Government response to the Women and Equalities Committee's first report of session 2024 to 2025: women's reproductive health conditions

CP 1276

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Presented to Parliament
by the Secretary of State for Health and Social Care
by Command of His Majesty

March 2025

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Introduction

The government welcomes the Women and Equalities Committee's report on women's reproductive health conditions. We recognise how important this topic is, and we are grateful to everyone who has contributed their time and expertise to the inquiry and for the recommendations that they have made.

Reproductive health conditions are very common. For example, endometriosis is estimated to affect 1 in 10 women of reproductive age, while the prevalence of heavy menstrual bleeding in the adolescent population is estimated at 37%.

As acknowledged in the report, despite being so common, women and girls still face challenges accessing care for their reproductive health. The report:

- highlights a number of important issues such as a lack of education and awareness of what a 'normal' period is or the symptoms of common reproductive health conditions
- details examples of delayed diagnoses, with women forced to make repeated visits to healthcare professionals, and poor experiences - for example, undergoing gynaecological procedures without sufficient pain relief
- notes the importance of education and continued professional development for healthcare professionals, and the need for more research into women's reproductive health conditions

What the government is doing to improve women's health outcomes

The government agrees with the overarching aims of the findings and recommendations for improving women's health outcomes and experiences. We acknowledge the impact that reproductive health conditions have on women's lives, relationships, and participation in education and the workforce.

The report acknowledges that, since the publication of the Women's Health Strategy for England, some progress has being made, including:

- the appointment of the Women's Health Ambassador
- work to build trust with women from marginalised groups
- improved research into reproductive health conditions

However, we recognise that much more needs to be done to support women with reproductive health conditions, particularly around:

- listening to women
- improving information and education
- improving access to healthcare services

Tackling waiting lists, including for gynaecology, is a significant part of the government's health mission Build an NHS Fit for the Future.

NHS England's Reforming elective care for patients plan, published in January 2025, builds on the investments already made with an ambitious vision for the future of diagnostic testing to ensure that patients receive more timely, accessible and accurate diagnostic testing, including for women's reproductive health conditions. It sets out how the NHS will:

- reform elective care services
- meet the 18-week referral-to-treatment standard

For gynaecology specifically, NHS England will support the delivery of innovative models, offering patients care closer to home and piloting gynaecology pathways in community diagnostic centres.

We are also working with NHS England and the Women's Health Ambassador on how to take forward the Women's Health Strategy for England, by aligning it to the government's missions under the Plan for Change and forthcoming 10 Year Health Plan.

As we develop the 10 Year Health Plan, we are working with the sector to identify the right actions and interventions that will deliver the required changes for women and babies. Some of these will require time to implement, but we will also identify immediate actions to drive forward change now.

The 10 Year Health Plan will set out how we tackle the inequities that lead to poor health, including those for women. As part of this, the government is committed to setting an explicit target to close the Black and Asian maternal mortality gaps.

We have worked closely with our arms-length bodies and other government departments to consider and provide a response to each of the report's recommendations.

We are committed to improving women's health as we reform the NHS, and women's equality will be at the heart of our missions. This report will support the government to consider what further action can be taken to ensure that the health needs of women and girls are prioritised, particularly as we develop the 10 Year Health Plan.

Public understanding of reproductive health conditions

Recommendation 1

The government should ensure teachers tasked with delivering the menstrual and gynaecological health element of RSHE receive the training necessary to deliver it effectively. Information on women's reproductive health conditions should be taught early on in secondary education, preferably around the time most girls first experience menstruation. That information should include guidance on what is and is not considered to be healthy reproductive health and cover intersectional differences, preparing pupils to advocate for their needs and seek help when necessary.

Recommendation 2

The guidance fails to recognise the importance of boys and men understanding reproductive health conditions that their peers might experience and their role in changing the culture and stigma that girls face. The statutory guidance should specify that boys should be taught about female reproductive health conditions.

Government response

We agree that all students, including both girls and boys, should receive comprehensive education on menstrual health, and that all girls and women should be informed on what a 'normal' period is.

Relationships, sex and health education (RSHE) became compulsory in schools in September 2020, and all pupils are taught the facts about areas of women's health. The RSHE curriculum covers several areas of women's health, including:

- menstruation
- contraception

- fertility
- pregnancy
- menopause

The 2019 Relationships, sex and health education (RSHE) statutory guidance states that primary and secondary school pupils, including boys and young men, should be taught important facts about the menstrual cycle and reproductive health, including:

- what is an average period
- the range of menstrual products in the market
- the implications for emotional and physical health

The Department for Education (DfE) is currently reviewing the statutory guidance and exploring whether any changes to existing content are required, including on menstrual, gynaecological and reproductive health. DfE is working with the Department of Health and Social Care (DHSC) and the government's Women's Health Ambassador, Professor Dame Lesley Regan, and will consider the relevant recommendations from the Women and Equalities Committee in developing revised guidance. The results of the public consultation, and the government's response to it, will be published this year.

It is important that teachers have the confidence to teach RSHE effectively, including teaching about menstrual and gynaecological health. To help teachers deliver this content effectively, DfE publishes a range of online Teaching about relationships, sex and health teacher training modules covering each of the main subject areas, including sexual health and the changing adolescent body.

Once the review has concluded, we will consider whether further support or materials for teaching are needed and how they can best be provided, including through any resources made available from Oak National Academy, the DfE public body that provides resources for teachers.

Recommendation 3

To supplement improvements in the provision of information on the NHS website, we recommend the inclusion of an interactive tool which can help women to determine whether they might have a reproductive health condition. We further recommend that information on specific conditions contains links to the relevant medical guidelines so that

patients can make themselves aware of the care they should expect. Information on the website should be made accessible by default, including in different languages. The link between reproductive health conditions and mental ill health should also be clearer, with information on how to access support signposted. Women's health hubs should be commissioned to provide tailored information at a local level, in a range of formats suited to their local population.

Government response

We must ensure high-quality health information and signposting is available for everyone across the country. We know that many women access health information through online sources, including the NHS website and social media, as well as through family and friends, and healthcare professionals.

The NHS website is designed to provide accurate, clinically assured guidance across a broad range of health topics, helping people understand their health and determine next steps for managing it. A dedicated Women's health area has been created on the NHS website, bringing together over 100 topics related to women's health and providing easily accessible guidance to support women at every stage of life.

Topics include a range of women's reproductive health issues, including:

- menstrual health
- gynaecological conditions
- contraception
- pregnancy and menopause

It also includes information on other health issues that may affect women, including:

- dementia
- heart health
- mental health
- cancers

While the website does not offer a triage service or diagnose conditions, it directs people to appropriate services such as 111 (online or telephone), pharmacies or their GP practice,

where people can discuss their specific symptoms and be signposted to services or receive the care they need.

A core responsibility of the NHS website is ensuring that all content is clear, evidence-based and accessible to everyone. In line with the NHS website's agreed approach, content is focused on being clear and easily translatable by translation tools chosen by individuals. While the NHS does not clinically assure information produced in alternative language formats, this approach ensures the original content remains accurate and reliable while enabling translation.

NHS England is exploring how best to link to additional resources from the NHS website, such as support services and charities, where further information would be helpful. For example, the updated page on endometriosis includes links to charities, online communities and support services, providing women with further guidance and support.

Women's health hubs are critical to delivering tailored, specialist care to local populations. Women's health hubs provide condition and treatment-specific information alongside clinical care, enabling shared decision making. Provision of information is one of the primary aims of women's health hubs as set out in the Women's health hubs: core specification. While not all information can be provided in every language, local areas are responsible for ensuring accessible information is available in the most common languages spoken within their communities. DHSC and NHS England encourage local areas to share good practice and resources through the network of women's health champions and the FutureNHS platform.

Over financial years 2023 to 2024 and 2024 to 2025, £25 million of funding was provided to local systems to develop women's health hubs as a proof of concept. Integrated care boards (ICBs) are responsible for commissioning services that meet the healthcare needs of their local population and have the freedom to do so - this includes women's health hubs. We continue to engage with and encourage ICBs to use the learning from the women's health hubs pilots to improve local delivery of services to women.

Recommendation 4

With women and girls relying on online spaces and a proliferation of femtech apps to fill gaps in their knowledge of reproductive health conditions, the NHS should increase its own digital and social media presence in relation to reproductive health conditions. This should be consistent rather than a one-off campaign and monitored to ensure it reaches those in need of support with their reproductive health.

Government response

The NHS recognises the growing reliance of women and girls on online spaces and ‘femtech’ apps for information about reproductive health. In addition to the women’s health area on the NHS website, several other initiatives are underway to strengthen the NHS’s digital and social media presence, ensuring consistent and accessible support for those in need.

In 2024, 2 new video series were published on the NHS YouTube channel, one on endometriosis and another on heavy menstrual bleeding. These series provide women and girls with more evidence-based information and include short videos featuring NHS doctors.

In recent months, the NHS has also used its NHS Instagram channel to provide users with information on a range of reproductive health issues, including heavy periods, contraception, menopause and cervical cancer.

This year, NHS England will create additional social media content focused on reproductive health conditions as part of an 'always on' strategy, ensuring the information is continuously available and easily discoverable when needed. Awareness days, weeks and months will be leveraged to amplify trusted, authoritative NHS content during important moments, fostering engagement with heightened conversations online. Wider media monitoring will continue to identify timely opportunities to publish content that is aligned with current coverage of relevant topics.

Under the overarching theme of 'women’s health', NHS England recently launched a competition to identify innovations that improve women’s health. Three high-priority sub-challenges are being addressed through this competition:

- gynaecological conditions and hormonal health
- mental health
- chronic conditions and long-term health

The successful projects include:

- digital mental health support for ethnic minority women that provides access to community-based interventions for support
- 'medtech' devices that aim to reduce complications in pregnancy and childbirth

- diagnostic technologies that will enable access to care and better self-management of long-term and hormonal conditions

Accessing a diagnosis

Recommendation 5

The NHS needs to urgently implement a training programme to improve the experience of treatment and diagnosis in primary care for women, girls, trans and non-binary people with reproductive ill health. Improving early diagnosis, including through the provision of follow up appointments, must be a priority to prevent a worsening of symptoms. The programme should seek to challenge racial biases and ensure that all those experiencing pain are believed and able to access treatment and support quickly. It should include training to support women and girls whose socio-cultural situation or beliefs make it harder to discuss reproductive health conditions and involve women and girls with lived experience.

Government response

The government recognises that raising awareness of reproductive ill health is crucial to improving people's experiences of care and ensuring that no one feels that their pain is dismissed, regardless of ethnicity or socio-cultural situation or belief.

In terms of treatment and diagnosis, NHS England's plan on reforming elective care for patients (linked in 'Introduction' above) sets out how the NHS will reform elective care services and meet the 18-week referral-to-treatment standard by March 2029. This will mean earlier diagnoses and treatment.

However, we know that women are not always listened to when they first seek care – and that some groups experience this even more acutely. Racial biases in how care is delivered are not acceptable. We are committed to addressing racial biases and ensuring that all individuals experiencing pain are believed and supported to access treatment quickly.

To address this, and to help GPs and other primary healthcare professionals develop their awareness of reproductive health conditions, the Royal College of General Practitioners (RCGP) has created a Women's Health Library. This contains educational resources including e-learning modules and guidelines on women's health that are relevant to GPs and other primary healthcare professionals. It brings together:

- national guidance
- resources produced and accredited by RCGP
- resources from the Royal College of Obstetricians and Gynaecologists (RCOG) and the Faculty of Sexual and Reproductive Healthcare (FSRH)

NHS England is actively assessing workforce training gaps and scoping future clinical training needs as part of the wider approach to workforce reform. It will work closely with professional organisations, including RCGP, FSRH and RCOG, to support practitioners to achieve the required competencies for delivering high-quality women's health services in the community.

Women's health hubs are well positioned to assess the training needs of healthcare professionals in both general practice and the wider community. By working closely with general practice, hubs can help identify gaps in knowledge and skills while supporting the upskilling of healthcare professionals. This approach ensures that care delivery is informed by best practices and the lived experiences of women and girls.

Recommendation 6

Improvements in diagnosis times should be made a key performance indicator for the Women's Health Strategy for England.

Government response

Cutting waiting lists, including for gynaecology, is a critical part of our health mission to build an NHS fit for the future and a top priority for this government. NHS England's plan on reforming elective care for patients (linked in 'Introduction' above) sets out how the NHS will reform elective care services and meet the 18-week referral-to-treatment standard by March 2029, meaning earlier diagnoses and treatment.

The plan sets out how, in gynaecology, NHS England will support the delivery of innovative models, offering patients care closer to home and piloting gynaecology pathways in community diagnostic centres (CDCs) - for example, for patients with post-menopausal bleeding.

We are working with NHS England and the Women's Health Ambassador on how we take forward the Women's Health Strategy for England (linked in 'Introduction' above) by aligning it to the government's missions and forthcoming 10 Year Health Plan. As part of

this, we will consider the committee's recommendations on key performance indicators and metrics.

Measuring diagnoses times for reproductive health conditions such as endometriosis would be a useful indicator for measuring progress. However, this is currently challenging to operationalise.

For example, women may not always receive a definitive diagnosis because milder forms of the disease can be managed with a presumed diagnosis and therefore avoid the need for an invasive procedure (so, in line with National Institute for Health and Care Excellence (NICE) guideline [NG73] Endometriosis: diagnosis and management, women are often treated initially in primary care for suspected endometriosis). Only some women with endometriosis need to be referred to secondary care for further investigations and treatment.

Furthermore, primary and secondary care administrative data sets are not currently linked in a way that allows us to follow individual patient pathways and measure diagnosis times. An ongoing Office for National Statistics study on endometriosis is working to link primary and secondary care data to:

- better understand diagnosis times
- estimate how many women are living with undiagnosed endometriosis

This study will help inform future work.

NHS England is also looking into metrics that best reflect timely access to care and outcomes for women. This work will:

- explore whether time to diagnosis is the optimum measure
- identify any gaps in data or limitations in data capture that could affect the ability to adequately measure and report on performance

For example, patient experience measures, such as those gathered through the government's Reproductive Health Survey for England 2023, are also important for measuring progress.

Recommendation 7

We support the Royal College for Obstetricians and Gynaecologists' initiative for a guideline on inclusive care. When finalised it should be implemented throughout the

healthcare system and medical practitioners must receive adequate training, with implementation monitored by the RCOG.

Government response

As referenced in the report, RCOG is developing a guideline on the care of trans and gender-diverse adults in obstetrics and gynaecology. RCOG aims to publish this in 2026.

The government is committed to delivering inclusive services and improving the experience of care for all individuals, including trans and gender-diverse people. We are supportive of efforts to develop inclusive guidance and enhance awareness across the healthcare system.

NHS England is also dedicated to improving inclusion and awareness for trans and non-binary people through its LGBT+ (lesbian, gay, bisexual and transgender) health programme. This programme is focused on enhancing the delivery of equitable and respectful care, ensuring that trans and gender-diverse individuals feel supported and included within the healthcare system.

While NHS England will not take an active role in the implementation of the guideline across the health system, it encourages healthcare providers and commissioners to engage with inclusive guidance, including the forthcoming RCOG guideline, as part of their broader commitment to equality and patient-centred care.

Accessing treatment and support

Recommendation 8

The NHS must take steps to ensure healthcare practitioners keep up to date with the full range of diagnostic and treatment options available for reproductive health conditions. Those options, as well as waiting times and potential outcomes of surgical procedures and non-invasive alternatives, should be communicated to patients as a matter of course to allow informed, shared decision making. The NHS should identify and address any regional disparities in the availability of particular treatments and support.

Government response

The government is committed to ensuring that women receive comprehensive, up-to-date information about diagnostic and treatment options for reproductive health conditions.

Healthcare professionals are expected to provide women with detailed information ahead of any surgical procedure, enabling them to make informed decisions about their care. This includes discussing:

- the full range of options available
- waiting times
- the outcomes of surgical procedures
- non-invasive alternatives

Women should also have the opportunity to discuss pain relief options, including local or general anaesthetic and alternative treatments such as pelvic ultrasound, where available.

These conversations should be undertaken using a shared decision-making approach that ensures individuals are supported to make decisions that are right for them. NHS England has published a summary guide on the use of shared decision-making. These discussions and approach:

- ensure that women understand what to expect
- help women explore the relative benefits and disadvantages of available treatments
- promote informed decision-making
- ensure that care is tailored to individual needs and preferences

All healthcare professionals are required to undertake continuing professional development (CPD) and maintain up-to-date knowledge of new diagnostic and treatment options. Their scope of practice is overseen by:

- professional accreditation schemes
- employer appraisals
- professional obligations to stay current in their field

While not all healthcare professionals specialise in women's health, women's health hubs provide a higher level of expertise and care. These hubs allow women to have in-depth discussions about their options prior to procedures and ensure access to specialist knowledge.

By reducing regional variation in the quality of information and care provided, women's health hubs are helping to address disparities and improve outcomes regardless of a woman's initial point of access.

Recommendation 9

The NHS must do more to monitor and enforce protocols governing procedures such hysteroscopy, IUD fitting and cervical screening and ensure that they are underpinned by informed consent and are trauma-informed. A risk assessment that allows a patient to make an informed choice on the recommended procedure should be undertaken as standard, taking account of any previous history of undergoing related procedures. This should also include consideration of the patient's mental and physical preparedness for a penetrative procedure, particularly in cases where the individual has not had or recently had penetrative sex. The full range of options on pain relief, including anaesthesia, should be considered and a clear commitment made that if the level of pain during the procedure is unbearable, that procedure will be halted and a separate appointment will be made. As membership bodies, the Royal College of Obstetricians and Gynaecologists and the Royal College of General Practitioners should be doing far more to ensure their members adhere to guidelines and best practice.

Government response

It is unacceptable that some women have such poor experiences during procedures such as hysteroscopy, intrauterine device (IUD) fitting and cervical screening.

Experiences of pain during these sorts of procedures can vary significantly from one woman to another. Some women may find the procedure very painful if they are not provided with the appropriate pain relief and support, while others experience little or no pain.

As with all procedures, we expect healthcare professionals to fully explain the procedure in advance, including:

- expected symptoms
- side effects
- risks

These conversations should be undertaken using a shared decision-making approach that ensures individuals are supported to make decisions that are right for them. This provides

a collaborative process through which a clinician supports a patient to reach a decision about their treatment, bringing together:

- the clinician’s expertise, such as treatment options, evidence, risks and benefits
- the patient’s preferences, personal circumstances and values

NHS England has published a summary guide on the use of shared decision-making (linked in the government response to 'Recommendation 8' in 'Accessing treatment and support' above).

Procedures should be carried out by trained professionals who:

- prioritise the patient experience
- create a supportive environment
- ensure patients know they can request that the procedure stop at any time

Where appropriate, referrals should be made to providers who can offer additional pain relief options.

Membership and professional bodies have developed a number of guidelines to support clinicians in the delivery of procedures, and DHSC expects providers and healthcare professionals to have regard to relevant clinical guidelines.

For example, RCOG published an updated Green-top Guideline No. 59 on outpatient hysteroscopy in September 2024. The guideline is for health professionals and aims to support the provision of evidence-based, high-quality care, with particular reference to minimising pain and optimising the patient experience. While RCOG guidelines are not mandatory, they are designed to:

- support high-quality care
- encourage local implementation tailored to patient needs and institutional capabilities

FSRH has published clinical guidance on intrauterine contraception procedures. This highlights the need to provide effective pain relief and address patient anxiety. FSRH guidance:

- stresses that healthcare professionals should work in partnership with patients to establish the best strategies for reducing anxiety and minimising pain

- highlights the importance of identifying individuals who may experience more discomfort, allowing for tailored pain relief and support

For cervical screening, informed consent is supported through information signposted within the Cervical screening: leaflet for women considering screening invitation. This includes:

- advice on the relevance of screening in relation to sexual history
- a clear description and diagram of the screening process (including the use of a speculum)
- what to do if someone thinks having screening will be difficult for them

It supports autonomy, explaining that screening can be stopped on request at any point. NHS information is also available specifically for people who find it hard to attend cervical screening. This:

- covers ways in which screening may be made more accessible for people with a history of trauma or abuse
- includes a checklist printout for people to use if they don't wish to verbally explain their concerns

NHS Cervical Screening Programme good practice guidance provides sample takers with information on supporting people who have experienced trauma or sexual abuse.

Despite this, we know that some women have very difficult experiences with such procedures. NHS England will hold a roundtable on procedural pain in spring 2025. This event will bring together stakeholders to:

- discuss issues raised through women's lived experiences
- review professional training needs
- identify system changes required to prioritise the recognition and management of pain

The scope of this work will include both:

- procedural pain (for example, from IUD insertion)
- pain associated with conditions such as menstrual pain and endometriosis

It will incorporate findings from a literature review (academic and grey literature), patient stories, complaints and focus groups to develop actionable recommendations for implementation.

The roundtable and subsequent recommendations will help consolidate insights and address gaps in care, ensuring that all women undergoing procedures are treated with respect, compassion and appropriate pain management.

Recommendation 10

Concerns about painful procedures have been raised for years with little sign of progress. We recommend the NHS collects data on whether guidelines for hysteroscopy, IUD fittings and other potentially painful gynaecological procedures are being adhered to. That data must include surveys of patient experience. Without the pressure of having this information captured we are sceptical there will be the necessary drive to improve the level of care.

Recommendation 11

Reducing the pain women experience during invasive procedures should be made a key performance indicator for the Women's Health Strategy for England.

Government response

We agree with the importance of understanding and improving women's experiences of procedures and ensuring women's pain is not dismissed.

We are working with NHS England and the Women's Health Ambassador on how we take forward the Women's Health Strategy for England (linked in 'Introduction' above) by aligning it to the government's missions and forthcoming 10 Year Health Plan. As part of this, we will consider the committee's recommendations on key performance indicators and metrics.

The NHS does not currently collect data centrally on the number of women who experience pain, or receive pain relief, during a hysteroscopy or other procedures. However, patient experiences more broadly are routinely collected for people attending healthcare services through the Friends and Family Test.

Pain relief will be recorded for individuals in their medical records by the practitioner performing the procedure and therefore proactive local audits can be conducted within healthcare settings to review local practices.

The government’s Reproductive Health Survey for England 2023 (linked in the government response to 'Recommendation 6' in 'Accessing a diagnosis' above) received more than 52,000 responses. NHS England, together with DHSC, will review the potential of conducting this survey on a regular basis to monitor self-reported experience of healthcare at population level.

NHS England will review national data collection processes and protocols, and consideration will be given to scoping a patient experience measure for women’s health services, including procedural pain, as part of work to develop next steps for the Women’s Health Strategy for England (linked in 'Introduction' above).

Recommendation 12

Individuals with a suspected or diagnosed reproductive health condition should be offered specialist mental health support from when they start to report distressing and/or painful symptoms and throughout diagnosis and treatment. Delays at each step of the process and a lack of treatment options make mental health support all the more essential.

Government response

It is unacceptable that too many women are not receiving the mental healthcare they need and deserve, and we know that waits for mental health services are far too long.

Reproductive health conditions can have a significant impact on women’s mental health. As part of our mission to build an NHS that is fit for the future and there when people need it, this government will recruit an additional 8,500 mental health workers to reduce delays and provide faster treatment, which will also help ease pressure on busy mental health services.

All NHS services and professionals caring for women should be familiar with taking a holistic approach to care, where physical and mental health needs are considered and managed together, providing emotional and psychological support to citizens as part of physical health services.

In some instances, there may be a need for additional specialist mental health input where clinical thresholds are met. For women who do require additional mental health support alongside treatment for their condition, several pathways are available.

For example, NHS talking therapies services provide evidence-based psychological therapies for individuals with:

- depression
- anxiety disorders
- long-term physical health conditions
- medically unexplained symptoms

Since financial year 2018 to 2019, all NHS talking therapies services have been commissioned to establish dedicated pathways for people living with long-term physical health conditions. In some areas, these services provide psychological support specifically for women with reproductive health conditions.

Specialist perinatal mental health services also support women with moderate to severe or complex mental health problems during and after pregnancy. They include:

- specialist community perinatal mental health teams
- inpatient mother and baby units
- maternal mental health services

Recommendation 13

All women's health hubs should be commissioned to include mental health support as part of their core specification.

Government response

We are committed to moving towards a neighbourhood health service, with more care delivered in local communities to spot problems earlier. Women's health hubs are an example of this approach and can play an important role in delivering the government's manifesto commitments on tackling long NHS waiting lists, as well as shifting care into the community.

ICBs are responsible for commissioning services that meet the healthcare needs of their local population, and they have the freedom to do so.

The core specification for women's health hubs (linked in the government response to 'Recommendation 3' in 'Public understanding of reproductive health conditions' above) sets out that their purpose is not to replace or duplicate existing specialist services.

Rather, they should act as a mechanism to improve pathways into these services, including mental health services where required. This could include:

- commissioning mental health provision within women's health hubs
- offering clear referral pathways from women's health hubs to mental health services or through other routes

Recommendation 14

NHS England should implement policies to ensure there are separate spaces for patients undergoing investigations or treatment for reproductive health conditions and obstetrics patients.

Government response

We sympathise with anyone suffering with infertility. We acknowledge the report's finding that hospital waiting areas and wards that bring together patients with reproductive health conditions and women who are pregnant, or have recently given birth, can have a negative effect on mental health and may prevent patients from seeking further medical support.

Estates are managed by individual providers and local systems, which are responsible for organising the delivery of services based on their capacity, needs and available resources. Decisions regarding the allocation of space must consider local factors, including demand and existing infrastructure, and the setting in which care is being delivered.

NHS England will publish the findings of the NHS maternity and neonatal estates survey, which examined compliance against the current estates standards, including the requirements of neonatal parental accommodation. The government's response to the House of Lords Preterm Birth Inquiry committed to publishing the survey in early 2025 and the ambition remains to publish it as soon as possible.

Recommendation 15

The use of terminology such as 'benign gynaecology' downplays the impact of reproductive health conditions and risks de-prioritising them for treatment that could significantly improve patients' health and lives. NHS England should cease to use the term benign in relation to reproductive ill health. The NHS should work with stakeholders to develop a way to describe these conditions that more accurately reflects the serious impact they can have on people's lives. This should include a wider discussion about what

treatments take precedence for surgery and the steps necessary to ensure that chronic conditions primarily affecting women, such as endometriosis, are appropriately prioritised. This re-prioritisation is required to address the fact that gynaecology waiting lists have grown at a faster pace than any other specialty since the pandemic.

Government response

The government recognises the harm that can come from the use of the word ‘benign’ to describe some gynaecological conditions.

In clinical terminology, the term 'benign' is commonly used across medical specialties to distinguish between malignant and non-malignant conditions, such as cancer versus non-cancerous tumours. However, in gynaecology, 'benign gynaecology' has also come to describe non-cancerous conditions, which may inadvertently downplay the impact of these conditions and create a perceived hierarchy of importance between cancer and non-cancer conditions.

We acknowledge the legitimate concern that this terminology may lead to conditions such as endometriosis and heavy menstrual bleeding being seen as less serious, despite the severe and sometimes debilitating impact that they can have on patients’ health, careers and families.

DHSC uses the term ‘gynaecological conditions’. For example, the government’s Women’s Health Strategy for England (linked in 'Introduction' above) has a priority chapter on ‘Menstrual health and gynaecological conditions’. This does not refer to ‘benign gynaecology’.

We support RCOG in advocating for a shift away from using the term ‘benign gynaecology’ in NHS settings. RCOG itself does not use the term ‘benign’ when referring to non-cancerous gynaecology conditions.

NHS England also recognises the need for language to accurately reflect the lived experiences of individuals with reproductive health conditions, not to minimise the impact that these conditions have on their lives. NHS England is working with individuals with lived experience to explore the impact of terminology within clinical settings. This issue will form part of discussions at the upcoming roundtable on women’s experiences of pain, ensuring that women’s voices are central to this work.

NHS England will also review internal information currently using the term 'benign gynaecology'. Collaboration with stakeholders - including the Royal colleges, NICE and other professional bodies - will help identify and move towards preferred terminology across the healthcare system. Women’s voices must be at the heart of this work.

Recommendation 16

Measures to reduce waiting lists for elective surgery should prioritise areas where waiting lists are longest and disparities greatest. The NHS should provide financial support to women to allow them to travel further to access care earlier.

Government response

Cutting waiting lists, including for gynaecology, is an important part of our health mission to build an NHS fit for the future and a top priority for this government. NHS England's plan on reforming elective care for patients (linked in 'Introduction' above) sets out how the NHS will reform elective care services and meet the 18-week referral-to-treatment standard by March 2029.

Significant measures in the plan include:

- empowering patients by:
    - giving them more choice and control
    - establishing the standards that they can expect to make their experience of planned NHS care as smooth, supportive and convenient as possible
- reforming delivery by working more productively, consistently – and, in many cases, differently – to deliver more elective care. For example, piloting direct-to-test gynaecology pathways in CDCs, such as for patients with post-menopausal bleeding
- delivering care in the right place to make sure patients receive their care from skilled healthcare professionals in the right setting – for example, through women's health hubs
- aligning funding, performance oversight and delivery standards, with:
    - clear responsibilities and incentives for reform
    - robust and regular oversight of performance
    - clear expectations for how elective care will be delivered at a local level
- actions to tackle health inequalities such as:

- a review of existing national initiatives with the aim of developing them and increasing their uptake, for example by improving signposting to and accessibility of local patient transport services for patients

Additionally, the NHS Getting It Right First Time (GIRFT) programme is a clinical improvement programme designed to improve the treatment and care of patients through:

- reviews of services
- benchmarking
- developing an evidence base to support change

Gynaecology is one of the 6 high-volume low-complexity specialties being prioritised through the GIRFT programme.

In relation to travel costs, patients may be eligible for either local patient transport services or to reclaim costs through the existing NHS Healthcare Travel Costs Scheme – the scheme allows eligible patients to claim a refund for reasonable travel costs.

Recommendation 17

Data and analysis must improve. The NHS should collect data on where there are delays in the system, where women are being referred from (which could highlight areas where community provision is lacking), which groups of women are most affected by delays (to allow better understanding of health inequalities), how many women are waiting for more than one type of treatment, and the satisfaction and outcomes of follow-ups, including which women and girls access this pathway.

Government response

We agree with the importance of robust data collection that supports analysis to help identify where and what interventions are most appropriate.

NHS England's plan on reforming elective care for patients (linked in 'Introduction' above) is clear that transparency is vital to help patients understand how their local and national health services are performing.

It sets out that NHS England will publish a suite of adult's and children's elective performance metrics (including 18-week performance, long waits and waiting times) in an accessible format, which can be ranked and used by both NHS staff and the public. NHS

England will also publish data that can be ranked on all aspects of choice. This will sit alongside, and make use of, published information on NHS England's website and will be available on the NHS App.

NHS England also commits to:

- increasing the availability and use of elective, cancer and outpatient data
- improving our understanding of clinical conditions by expanding diagnostic coding in elective care

The expectation is that this will be standard practice in acute providers by March 2027.

Patient experiences more broadly are routinely collected for people attending healthcare services through the Friends and Family Test (linked in the government response to 'Recommendation 11' in 'Accessing treatment and support' above).

Recommendation 18

The Government should review existing period and incontinence product schemes alongside the burden of need. We recommend the Government considers the merits of legislating for free provision for particular groups such as children, students, people seeking asylum and those in receipt of benefits. Products that are appropriate for heavy bleeding and other urogynaecological conditions should be available on free prescription. As part of their corporate social responsibility we call on the major manufacturers of period and incontinence products to help fund the provision of those products. The introduction of such policies should be supported by a public awareness campaign.

Government response

The government recognises the importance of women and girls being able to access the care they need for their reproductive health, including products to manage heavy menstrual bleeding and incontinence.

Since 2019, the NHS has offered free period products to every hospital patient who needs them. Since 1 January 2021, a zero rate of VAT has applied to all period products.

In England, there are extensive arrangements in place to ensure that prescriptions are affordable for everyone. Around 89% of prescription items are dispensed free of charge. Eligibility depends on:

- the patient's age
- whether they are in qualifying full-time education
- whether they are pregnant or have recently given birth
- whether they have a qualifying medical condition
- whether they are in receipt of certain benefits or a War Pension

Children under the age of 16, and young people aged 16, 17 and 18 who are in full time education, are exempt from paying the prescription charge. Further detail about exemptions from the prescription charge is available on the Free NHS prescriptions page of the NHS Business Services Authority (NHSBSA) website.

People on a low income can seek help under the NHS Low Income Scheme, which provides help with health costs on an income-related basis. The level of help available is based on a comparison between a person's income and requirements at the time a claim is received, or at the time a charge was paid if a refund is claimed.

If someone in receipt of benefits is entitled to help with health costs, they will receive:

- free NHS prescriptions
- free NHS dental treatment
- free wigs and fabric support
- free sight tests
- access to optical vouchers to help with the cost of glasses or contact lenses
- travel to an NHS appointment on referral by a primary care practitioner

More information on this scheme is available at Get help with NHS prescriptions and health costs.

Those who have to pay NHS prescription charges and need many prescription items could save money with a prescription prepayment certificate (PPC), which allows people to claim as many prescriptions as they need for a set cost. A 3-monthly PPC (costing £32.05) or an annual PPC (costing £114.50) will save people money if they need 4 or more items in 3 months, or 12 or more items in 12 months. To help spread the cost, people can pay for an annual PPC by 10 monthly direct debit payments.

The hormone replacement therapy PPC (HRT PPC) may be a good option for those patients who are prescribed qualifying hormonal medicines to help with the symptoms of heavy bleeding. Find out more about the HRT PPC, including the list of qualifying medicines.

Finally, no charge is payable for contraceptive substances and listed contraceptive appliances prescribed on the FP10 prescription form. This includes the combined contraceptive pill and intrauterine system (IUS) or hormonal coil devices, which can also be prescribed to help with heavy bleeding.

Recommendation 19

Clause 26 of the Employment Rights Bill should be amended to make clear that supporting women with reproductive health conditions falls under the definition of advancing gender equality.

Government response

Requiring large employers to produce an action plan alongside their gender pay gap reporting figures will ensure that organisations are taking effective steps to improve gender equality in their workplace and tackle pay disparities.

Many employers understand that, when women succeed, so does their business. Introducing this requirement will spread this message and ensure every large organisation harnesses the talent, creativity and brilliance of women in their workforce.

Clause 28 (formerly 26) of the Employment Rights Bill represents the first step towards requiring plans, with the details due to be set out in subsequent regulations. The language of the clause, as drafted, specifies 2 matters that are included as being "related to gender equality" and therefore employers would be required to cover them in action plans. These are:

- addressing the gender pay gap
- supporting employees going through the menopause

Our intention in mandating these action plans for large employers is to be led by the actions themselves, reflecting the fact that many of the interventions will be beneficial for people in lots of different circumstances. For example, improved provision of flexible working can be valuable for an employee balancing childcare as well as someone managing a reproductive health condition.

In the same way, ensuring that employers support staff going through the menopause will necessitate them taking steps that are positive for supporting women's health in the workplace more broadly. For example, menopause best practice includes greater discussion around women's health and awareness of potential workplace adjustments, which have a potential benefit across all women's health conditions.

The Office for Equality and Opportunity is already engaging with women's health organisations, and will continue to do so as the legislation and associated guidance is developed, to ensure that employers are encouraged to adopt best practice.

Recommendation 20

The Government's plans for the Women's Health Strategy for England should include support and guidance for women who have conceived as a result of rape, and for children born as a result of rape. This should include tailored information on the NHS website, including on rape-induced gynaecological issues.

Government response

We sympathise with anyone who is the victim of rape. Sexual assault referral centres have been co-commissioned by NHS England and police and crime commissioners since 2013. They provide a safe space and dedicated care for anyone who has been raped, sexually assaulted or abused. There are 48 centres across England and around 30,000 survivors access them each year.

Sexual assault referral centres provide timely, 24/7 response to meet the urgent forensic, medical, therapeutic and psychological needs of adult and child victims of rape and sexual assault, every day of the year. They are located across the country and available for everyone.

There is also an NHS page on Help after rape and sexual assault, which provides information for those who require it. NHS England will review current website content and develop information and guidance in the most appropriate and accessible format for those who need it.

NHS England has also funded enhanced mental health pathways to improve care for victims and survivors with complex trauma-related mental health needs, so that they can recover, heal and rebuild their lives.

We are working with NHS England and the Women's Health Ambassador on how we take forward the Women's Health Strategy for England (linked in 'Introduction' above) by

aligning it to the government's missions and forthcoming 10 Year Health Plan. We will consider the committee's recommendations on additional topics to be considered as we take this work forward.

Training and standards

Recommendation 21

The Department of Health and Social Care should set out plans to improve the accessibility and take up of professional development in women's reproductive health conditions among practitioners in primary care. Those plans should include allocating increased funding for training on reproductive health conditions and protected time for GPs to undertake that training.

Government response

As the report highlights, some reproductive health conditions are not always straightforward to diagnose. Nonetheless, it is not good enough that women with reproductive health conditions often experience a delayed diagnosis, which can lead to disease progression, more invasive treatments and more time in pain.

It is essential that all health and care professionals in primary care are able to support their patients, and we encourage primary healthcare professionals to take up relevant training and professional development offered in women's reproductive health.

GPs are responsible for identifying learning needs as part of their CPD. This activity should include taking account of new research and developments in guidance, such as that produced by NICE, to ensure that they can provide high-quality care to all patients. NICE has developed a suite of women's and reproductive health guidelines, and has recently updated guidelines [NG23] on menopause: identification and management and [NG73] on endometriosis (linked above in the government response to 'Recommendation 6' in 'Accessing a diagnosis').

All registered doctors in the UK are expected to meet the professional standards set out in the General Medical Council's (GMC) Good medical practice. In 2012, GMC introduced revalidation, which:

- supports doctors in regularly reflecting on how they can develop or improve their practice

- gives patients confidence that doctors are up to date with their practice
- promotes improved quality of care by driving improvements in clinical governance

GMC has also introduced the Medical Licensing Assessment (MLA) for most incoming doctors. The MLA content map includes several topics relating to women's health including:

- menstrual problems
- endometriosis
- menopause
- urinary incontinence

This will encourage a better understanding of common women's health problems among all doctors as they start their careers in the UK.

Women's health is also included in the RCGP curriculum for trainee GPs, including:

- gynaecology
- sexual health
- breast health

The curriculum also covers the healthcare needs of women across all diseases seen in primary care because it is important that women are treated holistically.

RCGP has published a Women's Health Library (linked in the government response to 'Recommendation 5' in 'Accessing a diagnosis' above), which brings together educational resources and guidelines on women's health from RCGP, RCOG and FSRH. This resource is continually updated to ensure GPs and other primary healthcare professionals have the most up-to-date advice to provide the best care for their patients.

As set out in our previous response to 'Recommendation 5' (see 'Accessing a diagnosis' above), NHS England is actively assessing workforce training gaps and scoping future clinical training needs as part of the wider approach to workforce reform. It will work closely with professional organisations including RCGP, FSRH and RCOG to support practitioners to achieve the required competencies for delivering high-quality women's health services in the community.

Recommendation 22

The approval of the anti-mullerian hormone blood test as another tool to assist in the diagnosis of polycystic ovary syndrome is a welcome development. NHS England should evaluate the merits of rolling it out nationally as a matter of priority.

Government response

Polycystic ovary syndrome (PCOS) is a complex syndrome characterised by:

- multiple follicles in the ovary
- menstrual irregularity
- high testosterone levels

Diagnosis is typically made using a combination of:

- medical history
- blood tests
- ultrasound scans

While the anti-mullerian hormone (AMH) blood test may have potential, there would need to be further exploration of how it could add value in the diagnosis of PCOS. NHS England would first need to work with NICE to evaluate its impact on quality of care and cost-effectiveness to determine whether its broader implementation should be recommended.

NICE has been asked to develop a clinical guideline on the assessment and management of PCOS and is now planning its development. Work in this area will include the diagnosis of PCOS, including consideration of AMH blood tests. NICE is exploring the possibility of collaboration with a reputable guidance-producing partner to enhance the speed and efficiency of this work. The progress of this guideline can be followed at Polycystic ovary syndrome: diagnosis and management.

Recommendation 23

The annual GP appraisal process should be strengthened to include a specific performance indicator on the diagnosis and treatment of women's reproductive health

conditions, including intersectional considerations. That indicator should include patient experience.

Government response

Primary care is often the first point of contact for women seeking help with their reproductive health and so it's vital that GPs are well supported to care for reproductive health conditions.

Doctors must regularly demonstrate that they are keeping their skills and knowledge up to date in order to practice and maintain their licence to work in the UK through the GMC's revalidation process. Appraisal is an important part of revalidation that requires doctors to collect examples of their work to understand what they're doing well and how they can improve. This includes any complaints about them and feedback from patients about their experiences.

Although performance indicators on treatment for specific conditions are not part of the GP appraisal system, it does involve a 360 degree review of performance, including patient experience. Patient satisfaction is also captured and analysed through the GP Patient Survey.

Recommendation 24

NHS Digital should collect data on how many hours of training primary care practitioners undergo annually in the field of women's reproductive health.

Government response

We recognise the importance and value of primary healthcare professionals undertaking training in women's reproductive health conditions. NHS England does not currently plan to collect data on training hours for primary care practitioners due to:

- the burdens this would impose on general practice
- potential overlap with the responsibilities of regulators
- logistical challenges

Primary care practitioners participate in CPD, which ensures they remain up to date in their field. The sufficiency of this training against their scope of practice is assessed through the appraisal process. It is the responsibility of both the practitioner and their

appraiser to identify and address any training gaps. Regulators also define CPD requirements, including the number of hours needed to retain professional registration.

Collecting data on training hours in women's reproductive health would not be feasible given the breadth and variety of CPD activities undertaken by primary care practitioners. The overlapping nature of their training areas makes it challenging to isolate and capture specific data on reproductive health training hours.

Furthermore, collecting this data would add to bureaucracy in general practice, which risks limiting the time GPs are able to spend with patients. The government is determined to cut red tape and reduce bureaucracy, ensuring GPs spend less time filling in forms and completing administrative tasks, and more time caring for patients. In October 2024, the Secretary of State for Health and Social Care and NHS England's Chief Executive Amanda Pritchard launched the Red Tape Challenge.

NHS England leaders – Primary Care Medical Director Claire Fuller and Medical Director for Secondary Care and Quality Stella Vig – are currently undertaking a review to look at reducing bureaucracy between primary and secondary care.

Recommendation 25

The Government should work with the RCOG, RCGP and the GMC to improve the teaching of women's health at undergraduate level and ensure it is an integral part of medical education for all those seeking a career in healthcare. As part of that work the Government should consider how to better incentivise healthcare professionals to specialise in women's reproductive health, including making obstetrics and gynaecology a mandatory rotation. This is necessary to address current shortages in this area and to tackle the long waiting lists for gynaecological care. The merits of using the quality and outcomes framework (QOF) or commissioning for quality and innovation (CQUIN) indicators should be part of its consideration of potential incentives.

Government response

It is important that healthcare professionals receive the necessary training to provide the best care possible for women with reproductive health conditions.

GMC is the regulator of all medical doctors practising in the UK. GMC – rather than the Royal colleges – sets and enforces the standards that all doctors must adhere to, and is responsible for ensuring that medical professionals have the necessary skills and knowledge to join the UK medical register. GMC is independent of government, directly accountable to Parliament and is responsible for operational matters concerning the

discharge of its statutory duties. Individual medical schools set their own curricula, which must meet the standards and expected outcomes set by GMC.

GMC has introduced the MLA for the majority of incoming doctors, including all medical students graduating from academic year 2024 to 2025 and onwards. Within this assessment are a number of topics relating to women's health, including:

- fibroids
- endometriosis
- urinary incontinence

This will encourage a better understanding of common women's health problems among all doctors as they start their careers in the UK. Obstetrics and gynaecology is already a mandatory rotation in undergraduate training.

All medical graduates must undertake and complete an integrated 2-year programme of general training in order to practise as a doctor in the UK. The foundation programme consists of foundation year 1 and foundation year 2. The programme acts as a bridge between undergraduate medical training, and specialty and general practice training. This is set by the Academy of Medical Royal Colleges, and obstetrics and gynaecology is an optional specialty rotation.

Curricula for specialty and general practice training is set by the relevant Royal college. Women's health is also included in RCGP's curriculum for trainee GPs, including:

- gynaecology
- menopause
- sexual health
- breast health

The curriculum also covers the healthcare needs of women across all diseases seen in primary care because it is important women are treated holistically. This ensures that all future GPs will receive training in women's health. RCOG also published an updated undergraduate curriculum in 2021, which aligns professional capabilities expected of foundation year 2 doctors and takes a 'life course approach' to women's health.

The Quality and Outcomes Framework would not be an appropriate tool for implementing training incentives, as it is more suited to monitoring clinical parameters. In addition, the

mandatory Commissioning for Quality and Innovation scheme has been paused and is therefore unavailable for incentivising training initiatives at this time.

Recommendation 26

Primary care practitioners should be trained to use women's common interactions with the healthcare system, such as cervical screening appointments, ante- and post-natal care checks and visits to STI clinics, as an opportunity to pick up hidden health concerns relating to reproductive health.

Government response

We recognise the opportunities for making every contact count across the health system, in line with best practice. The suggested contact points are delivered in a range of settings by a range of healthcare professionals. Work is already underway to maximise these routine contact points.

NHS England is planning to hold webinars for primary care practitioners, which will incorporate joined-up ways to promote opportunistic reproductive healthcare. Existing e-learning training packages will be reviewed as part of this recommendation and updated content incorporated to ensure alignment with this approach.

In 2023, NHS England published guidance for GPs on the 6 to 8-week maternal postnatal check. The focus of these appointments is wide-ranging but includes reproductive health issues including contraception and pelvic floor health, as well as wider health promotion. These interactions provide an opportunity to address reproductive health concerns in a targeted way.

More broadly, where women's health hubs are in place, they provide an educational and supportive role to primary care, embedding public health functions within their local population footprint. They play a key role in areas such as:

- preconception care
- contraception
- cervical screening

We will consider what else we can do to maximise routine contact points with health and wider public services. We remain mindful that a typical GP appointment lasts just 10 minutes, and so clinicians should continue to be supported to use their expertise and

discretion to identify the most relevant priorities for opportunistic discussion (for example, domestic violence is another important topic to consider).

More broadly, we also recognise it is crucial that primary care practitioners have the appropriate training to enable them to pick up on, and support, women's hidden health concerns. All 42 integrated care systems (ICSs) in England have a regional training hub that supports GPs and primary care networks by advising on, developing, delivering and procuring education and training. Training hubs work closely with health and care systems to:

- support workforce priorities
- tackle health inequalities
- support patients

Recommendation 27

The Department of Health and Social Care and NHS England should commission NICE to develop comprehensive guidelines for all reproductive health conditions. Those guidelines should be communicated to GPs and made accessible to patients through the NHS website to allow informed patient-GP discussions. Adherence to these guidelines by medical practitioners and any barriers to following them must be monitored, including their usefulness to patients.

Government response

We agree that reproductive health is an important area for the development of clinical guidelines. NICE has identified women's and reproductive health as a priority area for guideline development, and already has an extensive portfolio of guidance in this area, including guidelines [NG73] on endometriosis (linked in the government response to 'Recommendation 6' in 'Accessing a diagnosis' above) and [NG88] Heavy menstrual bleeding: assessment and management.

NICE is also currently developing or updating guidelines on important topics such as polycystic ovary syndrome (linked in the government response to 'Recommendation 23' in 'Training and standards' above) and [CG156] Fertility problems: assessment and treatment.

NICE cannot, however, commit to developing guidance on all reproductive health conditions as it has limited capacity that has to be prioritised across the full breadth of

NHS services. In 2024, NICE established a new approach to the identification and prioritisation of new guidance topics, including clinical guidelines, that ensures that its capacity is focussed on topics that will have the largest impact on the health and care system. Any new reproductive health topics would be considered in line with the prioritisation framework.

NICE guidelines provide authoritative, evidence-based guidance for the NHS on best practice and the NHS is expected to take them fully into account in ensuring that services meet the needs of their local populations. NICE provides a range of resources and advice to support the NHS to implement its guidance including resource impact assessments and clinical audit tools. It also has an adoption and implementation team that provides support to the system to enable the effective use of NICE guidance.

Recommendation 28

We find that women's health hubs have proven the concept that they can deliver improvements to women's healthcare. The Government must now allocate long-term, ring-fenced funding and resource to embed the hub model and further support its development. That development should include increased provision of ultrasound facilities within hubs. Funding should be accompanied by a break-down of how it will be used and which services will be available in each area.

Government response

We are committed to moving towards a neighbourhood health service, with more care delivered in local communities, to identify and address problems earlier and closer to home. Women's health hubs are an example of this approach and can play a key role in delivering the government's manifesto commitments on tackling long NHS waiting lists, as well as shifting care into the community.

We have heard evidence from ICSs on the positive impacts that women`s health hubs have on both women's access to care in the community and their experience. The published Women's health hubs: cost benefit analysis demonstrated £5 benefits for every £1 spent on women's health hubs.

ICBs are responsible for commissioning services that meet the healthcare needs of their local population, and they have the freedom to do so - this includes women's health hubs. The core specification for women's health hubs (linked in the government response to 'Recommendation 3' in 'Public understanding of reproductive health conditions' above) encourages ICBs to consider providing ultrasound and other diagnostic or treatment procedures in their women's health hubs. Many women's health hubs have access to

ultrasound facilities, but their use also depends on capacity and expertise to perform scans.

As a result of our pilot, women's health hubs have been established in 9 in 10 ICSs, and the government has no plans to close them. Reporting from ICBs to NHS England shows that the pilot funding is being used to open or expand a total of 88 hubs. As of December 2024, 80 of these hubs were operational. Women's health hubs have a key role in shifting care out of hospitals and reducing gynaecology waiting lists, and we continue to engage with and encourage ICBs to use the learning from the women's health hubs pilots to improve local delivery of services to women.

The government remains committed to improving women's health and we are working with NHS England on how we take forward the Women's Health Strategy for England (linked in 'Introduction' above) by aligning it to the missions and forthcoming 10-Year Health Plan.

We are acting on the findings of Lord Darzi's Independent investigation of the NHS in England and are reducing the number of national targets in the NHS planning guidance from 32 last year to 18 this year. This will allow local NHS leaders to make the best choices to meet the needs of their local population.

Recommendation 29

Integrated care boards must ensure that their hubs meet the specific demographic needs of their populations, particularly accounting for religious and cultural considerations.

Government response

We agree that women's health hubs must be tailored to the needs of local populations. For that reason, improving health outcomes and reducing health inequalities are key aims of women's health hubs, as set out in the core specification (linked in the government response to 'Recommendation 3' in 'Public understanding of reproductive health conditions' above).

To support ICBs in this, NHS England is developing an equity framework for ICBs to support reduction in inequalities in access and outcomes, with an initial focus on menopause and heavy menstrual bleeding. Women's health hubs are likely to play a significant role in the implementation of the framework.

More broadly, the National Health Service Act 2006 requires ICBs to reduce inequalities between people in both their access to health services and their health outcomes, and

ICBs are subject to the public sector equality duty, which requires that due regard be given to the 8 protected characteristics.

NHS England's National Healthcare Inequalities Improvement Programme is underpinned by 5 strategic priorities for system action on health inequalities. The framework for action and delivery is through the Core20PLUS5 approach for adults and children and young people. The approach defines a target population cohort and identifies 5 clinical areas requiring accelerated improvement.

Recommendation 30

The Government should develop a funding and training strategy to address the lack of LARC provision in general practice, particularly in those areas not covered by a women's health hub. This should include an assessment of whether the current fee structure is fit for purpose.

Government response

Long-acting reversible contraception (LARC), as one of the most effective and cost-effective forms of contraception, plays a crucial role in supporting women's reproductive health by:

- enabling women to make decisions on if and when they want to become pregnant
- supporting the management of menstrual problems and menopause symptoms

We acknowledge the vital role that GPs play in the delivery of high-quality sexual and reproductive health services, including provision of LARC. We continue to work with GPs, local authorities and other partners to understand the issues around the training required to meet the sexual and reproductive health needs of the population in multiple settings.

We will consider the fee structures for LARC, which will also cover areas beyond women's health hubs. To support a sustainable delivery model, it is important that those commissioning LARC services fully understand local capacity and demand. Information on future funding allocations will be announced in due course.

Research into women's reproductive health conditions

Recommendation 31

The Women’s Health Strategy for England should be updated to include priorities for specific, common conditions. We recommend the Government commits to reducing waiting times for an endometriosis diagnosis to less than two years by the end of this Parliament and to improved understanding, diagnosis and treatment of heavy menstrual bleeding over the same period.

Government response

This government recognises that women suffering with gynaecological conditions have been failed for far too long, and we acknowledge the impact that long wait times for diagnosis and treatment for conditions such as endometriosis have had on women’s lives, relationships, and participation in education and the workforce.

We are working with NHS England and the Women’s Health Ambassador on how government will take forward the Women's Health Strategy for England (linked in 'Introduction' above) by aligning it to the missions and forthcoming 10 Year Health Plan. We will take into account the committee’s recommendations on specific areas of focus as we do this.

Our previous response to 'Recommendation 6' (see ‘Accessing a diagnosis’ above) also sets out further detail on measuring and monitoring improvements in diagnosis times for conditions such as endometriosis.

Recommendation 32

The Government should allocate increased, ringfenced funding to support research into the causes, diagnosis and treatment of women’s reproductive health conditions. While increased funding will in itself attract more researchers to this area, NHS England and research bodies should also consider what steps they can take to increase interest among clinical academia.

Government response

The government funds research through the National Institute for Health and Care Research (NIHR), which is the research delivery arm of DHSC, and UK Research and Innovation (UKRI). The government fully recognises:

- the importance of funding research into the causes, diagnosis and treatment of women's reproductive health conditions
- the need to build research capacity in this area

Through NIHR, the government is undertaking a range of initiatives to increase investment in research into women's reproductive health conditions. NIHR welcomes funding applications for research into women's reproductive health conditions. NIHR funding is available through open competition, and we encourage researchers to submit applications in these areas.

The Health Research Classification System (HCRS) is a bespoke system for classifying biomedical and health research across all areas of health and disease, which has been used by UK health research funders and internationally since 2004. NIHR uses the recognised classification of 'Reproductive health and childbirth' as an indicator for spend on women's health.

NIHR is committed to improving the data landscape surrounding women's health, and is working to conceptualise and curate a portfolio of NIHR-funded research that is relevant to women's health. This work includes conditions that women experience differently from – or more commonly than – men, so is not limited to the causes, diagnosis and treatment of women's reproductive health conditions. The NIHR considers that this approach:

- maximises funding for research of high scientific quality
- is impactful for patients and the public
- is deliverable within the health and care system
- offers value for money

In the last 5 years (financial years 2019 to 2020, and 2023 to 2024), NIHR has invested approximately £258 million into research on reproductive health and childbirth, as classified by the HRCS. This figure reflects a 55% increase in investment from £42,820,393 in financial year 2019 to 2020 to £66,245,386 in financial year 2023 to 2024. NIHR also funds a £3 million Policy Research Unit in Reproductive Health, which launched in January 2024.

For example, NIHR is funding a qualitative study into patient and healthcare professionals' experiences of management, diagnosis and treatment of endometriosis. The findings from this research will be used to:

- support patients
- inform healthcare professionals
- shape health services to improve care journeys

The NIHR Academy welcomes applications for training awards from members of the clinical and non-clinical academic workforce who are conducting research into any aspect of human health, including women's reproductive health. For example, in the most recent round of doctoral fellowships, 3 awards were on reproductive health, continuing to grow the pipeline of clinical academics specialised in this field.

UKRI's Medical Research Council (MRC) supports the best scientific research to improve human health. Women's reproductive health research features across the entire MRC portfolio, with work ranging from molecular-level science to public health medicine.

For example, UKRI awarded £331,903 to Professor Susan Pickard, University of Liverpool, for 24 months (2023 to 2025) to study the medical, social and cultural dimensions of minority ethnic women's experience of menopause to provide guidance to aid healthcare interventions.

Conclusion

Recommendation 33

The Government should publish an implementation plan for the Women's Health Strategy for England detailing timelines, costs and resource.

Government response

We are working with NHS England and the Women's Health Ambassador on how we take forward the Women's Health Strategy for England (linked in 'Introduction' above) by aligning it to the government's missions and forthcoming 10 Year Health Plan.

We will consider the committee's recommendations on topics for inclusion and key indicators as we take this work forward.

Recommendation 34

We call on the Government to recognise the financial benefits of increased investment in early diagnosis and treatment of women's reproductive health conditions and provide the additional funding necessary to truly transform the support available to the millions of women affected by reproductive ill health in this country

Government response

The government recognises that early intervention is crucial to prevent women's reproductive health conditions from worsening and support women to remain in education and work.

As set out in previous responses to 'Recommendation 5' and 'Recommendation 6' (see 'Accessing a diagnosis' above), and 'Recommendation 16' and 'Recommendation 17' (see 'Accessing treatment and support' above), NHS England's reforming elective care for patients plan sets out how the NHS will reform elective care services and meet the 18-week referral-to-treatment standard by March 2029, meaning earlier diagnoses and treatment.

Information on future funding allocations will be announced in due course.

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