is, but not block anyone from getting the care they need should they go to hospital? You cannot prevent endometriosis, so Endometriosis UK has taken prevention to mean prevention of symptoms. There is a real positivity there because, of course, for some, if left untreated, endometriosis and mental diseases progress. It not only stops suffering but saves the NHS money if we drive that by trying to prevent things from getting worse.

There are some real positives, but we need to make sure that we still have the right secondary and tertiary care access should people need it. We should also support our GPs. Can you imagine how difficult it is for a GP to know everything there is? We should support GPs so they have the information and the access they need to support their own patients. That is where the neighbourhood hubs and communities come in as well.

Q38 **Dame Nia Griffith:** The other strand is this idea of using far more digital—what the Government call the move from analogue to digital. Where do you see the opportunities and possible difficulties there?

Emma Cox: One issue with the diagnosis of endometriosis is that things are missed—lots of symptoms are missed—and I have always felt that it would be a great thing for AI to help identify patterns of conditions. In fact, it is something the ONS is looking into. Just this morning I was talking to one of the new neighbourhood groups that is looking into doing a special thing on women's health. We run a nurse-led helpline with a couple of specialist nurses and we have been surprised by just how many people prefer to use email even though they can get evening and weekend calls. That is great, but not everybody does, so it is getting the balance between what the technology can really help with and what needs to be face to face. It needs to make sure there is no discrimination built into it and that it is not used at the exclusion of anyone who is going to use it or not.

Q39 **Chair:** Before you move on, Nia, I want to ask about tech. We recently heard from an Icelandic neuroscientist working in genetics who was looking for markers for endometriosis. How far along are we in learning from international counterparts? Are we partnering with some of this international research? Does anybody know?

Emma Cox: I am told that Norway has one of the best biobanks and data things because it has data from people from a young age. One of the ONS team is going to Norway to study for eight weeks. The team led by Krina Zondervan in Oxford is probably leading in endometriosis

genetics in the UK. There is an organisation that has always been based in the UK—World Endometriosis Research Foundation—which has developed protocols that can be used globally to collect samples so all the biodata can be used. There is also quite a large EU project across nine countries, including various UK projects. From what I understand, the Oxford team is leading on the genetics on that one as well.

Q40 **Dame Nia Griffith:** Continuing on the 10-year strategy, we hear that the costs of the integrated care boards are supposed to be reduced by 50%. What impact do you think that might have on women's reproductive healthcare?

Emma Cox: It is not really working for women's healthcare at the moment so I am not sure if I could honestly say. If it was doing brilliantly, it might be different.

Katharine Gale: There is a risk that it will stop new innovation and new pathways. We have often talked about the need to spend to save. If we are not doing that, then we are stuck with what we have, which is not working, so it is a real risk.

Dr Simpson: There is also a risk that inaction on ethnic health inequality will be deprioritised because that is what we always see when budgets are squeezed and when reorganisations happen. Part of the issue with that is that there might be short-term gain, but actually it jeopardises longer-term return on investment.

Dame Nia Griffith: And unnecessary pain and suffering.

Dr Simpson: Of course.

Janet Lindsay: There needs to be a relentless focus on inclusion because it has just been left behind. Whatever the newly created organisation is going to be called, the NHS and DHSC really need to be working with grassroots organisations. They know their communities best. This comes back to best practice: what are they doing out in the community and how can we help them to do it even better and reach more people? If they are doing it in one place, can we learn from that and implement it somewhere else? That will help with community, digital and prevention.

Dr Simpson: That is a really important point in relation to trust. Trust takes a long time to build with communities and it is really important for this kind of work and for equity in this kind of work. With the abolition of independent healthwatch organisations, there is a risk that the public will not necessarily have trusting relationships with ICBs as unconflicted arbiters of their concerns.

Emma Cox: To build on Janet's point, it feels like every NHS department has to invent its own leaflet on everything, and its own thing. If there was more concerted effort to say, "Well, something's been done and it's

good; everyone can use this," rather than it being reproduced in every ICB and trust, there could be savings overall as well.

Q41 **Dame Nia Griffith:** That sounds very sensible. The other thing that has been announced recently is the refresh of the women's health strategy. What do you all want to see from that? Do you feel that over the long term the Government are going to give it the importance and the centrality that you would like to see?

Emma Cox: There has obviously been a commitment by the Government around women's health and inequality, which I am sure we would all like to see. If we could see more measurable targets and clear actions, it would enable us to see more clearly the progress that will be made in the next few years.

Janet Lindsay: Refreshing the strategy is a really important thing to do, and there is great intention. Obviously, we need to see the plans and how they are going to be implemented, and then we need to make sure that there are targets and that we hold them to account.

Katharine Gale: Women's health is everybody's business if you work in healthcare. It is really important that we go back and put something in about education and make it a standard that everybody should understand the female body. Whether you are an orthopaedic surgeon or in neurology, it really does not matter. For me, it is about going right back to the beginning and saying, "Right, education of all," and looking at the role everyone can play in improving things. If you have a patient in front of you who is a woman, you need to be asking about menstrual health, about her period, and linking that with rheumatology or whatever she might be presenting with. We are missing opportunities. I think there is this thing that, "It's gynae and below the pant line and nothing I want to deal with," but we are female and many of our conditions are whole-bodied, particularly around pain and neuropathic pain.

Emma Cox: I realise this might be a somewhat dull point, but the coding in the NHS for menstrual conditions is shockingly bad. If the women's health strategy is going to be supported, the NHS needs to get to grips with how we code so we actually know how many people have endometriosis, fibroids and so on, and who is being dealt with in primary care or not. There is a real structural point there about the need to be able to audit. There are no audits done in quite a lot of those areas.

Chair: Data is never dull.

Katharine Gale: The aggregated data is really important as well, from ethnicity and from deprivation. Being able to drill down and look at the time to diagnosis and the processes that are happening from an individual's point of view is really important, and I do not think we have that information.

Dr Simpson: As an adjunct to those disaggregated quantitative data, we also need to collect qualitative data to actually understand people's experiences.

Chair: That is probably a good point to end today's really informative session. This was a brilliant way to start off the inquiry. Thank you very much.