

Women and Equalities Committee

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

Wednesday 17 December 2025

Ordered by the House of Commons to be published on 17 December 2025.

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

Questions 79-138

Witnesses

I: Kate Lancaster, Chief Executive Officer, Royal College of Obstetricians and Gynaecologists (RCOG); Ruth Bailey, Chair, Women's Health Forum, Royal College of Nursing; Professor Margaret Ikpoh, Vice Chair, Professional Standards, Training and Development, Royal College of General Practitioners; Dr Charlotte Porter, Vice President (Specialty), College of Sexual and Reproductive Healthcare.

Examination of witnesses

Witnesses: Kate Lancaster, Ruth Bailey, Professor Margaret Ikpoh and Dr Charlotte Porter.

Chair: Good afternoon and welcome to the Women and Equalities Committee. Today we are holding another evidence session on reproductive health conditions among girls and young women. We will be hearing today from Kate Lancaster, the chief executive officer at the Royal College of Obstetricians and Gynaecologists; Ruth Bailey, chair of the women's health forum at the Royal College of Nursing; Dr Charlotte Porter, vice president at the College of Sexual and Reproductive Healthcare; and Professor Margaret Ikpoh, vice chair for professional standards, training and development at the Royal College of General Practitioners—welcome to you all, and thank you. Margaret, your title is really long.

I am going to hand straight over to Alex, because we have a lot of questions to get through.

Q79 **Alex Brewer:** It is really lovely to see you all here today, and thank you for coming in. I will address this to all of you, so if you can keep answers fairly succinct, if possible, that would be great—as Sarah says, we have quite a lot to get through.

What advice or support can your organisations offer the Government as it looks to implement new guidance on teaching about menstrual health in schools?

Ruth Bailey: I represent the Royal College of Nursing, as you know, and we believe that this is an area where nurses play a key role. We know from polls that nursing is the most trusted profession, and we know that nurses play a key role. They have exquisite skills in listening and imparting health education. School nurses have an enormous contribution to make, but unfortunately the workforce in school nursing has reduced by 27%. What we ask from Government is for some investment into the workforce, which we know can really make an impact.

Professor Ikpoh: From a GP perspective, although we are not directly involved in the school curriculum, we have a number of GPs who are engaged in charitable objectives with Education for Choice, which is an organisation supported by the RCN and the RCOG, as well as Charlotte's organisation. This is about training the trainer: so, we go in and train medical students to go in and train secondary school students on reproductive health. We do that voluntarily, given the time constraints we have in general practice. Our ask, particularly with the younger cohorts where we feel we need more time in consultations, would be something to factor in time into our consultations—10 minutes is not enough to get to the bottom of cases, particularly if you are dealing with teenagers who have a complex case.



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The other thing we are anxious about is the Crime and Policing Bill that is going through at the moment, which will change the curriculum on sexual health. Currently, children are taught that they can generally get confidential sexual health advice from their GP or medical practitioners. While in general the Bill is a good thing, the unintended consequence is that we would have to report every 15-year-old that is having sexual intercourse with an 18-year-old to safeguarding. That would damage a great degree of trust between us and that cohort where there are no founded concerns around abuse. I would encourage Members to think about that and support us in addressing that issue.

Kate Lancaster: I will not repeat the very valid points that my colleagues have made. But to elevate those points, as we move forward with sexual and reproductive health training in schools, the overall aim needs to be about having the time that is required to do it properly, and destigmatising the conversations. We need to use properly anatomically correct phrases, even with very young children, and aim to impart some knowledge so that girls are empowered to manage some of their own conditions, but equally recognise when conditions exist that are not normal. We love the fact that the new rules have boys and girls taught equally. That matters as we develop as a society.

Dr Porter: We have to give young people the language to be able to express themselves about sex and say words like “vagina” in a comfortable way. That is important both for the young people and the people giving the information. My daughter is a teacher in a big secondary school in London and often the sexual health education is handed over to the youngest member of staff. That is not appropriate; those members of staff need to be supported. My experience of delivering sexual health in school is that it is important to be able to say words like “gonorrhoea” without blushing or becoming embarrassed, and it is important to support the staff in order to do that.

Q80 **Alex Brewer:** Have the Government sought your advice on teaching this part of the curriculum?

Kate Lancaster indicated assent.

Ruth Bailey indicated assent.

Dr Porter indicated assent.

Professor Ikpoh: Not that I know of, but I will come back to you afterwards if it is any different.

Q81 **Alex Brewer:** Ruth, what role can school and sexual health nurses play in identifying and referring girls who need menstrual health care?

Ruth Bailey: First of all, it is about recognising what is normal and what is not. We know from extensive research that women and young girls are often dismissed. They need to know what is normal and what is not. They need to have access to a skilled professional who will validate their concerns and who can talk to them about their options for management.



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Sometimes, that will be about a pathway to have further investigations to see what is going on; sometimes it will be about talking to young girls and their families, if that is appropriate, about what their choices are. It will be about making sure that their choices can be put into play.

It is no good saying to a young woman with heavy menstrual bleeding, “A Mirena coil will be just the job for you. It will completely transform your life”, if they then cannot access that because their primary care has not got a LARC fitter or they are not able to access sexual health. It is about making sure that people have access to appropriately trained healthcare professionals. It is important to note—I am sure you are going to come on to talk about education and training—that we need standardised education and training so that healthcare professionals recognise what is normal and what is not.

Q82 Alex Brewer: Thank you; I think we will come on to that in a minute. To clarify, you mentioned earlier that there has been a 27% reduction in school nursing staff. Is that affecting the ability to deliver this particular area?

Ruth Bailey: It certainly is. The knock-on effect is that the school nurses who are there are having to do more with less. We know that one of the key concerns across the nursing profession is around safe staffing, and the focus of their work is very much around safeguarding. That is an absolute priority for them, which frees up much less time to be able to do the listening, pastoral care and health promotion. That is consistently what our school nurses have told us.

Q83 Chair: Ruth, I just wanted to follow up on a question there. It says “school and sexual health nurses”. Is the title “sexual health nurse” sometimes a barrier to girls—particularly young girls—coming forward with issues about menstrual problems they are having?

Ruth Bailey: I don’t know that it is. I think there are two things here: the term “school nurse” is a recognised qualification; “sexual health nurse” is our umbrella. I would call myself a sexual health nurse; I work in primary care. There are school nurses who have additional training to be able to deliver sexual and reproductive health. There are sexual health nurses who are working in sexual health clinics alongside some of my colleagues here. The barrier is not about titles; it is about having the right nurse in the right place at the right time, funded and free to have those consultations.

Q84 Chair: Charlotte, did you want to come in on that?

Dr Porter: I would agree. I think it is about funding, having adequate appointments and adequate access to those appointments, and the ability to have walk-in clinics, particularly for young people.

Q85 Kevin McKenna: I want to look at diagnosis, diagnostic tools and treatments that are available. Kate, tell me a bit about what diagnostic tools are coming along and what progress has been made on them, and about new treatments.



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Kate Lancaster: Any new treatments and diagnoses are required to be built on evidence. We do know that in this country—and, in fact, globally—there is a real gap in research into women's health. In many ways, that is the bit you need first, before you do any more. We were delighted by the establishment of the National Institute of Health Research. There is a particular fund there for reproductive health, and the NIHR have developed their inclusion strategy.

There is a lot of work that is beginning to happen, and some surveys and research happening, but there is a real gap, particularly around data capture for inequalities and those areas of real concern. There are the new diagnostics and treatments, but they have to be built on evidence, and we know that there is a real gap around evidence for women, particularly for women-only treatments. That is the first thing.

Equally, we know that less than half of the surgical hubs and diagnostic hubs around the country, I think it is, are actually available for gynaecological treatments, so, again, we know that we have a big gap. While, to be fair, there is progress being made, there are huge gaps still, and we have so much further to go.

Q86 **Kevin McKenna:** Margaret, is that the case in primary care as well?

Professor Ikpoh: In terms of diagnostics, it is not usually our forum but, saying that, there are some really good symptom checkers that have evolved in the last year. Primarily, the one from Endometriosis UK has been quite profound in terms of dealing with patients, and it empowers them when they come to the consultation room. The challenge, once we refer the patient, is making sure that the whole system is aware that the tool exists, because often you get some pushback from your colleagues who say, "What does this mean? Have you tried A, B, C, D or E?"

Just to reiterate what Kate is saying with regards to research: in primary care, 90% of all NHS activity falls at our front door, but we get less than 10% of the funding and we do less than 10% of research. But this year has been quite extraordinary with the amount of funding that we have received from DHSC in terms of funding capacity and capability in primary care, so I am really hopeful for what the future is going to bring within that space.

Q87 **Kevin McKenna:** This is to anyone, really: is there anything more that the Government could be doing?

Kate Lancaster: One of the areas that we are a little bit concerned about is that, when women do find themselves in secondary care, one of the big areas that is lacking at the moment is availability of scanning, and we know that a lot of the diagnostic areas are very under-resourced. If you have gone along for an appointment and it has to be cancelled because the scan has not been done, we are seeing a lot of repeat appointments and all the rest of it so, on your question about diagnostics, scanning is a real gap that we are very worried about.

Q88 **Kevin McKenna:** Ruth, do you want to come in?



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Ruth Bailey: I just want to make the point that 2% of research funding is currently focused on reproductive health and childbirth. That, to us, is totally unacceptable. If it is in your gift to look at the allocation of research, that is a priority.

Q89 **Kevin McKenna:** That is very helpful. I nearly forgot you, and I should never let doctors talk over nurses; that would be very bad on a personal level. I will move on from diagnosis and treatment to the real reason we are doing this, which is the outcomes, and particularly the outcomes for minority ethnic groups. Charlotte, where do we need more research and data to understand how to get better outcomes, particularly for minority ethnic groups?

Dr Porter: I think we need to promote engagement and ensure that those women are able to access our services. I think that, sometimes, having the word “sexual” is not necessarily something that will draw in women from other communities. I am aware that we have lost, for instance, our clinic on a Friday afternoon, which was very important for some women to be able to access services. It is really important to draw people in and to hear their voices.

Online tools are important, and the College of Sexual and Reproductive Healthcare has produced something called “Contraception Choices”. That online availability of reliable information is really important, as is getting feedback from those voices on what they found on our website.

Q90 **Kevin McKenna:** For the Committee, why Friday afternoons in particular?

Dr Porter: It is about when women may be able to access services without other people knowing that they are going.

Kate Lancaster: I want to take us back slightly to research. On your point about equalities, one of the big things that I mentioned was the inequalities gap in research. Our view is that the Government need to do more to encourage people from ethnic minorities to take part in research. That is often where there is a data gap.

It is absolutely well recognised that women from ethnic minorities are likely to have poorer outcomes in a whole range of areas, particularly if you look at women’s OB conditions. We do not know enough about, for example, fibroids, which disproportionately affect black women. It is again about why that is the case, what the treatments are and—on the point earlier about innovation—how you can really drive that forward.

Equally, within the NHS, ethnicity reporting is not complete. We know that some members of staff struggle to ask, and it is sometimes easier not to ask. Actually, in our view, women’s self-reported ethnicity is what should be recorded. At the moment, we know that outcomes are poorer, but we do not have enough data to be able to say, “This is how we will tackle the problem.” Gaps are there before you actually tackle the outcomes bit.

Professor Ikpoh: The data gap is huge, and the Race Equality Foundation and Wellcome Trust have acknowledged that. I am hugely



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supportive of—and would encourage all of you to support—the all-party parliamentary group, which is chaired by Paulette Hamilton. Two days ago, they released a report on fibroids, which demonstrates that someone who looks like me is three times more likely to have a fibroid, and—conflict—I have a fibroid.

We should support those initiatives, because as bad as covid was—and it was terrible—one of the positives was the level of engagement with key stakeholder groups, such as the Caribbean & African Health Network; it has been absolutely profound. Any way that we can support that and embed culturally sensitive and competent material and resources in our practices would go a long way in engaging our patients.

Chair: I am sure I speak for the majority of the Committee in saying that we will always try and support Paulette's work; she is an absolutely brilliant colleague. I think this a good place to move on to workforce training.

Q91 Dame Nia Griffith: I would like to start with the initial training of doctors and nurses. How do you feel the training matches up to the needs in the field on menstrual and reproductive health?

Ruth Bailey: I can answer that very simply: it doesn't. There are a couple of key problems, one of which is that there is no fundamental requirement to have standardised basic education on women's sexual and reproductive health in nurse training, which may come as a surprise to some people. The NMC has set standards of proficiency for education, but they are not nuanced to reflect standardised modules on women's health; changing that would be very welcome.

The second problem is that roughly half of all contraception and reproductive health is delivered in primary care. The backbone of the workforce in primary care is GPNs—general practice nurses—and there is no standardised training for those nurses to deliver sexual and reproductive health. The way that the training works—and it is additional training—is that you do one module on immunisations and one on long-term conditions. There is no requirement to do one on women's health, though you might want to do one on cervical screening. Nurses that undertake additional training are self-selecting. We need to reach the people who are not self-selecting as well; we know that they are out there. Every nurse and doctor comes into work to make a difference to people; we all want to do the right thing, but you need to have sophisticated skills to be able to deliver on patient need.

Another key barrier is that many nurses are having to pay for their own training and education, which may come as a surprise to the Committee. My background is in sexual health, and I paid for my letter of competence to fit coils and implants. I am glad that I did, but if we are relying on the workforce to fund their own training then we already have a barrier. Commissioning does not reflect the current need: commissioning needs to be embedded in service planning not just to release people to undertake training but to release people like me from clinics to be able to train

others. I am going to stop there, because I think Margaret will have something to add to that.

- Q92 **Dame Nia Griffith:** Could I just butt in before we move on to doctors' initial training? When you say that nurses pay for the training themselves, is that purely financially, or are they expected to give up days off to complete that training?

Ruth Bailey: In primary care, nurses are more likely to have the funding to undertake LARC training and diplomas in contraception and sexual health. In sexual health, conversely, they are more likely to have to pay for it themselves. Yes, there is an expectation that you would not be able to complete a diploma without undertaking training in your own time—you just would not be able to do it.

- Q93 **Dame Nia Griffith:** It is obviously very disappointing to hear about that initial training thing. I will come on to the initial training of doctors, but I would like to pick up one more point that Ruth has made. In almost all professions, it seems very difficult to "sell" generic training. Everybody will pick a course in their specialty, rather than signing up for something general such as women's health. Is it a problem that people are selecting different types of training to undertake in their professional lives as opposed to their initial training?

Professor Ikpoh: From a GP perspective, it is a challenge. We have the broadest curriculum of any specialty, but we are given the shortest time to deliver it; it is from cradle to grave, and we only have three years. With the system and time constraints, and workload pressures, we have heard of the concept of dismissal that you have just alluded to. You often hear that patients feel dismissed within the consultation. Most GPs wake up to deliver evidence-based, compassionate care, but the system just does not allow them to do that. At least 64% of our membership—we have 54,000 members—say that they simply do not have enough time within the consultation.

There may be a degree of cherry-picking, but we are all committed, as GPs, to lifelong learning. Our curriculum is reviewed every three years, and we are appraised every year, with revalidation at the end of every five years. This is a real burning issue that we want to address. I keep coming back to the same thing about time and pressures on the system, which do not allow us to deal with the conditions that we need to deal with.

Kate Lancaster: Obviously, members of the RCOG have selected women's health, so all their training is in women's health and they are very familiar with the issues that we are discussing today. One of the thematic points, though, is that getting to secondary care is quite a hurdle, and the majority of care is delivered in primary care, as Margaret quite rightly says.

We do a qualification called the DRCOG for general practitioners to enhance their knowledge of women's health and the latest thinking in women's health. But it comes back to the point about time for training. I know you were talking initially about qualifying training, but this an issue

throughout careers. For example, if you look at maternity and having time away from the clinical environment to invest in updating your skills and focus on safety, all those sorts of things are really challenging when you have a busy clinical environment. It is not just about training or the funding for it, but about space away from the clinical environment.

We know training particularly works well where it is multidisciplinary—that is the gold standard, if you like—but having a whole team come away from a clinical area to train together is even more challenging, so it is hard to achieve.

Dr Porter: We know that trainers are more likely to be burned out, compared with their peers who are not doing training work, so it is really important that we support medical educators in their roles, whatever part of the multidisciplinary team they are teaching.

Q94 **Dame Nia Griffith:** What about the initial training of doctors?

Dr Porter: In terms of the medical student curriculum?

Q95 **Dame Nia Griffith:** Yes, do you think it is efficient?

Dr Porter: Obstetrics and gynaecology has been squeezed. When I was a trainee, we had to deliver 40 babies, and now trainees will witness six, so that there is a massive difference in the experience that our medical students get. That carries through into the experience they get in primary care. The training that they now have is based much more in community, and that means that they do not see what happens in secondary care. That division creates an increase in referral rates, I think.

Professor Ikpoh: Absolutely. When the European working time directive came in, although it was a good thing, it meant that there was a decrease in clinical contact in hospital environments.

Every GP will have core undergraduate training, and what we try to do as a college is to build upon that, to build their confidence as they progress through their career. We recognise the strength in working with the College of Sexual and Reproductive Healthcare and RCOG. We have produced a really good women's health hub and women's toolkit. I have made a note of the GPNs not having standardised training, because it is just madness that, as a general practice, we do not embody our GPNs in our training system.

We are trying to embed things culturally that we have been blind to. For example, we talked about racial disparities earlier. We have worked with NHS England and organisations such as Gilead in recognising symptoms of breast cancer for example—I know that that is not reproductive health—and reproductive issues in black and Asian women.

Q96 **Dame Nia Griffith:** Ruth mentioned selective training—those who select something. Are you saying that it is exactly the same in GP training and, because there is no standardised curriculum, it will be certain individuals who select to become more aware of the latest developments in women's

health?

Professor Ikpoh: Our curriculum requires every GP registrar to know about women's health issues. There are two clinical topic guides: we have one on maternal and reproductive health and the other on sexual health. They are all assessed through three different channels—testing and face-to-face teaching—so they are all required to know it through the curriculum, which is reviewed every three years. That is something that they cannot get away from, I'm afraid. They cannot select it at registrar level, but once you become a GP then you are, of course, an independent lifelong learner.

We have the women's health hubs, so we are seeing an increasing number of GPs opting to train up in them, which is great. It gives them flexibility, and gives us the flexibility to direct particularly complex cases to them, although I am mindful that in my patch in the far east—Hull—we do not have equitable access to those health hubs. Unfortunately, not all ICSs are treated the same. We would love to see every woman able to access the right place at the right time and with the right practitioner.

Q97 **Dame Nia Griffith:** Perhaps we could follow up on that in terms of the number of specialists overall. Do we have enough specialists in women's health?

Ruth Bailey: I would immediately say no, but you would not expect me to say anything other than that. As Charlotte says, one of the challenges with women's health being constrained within the initial curricula is that we want people to choose women's health as a specialty. I want people to choose O&G as a specialty, but if you have not experienced very much of it then you are unlikely to do so. One of my jobs is to encourage people into the specialty, but we need more training places and more time for people to train while they are there—and when they are there, we need to value those individuals and give them the space to learn and continue their development throughout their career. Medicine is changing so rapidly, particularly in women's health, so we need to keep that knowledge up to date.

Q98 **Dame Nia Griffith:** One last question: young women in particular often find it very difficult to go to a doctor or a nurse—dismissive attitudes have often put girls off—so is there any specific training in dealing with younger women and being sensitive to their symptoms?

Professor Ikpoh: Sometimes it is just kindness, not specific training. The other day, one of my daughter's classmates was not allowed to go to the toilet—it is just basics. She had leaked completely through and was too embarrassed to stand up. Ruth talked about the 27% reduction in nursing—that has an impact through the GP's front door. I will have a whole consultation from a patient just wanting a note to say, "Can you just tell them that I need to go to the toilet when I need to go to the toilet?". It is extraordinary.

Ruth Bailey: Evidence from Brook, which we work quite closely with, shows that young people want easy access, they want to be in a non-



medicalised environment, they need to have access to walk-ins—to be able to pitch up—and they need specially trained staff able to meet their needs. There is training and really good education around, but there is not a sufficient workforce or sufficient facilities for that kind of service, which we know can be transformative for young people, to be offered.

Dr Porter: Our diploma in sexual health specifically deals with young people as part of that curriculum, but we have fewer candidates undertaking that training. In terms of our specialty programme, we are overburdened with people wanting to apply, so we have a real mismatch in terms of the number of people who want to be involved and the number of people who are able to get a post working in community sexual health.

Q99 **Chair:** My question follows on quite nicely—well, not nicely. Throughout this Committee’s work on medical misogyny, through to this inquiry, I am often asked as Chair what simple thing can be done to change girls and women’s lives when it comes to their health. Quite often I say, “Just listen to us the first time.” We know that three quarters of girls say that their menstrual pain was completely dismissed the first time that they went to see their GP. I know that is something that you are all working towards eradicating, but that is the reality for a lot of girls going to their GP. This is also the case for a lot of grown women—and I am pretty sure that all of us at some stage will have had the same experience, where our pain was dismissed—but it is even more so for young girls, particularly when talking about their periods and menstruation. What needs to happen to stop girls and women’s pain from being dismissed, Kate?

Kate Lancaster: It is simple to say and hard to achieve, but it is that listening point, and I mean in all areas. First, it is about educating women, because often we are hearing that women themselves are not necessarily the best cheerleaders for their daughters. They say, “Well, it was like that for me; you need to put up with it.” That does not help us as a gender at all. There is something around understanding what is normal and, therefore, calling out what is not normal.

On period pain, for example, if it is hampering your ability to live a normal and productive life then it is not normal. It is about the pain, and it is about being able to have the discussion and actually listening to that individual. It goes back to Margaret’s point about kindness; it is simply about that human kindness. I think the feminisation of medicine generally is going to help. When you look at our demographics, about 75% of our trainees coming into the specialty are women. They will have had their own experiences.

When the women’s health strategy went out for consultation in 2022 one of the resounding comments that came back was about the inability of professionals to listen to women’s pain and not dismiss it. Whether that is period pain, hysteroscopy or whatever it might be, it is actually about listening and understanding that pain is a very individual thing. Labels like “a period-type pain” are actually enormously unhelpful, and some of the racial stereotypes, such as black women having higher pain thresholds

than white women, are just nonsense. It is about dispelling some of the myths and educating people, but mostly about listening.

Q100 Chair: How do we hold a GP or a nurse to a standard of “I have been listened to”? With some of the other metrics and training, it is much easier to say, “You have met this requirement; you have not met this requirement”, but when it comes to the basics of kindness and listening, they are supposed to be innate qualities, I guess, but some people actually have to learn them. How do we hold them to account and to that standard?

Professor Ikpoh: We have patient participation groups. For me, it is about patient empowerment; as a GP, the first thing I want to do is empower my patients to be able to hold themselves in the consultation and ultimately, if you are not happy, as I will say to any family member, go and seek a second opinion. There are pathways within general practice where you can do that. I am not encouraging people to complain, but if you are not happy about something, once I know better, I want to do better. Unless people report that and unless we can have a clearer pathway to that, then that is what needs to happen. For me, it is really about patient empowerment, and obviously about educating our GPs to be more confident about dealing with complex cases.

Chair: Thank you very much. I am going to hand over to Christine, who will finish off on managing pain.

Q101 Christine Jardine: Ruth, I will ask you this first: NHS England held a stakeholder event on women’s chronic and procedural pain last month; did your organisation take part in that?

Ruth Bailey: Yes, we had a representative from the RCN there, and I am really glad that we did, because pain management is absolutely key and is a central nursing concern. It is nurses who are primarily there at the bedside in acute care, where many gynaecological procedures are carried out, and also in the community in some of the roles that we have discussed today. What we really wanted to highlight as the college is that we can do something about pain; we can listen and we can validate.

What I think is really important is talking to women about their choices, such as for managing pain in gynaecological procedures or sexual health procedures, and being able to equip people with choices to empower them. It is also about being able to evaluate whether a strategy is working in primary care and to have ongoing dialogue, saying, “This is what we have put in place to manage your period pain. Come back to me in three months and tell me if this has worked, because if it hasn’t, we need to do something about it.”

However, all that requires time and investment in the workforce, and our nursing workforce is shrinking. That is a real concern to us. We have just under a 6% vacancy rate. The key concern is safe staffing—looking at our ratios of nurses to patients—because if we do not have safe ratios, we are on a hiding to nowhere in trying to give people quality care, listen to them, and go through their choices.



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Those were some of the things that we wanted to highlight in that important roundtable. The other thing to say is that, in working with patients, particularly in the community, some of the patients who have the most dreadful experiences of pain—by dreadful, I mean unable to function, unable to go to work and being disadvantaged in education and employment—need support from our surgical colleagues, and then face dreadfully long waiting lists. That is of extreme concern. It is actually really difficult, when you are in a clinical area, to watch somebody suffering and not be able to do anything about it.

Q102 Christine Jardine: Are there specific actions that came out of the event, that you are aware of, to try to bring that under control or address it in some way?

Ruth Bailey: One of the actions that has been highlighted—this is a recurring theme today—is investment in education, investment in the workforce, and something we have not talked about so far, which is looking at being able to invest in advanced clinical practice. That is about looking at freeing up nursing skills to going along a career trajectory: nurses as hysteroscopists or colposcopists, nurse consultants, or nurses working in pain management clinics.

The RCN published a report today called “Left Behind”. It identifies that nurses are twice as likely to stay on band 5—that is entry level—than their colleagues in other allied professions. That indicates that nurses are not having the opportunity to develop their skills and advance through the profession, and so are not able to make the impact on patient care that they could. If you are asking about Government asks, my ask is that you all have a look at that report.

Q103 Christine Jardine: How confident are you that the actions will be taken up and that these issues will be addressed? Nobody? That is worrying. Are you confident at all?

Dr Porter: I think there is a willingness from the professions, but there is a difficulty in terms of the funding that goes along to support that. If you are going to offer additional anaesthetic for procedures, you need to ensure that you have appropriate staffing to deal with problems that might arise. You also need to make sure that all your practitioners are trained so that they are able to offer those choices to women, and that women have the information to be able to make those choices before they come to their procedural appointment. There is a lot of background work that needs to go into allowing us to offer the kind of services that we all want to offer. None of us wants to feel that we are causing additional pain to our patients.

Ruth Bailey: One of the innovations that I think is really exciting is around conscious sedation. That involves offering women undergoing hysteroscopy conscious sedation, and that can be delivered by a nurse-led clinic. There are very few examples of that kind of innovation happening across the UK, and that means that our patients have a wide disparity of



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choices. So no, I am not confident, but I really would like to be by the end of the session.

Professor Ikpoh: I do not think we were present at this at all, but when patients come back to us and, for example, they have had a hysteroscopy and nothing has been discovered, you can feel the frustration. I always remind our doctors that pain is a symptom. We often forget that, most times, there is an underlying cause of that pain, and it is really important that we try to get to the bottom of that.

Kate Lancaster: Ruth mentioned that we know that women are waiting unacceptably long on hospital waiting lists for gynaecology. A report that we put out last year, "Waiting for a way forward", highlighted that although you are not going to clear the backlog overnight—I am sure we will come on to waiting times—one of the key things is how you look after women while they are waiting. Pain management is a really important part of that.

We hear far too often, "We won't do any pain management until we've had the diagnostic test." If you are asking women to wait a year for an appointment, you are condemning them to a year of pain. It is really important to communicate with women while they are waiting, first about how long they are going to have to wait, and secondly to make sure that they have the right support while they are waiting, and that includes pain management.

Q104 **Christine Jardine:** I want to go back to hysteroscopies. Kate and Charlotte, your organisations have guidelines, but despite that we are still hearing about women's experiences of pain during hysteroscopies and coil fittings. What steps have you taken to monitor that, and are they helping?

Kate Lancaster: I will build on what Charlotte said, because I think her answer was really comprehensive. We have produced a good practice paper that talks about how to ensure that women understand that sometimes even the choice of location where they are having their procedure will affect what pain management they can have. It is about informing patients and helping them to understand the implications of different location choices in terms of what pain management is available, and then discussing what the options are. With hysteroscopy, for example, we know that many find that it is not particularly painful, but there is a significant cohort that do.

It is really important that people are informed, first about what is going to happen to them and, secondly, about what their choice of location means for them—if it is in an out-patient setting, whether they will have proper pain relief and those sorts of things—and then that we work with them. Equally, if you are going to be delivering additional pain relief, you need the capacity within your organisations to be able to do that. We know that one of the things that the NHS is struggling with at the moment is capacity, but if you are going to be able to give women proper choices, you need to be able to follow that up by listening to them and giving them what it is that they are asking for.

Q105 Christine Jardine: Given what you have said, is there more that the NHS or the Government can be doing to ensure that your guidelines are followed?

Kate Lancaster: I think it comes down to the funding and the capacity. Sometimes that capacity is physical capacity—space to deliver these services—and sometimes it is capacity in terms of workforce. That is why the developments that Ruth is talking about around nurse-led initiatives and pain relief are interesting and really important.

Q106 David Burton-Sampson: Kate, you mentioned some of the myths around black women, in particular, and their pain thresholds. In fact, I met with some black women and an organisation who made me aware of how terrible those are. What steps are the Government taking, to your knowledge, to address racial and ethnic discrimination in the management of women's pain? What more do you think needs to be done to tackle discriminatory attitudes?

Kate Lancaster: Sadly, the NHS is a reflection of society more widely, so this is not just a case of "pin it on the NHS"; this is actually how we function as a society, and I think it is very important. With that context, if you look at women's services within the NHS—maternity, for example—we know that black women and Asian women have poorer outcomes. In answer to your question, "What are the Government doing?", they have launched their maternity review, and we know that that will have an inequalities lens on it. We are really pleased about that. We know that wonderful organisations like the Race and Health Observatory, led by Habib, are doing an enormous amount of work. Honestly, there is just such great work happening there.

But really, it is at every level of a service. For example, outcomes are affected by having good translation services available. That is not always the case, but translation and interpretation are really important for women. Imagine, for a moment, going through labour when English is not your first language and you cannot communicate with the individuals around you. That is not an environment that is conducive to excellent outcomes. If there was a magic bullet, we would have done it by now, wouldn't we? The point is that it is very multifaceted, and we need to tackle it at all elements. The Government are making steps, but there is so much more we need to do.

On the outcomes that you talk about, it come back to the research question. We do not know enough about the racial inequities and what is driving them. When we are looking at results of research studies, we do not know at the moment what the racial breakdown is. There are things like that that we need to do far more about, and pain is an element of that, but there are a number of myths. It is really important that we base this on science and, importantly, treat each woman in front of us as an individual, respecting their rights, their identity, and their wants and desires around their own health, and that we really work hard to empower them to be a partner in their care. That is not just a catchphrase; it really has to mean something.

Q107 David Burton-Sampson: Do you think we need a tougher approach to monitoring and enforcement in this area?

Kate Lancaster: I think we need a tougher approach to data collection—to every element of it. Data collection will help you. Data will be our friend here. When you look at things and are able to say, “This is happening over here; we have the data to prove it,” you can then talk to that part of the health service to say, “Can we improve here? This is what the data is showing us.” That is a really important first step.

Q108 David Burton-Sampson: Thank you. Charlotte, is enough being done to listen to the experiences of girls from black and other minority ethnic groups in relation to their menstrual and reproductive healthcare, and to involve them in the design of local services?

Dr Porter: It would be nice to see more being done. We lack services that are responsive enough for young people, because we do not have open access services that run reliably for defined age groups. In many places, the under-19 teenage clinics have become under-25 clinics, and that creates very different populations to deal with for the clinicians there, and also a waiting room environment that is less conducive, particularly for women from Asian backgrounds who may be very frightened by the complexity of what they see in the waiting room. Having services in safe spaces is really important for those groups.

It is also really important that clinicians, to the greatest extent that we can, reflect the population that we are seeing. It is incumbent on us, in our selection of our candidates coming through, to make sure that there is diversity coming through medical school and then coming into training programmes, so that we can have the right people sitting in front of our patients. It is very difficult to be it if you cannot see it, and it is important to make sure that we support people through their careers and think about how we mentor our younger doctors to ensure that they get into the right careers. We can do more.

Q109 David Burton-Sampson: Do any of you have any examples, maybe from around the country, where you are seeing good practice in this area?

Ruth Bailey: There are some amazing examples. There is a background of some communities being understandably mistrustful of services. They have had poor experiences, so why would they not be? There are some really concrete examples of organisations that have gone into communities. Margaret mentioned the Caribbean & African Health Network, which has done some amazing work with faith groups and community leaders to be able to have conversations. It has done some work about fibroids. There has been some really good work around menopause in menopause cafés and menopause health groups, too. We need to look at those groups, which are largely voluntary, and ask what they have delivered and what we can learn from them. We need to make a requirement where we have underserved communities—we know that they are out there—to be able to commission some really imaginative, creative working with communities.



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I want to reiterate the point that Charlotte made that the NHS healthcare workforce is a segment of our society. In the nursing workforce, we know that nurses of colour are under-represented in leadership. That needs to change, because we need to have senior nurse leadership that will inspire and support nurses of colour as they advance through their careers, but also ensure that they are working as community leaders within underserved communities, to challenge and help us understand that racial bias, which is too evident.

Q110 David Burton-Sampson: Margaret and Ruth, to what extent are courses in unconscious bias and cultural awareness available to your members, and how many actually take them up if they are available?

Professor Ikpoh: We have really tried our best. It is not lost on me that, as a black woman, I am trying to change the narrative in what was historically a very white space. We are offering a lot more than we did even a year ago in terms of continuing professional development as a college.

I am a patron of CAHN, and I am a huge champion of it. Essentially, the volunteering with that agency around covid is what led me to where I am now, if I am honest with you. I have seen the power of how community works. We work with a lot of ethnic minority research inclusion groups embedding culturally competent frameworks in primary care settings. But it is hard, because it is not mandatory. If nothing is mandatory, people will pick it as a nice to have. As I said in one of the rooms down the corridor the other day, if, as a woman of colour, my pain is being dismissed or I am five times more likely to die in childbirth, that is putting my life at risk. I would like to see it mandated, if I am honest with you, because it is important for all women of colour.

The biggest thing that we need, which was quite difficult to hear from the NHS Race and Health Observatory, is trust. Our communities simply do not trust us. We have a lot of work to do to regain and build back that trust. A lot of really positive things are happening with the community groups that we have discussed here today, so I am hopeful for the future—I have to be.

Ruth Bailey: I will just reiterate the same points. There are some fantastic modules and training to enable people to understand racial bias, but they are voluntary. I have to say that the best training that I have had has been in my voluntary roles and not in my substantive posts. That needs to change.

Q111 David Burton-Sampson: What is the take-up of the courses?

Ruth Bailey: The people who recognise the need are the people doing it. That is the trouble.

David Burton-Sampson: The ones who probably do not need it.

Kate Lancaster: In our specialty, obs and gynae, half of our doctors in the UK are international medical graduates. That is really important and it



is something we are very proud of. We were talking about resources—as a result, we have recently launched a cultural communications toolkit to help doctors to navigate what is sometimes an area that they do not necessarily feel confident in. I cannot talk to you about uptake, because it is quite new.

We have also done a lot of work in terms of race equity within the profession. What you do in your workforce translates into how patients are cared for, so we have developed a really comprehensive race equity toolkit. It launched in the last few weeks, so it is too early to talk about uptake, but we are very hopeful that moving forward in those areas will help us.

Dr Porter: Active bystander training is a really powerful tool that we are going to introduce to next year's group of trainees so that all our trainees will undertake that along with their educational supervisors. The other positive thing from a sexual health point of view has been post-pregnancy contraception. The data from the London experience suggests that there is no difference in the choices women make for post-pregnancy contraception when it is delivered immediately post-delivery. That is really revolutionary in terms of access to contraception for women from black and ethnic minority groups.

Q112 **Nadia Whittome:** I wonder whether anyone on the panel could speak about the difficulties that trans men and non-binary people may face in seeking help for reproductive health problems. I raise that because I have had communication from trans people who report being turned away for things like cervical smears or treatment for UTIs. It would be good to know what is being done to improve inclusion and what more you think should be done.

Ruth Bailey: We certainly know that the trans community is one of the most vulnerable groups in our society. Trans people are disproportionately represented in terms of their history of abuse and in terms of living in poverty. We know that they are a group with particular needs. We know that there are higher rates of ADHD and autism in trans people. We have some good resources. The RCN published a document called "Fair care for trans patients" a number of years ago, which is currently being updated. The College of Sexual and Reproductive Healthcare has some statements—sorry if I am stealing your thunder, Charlotte. We have some really good resources on providing contraception for trans patients.

In my real-life job as an ANP in primary care, I see trans patients as part of a locally commissioned service to sort of hold people while they are having shared care and, unfortunately, facing really long waiting lists for care in specialist gender clinics. We look after them and have an annual review.

There are specific challenges with non-binary and trans patients accessing cervical screening. We know they are under-represented. A couple of things really help. We have fantastic guidance from the Eve Appeal, which we work with really closely at the college and which supports nurses who



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do the majority of cervical screening. The technique to do it is different, but the biggest barrier is people's attitudes. We can change attitudes, and that is a good thing.

The other thing that we hope to introduce is HPV self-sampling in the new year, which will be fantastic for trans people as it opens up another choice. There are some pockets of really good practice. It is about how we translate that across the health service and how we build confidence with the workforce to be able to meet those people who have particular and complex needs. To do that, we need to make sure that people are adequately trained and that they have the time and space in their consultations to meet those specific needs.

Q113 Nadia Whittome: That is comprehensive, thank you. Does anyone have anything to add?

Dr Porter: The College of Sexual and Reproductive Healthcare has just held its first training day for issues around trans health. More than 100 people attended that, and we are hoping to build on that to do it again next year.

Professor Ikpoh: That was such a comprehensive answer, but I would like to add that we are about to launch our trans health module, which will come out in the next couple of weeks. I am not aware of any reports personally of people being turned away, because our coding systems should not really allow that to happen in general practice, but we are doing our utmost best to make sure that we are as inclusive as possible, recognising that EDI and belonging frameworks are not as advanced as they are in secondary care. That is something that we are working on.

Q114 Rachel Taylor: We had quite an extensive debate yesterday around trans healthcare. One thing that came up consistently, which I wanted to touch on with you, Margaret, is whether there are any guidelines for shared care, particularly where trans adults have been prescribed hormone treatments but GPs are not following that through with shared care arrangements. Trans people are finding that very difficult. Do you have guidelines and standards on that?

Professor Ikpoh: We do not have any current guidelines that I am aware of, but I will get back to you about that after this Committee just to double check. I am aware that we have GPs with extended roles that we are developing now, and trans health is an area I am looking at personally, so hopefully we will be able to embed some guidance with that particular cohort.

I am also mindful that not every GP will have the level of expertise that is required to be able to deliver the appropriate and right care for our trans patients. I am mindful that there is a large cohort that want to do that, and should be enabled to do that appropriately.

Rachel Taylor: That is really helpful, thank you.

Q115 Nadia Whittome: On gynaecology waiting lists, we will come to discuss



the impacts of the women's health hubs later on, but are there examples of other local initiatives that have been successful in reducing gynaecology waiting lists? What steps are being taken to treat women in the most deprived areas who are waiting the longest for treatment?

Kate Lancaster: I will pick that up in order. It will be hard not to come on to the women's health hubs with that question, but I will try and keep a bit of distance. We produced a report last year looking at the waiting list. You will know that the waiting list for gynaecology existed pre-covid, but was impacted very badly by covid. There has been a real focus on elective waiting lists across all specialties, but with a particular focus on gynae. At the time we produced our report, 750,000 women across the United Kingdom were waiting to get into secondary care, either for diagnostic tests or for procedures, so it is an enormous number. Some 600,000 of those women were in England. We are now a year and a month later, and the waiting list in England stands at 576,000. Clearly, there has not been the progress the country needed.

We know there have been some improvements. For example, the number of women waiting for more than a year has declined, which has to be good news, but we still have so much further to go. We know, for instance, that roughly 57% of women are seen within the time of the 18-week standard—remember, of course, that some of that might be for diagnostics, so it is a step on a pathway—but we know that that percentage is below the average for other specialties. We would argue, as you will not be surprised to learn, that this is a particularly special case that requires particular focus.

On your point around—may I stray into women's health hubs, or would you like me to leave that?

Q116 **Nadia Whittome:** We have a separate section on women's health.

Kate Lancaster: We have seen that the material impact they can make on the acute waiting list is so pronounced that you almost cannot see those two things separately. However, if you will allow me to circle back to that when we get to women's health, I will.

Q117 **Nadia Whittome:** Absolutely. You mentioned elective gynaecology appointments just now. Why are they often the appointments that are first to be cancelled? Would you support changes to the way that elective gynae is prioritised in the system? If so, what kind of changes would you support?

Kate Lancaster: It is a difficult one. There are a number of elements to it. For example, within the healthcare system, it is often referred to as benign gynaecology, which sounds not very important. I think there is something about the nomenclature that could be improved, because I am sure for the 576,000 women on the waiting list, it does not feel trivial.

Q118 **Nadia Whittome:** They are not electing it for the fun of it, are they?

Kate Lancaster: Exactly. We know that for some of those women, waiting so long is really affecting their mental health and their ability to go to



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work. Indeed, we know that some women are so extremely unwell they cannot leave the house. The impact that this is having on people's lives is really material and I think it has to be an area of focus.

I am sorry; I have forgotten the last part of your question.

Q119 Nadia Whittome: I can repeat it, because I know that I asked it in a few different parts. I asked whether you would support changes to the way that elective gynaecology appointments are prioritised.

Kate Lancaster: And why are they mostly cancelled? Yes. I think the part about why they are cancelled is often the name. If you are running an acute hospital at the moment and you are short of capacity—we know of hospitals that are running at 107% occupancy at the moment and things like that; the NHS is under considerable pressure—and you are looking down your list of specialties, and you have things planned for theatres the next day, you are not going to cancel cancer and you are not going to cancel heart surgery. You are going to look at the things that will not necessarily impact people's length of life—although actually, what we know with gynaecology is that quality of life is enormously important—I suspect that that is why, certainly for surgical procedures. We also know that there is a big issue with theatre capacity, as well, which probably contributes to the situation. In terms of what you do, that is the women's health hubs.

Q120 Nadia Whittome: Excellent; thank you. Charlotte, do you have anything to add to that?

Dr Porter: Pushing work into the community is probably really important from this point of view. That transformation of the NHS, to provide a community-based service, is ideal for women, but we need to move the capacity into the community at the same time.

There is a problem with things being considered "benign". If you are not on a two-week waiting list, you are much more likely to be cancelled. We are also bounced by things such as trauma. Consequently, where care needs to be offered immediately, elective procedures sometimes go by the board.

The other thing that really makes a difference is the tariff for your procedure, because if the trust is not making money on that number of procedures, it will look differently at how many it offers. The tariff for orthopaedics is much better than the tariff for gynaecology, so there are disparities in which services are prioritised for theatre time.

Gynaecology has changed massively in my working lifetime; we do far fewer hysterectomies, and we now think about fitting Mirena coils. Those can be fitted very effectively in primary care, but the tariff for funding in primary care is too low to allow most GPs to think about even offering that service without making a loss.

Nadia Whittome: That is shocking, given the difference they make to women's lives.



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Dr Porter: Yes, it is shocking. Therefore, we must prioritise that structuring and think about how the commissioning works. When you are commissioning things through local authorities for sexual health, and through ICBs for gynaecology, some things get left in the middle. Unfortunately, one of those things is women's health.

Nadia Whittome: That is really useful—thank you.

Q121 **Chair:** Nadia, before you go on to the LARC question, can I ask about the prioritisation of specifically girls' reproductive health? Having taken lots of evidence in the medical misogyny inquiry, and throughout this one, we know that grown women—who can advocate for themselves, who know their bodies, and who have experienced problems within the health system before—have trouble arguing for themselves. What happens to girls and the priority for them when it comes to accessing the healthcare they need? Are you seeing any prioritisation because they are young and you are trying to get treatment to them earlier, rather than them having to wait until an issue is perhaps more complicated down the line? How do we combat that? How do we ensure that we get girls the treatment and the diagnosis they need when they first come in, and not leave it until 10 years later when they have problems with fertility or something else?

Ruth Bailey: That links back to many of the themes that we discussed earlier on. It goes back to education, and it needs to be about equipping the workforce to do that. There also needs to be a clear pathway, which there is not at the moment. There is some provision for paediatric gynaecology in secondary care, but it is really few and far between. Those young women face a very long waiting list, and that is only if their issue has been diagnosed and they have been referred appropriately.

I think the way the care works in primary care is that it is incentivised through the QOF system, which is where care is prioritised, but there is no recognition of a specialty or provision for young girls. They usually come to me in primary care because they have heavy periods that someone in the family has noticed, or they come for contraception. It takes quite a lot of courage for people to come. I think it will help to have the provision of the kind of clinics that Charlotte was talking about—so there can be a drop-in clinic at school, or somebody in a youth centre who people can talk to. It will also help if people can raise this as an issue with some of the innovative work that we have talked about in reproductive health and sex education in schools.

Q122 **Chair:** Thank you. Charlotte, did you want to add anything before I hand back to Nadia?

Dr Porter: What we do know is that we are seeing far fewer young women. The public health Fingertips data would suggest that, in 2015, we were seeing 15% of 16 and 17-year-olds in sexual health services, and now we see 5%. That is a massive change, which has partly been driven by covid, and partly by service change. For me, the difference between running an under-19s service and an under-25s service is enormous for that group of women.

Q123 Nadia Whittome: To what extent do you think the way LARC is commissioned is a factor in the long gynaecology waiting lists?

Dr Porter: I hesitate to step into gynaecological territory, to be fair, because I am a sexual and reproductive healthcare doctor. It is very challenging; we are kind of occupying the same space, and we do not want to compete. I think it is very difficult that, in secondary care, you are unable to fit a Mirena. A woman might go and see a specialist in a gynaecology out-patient clinic and be told that she needs to have a hormone coil and that she can access that with her primary care provider. However, her GP may not have a fitter, because of the issues around funding, and she will therefore try to make an appointment with sexual health. If she is over 50, she might not be able to get in, because she is not at risk of pregnancy. The funding is not clear: it should follow the woman and not the procedure.

Kate Lancaster: The commissioning is a real issue due to it being segmented in the way that it is. We hear from obstetricians that when they deliver a baby, even if the woman wants to have a coil fitted, they are not permitted to do it. That feels like a perfect time to talk about contraception, but that cannot happen because of the way it is commissioned. We know that £1 spent on contraception saves the health service £9, so it feels like something that ought to be sorted out quite quickly. A bureaucratic issue means that there are different pots: some money sits in public health and some in primary care, depending on what you are doing. If you are an individual clinician, you might be able to fit it for heavy menstrual bleeding but not for post-partum contraception. That just seems odd.

Ruth Bailey: I think there is enormous potential to expand in primary care, but it needs to be funded. I think there is enormous potential within the nursing workforce, who have the appetite and the skills to do it, but it is a nonsense if they have to pay for their own training, or if it is not prioritised in the practice because it will not be remunerated.

I fit coils in primary care; it is one of my favourite jobs. I like to do it, but I cannot always do it. There are times when I have needed to say to a woman, "I'm really sorry; I haven't been able to fit your coil"—for whatever reason—"we need to get you to sexual health, where they can do it under ultrasound, or use a cervical block." Sexual health say, "Well, we can't do it because your lady wants a Mirena and she's in a same-sex relationship," or, "She needs it for HRT and we're not funded to do it. Go to gynae." Then you face a waiting list of over a year, and that does not serve women.

Dr Porter: Likewise, with post-pregnancy contraception and IUC fitting, we are very fortunate in Nottingham that we were able to devise a system for women to be able to access their contraception, but I have colleagues across the country who encourage their pregnant patients to go to their local sexual health service so that they can be prescribed a coil to take with them to be fitted at the caesarean section because that is otherwise not available.



Q124 Nadia Whittome: I have a quick follow-up for whoever can give it their best guess. Can you estimate the proportion of women on the gynaecology waiting list who are there unnecessarily because of the way that LARC is commissioned?

Kate Lancaster: I do not have those figures to hand, but I could try to find some more data on that, or a breakdown of who is on there. I do not have it with me.

Nadia Whittome: That would be really useful. Thank you so much.

Ruth Bailey: I do not have the figures either but if you are going to do that, I would suggest to add to it by also looking at the people waiting for pessary fits while you are at it.

Q125 Kim Leadbeater: I have the long-anticipated questions on women's health hubs—ta-da! Thank you to the panel for coming in; this is really interesting. It would be good to get thoughts from all four of you on women's health hubs if we can, but I will go to you first, Ruth. The RCN seems to have been more sceptical than most organisations about women's health hubs and how they operate in practice. If you have any concerns, what are they, and how could they be addressed?

Ruth Bailey: It is not a scepticism in principle because we have seen really impressive examples—Liverpool being one of them—of how they work and serve women so well. Our concern is that when women's health hubs first came into being, the idea was that people would shape them in a way that serves the needs of their local community. That sounds great, but it meant that the hubs were not offering concrete services that women needed and that ICBs struggled to provide them because the funding was not recurring. That meant it was very difficult to put people into those roles, and that is why we are sceptical. In principle, yes please, fund it and we will all come and work in them—it would be a fantastic opportunity.

The second disappointment for the RCN is that part of women's health hubs is having a women's health champion. Again, that is great, but actually there are very few women's health champions who are nurses. We are the biggest part of the workforce and we have an enormous amount of skill to offer, not just in caregiving but as policymakers and researchers. It is really important that women's health hubs, where they have been really successful, utilise all the talents and expertise of the multi-professional workforce, and we need to see that reflected in health hubs.

I think there is particular scope for advanced practice. I know I keep banging on about it, but I do think that it is underutilised. Looking at reforming the nursing workforce and at how our pay structure works would be really helpful to ensure that the workforce is skilled and staffed appropriately.

One of the things that I am sure the Committee is aware of is that nurses working in primary care are not on Agenda for Change, so there is a big disparity between the pay of nurses in secondary care on Agenda for Change and those in primary care. About a third of primary care nurses



did not receive the 6% uplift that nurses who were on Agenda for Change had.

The other huge disparity, which is a real concern, is the fact that nurses working in primary care are disadvantaged: they do not get the same maternity pay, they do not get the same sick pay and they do not get the same annual leave. What incentive is there to move from secondary care to work in primary care, if that is where the Government are going to start shaping and putting the accent on care? You can understand why we have some reservation.

Q126 Kim Leadbeater: That makes absolute sense. There are issues around the workforce, but in the first part of your answer, there are also issues around what the hubs are actually doing. It feels as though there needs to be some prescription around that, but then also some flexibility as well, depending on the community that the hub is serving.

Ruth Bailey: There could be some standardisation around what those outcomes are—what are the hubs there to serve? Of course, the hubs need to be responsive to the needs of the local community—everybody would want that—but it cannot be freestyle either.

Q127 Kim Leadbeater: Kate, you were saying that you have called for renewed ringfenced funding for the hubs, so I would love to know your thoughts.

Kate Lancaster: A lot of the themes we have picked up this afternoon could be addressed through women's health hubs. What we have seen is, where they are established and where they are delivering the core specification, they are very successful. Putting funding to one side for a moment, we were delighted to hear the women's health Minister reiterate her commitment yesterday. She said that women's health hubs were a wonderful example of care moving into the community, and they can be that.

In terms of disparities and inequalities, we know that if you put women's health hubs in the most deprived and challenged areas, you are going to address some of the inequalities of access, and you are likely to make a big difference there. The key to this is partnering with secondary care so that you have some highly skilled, dedicated staff. They have worked best where you have some really dedicated GPs who have made it their business to really understand women's health. The magic is where they often have really good relationships with gynaecologists in the secondary care, so their skills are exceptionally high and their dialogue with secondary care is really good.

The Government's own figures say that for every pound that is spent, you can get a £13 return on investment, so the question is: why don't we have them everywhere? Look at the wonderful hub in Tower Hamlets, for example. We know that they took the acute waiting list and treated the vast majority of it in the community. You asked earlier whether some of these referrals to secondary care are unnecessary: if you have well-trained GPs, yes, they are unnecessary. Imagine the capacity that could then be freed up in secondary care to treat the people who actually do need



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operations and the things that can only be delivered there. Women's health hubs are really in line with the Government's shift into the community. I suppose the puzzling thing is, why are they not everywhere?

We know that progress has been made, and we can all cite the good examples of Liverpool, Birmingham and Tower Hamlets—and there are lots of others—but there are still areas that are underserved. From our point of view, we are keen that ICBs get on and take charge of these, because women's health and the prosperity of our nation will improve if women can access hubs—everything from the education that we were talking about to delivering care closer to their homes that is more personalised. I will stop there, but it is hard to know why we do not have more of them.

Q128 Kim Leadbeater: That is really helpful. It feels like I am getting a lot of positive vibes on the women's health hubs. It sounds like it is potentially a very patient-centred approach, because it is joined-up in a multidisciplinary way.

Kate Lancaster: I do not want to dismiss Ruth's concerns about staffing, because like any wonderful new initiative in the NHS, it relies totally on workforce. Unless we solve the issues in the workforce, this is not going to work. You cannot just magic them up, and hope that somehow you will knit some staff to work with. You actually have to invest in it.

Q129 Kim Leadbeater: Margaret, do you want to add anything from the perspective of a GP?

Professor Ikpoh: There is an additional concern. While we are quite supportive of women's health hubs, and have done a lot of work around them, there is an issue with the underserved areas. We know as a college that underserved areas, particularly poorer areas, will get 14% more patients per GP, and get 7% less funding. That is really critical. We do not want to drive and widen the health inequality in the system.

The other thing that I am a little anxious about is the unintended consequences. While we are wholly supportive of women's health hubs, we would not support removing reproductive healthcare entirely from general practice, because the patient is such that we do not deal with them in silos—we do not deal with their issues in silos. Reproductive health will impact on their families, their metabolic health and all other parts of the system. The last thing we would want to see is that, by removing that, we deskill the workforce that we are trying to build the confidence in, as we have talked about this afternoon. We would not want to create secondary waiting lists for people to be seen in a women's health hubs, so we need to be mindful of that. But on the whole, we are supportive.

Q130 Kim Leadbeater: Charlotte, anything to add to finish off?

Dr Porter: We just need to work together. It is a way of making women's lives better and making professionals' lives better. If we can work in teams, we can support each other, learn from each other, and take that learning forward and spread it out to the wider community.

Kim Leadbeater: You have been a great team today.



Q131 Chair: Charlotte, I have a final point about women's health hubs. I do not want this to be a downer—sorry, guys—but some women's health hubs are not actually physical spaces. When we talk about women's health hubs, often people will have an image in their head of a literal hub—a one-stop shop. That is not the reality for a lot of places across the country, such as my hub in Luton, where it is a network of people working together. What needs to be done? Have you seen a preference, a better way of working, or better outcomes where you have those hubs physically present in communities, or is it better to have those networks of people so that skills can be kept within local services? Is a mixture of the two needed?

Dr Porter: There is probably enough work to go across both, if I am honest. An enormous minority of the work in primary care is around women's health. I think about 25% of consultations relate to women's health, so there is a huge amount of work that we can do. We support our GPs with a WhatsApp group, in terms of getting immediate queries. Intelligent triage is really important in terms of trying to ensure that women get to the right place. If you can do your triage as a team, then you can work in a virtual way.

Chair: There is enough to go around then. For our final questions, I hand over to Rachel.

Q132 Rachel Taylor: I will come to you first, Kate. Thank you for the wonderful event that your college put on last Friday. I was there to welcome my friend, Dr Alison Wright, as the new president of the Royal College—it really was a wonderful day. I want to talk about the women's health strategy: looking to the future of that strategy; how we develop it going forward; and the reorganisation of how we look after our health service. What is your assessment of the impact so far of the women's health strategy for England on girls and young women's menstrual and reproductive healthcare?

Kate Lancaster: We think that some progress has been made. Without banging the drum again, I think that women's health hubs are an example of where we have made progress. I mentioned earlier the focus on research for the NIHR—that is a very welcome area—but we think there is a lot more to do. We warmly welcomed the refresh, which was published in 2022. We now have them in all four devolved nations, which is excellent.

The 10-year health plan is a real opportunity to recraft the women's health strategy across the 10-year timeline and against those three shifts, because why have it constructed in any other way, in many ways? We are therefore delighted, in our building—which you have visited—to have 15 women's health organisations all co-located in the same building. We were able to invite the Department of Health and Social Care and NHS England to hear what we thought of the existing strategy and to give them some pointers for the new one. We are very pleased with that.

We also published a short report—I am happy to share it with the Committee—which is an assessment of progress against that first strategy



and an identification of where we think they need to go next. That might be a useful piece of evidence for this Committee. It outlines quite briefly where we think there is progress and where the focus still needs to be. We are happy to send that in.

Q133 Rachel Taylor: That would be great, thank you. Ruth, is there anything you think needs to be included in the renewed strategy next year?

Ruth Bailey: First of all, we are delighted that it is being refreshed and renewed. We have really welcomed the opportunity to be part of the roundtable discussions looking at what needs to be in there. We certainly attended the ones on menopause, pain and all the others. I welcome the opportunity to have those discussions.

I guess what we really want is to make sure of some discrete, measurable targets. The RCN was slightly concerned about the lack of specific identification of women's health strategy in the NHS long-term plan—that concerned us—so this is an opportunity to address that and put it right. It is about having clear, discernible and measurable outcomes that are realistic. The report from RCOG is going to be helpful but, as ever, success is going to be reliant on very clear commissioning and funding.

We would want to see some ringfenced funding for women's health, and real, meaningful investment in the workforce. I will not go through the things that we have discussed already, but they relate to education, specifically on investment in the nursing structure and workforce, with the difficulties that I have discussed today.

Q134 Rachel Taylor: Thank you, Ruth. Margaret, do you want to add anything?

Professor Ikpoh: Yes. To echo slightly what Ruth is saying, I think that GPs like me witness at first hand women's health issues at the front door. We welcome the women's health strategy and the refresh, but no strategy can be realised unless we embed a culturally competent and confident workforce that is funded adequately, for all the reasons we have discussed, to realise that strategy in its entirety.

Q135 Rachel Taylor: Thank you. Charlotte, is there anything else?

Dr Porter: We are obviously very keen to see sexual and reproductive health included in the women's health strategy in a life-course approach. Starting early and working through the life course in terms of pregnancy, post-pregnancy and thinking about how we incorporate post-pregnancy contraception is a really equitable way of delivering services.

Q136 Rachel Taylor: Thank you. Ruth, how concerned are you that the reforms—including the merger of NHS England into the Department and cuts to the ICB operating budgets—might impact efforts to improve menstrual and reproductive health?

Ruth Bailey: It is of deep concern. Locally, we see still some confusion about the ICBs, as they reorganise. The arrangements for neighbourhood hubs are unclear at this stage. They have to go through a process of design, but there is concern about jobs and redundancies, about what a



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new establishment might look like, and where women's health hubs fit into the ICB and funding. Probably the thing that makes the most difference in clinical practice at the moment is the constriction of training and education budgets, and because those training arrangements are not clear for 2026, we are unable to imagine what that is going to look like.

Professor Ikpoh: It is the inequities in funding, which already exist in ICSs and ICBs. With the changes that are afoot, we have no assurances that that will get any better. That is our real, deep anxiety.

Q137 **Rachel Taylor:** Does that affect your service as well?

Professor Ikpoh: In how we are going to recruit for next year, in terms of the next generation of trainees coming through, particularly when we have GP unemployment and underemployment. That is a bizarre paradox that exists.

Q138 **Rachel Taylor:** Thank you. Kate, do you think that the reforms have any long-term implications?

Kate Lancaster: I am long enough in the tooth to have seen a number of reorganisations within the NHS. My observation over time is that any changes to structure risk taking focus off what we are trying to deliver.

Chair: Thank you so much to our panel. That was absolutely fascinating. It was horrifying in certain parts, but it is really clear that we have come a long way, and yet have a long way to go as well. Thank you so much. On behalf of all the Committee, I wish you a very merry Christmas.