

Women and Equalities Committee

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

Tuesday 3 February 2026

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Members present: Christine Jardine (Chair); Alex Brewer; David Burton-Samson; Dame Nia Griffith; Kim Leadbeater; Kevin McKenna.

In the absence of the Chair, Christine Jardine was called to the Chair.

Questions 191 - 232

Witnesses

[I](#): Baroness Merron, Parliamentary Under-Secretary of State for Women's Health and Mental Health, Department of Health and Social Care; Tabitha Jay, Director for Mental Health, Disabilities, Women's Health and Maternity, Department of Health and Social Care; Dr Sue Mann, National Clinical Director for Women's Health, NHS England.



Examination of witnesses

Witnesses: Baroness Merron, Tabitha Jay and Dr Sue Mann.

Chair: Good afternoon everyone and welcome to today's Women and Equalities Committee on reproductive health conditions for girls and young women. If I could ask Kim Leadbeater to start.

Q191 **Kim Leadbeater:** Thank you for coming this afternoon, Minister. It is lovely to see you and your colleagues. Let us get straight in there regarding the women's health strategy. When do you plan to publish a renewed women's health strategy for England, and will it take into account the concerns that are raised by this inquiry? It is fair to say the '22 strategy was widely welcomed as a step forward, but there was some criticism that it lacked clear, actionable and measurable targets. Is this something you are going to address? In summary, when is it going to come, what is going to be in it and are you going to take into account what we talk about in this inquiry?

Baroness Merron: First, thank you very much for inviting us. We are all delighted to be here. We certainly look forward to your report as well because it will help us, not just for the women's health strategy as has been raised but actually in the longer term. I wanted to put that on record if I might.

When will we publish? We are planning to publish it in the spring and you will have noticed we are heading that way by the weather so that is sooner than often Ministers say. That is the first general point I will make.

Secondly, what will be in it? I know that the Committee will understand that I cannot go into detail but let me tell you how we have approached it. I was very keen on two things when I came into post. One was not to rip up the strategy just because it was a previous Government because basically it is sound and we are making progress against it. However, there are gaps and it needs updating and futureproofing. Things have moved on since 2022 and I am pleased we got that decision, really.

What will be in it? What we are doing now and have been for a while is looking, for example, at where there are systematic blocks—there are a number—to progress on women's healthcare. The big issue for me that the Committee will be very aware of is that women's voices are not heard. Should I be shocked? I do not know. I have had the experience myself, as I am sure many have, of finding it hard to find a voice but also then being heard. That has been our fundamental problem here in this country about women's healthcare: first, it has been neglected over many years, but secondly, women's voices are not heard. You hear that a lot and it is absolutely true; every bit of engagement tells me that.



In broad terms, we want to address both those points, that women's health is not neglected, that it is not nice to but it is core. I have written this down but I did not complete the third word. I put when and what.

Kim Leadbeater: We were hoping to seek some reassurance that you would take into account the things that we do on the Committee.

Baroness Merron: Forgive me. I would be very keen to. I do not know when your report will be published. If for some reason it does not chime in, then certainly I do not regard renewing the women's health strategy as a, "That's it," because then we have to put it into practice, so yes, it will be taken into account. The last thing I just want to say is the other thing I am doing here in my drive to renew the women's health strategy is tying it in with the 10-year plan and that is another huge change since 2022.

Q192 **Kim Leadbeater:** Can you tell us a bit more about that? How will the women's health strategy align with the broader 10-year plan? Are there any examples of what that looks like?

Baroness Merron: Yes, there are some very good examples. If we think about the three shifts in the 10-year plan, how we get information to people, moving from analogue to digital and improving the NHS app, in terms of digital—I am sure we will talk about this more—there is our introduction of the menopause check into the NHS health check and the impact that has had straightaway, which I would love to talk more about here. We still tend to think in an analogue way, do we not? We think about going to the doctors, seeing the nurse, but of course, so much can be done digitally. I use analogue to digital as a good example.

We will talk quite a bit about the focus from hospital to community but I am glad that in the 10-year health plan—I was keen to get this in there—the Tower Hamlets Women's Health Hub was in there as an example of good neighbourhood practice. I really wanted a women's health example of neighbourhood practice and then sickness to prevention. Again, I am sure we are going to talk about this more.

In terms of that area—sickness prevention—again, I hope we will talk, for example, about the cervical cancer screening and the introduction of at-home testing, again, new solutions using technology and progress to better serve women and align perfectly with the 10-year plan. I would say to the Committee that what I have tried to do is mainstream women's health more, not to put it over there because it has suffered for that. As women, we are just over 50% of the population so I really do not get why I am over there, and I am sure the Committee would share in that.

Q193 **Kim Leadbeater:** The Committee would probably agree wholeheartedly that it is very important that women's voices are at the heart of this work and certainly we have tried to do that as a Committee. What about the lack of targets that was criticised in the 2022 strategy? Can you give any



examples of how you are going to make things that are actually measurable, actionable and people can see the results of?

Baroness Merron: When you see the women's health strategy, we want it to be something that people can look at and know what markers to put down. I am going to turn to colleagues to see if they want to add anything here, but I would very much agree that that is crucial. If you look at the total number on the waiting lists, since roughly a year and a half ago there are now 19,000 fewer waits for gynaecology procedures. Again, waiting is a whole new area that I am sure the Committee will talk to us about so I will hold back because we have a lot to say on that.

Q194 **Kim Leadbeater:** Do either of your colleagues want to come in on anything I have covered so far?

Dr Mann: Obviously the waiting list data is going to be really important in terms of measuring impact, but I agree that the previous strategy was a bit less clear on the shaping of it and this one will have more direction in that way with some measures that will be associated. More importantly than that, we see the importance of measures in terms of how well women are now and how much their health is improving. We are going to be introducing measures at local levels so that systems can look at the progress when they implement the strategy and the changes to see whether people are getting better, have better access to care or take up more screening. Those key things will be measured at regions, which will then report back, so you will find that they will be there.

Tabitha Jay: I was just going to add that we have done roundtables with stakeholders and it might be helpful to just say what the themes of those were. One was on women's health and targeted mental health support for women at all stages, one was about menopause education and raising awareness, one was on preconception health and prevention of long-term conditions for women, one was with DWP—chaired by Minister Smith and Minister Johnson—about women and work, which is a really interesting one, and one was on women's experience, including pain.

Q195 **Kim Leadbeater:** That is really interesting because again, some witnesses that we have had here have expressed concerns that there is not enough new stuff in the strategy, but it sounds as though some of those ideas are quite new. What can you say to convince the people we have heard from that women's health, including girls' and younger women's menstrual health—the focus of today's session—is a long-term priority for the Government?

Baroness Merron: This is me asserting it and of course I know you want more than that, but it is a priority. I know you have heard from our women's health ambassador and I am sure you have heard her say this: "This is the thing that happens 12 times a year for X decades of your life and yet it's not spoken of." The big message I want us to give is that women should not put up with things, which is what women do. We all do it. Not just women, but women particularly because it is apparently



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normal to have extremely painful periods; it is not. It is not normal to have heavy bleeding. You should be seeking help. We have moved so far from that that it has to be key. I actually totally agree with Lesley that this is a really good anchor point. That is how I see it and that is why I would say to you that you can be assured it will be in there because it is such a core point affecting all women.

We could talk similarly about menopause, but earlier in life—that is key—we have an access point. I am keen on access points like that. I am also very keen on making every contact count. Again, and I know Lesley speaks very powerfully about this, just a simple question thrown in here and there can expose so much and pick up difficulties early. That is her key point. As long as we do not normalise ill health, women and young girls will be empowered to speak up.

We have just talked about community diagnostic centres, which is one of the most exciting things we are doing. Anyone who has experienced one will know how fabulous it is to see a quick, personal service under one roof. That will make it easier. Neighbourhood health centres and women's health hubs are also easier access points.

Women's mental health is also important and talking therapies are self-referral. As you know, I am Minister for Mental Health as well as Women's Health. The easy access, self-referral and information you can get online are crucial and are empowering women to say, "I need help," and the help needs to be there. That is quite a lot of ideals but they are not superficial ideals. This is the NHS we are building.

Q196 Kim Leadbeater: A final one from me because colleagues are going to come in with more specific questions about menstrual and gynaecological health. As a health team and the Minister for Women's Health, what are your immediate priorities?

Baroness Merron: Do you mean very specific things?

Q197 Kim Leadbeater: On women's health, what are the things that you are focusing on in the short term?

Baroness Merron: On what we have already done, I was very keen that we put some markers down. I could not believe the reaction I got from the announcement to include menopause in the NHS health checks. I live in Lincoln and see a reflexologist who actually does not know what I do, and she said, "Have you heard what the Government's announced?" I am thinking, "What on earth have we said?" She said, "That menopause will be in the NHS health check. Me and my friends are all talking about it," because they felt recognised. That was the point. We have not even kicked that off and women feel more likely to seek help. My priority is to get women heard, seen, treated and diagnosed quicker. We have already made that one.

The other thing was in October and it was emergency hormonal contraception being made available in pharmacies; again, a really good



example of community healthcare. So it is tangible points like that and reducing the waiting lists for gynae, including getting women off those waiting lists who do not need to be on them because they can get the treatment somewhere else. I am looking for some immediate impacts as well as system change.

Kim Leadbeater: I got a few messages from some friends on the day that we made the menopause announcements as well.

Baroness Merron: You see? It was quite remarkable. I could not have predicted it.

Q198 **David Burton-Sampson:** We are now going to focus on, I guess, the core of this session, which is about menstrual disorders and gynaecological health. Baroness Merron, is there anything else that you have not mentioned so far? I know you have started to focus on some aspects in relation to both those areas, but is there anything else that you want to see included in the health strategy that you have not mentioned so far? I guess we have talked a little about quantifying some things you want to achieve. We talked about waiting lists, people getting better and the take-up on screening. Are there any other areas that you intend to quantify progress through the new health strategy and what are those measures?

Baroness Merron: As we bring NHSE and DHSC together, there is a tremendous opportunity there. We already work closely together but I always find it remarkable that I have to use those words. I want to see them integrated. Sue will have more to say on this, but for example, regions have already developed improvement plans in terms of women's health. They did deep dives into it over the summer and they have developed their improvement plans. They very much focus on best practice, which I know will be of interest to the Committee and are following that up. I know Sue can add more. The reason I like that, if you like, is that it is a system change that is embedded. The other thing is that in the future, there will be a national priority programme director and that will include women's health and maternity. So again, it is about bringing focus; I want to bring focus into our system.

Again—I will turn to Sue for a bit more on this—the NHSE women's health programme board and oversight group, again, is bringing a rigour that has been lacking. I know they are not sexy things that everyone can latch on to but you as parliamentarians will understand and your questions have already said this: if you do not nail it down, measure it, review it, insure, it just does not happen. Could I ask Sue just to comment? Because the NHSE work is really interesting.

David Burton-Sampson: Perhaps, Sue, if you could focus a little more on what those measurable outcomes look like.

Dr Mann: It picks up on those improvement plans. The improvement plans are shaped through some really key aims and the whole point of



the aims is that they are what we call smart aims. They are very specific and measurable and the kinds of things that they will be looking at will be that secondary to primary shift, so trying to support women away from the waiting lists, and looking at core, high-volume, low-complexity conditions. What I mean by that is things like menstrual health, urogynaecology—an unsung area that needs much more attention—menopause care and LARC, long-acting methods of contraception.

Then there is prevention, looking at things like uptake of screening and preconception care, bringing in contraception as a prevention rather than necessarily just a treatment, thinking about the whole system, looking at workforce and women's experiences, not just patient experience. That will be distilled into some key aims and the data dashboard that I talked about will provide the measurables to look at delivery of those things across a whole population. Trying to support regions, ICBs and the local system to all work to the same goals is the way we will start to shift things to better care, I hope.

Q199 David Burton-Sampson: Baroness Merron, do you think menstrual disorders should have their own research categories separate from the current broader category of reproductive health and childbirth?

Baroness Merron: What would I say on that? NIHR is our research arm, as I am sure the Committee well knows. It does not ring-fence funding and I am okay with that. There is currently research into conditions such as heavy bleeding, particularly looking at the diagnosis and care for teenagers, which is very much on point, and the diagnosis and care for teenagers who have painful menstrual cramps, for example.

I was also looking at the figures, and last year there was £4.7 million directly spent on the health of women and girls. Of course I know one has to look at the comparators but the NIHR welcomes applications. The issue is getting quality applications in for research funding. That is where the emphasis should be. We are not just reactive but proactively promoting the need for research and encouraging it. That is the key and that is a whole other area that is useful in this regard.

For me, research is absolutely key. If we do not know the why, we cannot work out the response or be as efficient and effective as we would want to be. May I ask if my colleagues might add anything on research?

Q200 David Burton-Sampson: Absolutely. If I can just add, given some findings of this Committee and Dr Mansour—you have been to some evidence sessions—there are clearly challenges and gaps in provision for menstrual and gynaecological healthcare for women that we all want to address. I guess what we are asking is should this be a thematic priority for the National Institute for Health and Care Research moving forward?

Baroness Merron: Something that I know the NIHR is going to be doing that is absolutely key and important is publishing a portfolio, which it has brought together to talk about the range of investments that are very



particular to the health of women and girls, and I actually look forward to seeing that portfolio published. I also think transparency is absolutely key because—to the point I was making earlier—it will look at any gaps against specific topics, which is the point, David, that you are raising. It will also signpost researchers to the areas of unmet need; in other words, where we are looking for that research. Women and girls' health is actually ripe for research and we would be very keen to see it but that portfolio will really help us.

Dr Mann: I was just going to build on that because that portfolio and just keeping the profile on women's health research is really important. I just wanted to add that we have the Policy Research Unit in Reproductive Health at UCL, which is really trying to look at what the emerging priorities are. It has an ongoing portfolio of research, which we work very closely with so that we can demand signal and then they can start designing these studies. That has been such an important body to start looking at what research is actually needed. We are really keen to continue that and promote it.

Baroness Merron: Can I just quickly say something on heavy menstrual bleeding? I could not read my own writing but I can now, so I apologise for holding this fact back. The bit I wanted to tell the Committee about was a comprehensive review on the effectiveness of different treatments for women with heavy menstrual bleeding that was funded by the NIHR, because we want that research to identify the best treatment options, which is exactly where we all want to go. I am glad I could read it eventually.

Q201 **David Burton-Sampson:** We have met Dame Lesley Regan a couple of times during our inquiries. What is your assessment of the impact on girls and young women's menstrual and gynaecological healthcare of having the women's health ambassador and do you intend to appoint a successor to Dame Lesley later this year?

Baroness Merron: I want to pay tribute to Dame Lesley. She does not just give a voice; she is enthusiastic, engaging—I do not like to say "infectious" in a health setting, but you know what I mean. Whatever the nicer word than infectious is, I am sure Lesley will take it as a compliment. That is what you need: a strong voice and someone who is not just a voice for others but encourages others to use their voice. It is a pleasure to work with Lesley because she brings an energy and you need that too. It has been good. It is very good to have a women's health ambassador who challenges the Government when we meet privately, in the nicest possible way, and brings her own clinical expertise and contacts. All that is very positive.

My understanding is that Dame Lesley was appointed as the health strategy came into play. We are renewing it. We have moved on. I cannot give the Committee an absolute answer, but as the Committee is very aware, Dame Lesley's contract comes to an end in June and we are already thinking, "What is it we need? Who do we need? What is the



project now?" The project now is rather different to what it was when that women's health ambassador post was set up. We have other voices. Sue is a clear voice, as I found straight away. I do not just mean personally, but the role that Sue has is intended to bring that focus and voice as well. As I say, we are considering how we move forward.

Q202 David Burton-Sampson: In light of what you have just said, do you think there is a case for a larger women's health leadership team, for example, a team of leaders on a regional basis or women's health specialities? Is that single women's health ambassador role really too big for one person?

Baroness Merron: The job is not just for one person. Many of us have responsibility and actually the people with the most responsibility are people working in the field rather than the Minister, to be honest. My reference to having a national priority programme director in the future is important. As I said, the regional development improvement plans all have to be monitored, reported and so on. I actually have never thought it is a job for one person at all.

Q203 Chair: Could I just ask for maybe a wee bit more detail on a couple of points? Are there any specific outcomes you are looking at from the UCL report? You said that you were looking at what your priorities might be.

Dr Mann: The UCL has a very well-established programme of work. It determines its priorities and has a series of outcomes and outputs that are then publishable. For example, at the moment it is working on something around changing attitudes to hormone use and contraception, which is really pertinent because we know that there are a lot of shifts in the way that people feel about taking hormones for contraception, so that is really useful. It is looking at the commissioning structures across the system; again, that is something that we know is a real issue for us. So working really closely with the policy priorities and then developing the research studies that speak to that is how it has worked. The way it has aligned is really helpful because it really feeds in directly to priorities and reports very regularly on its outcomes so it has clear outcomes.

Q204 Chair: One other thing I wanted to ask was, Baroness Merron, the phrase you used was that you thought women's health was ripe for research. Would it be fair to say that that implies that you feel that there has not been any research or there has been a shortage of research, and this is an area where there needs to be more work?

Baroness Merron: That is a very helpful observation. I do not think there has been an absence of research but I feel we would benefit from more research. The truth is—again, I am sure this Committee is aware of this—research gives a status to conditions, practices, all the rest of it, and rightly so. As I mentioned earlier, if we do not know why, how do we answer it? Yes, I feel there are a number of areas where research would be beneficial directly as well as indirectly by raising profile.



Research will allow us to harness technology—which is hugely exciting—including AI, which we are doing, for example, on breast cancer screening. These are things we could not have dreamed of.

Q205 Kevin McKenna: Thank you for everything you have said so far. I would like to look a little more particularly at LARC—long-acting reversible contraception—and gynaecology in relation to waiting lists, changes to healthcare delivery, such as women’s health hubs and so on. Tabitha, just quickly, I believe I worked with you sometime back when I was at NHS England, so I should flag that up first. You will not remember me; I was doing work with the Work and Health Unit.

Just digging into these issues, waiting lists in elective gynaecology since 2022 have been really stubborn and just not been coming down as fast as anyone would like. Why do you think that is?

Baroness Merron: We will all have views. My big thing on this one is that waiting lists have been the only place where women could be placed. Whether they should be on a waiting list is another thing. I am advised that the estimate is that around 15% of women who are on gynae waiting lists need to be on there; the rest could receive treatment in the community.

What worries me—I am sure it will worry this Committee—is that there are women who are on waiting lists when, if they could be directed to services, particularly in the community, they could be helped more immediately, more efficiently, closer to home, it would be cheaper for the NHS, and that woman would not have this waiting time for a procedure or operation of some kind hanging over her because she does not actually need it. Again, I have heard Lesley Regan be very strong on this point. I am sure there are other reasons however that would be mine, but I do not know if colleagues would like to add because it is a very interesting area and is the right question to ask.

Dr Mann: It is interesting because there are some, not positives, maybe that is the wrong word, but there has been more of an awareness around women’s health and people recognising that they do not want to or should not have to put up with things any more and go seeking help and care from their GPs. If the GPs reach the ceiling of what they are able to give, they only have one recourse of then referring to secondary care, so the waiting lists have grown and grown.

In a way, the system has outgrown that demand. Putting in place the middle layer in neighbourhoods to say, “Actually, if you’ve got something that your GP can’t manage, you don’t necessarily need to be in secondary care, but you do need to have somewhere to go.” That is the whole basis of that neighbourhood layer to say GPs are a really important part of a patchwork. That patchwork is partly secondary care, but it is also a whole range of other professionals, not just doctors, nurses, physios, but also the multidisciplinary team. That is really what we are trying to build and it will take a bit of time because workforce shifts and things like that are



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not going to be straightforward. You have waiting lists to deal with and double counting at the same time to try to improve that community layer is tricky. To see results immediately, we have to be patient but it is the right way to go and we are starting to make inroads in that.

Tabitha Jay: The hub at Tower Hamlets brought out some of this particularly—you have probably talked to it already—really demonstrating the reductions with only 25% of referrals needing hospital care, representing a 60% reduction.

Q206 **Kevin McKenna:** What do you think they got right in the Tower Hamlets hub model?

Tabitha Jay: That they had the single point of access and triage to the right care.

Dr Mann: I can build on the Tower Hamlets as well because single point of access is really key so that referrals come to a central triage point. What Tower Hamlets found is that if you review all the gynaecology referrals, GPs can work with a third of them—giving advice, guidance, support and dialogue—a third of them can be managed somewhere in the community in this interface layer, women's health hub, and a third of them need to go to secondary care. So that frees up secondary care for the people who really need to be there and their waiting lists come down.

Baroness Merron: I do not know if you have seen some statistics; they are remarkable. I will just mention a couple of them. Building on what I said earlier, actually, there was a reduction in the number of gynae referrals that needed to be seen in secondary care: in the first 12 months, only 25% of referrals needed hospital care. That is transformative, is it not? As constituency members of Parliament, I know you will know this, but it is interesting how many complaints there are about poor communication generally from men and women in the NHS. In Tower Hamlets, 95% of patients receive an initial response from their referral within 48 hours, 100% within five days, as it should be.

Q207 **Kevin McKenna:** It is interesting that you mentioned Dame Lesley in this. She was characteristically forthright with us. She thinks that about 85% of referrals that are coming through to secondary care can go through a community or a primary healthcare model. It is a high statistic. She said the current situation is ludicrous. I suppose the real question is, given these really good examples, and it can apparently be made to work on the ground, what is the Government actually going to do about this to make this happen? Is this going to be reflected in any refreshed women's health strategy?

Baroness Merron: Yes because it is so key. Another area is our transformation on diagnostic services, which I have already talked briefly about with the community diagnostic centres. We also want to increase capacity to include areas such as tests to support diagnosis of gynae conditions, for example, to have MRIs quicker, more available and the



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results quicker; the sooner you are diagnosed, of course, the sooner treatment becomes possible. And not just increasing capacity and opening more community diagnostic centres but also expanding the hours and days they are working. As we have all learned, there is no point in having buildings, facilities and so on that are not used. So investing in more resources, putting them in the community, but also having them open more would be key.

Honestly, if I had to focus on communication, that would be a full-time job. I am sure we have all seen examples of good and poor communication. This is where our emphasis on the NHS app is so important because actually that is already changing people's awareness of how to book an appointment, where to get information and being able to access medical services through it. When I think about it, I am doing things that I could not have done just a year ago and it improves the situation.

Tabitha Jay: On learning from Tower Hamlets and making that more the case nationally, Sue might want to say more because learning the lessons from women health hubs and making sure that that is fully incorporated into the neighbourhood health model, which is where lots more is happening this year and we are about to publish guidelines on that, is a big thing.

I just also wanted to mention in the context of waiting lines the fact that NHS Online includes these areas—diagnostics, menstrual health—as a priority and that is really going to help to reduce patient waiting time because it is delivering the equivalent of 8.5 million appointments and assessments in the first three years, which is four times more than an average trust so that is quite a big dent.

Q208 **Kevin McKenna:** With prioritising that in that system, what does that mean? How does prioritisation manifest in the system?

Tabitha Jay: They had to choose nine areas and this was one of them, so we made it into that important list.

Q209 **Kevin McKenna:** That is a lot of enabling things and actions to make things happen. Where do you see the blockers? What are the blockers that stop this from happening and may there still be things that we have to address?

Baroness Merron: It needed capital investment. We have confirmed over £6 billion extra capital investment so that we can expand capacity across diagnostics, electives and urgent care. Again, we need new ways of working. As Tabitha said, NHS Online is phenomenally exciting and will make a really big change. I should say it was not an accident that women's health conditions became one of the nine. Very specifically, it is for conditions such as endometriosis and PCOS as well. Why? Because we chose some conditions with the longest waits and where online consultation works best. It is the combination of that that meant it was



not an accident at all—I know Tabitha was not suggesting that—but an absolute deliberate choice. Again, back to blocks, we are not shy to take on the toughest. That is what I am trying to say.

Dr Mann: Another block is that what we are trying to do is get the system to move and it is a big beast. It is partly cultural and people working in different ways; people are very used to one thing, so trying to work with all the different types of professionals in that is hard. We have an organisation called CLEAR, which is amazing and is doing some more detailed work with us on two particular women's health pathways, one being heavy menstrual bleeding and the other urogynaecology. It is doing that fine detail of what does this mean for workforce? What does this mean for shifts of funds? How do you make it work? Then using that to create a workbook for the system so that other areas can then pick that up. It is working with a couple of ICBs to work out the fine detail and will then be able to take that to other ICBs to go, "Okay, this is how you make that shift happen. This is where you invest in different ways." That will be really helpful to the system to do that.

Baroness Merron: I am sure the Committee is aware but I should not overlook this; it is absolutely key. We are using capacity through private healthcare providers. We are providing NHS provision but through capacity in the independent sector, which is right because why wait if the capacity is there? So we are harnessing that.

Q210 **Kevin McKenna:** We have heard quite a lot about dysfunction in the commissioning system, particularly around LARC and so on. These are really great ideas but are you taking steps to really address the challenges around the commissioning of LARC and how long is this going to take?

Dr Mann: Every person in the system says this has been a struggle and contraception is a really good example of that, is it not? It is part commissioned by local authority, delivered in NHS settings, and it is hard. For people to find the bandwidth to take the time to find the solutions is difficult. Without over-egging the neighbourhood framework, we are going to be looking at how that actually gets implemented and therefore what the commissioning implications of that are and working more locally with people to try to co-design and co-deliver commissioning solutions.

Rather than saying, "Do it this way," we will look at really trying to work out what the barriers and constraints are and how we can support the system to come together. A lot of it is about communication, having the right governance structures in place and things like that, so that more detailed work. We are doing a regional roadshow to go around and work with the regions on that, really understand the barriers and think about the solutions and share.

Q211 **Kevin McKenna:** Particularly as we are starting to move towards a neighbourhood health service—whatever that means; clearly that is still being worked through—where do women's health hubs sit in that? It is a



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slightly older conception. How are women's health hubs going to fit in with this neighbourhood health model?

Baroness Merron: We were talking about it in some depth before we came in.

Kevin McKenna: That is handy.

Dr Mann: I am a big fan of women's health hubs. They were a good proof of concept; they were done very differently in different areas because of what was there before and evolved in different ways. We are taking that learning and saying it is absolutely important to have a hub or something that sits in the middle of primary and secondary care and it is really important to be able to deliver on those core high-volume conditions that I talked about but also take a bit of oversight for the population on things like prevention. It is really a central pivot for what happens in secondary care and what happens in primary care.

In terms of the hubs themselves, if you are in a rural area, those hubs might be a more devolved, diffused picture, and if you are in a more urban environment—for example, Tower Hamlets—you might have one women's health hub. That is fine because it is a relatively condensed population. So what they look like in practice is very different. My own hub where I work is a hub-and-spoke model so we sit out in the community a bit more, but it is really population-dependent.

I do not think we should be specifying exactly what that looks like, hence going towards this idea of the framework for delivery of that neighbourhood health centre provision is guided by these aims. The proof is in the pudding, is it not? You look at how well the population feel at the end of it in terms of their health and then you will know you are doing well. But that concept of intermediate care has to be there. People have to have somewhere to go. They cannot have a coil fitted online, so there is something that needs to be there. It is just that the configuration will vary according to local need.

Baroness Merron: Perhaps if I could just very briefly say I am looking forward to—it will appear soon—the NHSE good practice guide for local commissioners about commissioning services efficiently and effectively to meet the needs of women, which is the point the Committee is investigating in this discussion. In my and our view, every area has to actually develop its neighbourhood health services to ensure that women's health needs are met. For me, women's health hubs were the start of neighbourhood provision.

Now we talk about neighbourhood health services, which is where the model is going, and we all embrace it, but actually for me, it was women's health hubs that have done a lot of inspiration in that area. As Sue says, they take different forms and that is fine, as long as they meet the needs of the women in their area. I have worked closely with NHSE particularly on this, which has been very clear at working with ICBs



directly—certain individual ones in particular—to ensure that the women’s health provision is correct and I have kept a close eye on that. Could we improve it? Yes, definitely. Do we have the right idea? Yes.

Q212 Kevin McKenna: I have lived in Tower Hamlets and now represent a rural community and I know quite a few members of the Committee are particularly concerned about rural and coastal communities. Actually, if this is a model that is largely being developed in urban and metropolitan areas, how long will it take to develop these into a state where they really function in areas that, frankly, have been massively underserved by a whole load of health services and what is the funding that goes with that? Is there transformational funding? Will funding for women’s health hubs be ring-fenced as well to ensure that we are actually not going to hit that consistent problem around medical misogyny and misogyny in the system where women’s services get overlooked because the funding is not being properly allocated?

Baroness Merron: I very much appreciate the points you are making. Again, as parliamentarians, you will be aware that our whole drive is to have local decision-making and meet the needs of local areas for exactly the reasons that you say. If it is a top-down approach, it has not delivered as well as it should have. We can see that just evidenced in your comments. We are not prone to ring-fencing unless it is for something very specific but we do not generally do that because areas vary. Lord Darzi, when he did his review—which has led us to the 10-year plan—made it quite clear there were too many targets, for example. We have tried to be more supportive and, if I can use the word, permissive with ICBs as the local experts. There will be hiccups but fundamentally that is right because who else will know the area better than the local ICB? Nobody.

Q213 Kevin McKenna: Of course the ICBs are going through quite substantial reorganisation and, frankly, big challenges to their budgets. However the details are that are locally driven, locally designed and fit the local population, with those budget constraints that are quite significant coming into ICBs, how are you going to ensure that actually they are still going to deliver on these objectives, particularly, as you say, for 51% of the population?

Baroness Merron: Who wants to talk through our thinking on it?

Tabitha Jay: We have been clear with ICBs that we want them to continue with hubs, and if not, explain what they are doing instead to meet those outcomes that we need, including experience. Baroness Merron meets regularly with senior NHSE officials to monitor that progress, look at ICB plans and potentially challenge them. We have heard from integrated care systems how positive women’s health hubs have been for access and experience. We also have a cost-benefit analysis showing a £5 benefit for every £1 spent, which is compelling, but Sue might want to say more.



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Dr Mann: From an NHSE perspective—which I guess is really where it sits—there is a lot of work afoot to support transformation, for example, in the way that new funding models are being designed to help to drive that strategic and transformational change. That is happening not just in women's health but across the board. When you talked before about things like single point of access, that is being driven as a way to transform services and the funding models that are available will meet. Then ICBs locally will determine the bits of their budget that might be directed towards transformation, and I know that that varies according to local area.

Baroness Merron: Perhaps just one general point, again it may be stating the obvious, but funds are important. Experience tells us we can put monies in but what matters is not monies in—I know you were not saying this, but it is very important to put it on the record—it is outcomes and that is why reform is such a big part of what we are talking about. Lord Darzi said the system is not working. We can keep propping up the system or we can do something more difficult, and it is more challenging, but I honestly think it is the right thing to do. I accept the point very much about ICBs.

It is a similar point, I would say, about NHSE and DHSC. There is lots of uncertainty because of the changes, but you have to go through discomfort to come out the other end. To use a well-worn phrase, we are grasping a few nettles that have not been grasped and that does not come painlessly. I accept that but I also do not think it is painless to stick around with models that are not delivering.

Q214 **Chair:** Very briefly, if I could just check something. If you could just distil it down to us in one sentence, is there going to be guaranteed funding for the hubs? I could not discern that from what you were saying.

Baroness Merron: There is not currently. The last Government set up this initiative on women's health hubs, which was a good initiative and they provided funding for the first year to get them going. That target has been achieved, which is the reason it is not in the planning guidance. It was only ever there for a year. I cannot speak for every area, but women's health hubs are a very financially efficient and outcome-driven solution for an ICB that is seeking to provide—as it is required to—the right healthcare for the women and girls.

Q215 **Chair:** We will have to move on but it sounds very much like you are saying it is not guaranteed going forward. If we could move on to just talking about managing women's pain. I wonder if you share our frustration about the slow progress in improving the management of women's chronic pain and procedural, menstrual and gynaecological pain?

Baroness Merron: In a simple answer, yes, I do. That is why—Tabitha mentioned this—I was very keen to include this as one of the roundtables of bringing together women with lived experience, professionals, third



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sector organisations, NHS and so on to talk about this and feed into the women's health strategy. I have heard of many experiences that are quite staggering.

Q216 Chair: Will there be measurable actions as a result of these roundtables and things in the strategy?

Baroness Merron: Again, Sue might have something to say on this because it is NHSE that we have tasked with advancing the work on pain management, which also includes bringing together people on trauma-informed care, patient safety and patient representatives. We are looking at reviewing what is available already, literature and research-wise. But key in this—I am sure the Committee has heard it many times—is lived patient experience. I do not think there is much that is more powerful than that. Let me say to the Committee it is absolutely unacceptable that women have such poor experiences, particularly in pain management. There has been quite a lot in the Lords Chamber particularly and outside the Chamber to me directly on hysteroscopy. It is staggering and shocking.

Q217 Chair: What processes do you think will be or would you like to see put in place to assess the progress? When would you think we will see some tangible progress on this?

Baroness Merron: We need to review what the training needs are and have a greater priority on recognition and management of pain. We are back to systems now: we need to strengthen approaches to how it is dealt with. There are gaps in care so we need to identify them and then plug them. Sue, this is very much your area of work.

Dr Mann: Very much so. We are actually doing a fair bit in NHS England around this and it should form part of the strategy coming forward, but I absolutely agree that progress is unacceptable and people are still having terrible experiences. When we think about procedures, mainly what we are talking about is hysteroscopy, things like IUD insertions and sometimes just vaginal examinations. There are a number of places where we are putting our energies. We have engaged quite a lot with some groups that represent women who have had poor experiences. There is a group called TIGER and there is the Campaign Against Painful Hysteroscopy. It is really important to hear their voices, which we have been doing.

There is something about supporting women to get the right information, which is one thing about what they can expect and how to make informed choices. That is the first part of that. The College of Sexual and Reproductive Healthcare is doing a campaign alongside this at the moment about painful IUD insertions, really with the same ideas about trying to raise awareness among women and healthcare professionals.

Second is around training the people who are doing the procedures. We are first thinking broadly about how we can better support trauma-



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informed, compassionate, culturally competent care and thinking about some really basic principles that should go into training for delivery of women's healthcare across the board, whoever is involved in that. Those are core principles.

Then it is thinking more about what is available within the system. There are new pain relief options, anticipating which women might experience more pain and trying to have a shared decision-making approach to that. And then more long-term really trying to listen to women's experiences and measure them effectively so that you are not asking someone straight after a procedure, "How did it go?" but really trying to stand back and say, "How can we usefully measure how well people tolerate those procedures?" because they are never going to be nice, are they? Then use that to say, "Well, we need to have a standard of care here."

The last thing I will say is that there are some really interesting innovations coming online that we are trying to support around actually avoiding hysteroscopy if you do not need it. There are some new tests around things like testing for cancer of the uterus. Maybe in the future you will be able to do that with a swab and then you might not need a hysteroscopy. We have to be very careful about how we introduce these things because they have to be equivalent to a gold standard. There are all these things that are in train but they are not quick and that is something we have to be realistic about.

Baroness Merron: To your point about by when, the other area that is worth highlighting is by 2029, PROMS—patient-reported outcome measures—and PREMs—patient-reported experience measures—will be used universally. They measure the impact of care from the patient's point of view on what has happened, not the clinician's. They are already in use in orthopaedics and mental health but not in this area. Again, we are going to be collecting them in a much more systematic way. That will make a big difference and they will be published in the public domain, which is also absolutely key.

Q218 **Chair:** That all sounds very much like a lot of awareness raising and measures to relieve pain but going along with that is accountability. How can we add some accountability to the system? Something we have heard throughout this inquiry is that women's pain is put aside, dismissed and they are told to just put up with it. Do you think we need to add some accountability to that and how do we do that?

Baroness Merron: What I have just said will help actually because those metrics will be used and because they are published it is not going to look good to have a bad score. They are publicly available. I know for a lot of women it is just not practical to choose where they go but you can indicate your view when you are choosing your provider and it will be on the NHS app, for example. That will hold them to account. I should also credit the membership of professional bodies for their work. Sue did not make mention of that but the Royal College of Obstetricians and Gynaecologists just outlined its guideline on outpatient hysteroscopy. All



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that supports all that we are saying and will support women to have a better pain control experience. Of course, what you do not know, you cannot ask for. That is the other challenge.

Chair: I am just looking at the time. There is a lot to cover and obviously we want to go into it. I wonder if we could try to keep answers just a wee bit shorter just to make sure we get through everything.

Q219 **Alex Brewer:** I just want to come back to the very first point that Kim asked around whether your strategy is going to include the concerns that we are raising in this inquiry, and you said it might depend on timing. I just wanted to add that the clues might be in our questions today as to the kind of areas we are interested in. I wanted to follow that up with a question, which is have you taken on board our report from a year ago about medical misogyny more generally and the concerns and recommendations that this Committee has raised in that report?

Baroness Merron: You are quite right to pick me up on that. Indeed, in some ways, we do not need to wait for a report. I would say that a number of the areas that the Committee is looking at—you will not be surprised—they chime in well and I am grateful for it; it helps me.

On misogyny, I am sure you heard the Secretary of State; he was absolutely clear that medical misogyny has no place. Your report is extremely helpful in that regard, for sure. When committees report, I am personally very keen on the reports because so much of the good work—both in the Commons and the Lords—really assists us and we would be daft to not take account of what is said, to be honest. Of course, we respond to reports, as is required, and I like to be as positive as possible. If we cannot accept a recommendation then we will explain why. But I will tell you what it does for me: it makes me question and challenge, and the same for officials.

Q220 **Alex Brewer:** We heard a good deal of evidence so I am pleased to hear it. I have quite a long list of questions so I am going to push on. Do you think there should be a link to the Wellbeing of Women's period symptom checker on the NHS website?

Baroness Merron: Yes.

Q221 **Alex Brewer:** What are the barriers to making it happen?

Baroness Merron: We are using the next six months for NHSE to look at how best to do it, make sure it all works and so on. To those of us who are not very technical—I am sure that every member of this Committee is extremely technical, but I am not—it sounds very straightforward but I am assured it is not and actually I believe that, so I want to make sure it works. But the answer is simply yes, it is a great thing, and we want it out there.

Alex Brewer: Six months still seems a very long time from where I am sitting.



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Baroness Merron: We could expand or we can write to you on it if you would like.

Alex Brewer: The Committee would be very interested in understanding exactly what the barriers are to making that happen.

Baroness Merron: Absolutely.

Q222 **Alex Brewer:** Thank you. Do you think the NHS should be making more use of third-party media content produced by effective women's health communicators, for example Dr Sesay and Dr Arif?

Baroness Merron: Yes, and we try to do that.

Alex Brewer: Okay. Excellent.

Baroness Merron: Am I doing better?

Q223 **Alex Brewer:** Yes, thank you. We have heard a lot throughout this inquiry about the difference between the acceptability of naming men's genital parts and the taboo of naming women's body parts and therefore there is significant work going on to combat this. They told us that NHS bureaucracy might be preventing some menstrual health content from being published by NHS social media channels. Would you take action to streamline that bureaucracy?

Tabitha Jay: The social media regulation may not be an NHS thing; I think that is DSIT with the Online Safety Act 2023, trying to regulate harmful content and whether it is successfully distinguishing between harmful and helpful content. We are very keen to advocate for that distinction to be right.

Alex Brewer: That was my next question, but this is specifically about it getting on to NHS social media channels.

Baroness Merron: I may be misunderstanding the question but I guess we are all thinking about, for example, TikTok being able to access the information; it may not happen because of the way its platform works. That is an issue.

Q224 **Alex Brewer:** One way that young women access health information—not just young women, it has to be said—is through social media channels: TikTok, Instagram and so on. In order for them to do that, it obviously needs to be pushed out via the right channels and then not be deprioritised or shadow-banned by those social media algorithms. These are two separate things that I am looking at. The first one is, is it going out on NHS channels?

Dr Mann: NHS has social media channels; we use YouTube and things like that. There is obviously a bit of tension between the need for safety. In terms of information, NHS England really prioritises what the best information is to share. There are a lot of layers of scrutiny and that is what makes it a little more difficult. I understand that the pace of change



and important influencers like Aziza and Nighat push out very effectively into the system. Trying to marry those things up and ensure the quality and safety of that is complicated because of the controls that are in place, I guess, for every information source that is coming in, which is not just the high-quality stuff, but it is a whole mixed bag.

Baroness Merron: Perhaps I can just say that I understand the issue completely and am sympathetic to it. It does not sit within my gift but I am in the process of raising it with DSIT Ministers. I cannot speak for them at this stage. It may be something the Committee would want us to come back on but that is what I am doing because I absolutely recognise the point you are making.

Q225 **Alex Brewer:** I would be interested to know whether those conversations that you are having will feed into the women's health strategy as a part of it.

Baroness Merron: If I can be a bit broader, the women's health strategy will be looking at how we get our information out and making it appropriate to different groups who—as you say—receive their information in different ways. As I say, if there is a DSIT matter, that will be separate from the women's health strategy.

Q226 **Alex Brewer:** As a woman and parent of a teenage girl, and boy for that matter, my concern is that we are currently living in an age where teenagers can go on to social media sites and strip someone naked digitally but cannot access accurate information about their own bodies. That is a digital problem but also a health problem. What I am trying to dig out a little more here is to what extent would you be working with DSIT? Do you share their confidence that the Online Safety Act 2023 is enough to help prevent this? How much joint working is there going to be or is there currently between the two Departments?

Baroness Merron: I probably cannot answer that directly; I do not have a direct answer. As we said, we use the various platforms—YouTube, Instagram, Facebook—for the very reasons that you have explained, to explain topics that we are talking about here, including menstrual health. We know that 18 to 34-year-olds are not very likely to go on the NHS website. Some of us might, but not that group. We know that and therefore we have to work with that.

I am going to raise this point about shadow banning, which you also raised. As I say, with DSIT, I just do not have the information about that to be able to share with you or I would have. In fact this will help me; I can say this was raised with me at the Committee as well. But it is a whole area for the Government actually, and not just exclusively on women's health as we know. I am saying I get it completely; it does not sit within my gift. Actually, the Online Safety Bill will only cover certain areas. I am not sure that it deals with shadow banning because it is more about regulation than being, I will use the word permissive, meaning to allow.



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Alex Brewer: This is something that is very definitely affecting the content.

Baroness Merron: I am grateful to you for making the point, actually. Thank you.

Q227 **Alex Brewer:** That is okay. Can I take it then that you have not specifically had conversations with social media platforms about stopping this but you would raise that with DSIT instead?

Baroness Merron: We would not; that would be DSIT's responsibility, but we would raise it with DSIT and that is what we are doing.

Q228 **Dame Nia Griffith:** Minister, I am delighted to see you. If I can turn first to femtech and just pick up on some things that the Committee has looked at before I joined it, so I can take no credit. First if we start with the 2022 strategy and ask you really whether you think it got the right balance between embracing potential benefits of, I suppose you would just call them commercial products like femtech apps with things such as period trackers and mitigating the risks that they could pose to women and girls. Linked to that, what options have you considered for regulating and how do you actually see the NHS's role in femtech developing over the next few years?

Baroness Merron: It could play a greater role, and the renewal of the women's health strategy will acknowledge that because—as you have rightly observed—the original women's health strategy did not really grasp it. The digitisation point is perhaps a gap I was keen to close. Digital health technologies are our way forward and they will continue to develop.

What I should probably say to the Committee is we are improving the process for digital health technologies to set the standards that your question is seeking so we want to embrace it more. They are absolutely an ever-greater part of the care and treatment that we are providing, not just in terms of women's health but that streamlined route to assure and evaluate their use and practice is really key. Their use varies widely across the NHS, and again we want to make it more widely available, taking into account that not everyone can access digital health technologies. That point has been raised a lot in the Lords Chamber, as you can imagine.

Q229 **Dame Nia Griffith:** I am sure, and I am going to look at the reverse of that in a moment. Dr Mann, I understand that back in November 2024 you actually told this Committee that a call had been issued for femtech proposals. I wondered what had actually come of that, and if you have any more to say about the femtech strategy being set out in the women's health strategy.

If I can just pick you up on something else you told this Committee: you said that the NHS has a whole team looking at innovative things and I just wondered what the gender, age balance and other characteristic



balance was on that team. Are we looking at a lot of middle-aged men and do they know where teenage girls access their social media? Does it determine which innovations they look at more quickly than others? In other words, are we going to fall into the same trap as everywhere else in the health service where research into women's issues is lower down on the list?

Dr Mann: That is a very good question and there are a number of things there. The team that I think you are talking about is the Innovation, Research and Life Sciences team, which is constantly evolving a strategy to look at how to bring new innovation and tech to actually reach people. I cannot tell you the exact makeup of that team but I take the point that you are making and it is a small team. I would say that it is really aligned with us and women's health has become quite an important priority for it. It does a number of things. It demands signal and is looking for innovations in particular areas. It supports innovators to bring things to develop and then bring to market. That fund that you were talking about—I forget the acronym—funded a number of individual projects. I would need to check as to where those are at; I do not have an immediate report on that, but definitely the funding went out to innovators.

I would say as well that it works very closely with what we call the Health Innovation Network, which sits in the region, so bringing that tech and saying, "What are the needs of this community? What innovations are happening locally?" It is quite a symbiotic relationship. I know for sure that there is a very large female contingent in that team of people working out in the regions and often they are the ones who are looking for what the need is and where the innovations are happening.

There is some interesting tech that is coming through. There is a lot of tech around things like management of incontinence and CBT for menopausal hot flushes, so that is another one that is coming up on the agenda. There are some really interesting things that are happening, and of course we stick much more to what is called the medical devices side of things rather than the more wellbeing apps because those are the ones that really need the regulation and the development.

Q230 **Dame Nia Griffith:** If I can return to a couple more general things. Minister, you said that 85% of people on gynaecological waiting lists should actually be treated in the community, not in hospitals. Does that beg the question about whether there should be a huge input into GP training, followed by a suggestion that anybody on a waiting list should actually go back to their GP?

Baroness Merron: It raises a lot of questions. Actually the main thing it raises for me is the need to focus on the waiting list to guide and support women to the right place. Kevin raised the 15%/85% because Lesley Regan may have said it earlier in the Committee. Of course GP training is key, but now GPs are incentivised to seek an opinion from the consultant before they actually send them to the consultant. That is a relatively new



system and is a whole different way of doing things. The difficulty we have is that people have been on waiting lists for a very long time.

- Q231 **Dame Nia Griffith:** One last question—but definitely not least—is with the new strategy coming out, what steps are you taking to ensure and involve disabled women in helping to design and improve the opportunities they have for access to the right information and treatment for their menstrual and gynaecological care?

Baroness Merron: The consultation—which was massive—on the 10-year health plan was absolutely focused on ensuring that all groups were represented. That was the first thing, and of course we are looking to that, as I mentioned at the beginning of the Committee. As we have drawn together people with lived experience, third sector organisations and professionals, at the core of it has been ensuring we have a wide representation. You are absolutely right to talk about disability because that very much affects people's experience. I have spoken to one of our colleagues who experiences it very directly about that very matter.

- Q232 **Chair:** There is something I was wondering about. Women with some conditions, such as polycystic ovary syndrome, may have problems with their fertility. Should women in this sort of position have more support from the NHS and have their eggs frozen? It is not directly related to what we have been talking about today, but it is something we are looking into.

Baroness Merron: We do not have a policy in that area. Just to say, I met very recently with Michelle Welsh MP to discuss PCOS; it is something very much in our sights and I very much recognise we could do a lot more. We did not discuss this point that you raised, Chair. If the Committee is going to recommend that, of course we will respond to a recommendation but I do not want to pre-empt that. I cannot say that is currently something to which we are committed. Is that fair?

Dr Mann: That is fair. Women with PCOS sometimes—not always—experience a range of different fertility problems. It is important to say that. One of the most common problems that they have is that they have eggs but they do not release them. They definitely need to have multidisciplinary care and good access to fertility services. The most effective way of managing it and the best treatments for them need to be locally shaped with the services; sometimes that is to stimulate egg release because the eggs are there.

Chair: Thank you all for coming along and for your evidence today. We have covered everything.