HOUSE OF COMMONS

Women and Equalities Committee

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

Wednesday 21 January 2026

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Watch the meeting

Members present: Sarah Owen (Chair); Alex Brewer; David Burton-Sampson; Dame Nia Griffith; Christine Jardine; Kevin McKenna; Rebecca Paul.

Questions 139 - 190

Witnesses

I: Professor Dame Lesley Regan, Women's Health Ambassador for England; and Dr Sue Mann, National Clinical Director for Women's Health, NHS England.

Examination of witnesses

Witnesses: Professor Dame Lesley Regan and Dr Sue Mann.

Chair: Good afternoon, and welcome to the Women and Equalities Committee. Today we are holding an evidence session on reproductive and menstrual health conditions among girls and young women. It feels like we are on repeat because we had a session on medical misogyny, which touched on girls' health but focused mainly on women. From that, we discovered that, if we get this right from an earlier age, we can avoid some delays in diagnosis and treatment further down the line. Today we will hear from a fantastic panel. We have Dr Sue Mann, the national clinical director for women's health at NHS England, and Professor Dame Lesley Regan, women's health ambassador for England. Welcome to you both, and thank you for coming. We have a lot to get through, so I am going to hand straight over to Alex.

Q139 **Alex Brewer:** Briefly, Lesley, what has been your proudest achievement as women's health ambassador in relation to better supporting girls' and women's menstrual and gynaecological health?

Professor Dame Lesley Regan: Happily, I can say that in the last three and a half years, we have made quite a bit of progress. We have not gone fast enough or far enough, but I am a very impatient person and have been waiting a long time to get it better. I want to say, though, that to have a situation where everybody knows what we are talking about when we talk about the importance of improving women's health improves everybody's life in society, male or female, and it is a big step forward because that was not the case. If I had invited a group of doctors to come to a women's health conference five years ago, they would have said, "Well, what are you going to talk about?" We now understand that, and we have a very clear understanding—not just among healthcare professionals, but among women and men in the community, the patients we serve—that women's health is not just about reproduction, pregnancy, periods and the menopause, although sometimes if you look at the *Daily Mail*, you might not believe that.

We now understand that there are lots of things that affect women disproportionately for a variety of reasons—perhaps we can come back to that—because they are women, because of their biological sex, and because of the phases and transitions they go through across their life course. The other thing I am proud of is that we have a much better understanding of how this is a continuum, and that girls and women need to be looked after across their life course. As a healthcare system, we cannot provide all that; we have a lot of other agencies and Government Departments to contribute to that. There is also a societal shift about helping oneself. That is not putting the onus back on to girls and women; it is saying they need to be empowered. It is a rather overworked word, but they need to be empowered to know what they can do to improve their health and longevity.

I often repeat this point: my twin daughters are in their 30s, and they will be the first generation of women who, without doubt, will live longer post-reproductive than they were reproductive. That has never happened before in our society, apart from some people about whom we have remarked, "Oh, my goodness, she lived to a great old age," but that is going to happen. The things that are going to be really important for us to understand, and to provide health services for, are cardiovascular disease and the complications of MSK problems and osteoporosis, frailty and dementia. We have to have a really big push towards getting everybody in society to understand that those are the big things that we really have to improve.

Q140 **Alex Brewer:** You touched a little on what needs to happen next, but are there any areas where you are disappointed in terms of progress or where there could have been more removal of barriers, for instance?

Professor Dame Lesley Regan: It is always easy to be negative about things, but I have this incurable optimistic streak, so I am going to hang on to it. What we have shown with the women's health hub pilots has been really promising and, if we can find ways to scale them up, I would argue that a neighbourhood health hub is everything that the women's health hubs have tried to facilitate and prioritise. It is about understanding wrapping services around the user rather than make you, Alex, as the user, have to go round all the different services. It is not difficult to do if you just put yourself in the position of that woman and how frightening it might be if she has not been very well educated or knows nothing about the healthcare system. How does she navigate all that?

The concept of the health hubs has been a really important shift, and I would argue that the three shifts now in this Government's manifesto—the 10-year plan—are everything that the women's health strategy has been trying to achieve. From analogue to digital, disease to prevention, hospital to community—that is what the strategy is all about. As I spent time talking to many healthcare and non-healthcare professionals about the women's health strategy in different specialties, I was most struck by the MSK osteoporosis and cardiovascular people, and the neurologists. Just about everybody says, "Oh, well, we'd really like to do that in our specialty too." If we can keep pushing towards neighbourhood delivery, we will all make progress, and not just in my and Sue's field, but in a lot of other fields in medicine as well.

Q141 **Alex Brewer:** Sue, you are the first ever NHS national clinical director for women's health. Can you talk a little about the benefits the role has brought to girls and young women's menstrual and gynaecological health?

Dr Mann: It has been a really big step forward, and some of the stuff I can talk about seems like back-office stuff but, actually, has made a significant difference and has raised the profile. A lot of what Lesley and I say will obviously overlap, but it has raised the profile of the issues for

women across their whole life course and end-to-end pathways. Away from gynaecology, disease and solely maternity, which are all really important issues, but broadening it out and saying, "Actually, we need leadership to drive forward that whole continuity of care for women from cradle to grave, but also across primary, community, secondary and specialist care." It has created the engine room and the energy around that and, not to take full responsibility for it, having the role has enabled us to thread the idea of women's health through all the different aspects of the NHS. For example, when you look at community diagnostic centres, do not forget how women's health works for women. Or electives, gynaecology. We need to think about that and really be present at every door. Think about inequalities for women; think about the intersectionalities.

Creating that engine room and then driving change and working with the system is all quite boring stuff, but what you see on the ground actually makes a difference because we then work with people on the ground and set a framework for how to deliver care and reach people better. That is the hidden stuff. Of course, there are some impacts that you will see in the media. You will see the new NHS online, which has women's health as key pathways. You will see menopause in NHS health checks; you will see it is spattered through a whole lot of things. That is new, or I like to think it is new, and it is partly a big collaboration across the Department of Health and NHS England. I feel that having that sort of figurehead has made a difference.

Q142 **Kevin McKenna:** I just need to draw attention to my entry in the register of interests, because I worked at NHS England. I think we briefly overlapped, Sue, but we never worked together, unfortunately. I want to ask a few questions about the relationships, sex and health education curriculum. Lesley, what are the Government doing to make sure this new RSHE curriculum is delivered effectively in schools, and what does "effectively" look like for you?

Professor Dame Lesley Regan: To me, "effectively" means that every girl—we can come back to the boys later—understands exactly what a normal period is; she has the tools and the knowledge to understand that when she comes of reproductive age, which is quite young now in the western world, she has the capability to control if, when, with whom and how many times she becomes pregnant. Those are the key issues. If she embarks on a sexual relationship, she should understand how to prevent being traumatised and getting an infection or some other problem. If we embed those understandings in girls and boys during their school years, all the rest of women's health across their life course falls into place. We would not have women becoming menopausal, possibly prematurely, and wondering what the hell has happened to them. I still see women who just did not know that their eggs were going to run out. That is because they did not know about their life course and the fact that, when you start to menstruate, it usually means you have started to ovulate and use up that egg reserve. It is really about getting that knowledge. You asked

what we are doing about it. A couple of years ago, I chaired a review on the age-appropriateness of sex education for the Department for Education's task and finish group. It certainly opened my eyes to lots of the barriers there have been. There have been lots of misconceptions—pardon the pun—regarding what is needed and the age groups at which girls and boys need to know about these things.

If I marry that up with the charity I chair—Wellbeing of Women—we have done quite a lot of work in schools to promote period workshops. The recipe we have found most effective is to run a workshop for a group of 10 and 11-year-olds in the same room, and then a group of 17 and 18-year-olds where they can ask anything they want. There are no questions barred, and lots of very frank answers. We then invite boys to the myth-busting session at the end. Sometimes, in the past, the headmistress has said, "Oh, we don't have boys in sight." The response from Wellbeing of Women was, "Well, if you don't bring the boys along to the session at the end, we ain't coming." It is always the young men who say, "Wow, this is so useful because I now know what I can do to support my sister or my mum," or whatever. At the end, there is always a little girl who wants to quietly tell me in the corner the story about her best friend who woke up one day and thought she had died and gone to hell because she was in a lot of pain and, when she looked down, there was blood all over the bed. When you have heard this four or five times, you realise it is figurative.

We cannot live in a society where 10 and 11-year-olds have that sort of fear. We have to find some ways through it. I really learned from all the concerns about safeguarding around not introducing sexual concepts to young people because that might encourage them to go and explore it. I came back completely the other way and realised that ignorant children are vulnerable; they are not safe. When you talk to paediatricians and psychiatrists who do safeguarding and sexual abuse work, they will tell you that the young girls who have been worst affected do not actually know what is happening to them until they either go to see someone for treatment or they go to their school lesson, and it is usually the treatment. I do not think any society can tolerate that once you have realised what the problem is.

Q143 **Kevin McKenna:** Would that change how you framed this from the outset? If you were to do it again, what would you change?

Professor Dame Lesley Regan: The curriculum has now been published. It was published in July. The Department for Education has employed Oak National Academy to help it with materials to give teachers the tools they need to give comprehensive advice and to run comprehensive lessons. I have not seen a recent iteration. I saw it again about November time, but it was really coming on and it was very much focusing on infographics and animations as opposed to just boring pieces of A4. That was important. It was also focusing on group discussions and how to get young people to talk about their experiences and, most

importantly, to develop a mutual respect for each other, and members of the opposite sex if they are in a single-sex school.

Q144 **Kevin McKenna:** What concerns do you have about implementation?

Professor Dame Lesley Regan: My personal concern is that we need to incentivise the teaching profession. I am not a teacher, but we need to incentivise in some way. I do not mean financially, but incentivise teachers to think that this is a really important part of their career and portfolio. We could find some way of rewarding them with certification and an understanding that this is going to make them an even more employable individual. There may be teachers listening to this today thinking, "Well, I don't want to do that." But if you do it that way round, as opposed to imposing that task perhaps on the person who was not in the staff room at the time the decision was made—which a lot of teachers have told me has happened to them—then we would be training a cohort of future teachers who really want to do it, believe in it, and who are then respected among their peers.

Q145 **Kevin McKenna:** That is really helpful. Sue, should it be left to teachers to tailor health education, and menstrual health education in particular, to their intake, particularly thinking about minority, racial and ethnic groups? Or do teachers actually need some external guidance on this?

Dr Mann: Teachers are going to need support in delivering this, because we know that people are people, and they have a variable amount of knowledge, do they not? They deal with different populations of children, so they are definitely going to need some help and support with that. The guidance is great; it is a good first step; and I really welcome it. The really important things about it are that young children are going to be able to understand their bodies and name their body parts, which is really key. Then, as they get older, they will be able to start to understand their menstrual and reproductive cycles and spot when things go wrong. In the NHS, we see some of those young girls when they are missing school and it has become a problem. If we had the continuity, we would start from the beginning as this is the place to start, is it not? I absolutely agree there is a diversity of need. Children will have different experiences at home and might have different cultural environments, so part of that is supporting the parents to support the children. We have to make sure it is tailored to something that is appropriate, but also make sure that everybody has some equity of information. Democratising information well is really important. I have no doubt that many teachers will need some support with that.

Q146 **Kevin McKenna:** Across a population, where there is a variation in prevalence in different ethnic groups—for instance for black and south Asian women there is more PCOS and higher levels of endometriosis—do schools need support to identify the needs of their cohort of pupils and to tailor information to that?

Dr Mann: It is really important that we talk about symptoms. Young people who come to doctors and nurses in the NHS come with symptoms. They come with pain and heavy bleeding that they do not manage. We need to step forward and start talking about conditions so that people know what is normal, where to go or when to get help if they cannot manage symptoms. They need to know that it is not normal to have three days or more off school every month; it is not an acceptable thing to do, so they need to get help. Hopefully, the system is good enough to start teasing out whether these are normal bad periods or whether there is an underlying condition. To be honest, things like endometriosis and fibroids develop over time, so if young people have that understanding and know when to get help, we will minimise the development of those conditions much later on. It really starts here, and getting it right is here. But it is not so much the conditions; it is the symptoms they experience, what they should put up with, and what they should not tolerate.

Q147 **Chair:** On that, do either of you find that girls are listened to when they come in with those first signs of potentially developing something like endometriosis?

Dr Mann: Generally, we know that some challenges are still there and people tell us they do not feel listened to. There are really good pockets where people feel listened to, and some experiences where they do not. We really have to get on top of that. It is very difficult for girls because they are often told their periods are normal when they are absolutely not. There are two sides of it: empowering the girls themselves and their parents to say, "Actually, you need some help here." Then, it is really for the healthcare professionals and the school nurses who see them to make sure that they are taken seriously. When they say, "Okay, I can't manage this," there should be a route of access to the next place. We will introduce a skills framework for lots of areas of women's health with the basic knowledge that people should have, including how to think about providing compassionate and culturally competent care. The next step is to start thinking about a stepped level of skill mix in the community so that every person is able to work their way through rather than getting nothing or going to secondary care gynaecology. Obviously, general practice is the absolute central point of that and should continue to be so. It provides very good care but needs a bit of extra support for that.

Q148 **Chair:** We have heard anecdotally, and from some witnesses, that young girls who are expressing issues with their menstrual health very early on are quite often just offered contraception. The answer is just to stop the bleeding. Is some of the framework going to tackle that issue and find the causes of these symptoms rather than just stopping them? Are we moving towards that?

Professor Dame Lesley Regan: Very much so, but it comes back to Sue's point, which I really echo, that it is symptom-based as opposed to condition-based because you do not wake up one morning with endometriosis, nor do you wake up with terrible menorrhagia because of your fibroids. They develop over time, and there is a lot that can be done

if they are not basically allowed to deteriorate. The reason why we have these problems at the moment, and very distressed and angry women, is because they have been ignored and their problem is progressing while they are waiting for help. I get why they are angry.

There are lots of different ways in which one can alleviate that. For example, you will have heard of the Mirena devices. One of our next campaigns needs to be, "Please do not believe what everybody in your family, your mum, your grandma and your auntie told you about coils." The new coils with the progesterone hormone in them actually cure the problems that the old-fashioned copper ones used to cause—pain and heavy bleeding. That is exactly why we use the Mirena devices, and there are lots of different strengths and types such as Kyleena and Jaydess. We really have to get them to understand that these are ways of controlling it.

One thing I often say to young women, or girls between the ages of 12 and 18, who come to see me is that they have to remember that their womb lining has no brain of its own. All it does is respond to the hormones it is shown. We are going to put something into the womb cavity that will stop the womb lining from building up. It is not going to work this week, and it may be a bit crampy for a couple of weeks while it gets settled in, but after a couple of months they will notice that the bleeding is much less and the pain is so much better because the womb lining is no longer able to build up. Most importantly, we have to emphasise to them, and probably to their mother who is trying not to interject throughout this, that the moment you remove that coil—the Mirena device—their fertility will come back immediately. There is no post-pill amenorrhoea or missed periods or anything like that; it comes back straightaway because all you are doing is putting something mechanical there to stop the womb lining regenerating, if you like.

Q149 **Chair:** And that they can ask for pain relief—

Professor Dame Lesley Regan: And that they can ask for pain relief, yes.

Chair: It is pretty brutal.

Professor Dame Lesley Regan: Absolutely. It is not acceptable at all.

Chair: No, and if men were having something similar, I am very sure they would be offered pain relief.

Professor Dame Lesley Regan: That is often a comment I make as well.

Q150 **Chair:** Coming on to Wellbeing of Women's period symptom checker, will the NHS add a link to that in the women's health area of its website? If so, when?

Dr Mann: The period symptom checker is a brilliant tool; I do not know if you have seen it. I am very for it and would be really keen to see it used well. You probably know that the processes to get things on the NHS website are, for good reasons, very rigorous and require quite a lot of scrutiny and processes. Those checks and balances are there for a really good reason. Obviously, for this it has been very difficult to think about just going forward and hosting it. We were probably looking more carefully at the idea of it being a signposted thing. I definitely have that on the list of things I am actively doing.

Q151 **Chair:** I am going to push a bit more on this, because while there is a delay in putting a reputable period symptom tracker up there, young girls and women are finding different apps and social media tools which are garnering huge amounts of data about our health and our children's health and, shall we say, it is not always the most evidenced research and guidance. Sometimes, it is guidance that has been agreed by a different country. While we delay this, we are actually blocking and creating a barrier to really decent information for young people. Is there any timeframe to see this come up, even if it is just signposted on the NHS website, where parents and children will know this is something they can use, the data will not be abused, is not necessarily sold off to another company, and will give them NHS-approved guidance in a way that we all trust?

Professor Dame Lesley Regan: We need you to help us influence that.

Q152 **Chair:** Yes, but I am trying to find out from the NHS when we will see a process. Will it be within a year? I understand that you want to have stringent and robust policies in place, and that you would never want anything that the NHS would not approve of on its website. However, this seems a really obvious tool that is going to help young people. And all the while that it is not there, they are going to less reputable sites.

Dr Mann: Can I agree to take that away and come back to you on that?

Q153 **Chair:** Okay. Thank you very much, and I really appreciate that. Sue, you mentioned naming of body parts, and we had a fantastic session here.

Dr Mann: Oh, I watched it.

Chair: Did you? Did you ever think we would kick off a Select Committee with the words clitoris, vulva and vagina?

Dr Mann: It was so much fun.

Chair: It was so much fun, and we ended up with a song. Frankly, I never thought we would see that in this slightly stuffy environment. We really need to break down that stigma. Dame Lesley, we were told during that session, and we all know it, that social media platforms are repeatedly banning content about reproductive health, even from really reputable influencer GPs such as Dr Nighat Arif and Dr Aziza Sesay, for

being inappropriate. Aziza was also told she could not come in with those words written on her T-shirt. They are not rude words.

Professor Dame Lesley Regan: No. They are great T-shirts too, are they not?

Chair: Great T-shirts. I have mine and I cannot wait to wear it to Sainsbury's. But they are being told that they are inappropriate and this creates an added stigma. What is being done to tackle this problem?

Professor Dame Lesley Regan: You held a roundtable very recently—I think in November, or perhaps it was the beginning of December—on shadow banning, which was very well attended. There were a lot of individuals representing not only industry but organisations or companies that have been affected by this shadow banning. I did not really understand the phrase because it does not explain exactly what it means, does it? One of my suggestions was that perhaps you need to change the words to make it immediately obvious.

There is going to need to be a real shake-up in the way that companies are allowed to fiddle with the algorithms to get themselves further up the chain. It is beyond my technical skills to get myself up the Google whatever it is, but if I talk to my daughters about it, one of whom is a graphic designer, they tell me there is a well-rehearsed way of going about this. We are not going to change the way the young generation access information; we have to join them in those places and make sure it is full of really good, evidence-based, factual and correctly used terminology. We cannot beat it, so we have to not only join it but champion it. Both Aziza and Nighat spend a lot of time each month producing TikTok videos.

Chair: They are brilliant.

Professor Dame Lesley Regan: Yes, they are brilliant. The great thing about Nighat is that she has three boys, and they edit their mum's videos and put them online.

Q154 **Chair:** That is brilliant. She talked about some of the abuse she gets, as did Aziza. As two women of colour talking about women's menstrual health, they also suffer from an additional pressure that is not just from the algorithm; it is societal as well. You talked powerfully about the power of social media for good, and those two women are a fantastic example of it. But we are also in a conversation at the moment about banning social media for under-16s. Have you any thoughts or analysis about the potential damages or benefits of this on young women's and girls' menstrual health?

Professor Dame Lesley Regan: If we ban social media for under-16s, we are going to have to find alternative ways of communicating what they need to know, so we will have to pursue that. This ban is going to be quite difficult to police, but there will always be a need for really high-quality, evidence-based information that is straightforward and available

in lots of different languages. And we should not just talk about printed or spoken words; we should have animations. I do not know about you, Sarah, but when I see an infographic, I immediately remember it as opposed to if I read a paragraph; I might not remember what the percentages are. The infographics are very powerful, and we need to use all those things. There are all sorts of things. We also need to recruit quite a lot more "celebrities" to tell girls about the right things.

Q155 **Chair:** And engaging people. There are still medical professionals who are incredibly engaging. They may not be celebrities, but they speak about it in a passionate and informed way, in a trusted way, and in a way that is totally accessible. We also heard from deaf people and deaf organisations and charities, about not just different languages, but BSL being appropriate as well. As Aziza said, there is a real delay. "Too many hoops to jump through" was the quote she used around multilingual videos for the NHS. Whether it is screening or menstrual health in general, we have a real barrier here. We talked about this earlier in our private session, for example, some of the language around FGM. We use that phrase, but different cultures and different societies would not use that description of female genital mutilation; they would use something completely different.

Is the NHS doing anything to improve the accessibility of information, whether it is through using influencers and celebrities or people from the medical profession who speak—for want of a better word—in slightly more normal, accessible language and in a culturally competent way?

Dr Mann: Yes, there is a lot to that, is there not? On the one hand, it is the media being used, and on the other hand it is the content and the accessibility of the information that is being provided. In terms of the media being used, the NHS is using social media, and you have probably seen some of them. It uses YouTube, Facebook and Instagram, maybe in a less dynamic way than Aziza and Nighat, but we certainly pull on those, and there are some quite good endometriosis YouTube videos. There are some things around menstrual health; there is some good content. Obviously, we try to stick to the accessible information standards, so we think about the reading age, which is really important. The written content has been called bland, but it is very good, informative stuff. One thing about being culturally competent is that there is some generic information, but there are so many different communities that we absolutely need to be mindful of. It is about supporting the local systems to identify their particular populations and then help them to translate the information into the local languages or make it more accessible for particular populations.

Q156 **Chair:** Is there a strategy to prioritise ethnic groups? For example, we know many black women are much more prone to endometriosis, PCOS or ovarian cysts. Is there a strategy within the NHS that looks at prioritising accessibility of information to these groups on issues that we know impact them more?

Dr Mann: We have just developed an equity framework that focuses particularly on two conditions. One of those is heavy menstrual bleeding where we know that there are real inequities, and the other is menopause. That is the starting point, and it lays out a really comprehensive set of support tools for the system, including how to think about your communities, how to make the information accessible, what is already available and can be translated and modified for that local system. From a national point of view, we are constantly thinking about how we can do something useful that can then be localised because we cannot provide for every detailed bit—

Q157 **Chair:** Absolutely. We completely understand the pressures the NHS is under, which is why I am asking whether there is a strategy to prioritise areas where we know there are communities that are going to be more likely to suffer from certain menstrual conditions than others. The two that you mentioned are very much targeted at women, and one section is older women in general. Is there anything in terms of girls?

Dr Mann: Nothing specifically around girls, but certainly heavy menstrual bleeding transcends. In this tranche, it is specific to heavy menstrual bleeding. There are a number of conditions, so we focused specifically on those two at this point but we will certainly review the needs for information in other areas.

Chair: Thank you very much. I am going to hand over to Christine, but the Minister is on his feet, so I am worried that we might have votes. If we are interrupted, we will vote and come back as quickly as possible.

Q158 **Christine Jardine:** The 2022 women's health strategy emphasised the potential benefits to girls and women of femtech apps. Do we need actions in the renewed strategy to better manage the risks that can come with them? If so, what could that action look like?

Dr Mann: Obviously, there is an explosion of apps and there are some very good ones which have really moved things along for women getting information. We can broadly think about apps in terms of more wellbeing-type apps and then the more medical device apps. When we start thinking about risk in terms of clinical risk, we need to be thoughtful about what kind of information is being provided. You probably saw in the 10-year plan that there is going to be a link on the NHS app to apps that are checked and verified so that people can find their way to useful information. We are very wary that people are also getting misinformation.

One of the conversations that came up earlier was about things like hormones. That is a good example of where apps are giving people very confusing information about what is helpful and what is not. Part of it is to think about how you can regulate the apps, but part of it is also thinking about how we have better conversations with people so that we can take on board the information that they have received through apps and make sure that we have shared decision making which takes account

of their information, but also helps them to understand that in the context of what is good information and what is misinformation.

Q159 **Christine Jardine:** Would directing women and girls towards the correct apps be how you see the NHS, and part of its role would be very much to do that?

Dr Mann: I do not think the NHS will ever keep pace with all the apps that are coming up, and obviously it is a really huge and dynamic sector. The NHS has a whole team looking at innovative things coming through and getting early value assessments on whether they are registered as what are called medical devices or whether it is good, legitimate information. But keeping pace with all those apps is an ask.

Professor Dame Lesley Regan: We need to think very much about how we partner with industry, pharma, charities, and VCSEs in general, because there is an enormous amount of good work going on and both our organisations have had a tendency to say, "Oh no, we don't do that." I famously commented about needing an open door, or a door that is recognisable that you can go to, bring your idea and then be guided through a pathway which lets you get special treatment, or you do not have to go through the governance and the probity or whatever, but you are guided rather than having to find your way because a lot of these organisations and charities and things just give up as it just becomes too difficult.

I do not think we can afford to do that any more; we really have to welcome their expertise. For example, the number of charities or self-help groups that will invest hard-earned money into getting another information sheet about something that there are masses of really good information sheets about is just nonsensical. We really have to find a robust and honest way of partnering with a lot of other sectors to improve healthcare for girls and boys, and for women and men.

Q160 **Christine Jardine:** Is there an aim to make femtech functionality, such as tracking menstrual wellbeing, available through or via the NHS app?

Dr Mann: Yes, there is. It is the ambition to have access to verified and recognised apps, including femtech apps, across the whole spectrum of healthcare on the NHS app.

Q161 **Christine Jardine:** We have heard from a range of witnesses who have emphasised the risks of femtech, which is based predominantly on data from white, middle-class users, changing health inequalities for more disadvantaged groups. How should that be addressed?

Dr Mann: We have to be very mindful. It is true across the sector, in AI and in research, that lots of the data that we use and plug in is not representative. We need to continue to be critical about how we look at data, understand which populations are being missed, and always be mindful that we are looking at it through a very particular lens. We need to continually strive to try to make sure that we get representation from

those groups that are not represented, so that we start to get the data that goes in being much better and much more recognised. There are all sorts of ways to do that, but working closely with the communities themselves, understanding more about their needs, but also how they want to be engaged with research and those kinds of data collections. Coming at it from the two ends: remain critical, but actually let us try to change the kinds of information we are seeing.

Christine Jardine: Dame Lesley, do you want to add anything before we go to vote?

Professor Dame Lesley Regan: No, you go and vote. I will be here when you come back.

Chair: Thank you. I am going to suspend the sitting for these votes; we will be back as soon as we can.

Sitting suspended for Divisions in the House.

On resuming—

Q162 **Dame Nia Griffith:** Thank you very much indeed for coming in. Obviously, there has been considerable concern about the proportions of research that are devoted to various different things. Has there been any progress in increasing the volume of research into women's reproductive health?

Professor Dame Lesley Regan: Yes, there has been an improvement. It started from a very low baseline, though. I think 1% of research spend goes specifically into women's health. The strategy, together with all the work that consultancies like McKinsey have done to try to demystify or myth-bust some of the things that were considered or wrongly thought about women, has helped organisations that are involved in research and the funding behind it to think rather differently about it. For example, the NIHR, which is obviously in the Department, is no longer able to assess grants, let alone grant them for research, if they do not include women, and women of reproductive age, if that is relevant. In the past, women of reproductive age were often excluded, particularly if it was an intervention trial, because they were worried about an unknown pregnancy, or a known pregnancy. I find this extraordinary: women were thought to be too complicated. I have often had pharma and industry telling me, "Oh, no, no, no. It's a niche market," to which my response has recently been, "Well, what can be niche about 51% of the population?" But that is what has been said. In fact, the work on purely reproductive stuff accounts for only a very small percentage of the problems in women's health. There is a much larger group of issues which disproportionately affect women: thyroid disease, rheumatoid arthritis, migraine, premenstrual tension and PMDD.

There is also a large group where women appear to be disproportionately missing opportunities for treatment. There is data to show that a male

presenting with palpitations and heart arrhythmia is three times more likely to be resynchronised electrically than a woman. That has opened an understanding of the fact that women's cardiovascular symptoms present very differently. It had been assumed until relatively recently—I am talking about the last three to five years—that everybody presented the same way, and if you had crushing central chest pain and a pain that radiated down your left arm, that was a possible heart attack. But women tend not to have that; they tend to have indigestion, pain in their back or just feel terribly worn out.

I mention cardiovascular disease specifically because it is a problem that affects women disproportionately and, because their symptoms are different, they have been neglected. They therefore tend to get their diagnosis later when their heart disease is more advanced. We have found that treatment has been trialled in men, but women respond differently. There was the classic thing about troponin levels which is the chemical they measure in the blood sample if you go into casualty with pain in your chest. It is now understood that troponin levels are much lower in women than they are in men. Women used to be sent away saying, "Oh, you haven't had a heart attack because the threshold's here." There is a much better understanding of that, and I am going on about heart disease because that is the major killer in this country.

Q163 **Dame Nia Griffith:** I understand. It is a slight deviation from our topic but, on that, is there any concerted effort to ensure a much more balanced cross-section of the population in the trials?

Professor Dame Lesley Regan: Very much so. That is what is changing. It takes time because there is a throughput when you set up a research study, perform a trial, and then introduce an intervention, is there not? There is a pipeline that has to be gone through, so it is not going to happen overnight but it is certainly moving. Many of the major funders now—NIHR, Wellcome, MRC—are not going to fund something if it relates to women if women are not proportionately, i.e. 51%, of the trial cohort.

Q164 **Dame Nia Griffith:** In terms of the particular study of this inquiry, what remaining gaps do you see in relation to menstrual and gynaecological health research?

Professor Dame Lesley Regan: It is not so much the gaps, but we have to implement what is known about it. It comes back to Sue's point, which she put well. Someone would say to me, "Well, we must do something about endometriosis." We do not need to do something about endometriosis so much as make sure that girls and women understand what a painful heavy period is, what is acceptable or normal and what is not, so that we actually have the focus on the right things that will change it, and then get health professionals to understand that.

Q165 **Dame Nia Griffith:** In other words, if you were renewing the women's health strategy, would you focus on learning from what we have found

out, and implement it more universally as opposed to perhaps patchily, as it may be at present?

Professor Dame Lesley Regan: Yes. For example, the big killers of women that I was talking about at the beginning—heart disease predominantly, osteoporosis, MSK problems, frailty and dementia—all those groups working in the major conditions strategy are recognising that they have to look at women's studies and women's interventions in a different way, and they have to be seen as a different group.

Dame Nia Griffith: That is very helpful.

Dr Mann: The other thing to think about with research is that there are always the traditional researchers and the big studies, but the world has changed, has it not? The pace of innovation is so rapid, and responding to new innovations, particularly in this world, is really important. What we are trying to do is to think about the new innovations and how we can support these things with early promise. There are things like early diagnosis of endometriosis, for example, with blood tests and things like that, so supporting with small grants to develop those innovations, and then a sort of accelerator programme with things that show promise to try to get them accelerated through the system so that they can actually be used.

A good example of that is a new test coming out that can diagnose endometrial cancer through just a swab. That seems like a very important thing, and when we think about pain maybe later on, actually preventing people having hysteroscopies is going to be really important. Then, working with the system, we have something called the health innovation networks that work on the ground and say, "This is something that's a need. What do we have in terms of innovation? What do we know is good, works and is robust?" Then, "How can we adopt it and then scale it up more broadly?" So trying to think about that whole pipeline. The slow, long studies are really important to answer the big questions, and there are quite a few of them in train at the moment. So it is the two sides.

Q166 **Dame Nia Griffith:** Would you focus on some very practical things, which would hopefully make diagnosis much quicker and more accurate?

Dr Mann: Yes, I guess the particular area is really in diagnostics. You are right. That is the commonest place where there is that kind of innovation that will actually make a difference to people if we can get them out there.

Professor Dame Lesley Regan: The other thing that needs to be really focused on is training the next cadre of researchers because you can have all the money in the world and all the clever ideas, but if you do not have people trained to undertake research then it is not going to go anywhere, so that is really important. It is really important to particularly prioritise charities and funding organisations that provide training

fellowships or start-up grants to collect data, which then makes them much better able to apply for a bigger study.

Chair: Thank you. The bell has gone again for a Division on Third Reading. Once we come back, we will be able to finish the session properly. Until then, I suspend the sitting.

Sitting suspended for a Division in the House.

On resuming—

Chair: Once again, welcome back to the Women and Equalities Committee; I am told that there are no further votes until much later.

Q167 **David Burton-Sampson:** It is lovely to see you both here again, and thank you for coming in. I am going to talk about pain, unfortunately. Why is the message not getting across to all healthcare professionals that severe pain is not normal or acceptable in relation to procedures such as laparoscopies or coil fittings?

Dr Mann: There are pockets of good practice, and there are some procedures that women tolerate reasonably okay. But you are absolutely right that unacceptable levels of pain are still being experienced. We are making a really strong commitment to tackling that because it is really important.

There has been a bit of gestation here, because we spent quite a lot of time talking to people, to TIGER UK and to the Campaign Against Painful Hysteroscopy; we have looked at some evidence about how to improve pain, and we have been speaking to stakeholders, really trying to get a sense of what the whole problem is. It is obviously right through the system, and really making sure that women are adequately informed before they start to go forward for a procedure, that there is good, standardised information and making sure that every single person gets that information, and has a conversation to think about what their options are and what they can expect so they are coming in a little more prepared. We have heard loud and clear that it is really important to make sure that that information gets to everybody, and that people have clear choices about what kind of procedure they have, in what setting and with what pain relief. We are very clear that is what is needed at that end of the system.

The training of healthcare professionals and communication are key. When we think about the skills framework that I said we are developing and will publish, that kind of trauma-informed care, with good communication that is culturally competent and compassionate, will be included and will be key throughout all women's health services.

We are looking at new pain relief options, at what can actually be delivered in different settings, at how the systems are structured to enable people not to experience so much pain, and at what is available in what settings. You will realise that there are some new centres, such as

community diagnostic centres. If people are having hysteroscopies off-site, what is available? Those kinds of things.

Lastly and really importantly, we need to make sure that we record people's experiences in a way that they do not feel pressured to report good experiences. Really trying to think very carefully about what PREMs and PROMs we are going to use to ensure that the services can then look at what they are doing and where improvements are needed.

That is all a big bit of work, and we are certainly committed to making a difference with that. You will have seen in the 10-year plan about the commitment to patient experience and how we can help incentivise the system to help women get better experiences. It is something I feel quite passionate about, so you can rest assured that it is in train; I absolutely agree with you that it is not okay.

Q168 **David Burton-Sampson:** That is really helpful. Dame Lesley, do you think there are any particular reasons why women are still being made to endure significant pain, despite clear guidance against it? Are there workplace pressures or is it simple medical misogyny, for example? Do we need greater accountability for healthcare professionals conducting extremely painful procedures in contradiction to the guidance?

Professor Dame Lesley Regan: There is always going to be the importance of accountability. I am not going to use all those very emotive words, because I do not think that actually moves us on, but it is very important that the strategy refresh, which we are working on at the moment, emphasises how important girls' and women's experiences are, and how it is not acceptable not to listen to them or to presume that somebody from a different ethnic group to myself has a higher pain tolerance or, because she has delivered two children vaginally, she does not "deserve" or is not going to need any form of pain relief.

A really good example is young girls who are coming in quite disabled with painful or very heavy periods and are not able to go to school. If they are under the age of 16 and you do a speculum examination in an out-patient clinic, you are probably going to traumatise them. If I did that to a 15 or 14-year-old, they are never going to go to a gynaecologist again, are they? And they are the group that will never have a smear again, they will be frightened of all sorts of things. So my challenge is often persuading the person who is with them—the family member, guardian or whoever—that actually what they need to do is to come in for a very quick day-case procedure, somewhere where they are going to have no memory of what is going on. You do not even need a general anaesthetic, you can now provide deep sedation in a relatively low-tech day surgical unit, and they will have no recollection of it. It is really important that it starts very early and then continues, that nobody needs or should have pain, and that we must ensure that we provide for it.

Q169 **David Burton-Sampson:** Sue, what was discussed and what actions were taken forward as a result of the NHS England stakeholder meeting

on women's chronic and procedural pain held last November, and when are we likely to see any progress?

Dr Mann: You will be aware that a number of stakeholder panels were convened as part of the strategy refresh, and the roundtable on pain was part of that group. It combined the intention to do that anyway with this plan, so it will be a commitment in the strategy. Obviously implementing things takes time, but rest assured that this is very much a live issue and we will be reporting back on what actions we have taken. I cannot give you an absolute date on it, but it is under way as we speak.

Q170 **David Burton-Sampson:** Do you know when we could expect to be given an exact date? Do you know the timeframe for putting the timeframe in place?

Dr Mann: An exact date for making the change or what is actually going to happen?

David Burton-Sampson: What is actually going to happen.

Dr Mann: There will be some things that come through in the strategy that supplement it with a follow-up, with some reporting about what else we are going to do.

Q171 **David Burton-Sampson:** Dame Lesley, in your last response you touched briefly on some experiences of black women. I have met some who have given me horrendous stories of the way they have been treated in terms of their expected level of pain tolerance during certain procedures, especially women-specific procedures. How prevalent do you think these discriminatory attitudes are among healthcare professionals towards black women's tolerance of pain, and what steps have been taken to address them?

Professor Dame Lesley Regan: Even if there were only one or two examples that I am aware of, it is not acceptable; one case is far too many. But the accountability issue is really important. Sue commented on collecting data about experience in a non-pressured way so that nobody feels that they have to say, "Oh, it was fine"; there are sophisticated ways to do that and collect the data.

But most importantly, I suppose the thing I often say to trainees when I am teaching, or when they are with me and learning, is that you need to think about how you would like your sister, your daughter or your mum to be looked after. That may sound very simplistic, but it is really quite important, is it not? You have to think about how you want somebody you really care about to be looked after, and would you want them to be experiencing what is obviously a painful procedure?

Q172 **David Burton-Sampson:** The fact that a pressure group was set up to lobby on this issue, and I have had groups come to meet me, says that this is quite a big problem.

Professor Dame Lesley Regan: It is, and there are a lot of contributory factors. The NHS is strapped for cash and strapped for time. Say if Sue was to come and see me, for example, or if one of my daughters, a young woman in her 30s, was to go and see Sue, putting some Instillagel into their vagina and waiting five to 10 minutes takes time. Then possibly putting an injection into the neck of the womb, saying, "I am going to ask you to hold my hand while I put this in"—or hold the nurse's hand or whoever—and waiting another 10 minutes, takes time. Plus it takes resources. They are not expensive things, and that has been our argument throughout. That is why we need to have a roundtable on it, and to keep following up. But it does take time. I am not against that; I am just saying we have to factor that in, and say that it is just not acceptable. That is why the community space is going to be so much more helpful, and will be able to facilitate so many more girls and women to get the care they need in the way they need it, and with the right pain relief.

Q173 **David Burton-Sampson:** One final question for both of you, relating to this whole topic of potential discrimination. Do we need some tougher actions to tackle unacceptable racist assumptions in this particular area?

Dr Mann: We definitely do. We can learn a lot from maternity, because we know that the outcomes for women of colour in maternity are so much poorer, and maternity is a little ahead in terms of putting things in place. The structures that are embedded in the NHS definitely need to shift.

Trying to embed culturally competent staff within those services is really important, and we will work really hard to make sure those staff are there, as a start. It does not solve the problem, which is much bigger than that, but it is a really good first step and is certainly a marker of a good service standard.

Professor Dame Lesley Regan: The team sitting behind me have heard this story so many times in the last couple of weeks, but it really struck me. I saw a relatively young black woman who was brought in on one of my day surgery lists early in the new year. She had been in and out of my hospital for the best part of 11 or 12 days, occupying a bed. During that time, she had had two blood transfusions and she had a problem that nobody had got to the bottom of. She was being transfused because she kept losing a lot of blood. I felt really upset about the fact she had had these two procedures, yet the problem had still not been resolved. I must say—possibly this is my character—I went through the notes in the hospital system and made a note of everybody she had seen. I worked my way around them all saying, "Why did this happen? What was it that made you think she did not need painkillers, which is why she refused to have anything further done in casualty or in the gynae out-patients?" There were a lot of people who were, in my opinion, behaving inappropriately. The leadership teams have to accept that it is happening and that we must not tolerate it at any time; they must find ways to say

that we cannot do that in an encouraging way, as opposed to in an accusatory way.

Q174 **Chair:** I just want to ask a follow-up question. Is the NHS prepared for the obvious training need we have there? And is it robust enough to withstand the obvious criticism that we are seeing around what some political wings will call a "woke" culture rather than what we actually need as a society to be able to best provide healthcare for women from all walks of life?

Professor Dame Lesley Regan: I do not think there is anything woke about pain, because pain is an experience, is it not? Every person in this room will have a different experience of pain, and they may well have different thresholds. When you say "woke", if you are referring to gender, my view has been very simple about this throughout my practising life—and I have now been around for over four decades in a gynaecology clinic. If you walk through the door, whatever you look like, whoever you say you are and whatever your name is, if you need me I will look after you. That is what we have to imbue in the generations that will be replacing us.

Q175 **Chair:** That is very welcome to hear, and obviously this is not an issue I would ever describe as woke. But I know that there are areas where there is political change across the country that may perhaps impact on how ICBs function, particularly if there is a change in mainstream thinking on EDI, for example, or that actually catering and being culturally competent should not be a priority for something like the NHS. Do you think the NHS has had that embedded enough to withstand any political pressure that may come in the future?

Dr Mann: Health inequalities are firmly embedded, and Core20PLUS5 is alive and well. For those of you who do not know, Core20PLUS5 is a whole system for trying to improve and reduce inequalities around socioeconomic disadvantage and ethnicity across major health areas. There is work alongside, for example, the electives plan for tackling inequalities. It threads through absolutely everything, and it needs to be embedded. But there is a much wider issue, is there not, about the leadership and people working in the NHS and society? It is obviously a big issue, but it is certainly embedded in NHS policy, yes.

Q176 **Kevin McKenna:** From working in NHS England and then working in hospitals, I am very aware and know what some of the policy at the top is. I know from my local hospital, which has some really big cultural challenges about racism towards staff but also from staff, that actually there can be a disjunct between the policy stance at the NHS at a national, regional, or even trust leadership level, and the cultures on the ground.

What work do you think we really need to do to make sure this is not just Core20PLUS5 and all the great stuff that is doing, and that it is right down to the front end, particularly when the NHS is resource-starved and

time is tight? Cultural change takes a lot of time and is quite hard to do, so what more do you think we need to do there?

Dr Mann: It is leadership from the top, and the national level sending a signal, but a lot of this stuff is also really embedded in our local institutions and organisations. A good example of one initiative would be the cultural champions who are now embedded in NHS organisations to look at racism on both sides and try to manage and ease that kind of issue.

These are local and national issues, but if we do not address them, Core20PLUS5 is not going to do it; it needs to be threaded through everything. But it is having it in every single policy and sending a signal to say that it is absolutely at the core of what we do. What gets done and gets led on the ground is also really important.

Q177 **Dame Nia Griffith:** You have already touched on training, to a certain degree. Unfortunately, we have heard rather negative things such as nurses having to fund their own training, GPs telling us they cannot find the time to do the training, and trainers with burnout. So how do you think we need to go about ensuring that we get better training right across the board in women's menstrual issues? Particularly GPs and frontline nurses, in the many different contexts in which they work. What should we do about the situation?

Dr Mann: On some levels, the system change is going to help to support the community of practitioners who are trained and fit for purpose. Starting from the primary care perspective, we have heard from previous witnesses that it has a huge portfolio of work, and they also have very little time in their specialist training. Some, not all, get training in obs and gynae, and one of the issues will always be variation; we need to ensure that we have a population of healthcare professionals who women can move seamlessly between. If skills are not met in one setting, it should be very easy to access them in another.

There is a basic level of skills that should come through the training, and we are going to be helping to map those to make sure that every single person on the frontline has those skills. They will also be supplemented with people who are working in the hubs or neighbourhoods. We will use the system to look at what skills they have, and to make sure they meet the needs of the population. It is very much that kind of population approach: "These skills are needed for this group of women, so where would they find them?" If I were experiencing very heavy bleeding and went to a GP whose primary interest might not be obs and gynae and I wanted an IUS, where would that GP easily send me straightaway to get what I wanted, or know where to refer? Those pathways are really important. We are working with a really good organisation called CLEAR that is, at this moment, trying to map out the pathways for what the workforce is and what the training needs are to match that.

Professor Dame Lesley Regan: There are some other factors that are starting to contribute to this problem. The GMC is introducing its medical licensing certification to ensure that, whatever branch of medicine you go into, you will have some knowledge of women's health. This is really important because women are 51% of the population, and the vast majority of them are menstruating at any one time, for example.

But you were talking about procedures, and if I go back to the Mirena coil example, the problem has been the commissioning for providing contraception, management of painful heavy periods and menopause. The Mirena coil is often a very useful tool for these because it protects the womb lining—the endometrium—from being over-activated by the oestrogen part of hormone replacement therapy. All three of those are obviously done by the same thing, and it takes exactly the same technique to put it into the uterine cavity in a painless and effective way. Yet you will find people you know who have gone along for contraception and been told, "Oh, you cannot have that done here because we only do menstrual management," or, "We only do menopause", and vice versa. And by the way, while that young woman, or older woman, is having this procedure done—is undressed—often the clinician that she is with is not meant to do their cervical smear at the same time because that is also commissioned in siloed pathways.

That is why we have to talk about leadership in terms of understanding that we have to wrap services around women. That is the right thing to do for women to be able to contribute and not have to go to umpteen different appointments; we have to instil in those leaders the fact that we cannot afford to carry on doing this so badly, because it is costing an absolute fortune. It is costing money that could be used to channel into the research you were asking about earlier, and/or improved services for all those things that we are going to have as older women because we are going to live much longer than our grandmas. So we have to think about it.

The comment about payments for GPs often comes about long-acting reversible contraception or putting coils and implants in. They will say that they cannot afford the back pay to fill up their surgery while they go to weeks and weeks of training courses. But the health hubs—or the neighbourhood hubs—are a perfect training resource. If you came to me and you wanted to learn how to do that, and we spent a day together where all we were doing was putting in Mirena coils or implants into arms, you would have the experience you needed in a very short space of time.

We also have to make that a training programme that is free for the person being trained. You cannot expect people to want to spend their hard-earned cash, particularly if they are nursing professionals or healthcare assistants, on getting the training and then maintaining the certification for something that is meant to be improving the lot of the patients they are looking after.

That is when I come back to the partnerships I was talking about earlier. We need to partner with other organisations that will provide this training for them in packages, so that it becomes the easy thing to do. One of my friends—a late friend, I should now say—used to work on the maternity thing on PROMPT, Professional Training in Obstetrics. He used to say, "You have to make the right way the easy way." When we are talking about devices and procedures in primary and community care, we have to make it easy for all healthcare professionals to do the right thing.

Q178 **Dame Nia Griffith:** On that note, I was a bit surprised to learn that training in sexual and reproductive health is not a standard or compulsory part of nurse training. Why is that, and have steps been taken to make it universal, rather than something that can potentially be left out?

Professor Dame Lesley Regan: I am not that au fait with the nursing curriculum; the last time I looked at it was when I was president of the RCOG and was collaborating with the Royal College of Nursing. I thought we had made big steps by taking the view that at least half, perhaps a little more, of all the patients a nurse will look after will be female and that we need to understand what their needs are. But the fact that we are having this conversation means that we do not have it right.

As I say, we have to make the right way the easy way, and provide training that is easy to get for the person who needs it. The health hubs are not only a good training resource; the pilots we have assessed have also identified that they are a really good workforce retention tool as well. If you are in a bit of a burnt-out state in my specialty, it is actually much nicer working in an environment where everyone says, "Oh yes, come on, we can get that sorted out for you, no problem." It is actually a much more pleasant way to work than always saying, "No, we cannot do that here."

Q179 **Kevin McKenna:** I am just thinking about how complicated gender relationships in nursing are—they are actually really complicated. But I wanted to just talk briefly, Lesley, about disabled girls and young women. I know you were asked to look at engaging with groups who are maybe under-represented or under-engaged with in the 2022 women's health strategy. Have you managed to have engagement with disabled girls and young women, and what did you find out, particularly about any barriers they face to accessing healthcare?

Professor Dame Lesley Regan: You have all met Dr Nighat Arif; she and I have founded something called the Women's Health Collective, which sits under the umbrella of Wellbeing of Women, the charity I chair. It now has 80 representatives from marginalised groups, and this is not just cultural, religious or ethnic groupings; it is also disability, including neuro-disability and every form of physical disability. You will be glad to hear we also have quite a few men on this Women's Health Collective, because they are really interested in working with their communities to promote better health for girls and women.

That is not the answer but happily, due to someone's ingenuity—not mine—we managed to get a big grant from the Lottery Fund to fund this for the next three years. That means we are able to offer travel expenses and, in some cases, childcare expenses and a small token stipend for those women we want to reach and be much more efficient at reaching, as opposed to saying that they are difficult to reach. We have adopted the view that, actually, no one is difficult to reach, but some people are much easier to ignore than others. It means, for example, that we can get people from the north of England to come to a meeting in person, which they would not otherwise be able to do because they would not be able to take the time off work, because they had caring responsibilities or because they could not afford the train fare. That is a way forward, and we have used them already. When I say "used them," I mean we have worked with them to produce various pieces of information, some of which I have just sent into the strategy.

We had a meeting in October time, when we had about 40 of them come to a venue. We sat down and did workshops throughout the day, and we asked them what they wanted, not what I thought they wanted; we have just submitted that information. It is very rich information coming from all different walks of life, and it is actually quite awesome when you read what some of these girls and women have been exposed to. In many cases it is not because people do not know or are ignoring them, but that they had just not realised that that was their social or socio-economic setting. They need to be made aware of that so that they can take the right steps to make it correct. Going forward I am hoping that this Women's Health Collective will have an increasingly important role in informing us about what the women and girls out there want, as opposed to what people who look like Sue and I think they need.

Q180 **Kevin McKenna:** If there is anything you could share with us after this, that would be really helpful.

Professor Dame Lesley Regan: I would be very happy to.

Kevin McKenna: Particularly around any differences between women with visible disabilities and physical disabilities, and then the non-visible disabilities, and maybe people who are neurodivergent as well.

Professor Dame Lesley Regan: I have learned a lot from the neurodivergent representatives we have had, because they really do have problems. One of the other things that has been interesting is linking it up with—and it is connected—heavy menstrual bleeding. Women who have very heavy menstrual loss every month, 12 times a year for many years of their lives, often become iron-deficient. There is now an emerging evidence base to show that when your serum ferritin goes down—not the haemoglobin that we have all the point-of-care testing for with an easy pin prick, but ferritin, which we need to get a point-of-care test for—you feel exhausted, washed out and unwell. There is now data showing that it may be one of the factors that is contributing to the increased incidence of ADHD and autism in teenage girls. It is actually

very easy to treat, but you have to diagnose it, so you have to listen to the symptoms and then make a diagnosis, not just take the diagnosis and then work backwards.

Kevin McKenna: I imagine if you are very tired, it is much harder to mask. That would be my hypothesis, but anyway that is fine.

Professor Dame Lesley Regan: The other thing to ask them is whether their hair is falling out, and invariably the young woman—or not so young woman—will say, "How did you know?" But when your ferritin levels are very low, your hair falls out. And again, the normal ranges have been constructed in men, and we need to understand that the normal range in a man who is not losing iron store every single month is very different from what women need.

Q181 **Chair:** Dame Lesley, you talked about the kind of problems with the long-acting reversible contraception fittings, such as coils or implants, and that that has been really broken for years. One area that we have heard is really damaging for women is access to menstrual health for lesbians, and particularly the discriminatory impacts they are having. We have had examples where lesbians have had to lie that they are actually having sex with men in order to be able to get access to either an implant or a coil. Are any steps being taken to end this discriminatory impact on lesbian women, and on women who do not have sex with men?

Professor Dame Lesley Regan: I come back to my earlier comment, that if you walk through the door and you say you want something and I am able to provide it, I am going to say yes. But I have never heard of that experience, and I do not disbelieve you if that is what you have been told. I find it shocking on all sorts of levels: intellectually, emotionally and professionally. Again, we come back to the fact that possibly the key to this is not always thinking, "Oh, we have to train the healthcare professionals better," but we actually have to get girls and women to understand what they need to do to be effective advocates for what they need.

Q182 **Chair:** I think many women and girls have found that effective advocacy on this one is actually to lie, because otherwise they will not get access to the treatment they need. I wonder if the NHS is taking any steps on this, particularly as it is not just a problem for accessing hormone-related menstrual health; it is also a problem even when it comes to smear tests, for example, and we heard evidence about that earlier in this inquiry.

In the same way as we see with racial discrimination, is any work being done for lesbian, bi-women and trans men for a greater understanding from NHS services, so that when somebody walks through the door they get the treatment that Dame Lesley has described?

Dr Mann: Completely, and what you were initially talking about was the kind of commissioning chop-up that people are experiencing. It chops up their care. No one should experience having to lie for care, or having to go around different houses to find what they need. So I completely

recognise that point, and lying about anything in order to get care is not acceptable.

We are tackling this. This is absolutely at the core of the neighbourhood framework and neighbourhood good practice. Delivering good neighbourhood care is about collaboration, and what we are talking about is actually getting the leaders together and saying, "Everybody knows this is a problem, so how are we going to solve it?" Some local areas have found solutions. They are not very complex solutions, but it is about getting people around the table and just saying, "There is a really clear solution to this." We can work out the exchange of money, but it is about driving it forward and getting people to own it. We will start to shape some ways of thinking about that in the good practice guide. We are working with the regions and the ICBs to think about that in more depth, and measuring the outcomes as well.

Q183 **Chair:** When do you expect that piece of work to be rolled out more widely?

Dr Mann: It is imminent, I would say. We will be rolling out and meeting all the regions in the next six months, and then having those conversations.

Q184 **Chair:** Excellent. Would you be able to feed back to the Committee at some stage on the progress?

Dr Mann: Yes.

Professor Dame Lesley Regan: We are doing a road show, are we not?

Dr Mann: We are.

Q185 **Chair:** Are you two always a double act?

Dr Mann: Quite often, yes.

Professor Dame Lesley Regan: It is very effective, because we have two different organisations that used not to talk to each other, and now they are talking all the time.

Chair: Brilliant. That is very good to see.

Q186 **Alex Brewer:** I wanted to talk very quickly about the women's health hubs that we have mentioned a little, so I am going to cut straight to the chase. Is there a risk that Government reforms, around scrapping NHS England and so on, are going to threaten the sustainability of women's health hubs?

Dr Mann: First, the work goes on, and the reforms are happening; NHS England is combining with the Department of Health and Social Care, and we continue to do that work. In terms of women's health hubs, this is obviously a time of change, which makes it more challenging as there is probably a little less bandwidth for people to do things at the moment.

However, there are a number of drivers, are there not? There is the secondary to primary shift and the elective waiting list, and we absolutely know that in gynaecology these are demand driven. We need to find a solution in the community to tackle that, so there are a lot of reasons why systems will want to find that solution.

Hubs are a cost-effective solution, but the problem is that they were small pilot tests of concept, and the challenge now is their spread and adoption. There are lots of examples of good practice that show this works for waiting lists and for people's care, but there is just the challenge of double-running—trying to deal with the waiting lists and then building a transformation. Transformation takes time, but I really believe the will is there. I have been speaking at the RCOG and with lots of different parts of the system, and we speak locally very frequently, do we not? There is a lot of will in the system to do it.

There are plenty of primary care professionals who want to diversify their portfolios, both nurses and GPs. They bring their expertise, then they go back to their primary care practices and it gets spread and others learn from it. I really believe that it is a transformation that will bed down, but it is going to take a bit of time.

The system is worried about how to fund that change. We will be thinking about what funding is within the financial frameworks in order to try to drive those shifts. But of course there is still the waiting list to get on top of, so there is going to be a time when that will be a bit trickier.

Q187 **Alex Brewer:** I represent a semi-rural constituency where public transport is, at best, threadbare. We do not even have part of a conurbation, if you see what I mean; we have lots of small towns and villages. Put it this way: it would be an extremely long time, with many women's health hubs opening up, before we got one in my constituency. There are many areas in the UK that are even more rural, with even more threadbare public transport. What is the plan for such areas of the UK, so that women there are supported? How long will that kind of filtering down and bedding-down process take?

Dr Mann: It should not have to filter down, but that is absolutely recognised, and it is therefore much more of a neighbourhood approach. In rural neighbourhoods where people cannot get to places, it is how we ensure that they have somewhere they can go. But local systems so they do not need to go to one particular place for everything.

We have a set of clear aims that are the things that really need to be delivered. How that happens is really dependent on geography, populations, what is already there, what skills are in the system. So it really requires a kind of mapping of that and then shaping it up so that it will reach you as well.

Q188 **Chair:** Thank you very much for your patience with our delays for voting. I have one last question. January is Cervical Cancer Awareness Month.

We have seen other countries across the globe being able to eradicate cervical cancer, yet we are falling behind. In the last three years, we have seen 400,000 children leaving school without receiving the HPV vaccine. In some areas, such as Lambeth, take-up is as low as 38% among year 10 girls. Is the NHS on top of this importance of increasing the uptake?

Professor Dame Lesley Regan: We have all been talking about the elimination programme because this is a preventable disease. There are not that many cancers that are preventable—at this moment in time, I should say—but this is. That is really important.

We have to overcome vaccine hesitancy as well. I want Taylor Swift to stand up at the beginning of her concerts and say, "It is really cool to have your HPV vaccine, go and have it." I am sure she would do it if somebody knew her well enough to get to her.

Chair: She is not on my call list, I am afraid.

Professor Dame Lesley Regan: No, and she is not on mine, otherwise I would have done it. But it is a good example. She is a cool figurehead for that particular demographic, and we have to do things like that. Then there is the catch-up programme, is there not? That started last July, and it is going on until March '26. But presumably what we will need to do, having looked at the figures and seeing that we are behind where we wanted to be, is continue that programme.

Q189 **Chair:** Absolutely. The message, hopefully, is that a parent will do anything to protect their child, and this is one of the easiest ways to prevent a cancer that we know is preventable.

Dr Mann: We had Harry Styles doing a campaign, so I do not know if that chimes. But yes, the communication is really important, and there are quite a few things happening in terms of the communications and trying to get the message out to people. Bearing in mind also that the people who are really important are the never screened, and we know that there are lots of inequities in terms of who does and does not attend.

You probably know that a self-sample test is being rolled out. That is going to be sent to people who have not come for a smear and are six months overdue. That is going to help pick up some people who might have never come because it is embarrassing, difficult and inaccessible.

Q190 **Chair:** Can people request that?

Dr Mann: At the moment, it is being rolled out for people in some areas who find it very difficult to have a smear; it is a sort of incremental roll-out.

Professor Dame Lesley Regan: There are also quite a lot of areas where women have to go to a sexual health clinic to have a smear, and if you are a Muslim woman or an Orthodox Jewish woman, you are not

going to go to a sexual health clinic to have that done. So we have to make it much easier and make every contact count, then use that and be very opportunistic about saying, "Well, have you had this? We must get it done."

It comes back to a comment I was going to make earlier about the waiting list. Sue and I did a piece of work for Baroness Merron last year on looking at the gynaecology waiting list; the headlines are 600,000 women. But what really shocked the two of us was that 85% or more of them were not going to need anything invasive or anything in a hospital, so why are they on the waiting list? When we wrote our foreword, we said that this was not a bit of tinkering to make every bit of the system a bit more productive; this is about a radical rethink of moving and shifting left into the community. It is ludicrous that 85% of 600,000 women are waiting for long periods of time for things that they do not need to wait for at all.

Chair: Absolutely, and that is a great place to end. Thank you very much again for your patience, and for sharing your expertise and knowledge with the Committee. We are very grateful. That brings the session to a close.