Department of Health & Social Care

The Renewed Women's Health Strategy for England

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The Renewed Women's Health Strategy for England

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

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Forewords

Secretary of State for Health and Social Care

The NHS has a problem with basic, everyday sexism and an appalling culture of medical misogyny.

Almost every week, I hear profoundly shocking stories from victims of some the NHS's worst scandals. Women whose babies died in our care when they could have lived, women who have been treated appallingly by medical professionals and left in agony, disfigured and traumatised by botched surgery and negligent care. Each story is unique, each told with heartbreaking clarity and each with a common theme: that at their moment of greatest vulnerability, they were let down by the very people they placed their trust in.

Being ignored, gaslit, humiliated and disrespected are all-too-common experiences for far too many women. More than eight in 10 say there have been times when healthcare professionals did not listen to them. I have seen examples of it in my own family, and you may have examples in yours. Failure to listen is how we end up with tragic cases like Jessica Brady, who died from cancer after her condition was missed - or dismissed - despite more than 20 appointments at her GP practice.

We have introduced Jess's Rule in her memory so that GP teams have to "reflect, review and rethink" if a patient presents three times with the same or escalating symptoms. We have also stood up a rapid investigation into maternity services, taken urgent action to bring down gynaecology waiting lists, made the morning-after pill available for free at high street pharmacies, and introduced menopause questions into routine health checks.

But there is so much more to do because the blunt reality is this: though founded on principals of equality, the NHS is failing women and girls on even the most basic measures of healthcare.

Gaping health inequalities exist, not only between men and women - women spend more years in ill health than men, despite living longer - but also among women. The wealthiest 10% of women live almost 10 years longer than the poorest 10%, while the most deprived spend over a third of their lives in bad health. There are also ethnic differences in outcomes and risk factors.

Our renewed Women's Health Strategy is our response to these injustices. It takes forward the work of the previous Government and goes further and faster to fill the holes they left. It sets out how we will bring a relentless focus to deliver women's health priorities, support them to lead healthy, fulfilling lives and ensure that women are considered fully in healthcare research and innovation. All of this will be underpinned by an NHS that finally listens with respect, dignity and compassion to the voices and the choices of every woman and every girl, every time.

Of course, every day women receive outstanding, compassionate care from dedicated NHS staff. But one woman forced to suffer in silence by a system that fails them is one too many. Our mission is to dismantle the culture and ingrained behaviours that allow medical misogyny to fester and grow. That work has already begun and our renewed Women's Health Strategy promises a fairer, healthier future for women and girls everywhere.

Wes Streeting

Secretary of State for Health and Social Care

Minister for Women's Health and Mental Health

Every woman reading this knows that to fully exercise power over our lives, we need to be at the top of our game - mentally and physically. Yet, we also know that women's health has been neglected for too long. All of us who use the NHS feel this instinctively.

As a health minister, I also hear from women whose conditions were misunderstood or misdiagnosed, who were not believed when they sounded the alarm about their symptoms, or whose pain was simply ignored.

While every woman can relate to such failures, they do not fall on us equally. Our wealth, ethnicity and where we live all make a difference. The wealthiest women can expect to remain in good health until they're 70, which is 20 years longer than the poorest women, while those living in the most deprived communities are more likely to get cervical cancer and maternal mortality rates are highest among Black women.

All this is a result of the undeniable truth that healthcare systems were just not designed with women in mind.

The renewed Women's Health Strategy is reason for hope, and I am confident that it will ensure the health and care of women and girls is not just on the agenda but at the top of it. We are not starting from scratch. Progress is already underway to turn the tide on women's healthcare and to put women's voices centre stage.

As part of developing our 10 Year Health Plan, for example, more than 160,000 women took part in the biggest conversation in NHS history.

What they told us was that women's conditions needed to be better understood and that they needed to be treated with greater respect and dignity, and so this government is taking action not only to boost women's health but also to improve our experience whenever and wherever we use the NHS.

The 10 Year Health Plan sets out 3 shifts, each of which have distinct benefits for women. By shifting focus from sickness to prevention, we can narrow the gap in many health risks and inequalities women face, such as in heart disease, obesity rates, and levels of smoking and drinking. Moving more of women's healthcare into the community will mean appointments, tests and scans at times and places that fit in with our lives. And as we go from analogue to digital, wearable technologies similar to the fitness trackers and heart rate monitors on smartwatches will make it possible for clinical teams to monitor conditions and offer early advice and interventions.

There is so much at stake for women and girls right now. But our health matters to everyone. When women are healthier, their families are healthier. When we thrive, the economy thrives. When we are treated fairly, society is fairer. In short, when women's

health improves, life improves by every measure - for everyone. That is the promise of this strategy and the prize when we make it a reality.

Baroness Merron

Parliamentary Under-Secretary of State for Women’s Health and Mental Health

Women's Health Ambassador

I am proud to present this renewed Women's Health Strategy for England at a pivotal moment in NHS history. The ambition set out in the government's 10 Year Health Plan provides a clear mandate to move beyond well intentioned promises and commit to delivering sustainable improvements in women's health. This is an opportunity to embed the voices of girls and women at the heart of the design and delivery of their healthcare. We must include the conditions unique to women, those that affect women disproportionately and the conditions that present differently in women, most importantly cardiovascular disease and dementia.

Since publishing the initial Women's Health Strategy, public awareness of the many barriers that women face trying to access basic services to manage largely predictable health events has increased. We have made some progress in removing those barriers, but this refresh is our chance to travel further and faster. To be more ambitious and determined to close the gender health gap, not just between men and women, but also among and within those women experiencing the worst inequalities.

I continue to hear from girls and women how unmet need, delayed diagnosis and avoidable health issues have disrupted their lives. Their stories emphasise the importance of adopting a life course approach, recognising that our health is shaped from childhood, through the adolescent and reproductive years into later life. If we are serious about the prevention agenda, we must start earlier, listen more closely and act with greater urgency.

This is particularly important for menstrual health. Having heavy periods remains a seriously underestimated problem - all too often normalised or dismissed - despite being so common. Prolonged heavy or painful periods should be viewed as an early warning that something is wrong - a 'missed vital sign'. Routine enquiries about periods and whether they interfere with the woman's daily life are easy to adopt but could transform lives. They would prompt earlier investigation and reduce avoidable suffering by diagnosing and treating anaemia, iron deficiency, endometriosis and uterine fibroids sooner.

Prioritising health education in schools, communities and healthcare settings is the first step to empowering women with the knowledge and tools they need to help control their fertility, prepare for the best pregnancy outcomes and navigate the inevitability of the menopause. Women also need to understand what they can do to postpone the onset of disorders that will exert the most damaging impact on the length and quality of their lives: heart disease, dementia, bone and musculoskeletal (MSK) problems which lead to frailty and dependency.

As we look to the future, we must broaden our horizons to recognise that girls born today are likely to have more post-reproductive than reproductive years in their lives. We need to prepare them - alongside our health services - to manage this inevitable shift away from reproductive issues alone towards the importance of healthy ageing and the prevention of

chronic disease, supporting them to optimise productivity and quality of life at all stages. To succeed, we must recognise that our ambition to improve women's health cannot be achieved by health systems alone. It requires collaboration across many government departments and sectors. We must build partnerships with industry and the many excellent voluntary organisations in our society, who are all so eager to contribute.

I view this strategy as the next exciting step in our journey to deliver that ambition. Women deserve nothing less than a strategy that matches the scale of their contribution to our society and economy. When we get it right for women, everyone in society benefits.

Professor Dame Lesley Regan

Women's Health Ambassador for England

Executive summary

We must change

Our healthcare status quo is not working for anyone. Business as usual is particularly failing women across the country - with access, quality of care and patient experience having all declined. Outcomes have gone in the wrong direction, even as NHS spend has risen. To solve these entrenched, long-term problems, we launched the 10 Year Health Plan in July 2025 - a blueprint for 3 modernising shifts, for a 'fit for the future' new care model, and for a new focus on patient voice, choice and empowerment.

There are few clearer signs of the need for change than this country's inadequate women's health outcomes, as:

- the UK dropped from 20th to 26th place (out of 38) in the Organisation for Economic Co-operation and Development (OECD) on female life expectancy between 2000 and 2022. This compares with a drop from 14th to 19th place for male life expectancy during the same period[1]
- healthy life expectancy among women fell by 2.5 years between 2019 to 2021 and 2022 to 2024[2]
- women in England spend more of their lives in poor health than men, while only the wealthiest third can expect to remain in good health until retirement[3]

Performance data also shows that the NHS fails women badly. There are major challenges in gynaecology care - where average waits are 15 weeks, up from an average of 6.4 weeks in 2018[4]. Misdiagnosis of heart attack and undertreatment of some risk factors for cardiovascular disease is more common among women[5]. Recent survey data shows that the average time from first seeing a doctor with symptoms to an official endometriosis diagnosis in the UK is about 9 years and 4 months[6].

Working-class women and women from ethnic minority backgrounds are being failed most of all. The life expectancy gap at birth for women in the most deprived areas, compared with the most affluent, is 8.4 years[7]. And the fact that Black women experience the highest maternal mortality rates - and that babies born to Black women are over twice as likely to die in their first year compared with those

[1] The Health Foundation. 'Trends in international life expectancy at birth' health.org.uk
[2] Office for National Statistics (ONS). 'Healthy life expectancy, UK: between 2011 to 2013 and 2022 to 2024' ons.gov.uk
[3] ONS. 'Healthy life expectancy by national area deprivation, England and Wales: between 2013 to 2015 and 2020 to 2022' ons.gov.uk
[4] NHS England. 'Consultant-led Referral to Treatment Waiting Times Data 2025-26', January 2026 Incomplete Pathways Commissioner data file, National data table, england.nhs.uk
[5] British Heart Foundation. 'Bias and Biology - BHF' bhf.org.uk
[6] Endometriosis UK, 'The state of endometriosis care in the UK: a roadmap for driving down diagnosis times and improving access to care (PDF, 607KB)' endometriosis-uk.org (PDF, 607KB)
[7] ONS. 'Healthy life expectancy by national area deprivation, England and Wales: between 2013 to 2015 and 2020 to 2022' ons.gov.uk

born to White women[8] - is an injustice that shames our society.

If our approach to health and care does not work for all women - 51% of the population - then simply put: it does not work.

We must listen

At the heart of these challenges is a systematic failure to listen to women – and to ensure that they have genuine voice, choice and power.

Several years of National Cancer Patient Experience Survey data shows that women are less likely to be treated with dignity and respect and less able to discuss their worries when receiving hospital care than men - an indictment of NHS culture. Reviews into maternity services have consistently linked failures to listen to women and their families with unacceptable failures in maternity care. Women report their pain being dismissed and inadequate access to pain relief[9]. And almost half of women report challenges accessing their preferred method of contraception[10].

The NHS's inability to listen, its reluctance to give patients meaningful power and choice, and its tendency to disempower patients despite them being the real experts in their own health conditions – is 'by design'. That is to say, it is a feature of a care model that is:

- one size fits all
- too focused on provider interests, rather than patient interests
- highly paternalistic, centralised and bureaucratic

This does not work for anyone - but it negatively impacts women and girls most of all. The 10 Year Health Plan had a central and ironclad commitment to put patient voice at the heart of a new NHS care model - and to change the power dynamic between citizen and health service. This Women's Health Strategy continues that mission.

We will break with the past

The problems faced by women are not caused by a failure to recognise the problem. In 2022, government published the first Women's Health Strategy - underpinned by substantial engagement, including almost 100,000 responses to a call for evidence. Those submissions starkly demonstrated the many ways in which we have a health service that is not built for and around women.

But recognising the problem is not the same as solving it. Our view is that the 2022 Women's Health Strategy was set

[8] Ethnicity facts and figures, GOV.UK. 'Deaths of newborn babies' ethnicity-facts-figures.service.gov.uk
[9] Women and Equalities Committee. 'Women's reproductive health conditions' parliament.uk
[10] British Pregnancy Advisory Service. '49% of Women in the UK Face Barriers to Contraception Access, Reveals New BPAS Report' bpas.org

up to fail because it operated within and accepted an outmoded care model.

Put another way, while it had the right problem statement, it had nothing like the means to deliver real and lasting change. Predictably, the evidence is that its actions have not translated into meaningful improvements in women's access, quality of care, experience or outcomes.

This government does not believe that the necessary speed of progress can be delivered through incremental change. Change will only be possible through more fundamental reform:

- by delivering the 3 shifts and the patient empowerment at their heart:
    - the community shift, to give patients convenience and control
    - the digital shift, to give patients the same choice they now have in a range of consumer sectors
    - the prevention shift, to give people power over their health status and the ability to make the healthy choice
- through a new diverse and devolved operating model with patient voice and choice at its heart. A model that:
    - pushes power from the centre to providers and professionals - and onto patients.
    - anchors healthcare in patient choice - more personal health budgets, more options for self-referral and more direct patient influence over NHS funding flows
- through a renewed focus on quality, including an ironclad commitment to putting patient voice and experience at the heart of all we do (through patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs), and an equally strong commitment to radical transparency - including the publication of performance data

The purpose of this strategy is to apply the 10 Year Health Plan and, in doing so, to give women and girls real voice, choice and power. This will not be to the exclusion of men - we recognise that, in different ways, the NHS is failing us all. Indeed, improving the health of either men or women will also benefit the other. But their problems need different solutions - and the combination of this renewed Women's Health Strategy and our first ever Men's Health Strategy maximises our means to reduce health inequality.

What will change for women as we deliver this strategy

Change will be immediate and continue over the next 10 years. Women will experience:

- shorter waits for gynaecology care
- fewer painful procedures without informed consent or a choice of pain relief.
- easier access to contraception and screening close to home

- better information and more control over their health through digital services
- being listened to and taken seriously at the first time of asking
- fewer cases of repeating their story
- more control over their health through the life course
- improved working lives
- more opportunities to take part in research
- more digital therapeutics bespoke to women
- more women in life science and tech leadership

Why change is possible

If this is our task, there are more reasons for optimism than pessimism. We will harness the societal and technological enablers outlined by the 10 Year Health Plan to deliver decisive improvements in health outcomes and healthcare for women.

Digital healthcare will provide us unique opportunities to extend voice and patient choice. In the 10 Year Health Plan, we noted how digital had given consumers more choice in other industries - and how it would do the same in healthcare. We are prioritising menstrual and menopause problems as 2 of the first 9 pathways to be established in our new virtual hospital NHS Online. The NHS App will provide flexibility and choice in appointment booking, as well as functionality to communicate directly with professionals and draft or revise care plans. Digital health assistants will be able to help women order contraception from and to their home.

More broadly, we are in the foothills of unprecedented technological discovery and advance, which - if deployed in the right way - could transform women's power over their own health and healthcare. Our expanded NHS Genomic Medicine Service will include testing for inherited causes of disease including breast and ovarian cancer as well as major conditions like cardiovascular disease. This will give women the information they need to personalise their care or change their lifestyle. Our new National HealthTech Access Programme will streamline adoption of innovation in areas like cancer diagnostics for endometrial cancer and digital therapeutics for menopause. In consumer healthcare, tools like cycle trackers, fertility predictors and symptom diaries for chronic pain are both empowering and improving the lives of millions already.

Our new operating model will be how we pull through innovation - and push power out to providers, frontline staff and onto patients. For example, women live longer in poor health than men, and integrated health organisations (IHOs) will be incentivised to prioritise prevention and to delay sickness into later life. Our new Choice Charter will mean services are more receptive to patients' personal priorities.

It will also be how we drive culture change in the NHS. The health service's

historic paternalism does not work for anyone, but it works even less well for women. It combines with sexism in wider society to create the conditions in which women's voices go unheard, their dignity not respected, their expertise in their own needs and experiences going unheeded, procedures not being explained and pain not being treated. We know that this is not every woman's experience - many receive excellent care every day. And we know that the vast majority of healthcare leaders and professionals are driven to create a more just and equal NHS. This will be a plan to work with them to create a culture of equal treatment, and to tackle unconscious bias and medical misogyny.

Moreover, this will be a plan hardwired to reduce inequality. This strategy embeds in our new care models a focus on reducing health inequalities and giving power to marginalised women. It will require close and creative local partnerships, anchored by the relationship between the NHS and local councils to design joined-up approaches to meet the full range of women's health needs. This will be epitomised by new neighbourhood health services, with preventative and proactive care delivered for cohorts with similar needs.

Our priorities are women's priorities

A plan to give women voice, agency and choice must anchor its ambitions in the lived experiences, stories and priorities of women themselves. That's why our renewed strategy has been informed by extensive engagement. We have drawn on:

- the call for evidence that informed the 2022 Women's Health Strategy (nearly 100,000 responses)
- the biggest conversation about the NHS in history that informed the 10 Year Health Plan
- further engagement with experts and women with lived experience in the development of this plan

The message was clear: change is needed and, currently, is not happening fast enough. We have listened. This renewed Women's Health Strategy will apply the 10 Year Health Plan's new care model to make much faster, more decisive progress on 4 health outcomes that matter most to women across the country.

Our first commitment - and the golden thread of this strategy - is to make women's voices and choices central in healthcare

We will prioritise women in the creation and use of new indicators - like patient-reported outcome and experience measures - that will anchor our approach to quality improvement in patient voices. We will ensure women are not expected to endure avoidable procedural pain. We will provide women with straightforward access to safe and high-quality contraception, abortion care, fertility services, preconception care and support after pregnancy loss in convenient settings, with digital options available where appropriate. These actions are part of our focus on culture

change, acting through empowerment, accountability and financial flows to ensure women's voices are heard and acted on.

We will:

- establish the women's voices partnership in 2027, a new space for organisations representing women to inform national decision making, and - over time - regional planning and delivery. The partnership will have a focus on organisations representing women most excluded from traditional services
- develop and implement PREMs, and where appropriate PROMs, for core women's health pathways over the next 5 years, starting with gynaecological outpatient procedures
- help reduce variation in how GPs listen to and respond to women, using GP Patient Survey data to launch a quality improvement programme within 2 years to help GPs identify problems
- within 3 years, co-produce with women standards of care for the delivery of gynaecological procedures such as hysteroscopy, ensuring all women give informed consent and are offered a choice of pain relief
- improve access to contraception including ensuring all women can access emergency contraception for free from a pharmacy and encouraging simpler access to long-acting reversible contraception (LARC) within 2 years
- support the sustainability of abortion services including changing NHS payments and supporting integrated care boards (ICBs) to implement the NHS abortion commissioning guidance. And we will continue safe access zones outside abortion clinics - all within one year
- work with stakeholders to review the evidence for and implications of rolling out a graded model of care for repeated pregnancy loss
- improve care and support between pregnancies for marginalised communities, working together with the National Institute for Health and Care Research (NIHR) Maternity Disparities Consortium. We will engage marginalised communities to co-develop, co-implement and co-evaluate care and support before and between pregnancies, providing the UK's first blueprint for such care by 2030
- improve perinatal mental health, parent-infant relationship and infant feeding support in 75 local councils. Backed by over £900 million, through the Best Start Family Hubs and Healthy Babies programme we are taking action to create a more integrated, accessible system of support right in the heart of local neighbourhoods
- expand our world-leading prenatal genomic testing offer to provide vital

information to women during pregnancy and to support reproductive decision making

Second, we will transform NHS performance in services that matter most to women

We will improve performance on conditions that uniquely affect women (such as menstrual health and gynaecological conditions) as well as those that affect women differently or disproportionately (such as mental health, cancers and osteoporosis). In tandem with our commitment to revitalise NHS performance on elective waiting lists and constitutional standards more broadly, we will speed up diagnosis, treatment and care for women. Alongside that, we will eliminate the diagnostic odyssey facing women with conditions like endometriosis and fibroids and improve early intervention for cancer and osteoporosis. We will do so through the shifts from hospital to community and analogue to digital, including reforming outpatient services towards digital-first pathways and delivering our new neighbourhood health model. To measure progress on this aim, as we roll out PROM and PREM collection across the NHS, we will introduce a new measure of how often people have to repeat their stories to healthcare professionals.
We will act to improve safety in maternity settings, with further focus following the ongoing independent national maternity and neonatal investigation and National Maternity and Neonatal Taskforce. To end this national shame, we will set an explicit target to close the Black and Asian maternal mortality gap, informed by the Amos Investigation.

We will:

- launch a new programme to improve education for girls about their menstrual health, investing an additional £1 million from this year to support targeted work in schools and community settings. This will support girls' knowledge about menstrual health and when to seek healthcare
- introduce a menopause question into the routine NHS Health Check this year, raising awareness of symptoms and giving women the confidence to seek timely help
- shift women's health services into primary care and community settings, including a single point of access for gynaecology referrals and redesigned clinical pathways for heavy periods, menopause and uro-gynaecology within 3 years
- fund this year a specialist centre in each region for group-based approaches to women's health pathways including contraception, heavy periods, uro-gynaecology, and menopause. Each regional specialist centre will act as a demonstrator and centre of excellence, supporting local areas to design, implement and evaluate group-based pathways. We will roll these out in areas of highest health need or highest health inequality first
- prioritise menstrual problems (caused by issues such as endometriosis,

fibroids and adenomyosis) and menopause as 2 of the first 9 pathways to be established in the new virtual hospital, NHS Online, launching in 2027

- support early diagnosis of osteoporosis and improved bone health by funding 20 new dual energy X-ray absorptiometry (DEXA) scanners in priority locations, enabled by £2.6 million investment in the financial year ending 2026. This is on top of the £1.9 million already invested in the financial year ending 2025. This will provide an estimated 60,000 scans per year and improve image quality for patients
- improve safety in maternity services, providing better care and improve women's experiences around birth through the NHS Maternal Care Bundle and acting on the findings of the independent National Maternity and Neonatal Investigation and the Secretary of State's National Maternity and Neonatal Taskforce
- improve facilities to ensure bereaved parents have appropriate spaces. This year we allocated up to £9 million to over 40 trusts to enhance their bereavement facilities or estates

Third, we will support all women to lead healthy, prosperous lives

Data shows that women spend a disproportionate amount of their lives in poor health. Healthy lives enable the things that make life worthwhile - hobbies, relationships and the chance to participate in communities - and the ability to participate in a strong, fair economy. That's why for many women time spent in good health is a priority above and beyond simple gains in longevity. Healthier lives are the central commitment of this plan, which we will deliver through our new neighbourhood health model. This model will see the NHS and local government working closely together with strengthened primary and community-based care supporting people closer to home - as well as in partnership with the voluntary and commercial sectors.

The Government is committed to improving healthy life expectancy, or the time someone can expect to live in good health. Our 10 Year Plan committed to halve the gap in healthy life expectancy between the richest and poorest regions, while increasing it for everyone, and to raise the healthiest generation of children ever. For women, this means we will:

- reverse the decline in healthy life expectancy seen since the 2010s
- improve healthy life expectancy in the poorest parts of the country to at least 61 years from 50.5 years
- reduce the time women spend in poor health, as a share of their lives

Delivering these ambitions will achieve our commitment to halve the gap in healthy life expectancy between the richest and poorest regions in England. It also provides a simple target for the health and care system and wider partners to deliver against.

We will:

- deliver our aim to eliminate cervical cancer by 2040, including rolling out home testing kits for human papilloma virus (HPV), providing greater convenience and access. We will make HPV vaccination available in local community pharmacies to reach those who missed school vaccinations. Both are available from this year
- expand genomic testing for inherited causes of major diseases within a year, including BRCA1 and BRCA2 genes associated with higher lifetime risk of breast and ovarian cancer
- roll out breast pain and post-menopausal bleeding clinics nationally by the end of 2026 and invest in our wider community diagnostic estate as we deliver our new National Cancer Plan for England
- tackle the biggest causes of death and poor health in women by improving our focus on cardiovascular disease risk management and care, publishing a new modern service framework this year
- tackle rising obesity rates - a risk for multiple women's health problems including some cancers. We will support women to lead more active lives and improve their diets through campaigns, investment in sports, digital tools and supporting access to healthier food
- support women to drink less alcohol and smoke less - including creating the first smoke-free generation
- improve care for women living with frailty and dementia, publishing a modern service framework for frailty and dementia
- halve violence against women and girls (VAWG) within a decade. As part of the health system's contribution, we will invest up to £50 million to transform support for victims of child sexual abuse and exploitation across every NHS region in England, as well as rolling out a domestic abuse and sexual violence referral service and additional investment for victims and survivors
- improve support for women sleeping rough through helping councils to design and deliver effective outreach and services alongside NHS services
- support women to enter and remain in work through better treatment and management of MSK conditions. MSK conditions are one of the leading conditions reported by people who are economically inactive[11] (including due to long-term sickness), with women at higher risk than men
- support women affected by menopause in their jobs by

[11] Department for Work and Pensions (DWP). 'The employment of disabled people 2025' GOV.UK

introducing new requirements on employers with 250 or more employees to publish an action plan including support for employees experiencing menopause, starting in 2027, subject to secondary legislation

- partner with Vanguard employers as part of the Keep Britain Working Review to test how we can better support good health in work - with a focus on women's health across the life course
- give carers more power and convenience through the NHS App. When fully rolled out, the new My Carer function in the NHS App will allow people to securely prove they are providing care, book appointments and communicate with their loved one's care team

Fourth, we will create an approach to research and development that works for and empowers women

Research and development (R&D) are at the heart of advances in health. If women are not represented in research - and not represented in the leadership in research and innovation - it is unsurprising that their priorities are not *the* priorities.

We will:

- accelerate the deployment and spread of innovations that benefit women's health, launching a FemTech healthcare challenge within 2 years with a pot of £1.5 million. This will enable systems to work with promising FemTech developers addressing areas of unmet need, with a focus on community service models addressing health inequalities
- launch the NIHR R&D Innovation Catalyst this year to provide wrap-around support for high priority innovations, with R&D funding available across all translational phases of research if main milestones are met. We will ensure the R&D Innovation Catalyst considers women's health innovations throughout its operation, both for reproductive and pregnancy conditions, and by ensuring equity in its approach to innovations for any disease
- ensure women are not left behind in research. From now, NIHR will only fund research that appropriately considers sex-based differences. We will also make it easier for women to participate in clinical trials by integrating the Be Part of Research service on the NHS App - and in time automatically match patients with studies based on their own health data and interests
- support female founders in health and care. Within a year, through the NIHR we will launch a new accelerator for female founders with innovations addressing women's health priorities. Our new programme will provide funding and support through a programme including mentoring and advice for entrepreneurs, market testing and access, scale-up and commercialisation models

We will act on women's voices and choices

We have heard far too many examples of women not being listened to. The NHS has a problem with medical misogyny and we will not shirk this challenge.

The 10 Year Health Plan set out this government's commitment to putting a 'public megaphone' to the mouths of patients - alongside our plan to transition from a centralised state bureaucracy (with power concentrated in the centre) to a devolved and diverse NHS (with power wielded by professionals and individual citizens). Our focus on devolution and a radical redistribution of power is equally justified by the fact that a modern public service as complicated as the NHS, with 600 million patient interactions a day, cannot be effectively run from Whitehall. And because listening to people and acting on their experiences is a fundamental necessity of high-quality healthcare.

Patient voice is the foundation of both our approach to public service reform and to high-quality care for all. Voice, choice and empowerment are also areas where women are being failed. In the call for evidence informing the 2022 Women's Health Strategy, 84% of women reported times they were not listened to by healthcare professionals.

There is a lack of high-quality quantitative data on women's pain management in the NHS but international evidence - based on 21,000 patients attending emergency departments in the USA and Israel - found a systematic disparity, with women significantly less likely to receive treatment for a pain complaint compared to a male patient[12]. A study of UK Biobank participants also found that chronic pain disproportionately affects women, and that women reported more severe and impactful pain than men[13]. This academic evidence is supported by the abundant examples of women who report their pain being normalised or dismissed, such as those women who told their stories to the Women and Equalities Committee inquiry into women's reproductive health conditions.

This is no basis for progress. An NHS that believes it knows best, that dictates from the centre, that does not listen to feedback or learn quickly, that persists with one size fits all and does not accept patients as the authoritative expert in their own care is incompatible with better outcomes, access and experience. Quality improvement must start by listening to women about where care is failing, devolving choice and power about the kind of care they want to them, ensuring care is personal and proactive - all while maintaining clinical efficacy and the highest standards of safety.

[12] Guzikevits M, Gordon-Hecker T, Rekhtman D et al. Sex bias in pain management decisions, Proceedings of the National Academy of Sciences of the United States of America; 121(33):e2401331121
[13] Luo J, Woodward M, Ferreira ML, Harris K. Sex differences in the experience of pain in the UK Biobank cohort study. British Journal of Pain. 2026;22:20494637261418196. .

As such, our model for change in this strategy is to create a learning health system with women's voices at its heart - a system that continually listens, learns and acts based on what women are saying, embedding new approaches so that women's voices resonate from ward to board. Over time, this will be integrated with other sources of data so that women's reported experiences and outcomes - using measures that matter to women themselves - form a fundamental part of NHS data and performance information. This is a key driver of the culture change we need to see and a crucial part of our new devolved operating model, with power pushed out to providers and to patients in a new Choice Charter, including making funding flows sensitive to patient voice, choice and feedback, expanding personal health budgets, and giving patients greater choice and control through the NHS App.

To do so we will invest in new ways for women's voices to be heard and embed this data in mechanisms to improve quality, including payment reform and quality improvement. We will take additional targeted action to improve the way services manage women's pain. While our overall approach to centre women's voices will drive improvement in pain management, pain was a particular priority for women during our engagement informing the strategy and there is a need for further targeted action.

We will create new mechanisms for women's voices to be heard at national level

While our new operating model will shift power away from the centre to empowered and responsive local systems, we will also act to bring women's voices into government and national NHS policy and planning. This will ensure a golden thread of accountability from individual women to national leaders.

Action 1: we will establish the women's voices partnership, a new space for organisations representing women to inform national decision making.

The women's voices partnership will have a focus on organisations that represent women who are most excluded from traditional services, drawing on existing networks where appropriate. This new partnership, established later this year by the Department of Health and Social Care (DHSC) and NHS England, will bring together groups representing women in a regular forum with DHSC and NHS England officials to build on our productive engagement and relationships with women's health stakeholders, including the success of the network of champions and the roundtables informing this strategy. This will ensure that women's voices can inform national policy thinking and delivery planning outside of specific processes like the renewal of this strategy - and our focus on representing women most excluded from traditional services will help policy and planning to better reflect their needs.

Alongside the new national partnership and in line with the women's health neighbourhood approach, we will work with NHS regions to support ICBs to build on existing local networks and partnerships to engage diverse groups of women in planning and delivery. These priorities will be reflected in ICB improvement plans, with regional assurance and accountability for progress overseen through the national women's health programme board and informed by the women's health data dashboard described below under action 32.

Action 2: we will reform accountability and oversight to refocus how we view and measure quality to put patient voice at its heart.

From this year a new national director of patient experience will be appointed to oversee the collection of enhanced patient and carer feedback, ensuring greater transparency in the views and experience of women and girls. The national director of patient experience will work closely with the national clinical director for women's health and the national programme priority director for women's health, maternity and neonatal care and children and young people.

We will create new routes to collect data on women's voices in systems and providers

The vision set out in the 10 Year Health Plan and further steps set out in this strategy to centre women's voices create the foundations for a transformed approach to collecting patient feedback. Over time, this will be integrated with other sources of data so that women's reported experiences and outcomes - using measures that matter to women themselves - form a fundamental part of NHS data and performance information.

Action 3: we will develop and implement PREMs, and where appropriate PROMs, prioritising key women's health pathways, starting with gynaecological outpatient procedures.

These will provide new insights about the impact and experience of health conditions and NHS services from women's perspectives. Additionally, this year we will implement a new PREM for maternity care, developed and informed by recent research commissioned by NIHR.

We will use insights from what women are saying to improve how services respond

We will act so that - over time - this patient-reported data is used at multiple levels in the health system to ensure services are listening, responsive and providing the best possible experiences and outcomes. Everyone from chief financial officers to service managers and clinicians will understand and act on what women are saying.

We have taken the first steps. Last year we announced Jess's Rule, named in honour of Jessica Brady, encouraging all GPs to think again if they have been unable to offer a diagnosis after 3 appointments or if symptoms have worsened. As well as supporting the earlier identification of the most serious, potentially fatal conditions, this approach

could help women with symptoms like pelvic pain that are not getting better. This builds on the recent rollout of Martha's Rule to every acute hospital in England following a successful pilot. Marth's Rule empowers patients, families and carers to escalate concerns for review from a different clinical team if they are concerned that somebody is deteriorating and not being listened to - which is a particular concern for women.

Our next steps are to launch new uses of patient-reported data in payment models, quality improvement and patient choice.

Action 4: we will test 'patient power payments' - prioritising some gynaecology services as our first step - which would vary the amount NHS trusts are reimbursed depending on women's feedback on their experiences, including pain management.

As set out in the 10 Year Health Plan, patient power payments are an innovative approach to funding flows in which patients are contacted after care and given a say on whether the full payment for the costs of their care should be released to the provider. Prioritising gynaecology services will provide a new mechanism to ensure providers are responsive to women's voices, helping create a culture where women's pain is taken seriously and they are offered clear information and choices before procedures such as hysteroscopy. We have selected gynaecology following feedback suggesting women are having avoidably poor experiences, particularly because of not being listened to or supported with pain management. Any funding withheld due to poor experiences would be used for targeted improvements to the same services. Subject to the results of our testing and trials in 2026 to 2027, we will make recommendations for using patient power payments in the 2028 to 2029 NHS Payment Scheme.

Action 5: we will help reduce variation in how GPs listen to and respond to women, using GP Patient Survey data in a quality improvement programme to help GPs identify problems.

We will update the GP Patient Survey data platform to include a specific focus on women's experiences of feeling listened to. Through this we will identify variation between GP practices and support improvements.

Action 6: we will launch My Choices in the NHS App, enabling people to find and compare providers including based on measures of patient experience.

My Choices will provide data on healthcare providers, including distance to home, waiting times, outcomes and patient experience measures. This will give power to women to choose care providers with more confidence they will receive the care they need - and be listened to and believed.

We will act to improve women's experiences of pain

Services that listen and respond to women's voices will by their nature respond to women's pain. But the stories from women around the country make clear that more direct action is needed to drive change and ensure that no women is expected to live in pain or experience

painful procedures without appropriate support and care. One in 3 women reported severe pain scores of 7 or more out of 10 during NHS outpatient hysteroscopy procedures without sedation[14].

Action 7: we will co-develop with women a standard of care for the delivery of gynaecological procedures such as hysteroscopy

This will ensure women have the right information and understanding of a procedure to allow informed consent, and that they always have a choice of effective pain relief.

Action 8: we will work with Getting It Right First Time (GIRFT) workstreams in secondary care gynaecology and chronic pain

This will improve standards and reduce variation in both procedural and chronic pain management, including chronic pelvic pain.

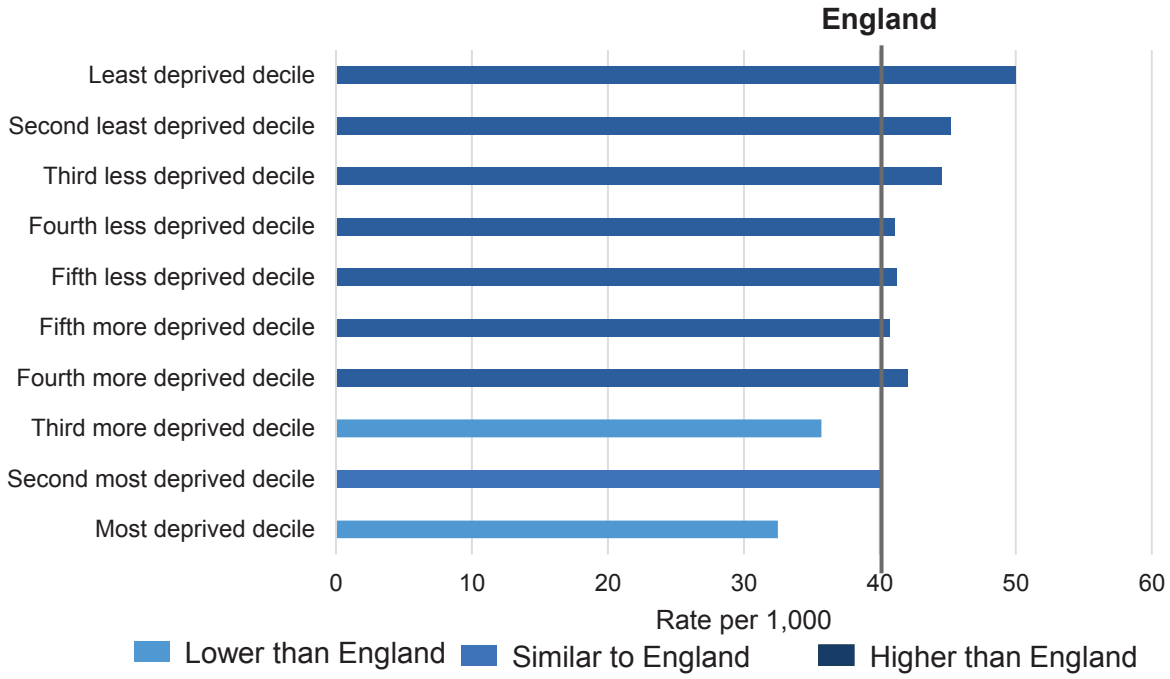
[14] Royal College for Obstetricians and Gynaecologists (RCOG). 'Pain Relief and Informed Decision Making for Outpatient Hysteroscopy (Good Practice Paper No. 16)' rcog.org.uk

We will support women's reproductive choices

Supporting women to make informed, confident reproductive choices is fundamental to ensuring they are heard and empowered - as well as for improving lifelong health and reducing inequalities. Ensuring that every woman can easily access clear, trusted information alongside high-quality contraception, abortion, pre-conception, fertility and pregnancy-loss services is central to this ambition. Yet too many women still face barriers shaped by geography, circumstance, culture or fragmented care. Almost half of women reported that they had encountered challenges accessing their preferred method of contraception in a 2024 survey commissioned by the British Pregnancy Advisory Service, with more than 1 in 10 saying they could not get an appointment with a healthcare professional to access contraception at all[15].

Women are estimated to require access to contraception for 30 years on average to support their pregnancy choices[16], and

Figure 1. Rate of prescribing for LARC, excluding injectables, in England by deprivation, 2024



Source: Office for Health Improvement and Disparities (OHID). Sexual and reproductive health profiles: statistical commentary, February 2026. GOV.UK

[15] British Pregnancy Advisory Service. 'Contraception Re-Imagined: The Unfinished Revolution' bpas.org
[16] DHSC. 'Women's Reproductive Health Survey 2021 national pilot: contraception and abortion results' GOV.UK

we are seeing changing attitudes and patterns of use around different forms of contraception. LARC prescribing is lowest in the most deprived areas (as shown in Figure 1 above), suggesting that health inequalities are worsened by a lack of appropriate information and services for these women[17]. Despite the substantial progress achieved through the original Teenage Pregnancy Prevention Strategy, significant variation and inequalities persist across local areas[18].

For women who become mothers, the interval before they become pregnant - known as preconception - is an important factor in the outcome of that pregnancy and the longer-term health of mother and baby. Short interpregnancy intervals increase the risk of obstetric complications and of prematurity and low birthweight babies, with potentially significant long-term consequences for both mother and child[19]. Additionally, women's health status and behaviours going into pregnancy affects their risk of complications and their child's long-term outcomes. There are stark inequalities: women from deprived areas, ethnic minority groups, and those with limited access to healthcare are more likely to enter pregnancy with unmanaged long-term conditions, obesity, poor nutritional status or higher chances of smoking.

In 2022, there were around 3 times as many abortion procedures as hip replacements[2021], yet abortion services are rarely highlighted in strategies or performance data.

An important criticism of the 2022 Women's Health Strategy by women and expert organisations - like the Royal College of Obstetricians and Gynaecologists - is that it did not set out what government is doing to support women's reproductive choices so that they are in control of if, when, with whom and how many times they become pregnant in their lives.

In this strategy we address this gap from the 2022 Women's Health Strategy and set out how we will reflect women's preferences, provide greater choice and control and support their lifelong outcomes by:

- ensuring that women have straightforward access to the full range of contraception that meets their individual needs and preferences
- improving access, quality and reducing inequalities in abortion care
- improving preconception care
- improving support for fertility and pregnancy loss

[17] OHID. 'Sexual and reproductive health profiles: February 2026 update' GOV.UK
[18] ONS. 'Conceptions in England and Wales: 2022' ons.gov.uk
[19] Schummers L, Hutcheon J, Hernandez-Diaz S and others. 'Association of Short Interpregnancy Interval With Pregnancy Outcomes According to Maternal Age' JAMA Internal Medicine 2018: 178(12):1661-1670
[20] OHID. 'Abortion statistics for England and Wales: 2022' GOV.UK
[21] NHS England. 'Finalised Patient Reported Outcome Measures (PROMs) in England for Hip and Knee Replacement Procedures (April 2021 to March 2022)' digital.nhs.uk

- improving care in and around pregnancy

We will ensure that women have straightforward access to contraception that meets their preferences

Women should feel able to make informed, confident choices about contraception, supported by high-quality information that reflects their preferences and circumstances. Timely access to a full range of contraceptive options across primary care, pharmacies, sexual health services and neighbourhood hubs is essential. Services should prioritise dignity, comfort, safety and proactive offers of pain relief. Significant challenges remain:

- women say that they do not always find it easy to access services that meet their needs and fit into their lives[22]
- LARC prescribing is lowest in the most deprived areas[23], worsening inequalities
- despite progress under the Teenage Pregnancy Prevention Strategy, substantial variation persists across local areas[24]

To address these gaps, services should better reflect women's changing preferences and support lifelong reproductive health outcomes with accessible, responsive and equitable care.

Case Study: expanding access to LARC Across Cheshire & Merseyside

Cheshire and Merseyside (C&M) introduced pilot funding across their 9 local areas to expand access to long-acting reversible contraception (LARC) for all indications - contraception, heavy periods and endometrial protection as part of HRT. Previously, comprehensive LARC provision existed in only 1 area, creating significant inequity. The pilot aims to reduce this variation by prioritising the areas of greatest need and delivering LARC in primary care settings, offering care closer to home with shorter waits than secondary care.

The programme supports the C&M ICB vision of establishing a Women's Health Hub in every area, with LARC as a core service. Early evaluation shows services have begun in the highest-need areas, with gradual uptake, targeted clinician training, and strong patient satisfaction. Two areas have already committed to recurrent provision, and 7 of 9 Places are projected to offer LARC for all indications by late 2026. Emerging cost-benefit analysis indicates substantial system-wide financial savings, strengthening the case for long-term sustainability.

[22] British Pregnancy Advisory Service. 'Contraception Re-Imagined: The Unfinished Revolution' bpas.org
[23] OHID. 'Sexual and reproductive health profiles: February 2026 update' GOV.UK
[24] ONS. 'Conceptions in England and Wales: 2022' ons.gov.uk

Action 9: we will support women's choices through providing free emergency contraception in pharmacies.

Learning from a successful model established by local councils working with local pharmacies, last year we launched a national programme to make free emergency hormonal contraception available from pharmacies across England. We will continue to fund this programme as an important way to reduce inequalities and provide fast access for women when they need it most. We have also made progestogen-only pills and combined oral contraceptive pills available from pharmacies without needing to see a GP first, making contraception more convenient as part of our neighbourhood services approach.

Action 10: we will ensure seamless access to contraception.

We will include contraception in the upcoming sexual and reproductive health framework to clarify current commissioning arrangements and share opportunities and best practice for closer working and improved pathways.

Action 11: we will improve post-pregnancy contraception and family planning.

Our new Healthy Child Programme guidance published this year sets out our expectations of health visiting services, including that some statutory health and development reviews (antenatal, new birth and 6 to 8-week reviews) should support family planning and sexual health including discussing contraception needs, giving advice and signposting.

Action 12: we will improve workforce capacity to deliver LARC.

We will work with NHS England, local councils and the College of Sexual and Reproductive Health (CoSRH), including training and certification for insertion.

Action 13: we will support digital access to contraception.

In 2025 NHS Shared Business Services launched an 'Online Sexual Health Services' framework agreement, making it easier for local councils and NHS organisations to commission online sexual and reproductive health services. In areas where this is available, women will be able to order contraceptives from home and have them delivered without needing to attend appointments in person. We will encourage local councils and ICBs to join this framework, building on the improvements many have already made in the provision of online services.

Action 14: we will improve pain relief in contraceptive device insertion.

We will publish a standard of care for delivering gynaecological procedures - including LARC fitting - to ensure women have informed consent and a choice of pain relief. In advance, we will write to the system setting out their responsibilities.

Action 15: we will help young people avoid unplanned pregnancies and support healthy relationships.

We will relaunch the teenage pregnancy prevention framework, updating it with recent developments but maintaining the same successful 'whole system' approach. This will be backed by

more detailed teenage conceptions data to support local interventions.

We will improve access, quality and reduce inequalities in abortion care

As well as access to contraception the suits them, women deserve high quality abortion services, should they ever need them. More abortions have taken place in recent years and while the implementation of telemedicine in early medical abortions has improved access, waiting times for surgical abortions (around 13% of procedures[25]) are above the National Institute for Health and Care Excellence (NICE) standards of 2 weeks[26]. Far too many women and girls are being denied timely access to surgical services and/or choice of procedure due to a lack of surgical capacity service planning.

To improve access, outcomes and reduce inequalities in abortion care, NHS England published new commissioning guidance for ICBs in March 2025. The guidance sets out quality and performance metrics and is supported by co-developed commissioning principles reflecting lived experience. These sit alongside wider interventions, including best practice case studies, an updated service model, changes to NHS payment policy, local work to improve financial sustainability, ongoing workforce development and a £3.9 million investment to expand specialist provision.

With the actions below, this forms the first comprehensive NHS plan to improve NHS abortion services in England.

Action 16: we will support ICBs to implement the 5 recommendations in the abortion commissioning guidance.

This guidance focuses on increasing surgical capacity and choice, joining up abortion services with sexual and reproductive health and contraception services to support better patient experience and a more holistic local offer - as well as the adoption of performance and quality metrics to support quality improvement and benchmarking.

Action 17: we will increase surgical abortion capacity.

We will continue to ask NHS trust providers to stabilise their abortion services and for all providers to work to increase surgical capacity over the medium term so that women and girls have better access, a better experience and true choice. This is supported by the move to variable payment by default for trusts in the 2025 to 2026 NHS Payment Scheme.

Action 18: we will improve the commissioning and funding of abortion services to ensure sustainable services and timely access.

We will continue to ask ICBs to ensure that payment arrangements for abortion

[25] DHSC. 'Abortion statistics for England and Wales: 2023' GOV.UK
[26] National Institute for Health and Care Excellence, 'Abortion care quality standard' (2021) nice.org.uk

services are sustainable and follow guidance in the NHS Payment Scheme. We are also changing the NHS Payment Scheme to remove financial disincentives to provision of timely abortion care. This makes clear that prices paid should not discourage the delivery of consultations, scans and procedures on the same day, and asks providers and commissioners to agree arrangements to ensure the service is safe and sustainable.

Action 19: we will continue to ensure safe access zones around abortion clinics.

Everyone has a right to freedom of expression in the UK and freedom of speech is one of the fundamental rights that we will always protect in this country. However, we must also balance the need to protect the rights of others from harassment and incitement.

That is why this government fast-tracked the commencement of the measure to enable safe access zones to be put in place outside abortion clinics. For too long, abortion clinics have been without these vital protections, and we are determined to do all we can to make this country a safer place for women.

The relevant legislation came into force from 31 October 2024. This makes it illegal for anyone who is within a safe access zone to do anything that intentionally or recklessly influences someone's decision to use abortion services, obstructs them, or causes harassment or distress to someone using or working at these premises.

We will improve preconception care

The actions set out earlier in this strategy to improve health for all women are an important part of improving preconception health. Since 45% of pregnancies in England are unplanned[27], those women who continue with unexpected pregnancies have had less chance to optimise their health in advance. But we will also take action to improve preconception health beyond our whole population interventions. This is an important aspect of women's reproductive choices and accompanies our focus on contraception - ensuring women can have babies if and when they choose, and that their health is optimised as they make those decisions.

Action 20: we will improve care and support between pregnancies for marginalised communities.

We will work together with the NIHR Maternity Disparities Consortium to engage with marginalised communities and co-develop, co-implement and co-evaluate care and support before and between pregnancies, providing the UK's first blueprint for such care by 2030. Initial goals, by the end of 2027, include reversing the worsening decline in preconception folic acid supplement use.

[27] Wellings, K. and others. "The prevalence of unplanned pregnancy and associated factors in Britain: Findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3)," The Lancet, 2013;382(9907), pp. 1807 to 1816.

Action 21: we will improve neighbourhood services for preconception health and address the risks of future long-term conditions.

In new guidance for neighbourhood women's health services we will set out responsibilities within neighbourhoods to drive improvements in population health and prevention including preconception health, contraception uptake, screening uptake, and risk of future long-term conditions.

We will improve support for fertility and pregnancy loss

Around 1 in 7 couples trying to conceive will experience some difficulty[28], and the risk of miscarriage is estimated at 15% or around 120,000 per year in the UK[29]. However, due to limitations in reporting pregnancy loss the true figure could be higher at around 250,000 a year[30]. A small proportion of women will go on to have repeated miscarriages[31]. Just as ensuring straightforward access to contraception is an important part of supporting women's voices and choices, so too is providing fertility services for those who need them - and responsive services and support where things go wrong.

Action 22: we will support ICBs to adopt upcoming NICE guidance on fertility problems.

NICE will publish an updated guideline for fertility problems to ensure that advice for clinicians reflects the latest evidence about diagnosing and treating fertility problems. The draft guideline includes updates to extend fertility preservation services (freezing eggs, sperm or embryos) to anyone facing medical treatments or conditions that could harm their fertility. These services should now be available to people of all ages when there is medical need, including young girls and teenagers. We are currently working to assess current provision of NHS-commissioned fertility services as a baseline to inform supporting material for every ICB to implement the new NICE guidelines in full.

Action 23: we will review miscarriage support.

We will work with stakeholders to review the evidence for and implications of rolling out a graded model of care for repeated miscarriage. The findings of a pilot study into the Graded Model of Miscarriage Care at the Tommy's Miscarriage Centre at Birmingham Women and Children's Hospital are expected this year. We will closely review the results of this study and work with our partners to consider wider adoption as part of a package of actions in response

[28] Templeton A, Fraser C, Thompson B. Infertility--epidemiology and referral practice. Human Reproduction 1991;6(10):1391-4.
[29] Sands. 'Miscarriage statistics' sands.org.uk
[30] DHSC. 'Government response to the independent Pregnancy Loss Review' GOV.UK
[31] Tommy's. 'Recurrent Miscarriage' tommys.org

to Baroness Amos's investigation into maternity and neonatal services.

Action 24: we will improve NHS support for bereaved parents.

The Sands National Bereavement Care Pathway was developed to ensure consistent, high-quality support for bereaved parents across the NHS. It sets out standards that NHS hospital trusts should follow when someone experiences pregnancy or baby loss, ensuring all bereaved parents receive equal, high-quality, individualised, safe and respectful care. All NHS hospital trusts in England have agreed to follow this pathway. We set out in the NHS Medium Term Planning Framework that all NHS providers and ICBs are expected to implement the National Bereavement Care Pathway for stillbirth and neonatal death.

Action 25: we will improve facilities to ensure bereaved parents have appropriate spaces.

This year we allocated up to £9 million to over 40 trusts to enhance their bereavement facilities or estates.

Action 26: we will introduce protected bereavement leave, including for pregnancy loss before 24 weeks.

Through the Employment Rights Act 2025 we are introducing new entitlements to protected bereavement leave including for pregnancy loss before 24 weeks. This ensures that those eligible have the right to take unpaid time off work to grieve, providing additional support at a difficult time.

Action 27: we will continue our support to recognise lives lost.

The Baby Loss Certificate Service was launched to provide recognition of a life lost, with over 100,000 certificates issued as of April 2025. In October 2024, this government extended the certificates to all parents regardless of how long ago their loss was.

Acting on women's voices and choices – summary of actions

Commitment	Responsible organisations	Timeframe
Action 1: we will establish the women's voices Partnership, a new space for organisations representing women to inform national decision making.	DHSC/NHSE	0-2 years
Action 2: we will reform accountability and oversight to refocus how we view and measure quality to put the patient voice at its heart.	DHSC/NHSE	0- 2 years
Action 3: we will develop and implement PREMs, and where appropriate PROMs for key women's health pathways, starting with gynaecological outpatient procedures.	DHSC/NHSE	1-5 years
Action 4: We will test patient power payments - prioritising some gynaecology services as our first step - which would vary the amount NHS trusts are reimbursed depending on women's feedback on their experiences, including pain management.	DHSC/NHSE	0-2 years
Action 5: we will help reduce variation in how GPs listen to and respond to women, using GP Patient Survey data in a quality improvement programme to help GPs identify problems.	DHSC/NHSE	0-2 years
Action 6: we will launch My Choices in the NHS App, enabling people to find and compare providers including based on measures of patient experience.	DHSC/NHSE	0-3 years
Action 7: we will co-develop with women a standard of care for the delivery of gynaecological procedures such as hysteroscopy, ensuring women have informed consent and choice of pain relief.	DHSC/NHSE, women with lived experience	0-3 years
Action 8: we will work with GIRFT workstreams in secondary care gynaecology and chronic pain to improve standards and reduce variation to improve both procedural and chronic pain management, including chronic pelvic pain.	DHSC/NHSE , GIRFT	0-2 years
Action 9: we will support women's choices through providing free emergency contraception in pharmacies.	DHSC/NHSE	Ongoing
Action 10: we will ensure seamless access to contraception.	DHSC/NHSE	0-2 years
Action 11: we will improve post-pregnancy contraception and family planning.	DHSC/NHSE	0-2 years
Action 12: we will improve workforce capacity to deliver LARC.	DHSC/NHSE, local councils, CoSRH	0-2 years
Action 13: we will support digital access to contraception.	NHS Shared Business Services, NHS and local government	Ongoing
Action 14: we will improve pain relief in contraceptive device insertion. We will publish a standard of care for	DHSC/NHSE	0-1 years

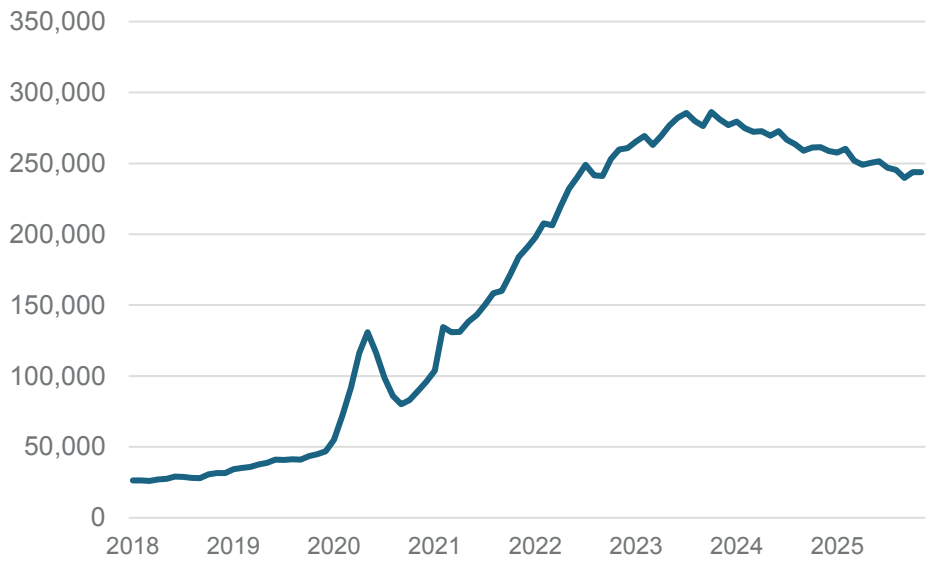
delivering gynaecological procedures - including LARC fitting - to ensure women have informed consent and a choice of pain relief.		
Action 15: we will help young people avoid unplanned pregnancies and support healthy relationships.	DHSC/NHSE	0-2 years
Action 16: we will support ICBs to implement the 5 recommendations in the abortion commissioning guidance.	DHSC/NHSE, ICBs	Ongoing
Action 17: we will increase surgical abortion capacity.	DHSC/NHSE	3-5 years
Action 18: we will improve the commissioning and funding of abortion services to ensure sustainable services and timely access.	DHSC/NHSE	0-1 years
Action 19: we will continue to ensure safe access zones around abortion clinics.	Home Office	Ongoing
Action 20: we will improve care and support between pregnancies for marginalised communities, working together with the NIHR Maternity Disparities Consortium.	DHSC-NIHR/NHSE	3-5 years
Action 21: we will improve neighbourhood services for preconception health and addressing the risks of future long-term conditions.	DHSC/NHSE	0-1 years
Action 22: we will support ICBs to adopt upcoming NICE guidance on fertility problems which expands fertility preservation.	DHSC/NHSE	0-2 years
Action 23: we will review miscarriage support.	DHSC/NHSE	0-3 years
Action 24: we will improve NHS support for bereaved parents.	DHSC/NHSE	Ongoing
Action 25: we will improve facilities to ensure bereaved parents have appropriate spaces.	DHSC/NHSE	0-1 years
Action 26: we will introduce protected bereavement leave, including for pregnancy loss before 24 weeks.	DBT	0-1 years
Action 27: we will continue our support to recognise lives lost through the Baby Loss Certificate service.	DHSC, NHS BSA	Ongoing

We will transform NHS performance in services that matter most to women

NHS performance data shows that too many women are waiting for services, with only 57% of gynaecology referrals seen within 18 weeks[32]. Almost 9 in 10 women on the gynaecology waiting list have no decision to admit[33], indicating most patients are waiting for an outpatient pathway. The vast majority of the 565,000 women waiting for gynaecology care could be better cared for in primary or community settings with shorter waits. There is also significant regional variation in gynaecology waiting lists, and health inequalities: women from ethnic group 'Any other Black background', 'Any other Asian background', 'Caribbean', and 'African' show the largest relative increase on the gynaecology waiting lists[34].

We are starting to see green shoots of recovery through our focus on elective recovery. Our 2025 elective reform plan set out how we will return to the 92% standard for 18-week waits, including £80 million for advice and guidance schemes with specific resources for gynaecology. We are increasing funding for gynaecology procedures with the longest waiting lists and adjusted prices for some

Figure 2: the number of people waiting more than 18 weeks for gynaecology services in England, 2018 to 2025



Source: Royal College of Obstetricians and Gynaecologists. 'Gynaecology Waiting times tracker' rcogwaitinglist.health.lcp

[32] NHS England. 'Consultant-led Referral to Treatment Waiting Times Data 2025-26', January 2026, Incomplete Pathways Commissioner data file, National data table; england.nhs.uk
[33] NHS England. 'Consultant-led Referral to Treatment Waiting Times Data 2025-26', January 2026, Incomplete Pathways Commissioner data file, National with decision to admit data table; england.nhs.uk
[34] Royal College of Obstetricians & Gynaecologists. 'New Year: Still waiting for a way forward' rcog.shorthandstories.com

conditions to encourage providers to reduce them. As a result, the gynaecology waiting list has fallen by 7.1% from its peak of 610,000 in August 2023 to 565,000 in January 2026 and the number of women waiting more than 18 weeks has fallen by more than 40,000 since a peak in December 2023 (as shown in Figure 2 above)[35].

But a more fundamental transformation is needed to create a system that works around women's lives rather than expecting the opposite. This strategy - building on our 10 Year Health Plan - sets out the means to do so through our shift to community and digital ways of working alongside investment and reform of services so that the NHS recognises and respond to women's wants and needs. To do so we will:

- speed up time to diagnosis and treatment through a shift to neighbourhood and community-based services that are designed around women's needs
- invest in digital-first models that provide faster and more convenient access
- improve support for conditions that affect women disproportionately or differently
- improve health and care for female survivors of violence

We will speed up diagnosis and treatment by redesigning clinical pathways and a community shift

A key theme in our engagement with organisations and experts informing the 2022 Women's Health Strategy was to prioritise integrated, holistic, and user-centred care models to respond to the varying needs of women throughout their lives. This means creating a system in which women can get what they need at the first time of asking - not to be moved between different services and healthcare professionals.

At present, access to diagnosis and treatment is often framed as a binary choice between primary care and secondary care. This does not reflect the complexity of women's needs or the ambition of delivering more care closer to home. We need a more graduated, stepped model of care that enables assessment, diagnostics and treatment to be delivered at neighbourhood or community level where appropriate. Delivered by a skilled multidisciplinary team with the competence, autonomy, and diagnostic capability to manage complexity safely, this model would maximise the contribution of nursing, allied health professionals and medical colleagues working collaboratively.

Through this we can deliver what women are asking for: earlier intervention,

[35] Royal College of Obstetricians & Gynaecologists. 'RCOG Elective Recovery Tracker Dashboard, Gynaecology waiting times in the UK over time' rcogwaitinglist.health.lcp.com. Calculated by dividing December 2025 total England gynaecology waiting list number by August 2023 total England gynaecology waiting list and subtract from 1.

avoiding unnecessary escalation to hospital services, and ensuring that people receive the right care, in the right place first time. This has not been delivered due to continued reliance on outdated care models which expect women to fit into one-size-fits all services which work for nobody. Our shift to neighbourhoods and communities will deliver the change that women have been asking for.

Through our new more diverse and devolved operating model, local areas will be empowered and accountable to design and deliver services that meet local needs. Our approach is to enable every area to understand their local need and what best practice looks like based on experience across the country, bolstered by targeted national support where the case for transformation is most urgent. Our immediate focus is on significantly improving the time to diagnosis and time to treatment which means too many women experience avoidable pain and distress.

Our investment in improved information and advice set out later in this strategy - such as a new programme to improve education for girls about their menstrual health - will help women and girls know when to seek healthcare, which is an important factor in time to diagnosis and treatment in conditions like endometriosis[36]. And we will ensure that access and services are improved when women seek care.

A core part of this improved offer will be neighbourhood women's health services. This model, learning from the proof-of-concept women's health hubs, will transform women's healthcare in every community in line with our 10 Year Health Plan neighbourhood model. Where high quality women's health hubs exist, they will continue to lead service delivery. In other areas we anticipate there will be a dedicated space within broader neighbourhood health centres.

Every neighbourhood will provide proactive, specialist and preventative women's health care that complements and extends the primary care offer, directly delivering intermediate care services and leading population prevention within neighbourhoods, including preconception health, contraception, and screening services. Care will be delivered via a network of providers, including community specialists in women's health and other services such as pelvic physiotherapists, pharmacies and psychological support.

ICBs will be responsible for commissioning these services. We will support them to do so, learning from the women's health hubs to provide clear expectations both for ambition and for how improvements in care will be measured and monitored. We will also support ICBs to share learning from

[36] The National Confidential Enquiry into Patient Outcome and Death. ‘A Long and Painful Road’ 2024. ncepod.org.uk

existing women's health hubs through our Network of Women's Health Champions.

As our first steps we will:

Action 28: we will speed up access to better treatment by directing women to the right place at the right time.

We will support ICBs to introduce a single point of access to assess all non-urgent referrals to gynaecology and women's health services enabling women to be directed to the best place for their needs, including community diagnostic centres, neighbourhood health centres and neighbourhood women's health services.

Action 29: we will standardise care pathways and remove unnecessary procedural delays.

We will redesign clinical pathways for the most common clinical pathways including heavy periods, menopause and uro-gynaecology. The single point of access will direct women to these redesigned pathways so that women are no longer expected to attend multiple appointments in different places for tests and treatments - helping reduce waiting times and improve experiences.

Action 30: we will improve productivity and empower women in common clinical areas, helping reduce waiting lists and supporting self-management.

We will fund a specialist centre in each region for group-based approaches to high volume low complexity women's health pathways including contraception, heavy periods, uro-gynaecology and menopause. Each regional specialist centre will act as a demonstrator and centre of excellence, supporting local areas to design, implement and evaluate group-based pathways which can improve access, experience, peer support and productivity. Centres will provide practical implementation support, shared learning, workforce development and outcome measurement, with early rollout focused on communities experiencing the highest levels of health need and inequity.

Action 31: we will develop and test financial models to encourage the shift of some women's health pathways into community settings, aiming to provide easier access and reduce waiting times.

Our outdated financial model is an important reason why the NHS has failed to shift services into community settings that work better for patients. As set out in the 10 Year Health Plan, there is no financial incentive to invest in community services that improve patient outcomes and deliver better value - indeed, the opposite is true. We will change that, through developing new approaches that make shifting care to community services the rational choice for the NHS, just as it is for patients and the public.

Action 32: we will deliver greater transparency on women's health and healthcare.

The 10 Year Health Plan was clear on our commitment to transparency. We will launch a new publicly available women's health data dashboard providing neighbourhood-level comparable data

about service performance, access, and patient outcomes and experience. We will expect ICBs and trusts to use this data to identify and address disparities in women's outcomes, performance and experience.

Action 33: we will work with NHS regions to identify local priorities and monitor progress using our new women's health data dashboard.

We will work with systems to drive performance through our National Women's Programme Board. As part of this, we encourage local systems to develop a shared women's health improvement plan across NHS and local government partners, drawing on quantitative data and insights from local women including through coproduction with local voluntary, community, and social enterprise partners.

Action 34: we will publish an equity good practice guide to enable ICBs to better understand and reduce inequalities in heavy periods and menopause.

These conditions have been selected as disproportionately affecting women from ethnic minority backgrounds and those women living in the 20% most deprived areas in England.

Action 35: we will set out and deliver a new workforce model to underpin neighbourhood health services across England.

The upcoming 10 Year Workforce Plan will modernise education and training so that staff are equipped to deliver these new service models and provide high-quality responsive care that improves outcomes and experiences for women and girls. We will supplement this by developing and publishing a framework setting out women-centred basic principles and core skills (basic, intermediate and advanced) that professionals need to deliver high-quality women's healthcare.

Case study: Sunderland Women's Health Hub

Sunderland established a community-based Women's Health Hub to improve access to menopause, menstrual health, contraception and diagnostic services, with a focus on women in deprived areas and those facing barriers to care. Delivered through primary care at Pallion Health Centre, the hub integrates GPs, advanced practitioners, nurses and sonographers to provide a coordinated 'one-stop' model, including LARC provision, cervical screening support, ultrasonography and phlebotomy. Outreach clinics extend access to refuges and other community sites.

Women played a central role in co-design, shaping priorities through focus groups, surveys and Healthwatch insight. Shared digital records ensured smooth referrals and continuity, while targeted training expanded local expertise in menopause and LARC care.

The hub has improved timely access, reduced unnecessary hospital referrals and increased uptake of women's health services - particularly among underserved groups. Challenges around commissioning complexity and workforce capacity were addressed through clear communication, professional training and strong cross-sector leadership.

An independent evaluation of Sunderland's Women's Health Hub by NIHR Applied Research Collaboration North East and North Cumbria found that for every £1 invested, the hub generates £8 in benefits over 10 years.

We will improve access to advice and services by investing in digital tools and digital-first pathways

The shift from analogue to digital will enable women to ask questions and talk to healthcare professionals, book and manage appointments, look at their patient records and self-refer to local services - all at times and from locations that work for them.

We also see digital as a tool to narrow inequalities and give power to those otherwise denied it in the NHS. In our 10 Year Health Plan engagement with autistic people and people with learning disabilities, remote appointments were supported in avoiding them having to enter busy and overstimulating environments. Additionally, those in the Gypsy, Roma and Traveller community said they could enable easier access for those with no fixed address[37]. To ensure

[37] DHSC. Engagement insight report: 10 Year Health Plan for England, Chapter 5: the 3 shifts - analogue to digital GOV.UK

digital is for everyone, DHSC will contribute to the government's digital inclusion drive and will make sure in-person appointments remain a choice for all who need and prefer them.

Action 36: we will prioritise menstrual problems (caused by issues such as endometriosis, fibroids and adenomyosis) and menopause as 2 of the first 9 pathways to be established in the new virtual hospital, NHS Online, launching in 2027.

This will give women a new, digital route to getting quick care if they choose it.

Action 37: we will capitalise on the accessibility and reach of digital health technologies.

In the longer term, we will launch HealthStore in the NHS App to support access to digital health technologies across multiple condition areas, including those in women's health and mental health.

Action 38: we will enhance and expand the NHS App to provide access and advice through a digital front door.

This will include options to get instant advice for non-urgent care, holding consultations through the app, and to get all the information people need about health conditions or procedures. Alongside this, a new Single Patient Record - accessible through the NHS App by 2028 - will bring together all medical records, ensuring seamless care and enabling women to review their complete health history and risk factors. Over time this will inform personalised health coaching through the NHS App. This will particularly benefit women who are managing multiple commitments (such as domestic labour and caring responsibilities in which women are overrepresented) or pregnant women who need more frequent contact with health services.

We will improve support for conditions that affect women disproportionately or differently

While women live longer than men, they spend more years in ill health. This is partly driven by higher or different risks in some conditions that affect both men and women, and also by conditions that affect women uniquely. These include:

- dementia and Alzheimer's disease are the leading cause of female death (16% in 2024), followed by heart disease and stroke (6.5% and 5.7% respectively, 2024)[38]
- cardiovascular outcomes are worse for men overall, however women are less likely to receive medication for cholesterol and are 50% more likely to be misdiagnosed following a heart attack[39], while heart disease kills almost twice as many women as breast cancer each year[40]

[38] ONS. 'Deaths registered in England and Wales: 2024' ons.gov.uk
[39] British Heart Foundation. 'Bias and Biology - BHF' bhf.org.uk
[40] Calculated from difference in crude mortality rate in 2024 for females for deaths due to malignant neoplasms of the breast and due to ischaemic heart disease (table 7, Deaths registered in England and Wales - Office for National Statistics)

- osteoporosis disproportionally impacts women, with more than 1 in 3 women (compared to 1 in 5 men) likely to experience an osteoporotic fracture in their lifetime[41]
- Frailty is more common in women than men, with notable health inequalities; women aged 65 to 69 from the most deprived 20% of the population are almost 4 times more likely to live with frailty than the least deprived 20% of the population[42].
- MSK conditions, such as osteoarthritis, rheumatoid arthritis and osteoporosis disproportionately impact females. In 2023 in England, estimates suggest 35.1% (10.4 million) of females compared to 26.6% (7.5 million) of males were affected by a MSK condition[43]
- around 1 in 4 women have a common mental health condition, compared to around 1 in 7 men. Women and girls also experience mental health challenges differently to men throughout life, with women almost twice as likely as men to have an eating disorder, more likely to have made a suicide attempt or self-harmed, and more likely to have post-traumatic stress disorder[44]. Different groups of women also have different risks, such as Lesbian, Gay and Bisexual women's 3 fold higher risk of intentional self-harm than their heterosexual counterparts[45]. Rates of probable mental disorders are twice as high for young women than for young men[46]. There is also increasing recognition of the links between hormones and mental health, such as in conditions like premenstrual dysphoric disorder (PMDD), and specific risks around pregnancy (addressed later in this strategy)

In addition to the impacts on women, these conditions have significant implications for NHS sustainability and the wider economy. For example, in 2019 the estimated cost of frailty to the UK healthcare system was estimated at around £5.8 billion per year[47]. The cost of dementia in the UK was forecast at £42 billion in 2024, reaching £90 billion by 2040 across health and social care costs, costs to unpaid care, and quality of

[41] Borgstrom F, Karlsson L, Ortsater G, Norton N, et al. Fragility fractures in Europe: burden, management and opportunities. Archives of Osteoporosis 2020;15:59
[42] National Audit Office. 'Primary and community healthcare support for people living with frailty' nao.org.uk
[43] Prevalence produced by multiplying prevalence by population data. Institute for Health Metrics and Evaluation. 'VizHub - GBD Results'viz.hub.healthdata.org; Office for National Statistics (ONS). 'Estimates of the population for the UK, England, Wales, Scotland, and Northern Ireland - Office for National Statistics' ons.gov.uk
[44] NHS England. 'Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/4' digital.nhs.uk
[45] Office for National Statistics (ONS). 'Self-harm and suicide by sexual orientation, England and Wales' ons.gov.uk
[46] NHS England. 'Mental Health of Children and Young People in England, 2023 - wave 4 follow up to the 2017 survey' digital.nhs.uk
[47] National Audit Office. 'Primary and community healthcare support for people living with frailty' nao.org.uk

life and economic losses[48]. Mental health, cardiovascular disease and MSK conditions are major categories of healthcare as well as drivers of economic inactivity, as set out later in the health and work section of this strategy. Pushing poor health later into life provides benefits to women's quality of life as well as to NHS sustainability and wider economic growth.

We have seen recent progress in ensuring knowledge is no barrier to women's concerns being addressed: the General Medical Council (GMC) introduced a new Medical Licensing Assessment for all medical graduates from 2024 to 2025 that includes topics relating to women's health. The GMC is now updating this to include additional topics and symptoms that reflect women's lived experiences, particularly recognising how gender intersects with ethnicity and deprivation. The GMC is also reviewing their education framework to ensure all doctors, physician associates and anaesthesia associates are equipped to meet the needs of all people, including through a focus on women's health and understanding of these wider factors.

We have acted to support women and girls' mental health, including prioritising funding for NHS Talking Therapies for common mental health conditions in the Medium Term Planning Framework, continued support for specialist perinatal and maternal mental health services, and - through NHS England - introducing new 'Staying Safe from Suicide' guidance and e-learning for mental health practitioners to improve suicide risk management processes by ensuring practitioners tailor their approach to the specific needs of each individual. As set out below, we are acting to reduce VAWG and address the health consequences of that violence.

The independent review into mental health conditions, attention deficit hyperactivity disorder (ADHD) and autism will inform a new approach to mental health. It will ensure that people with mental health conditions, ADHD and autistic people have the right support in place to enable them to live well in their communities. The review is looking at all age groups so this will include a focus on adolescent girls and common mental health conditions. It will carefully consider the evidence on prevalence and the perspectives of people with lived experience, and provide recommendations to government on implications for how it responds, including a focus on improving early intervention and cross-sector support for people.

Over the next few years we will invest in and transform services which have differential or disproportionately high impacts on women.

Action 39: we will improve cardiovascular risk management and care.

Later this year, we will publish a cardiovascular disease modern service

[48] Alzheimer's Society and Carnall Farrar, 2024. 'The economic impact of dementia' alzheimers.org.uk

framework. This will be our tool for ensuring consistent application of best practice care. It will also be our tool to apply the 10 Year Health Plan's new care model to the cardiovascular disease pathway, helping us to move to neighbourhood-led care, digital by default pathways and a focus on prevention. Finally, it will outline how we will work with the wider innovation eco-system to identify areas that could make a huge difference to cardiovascular disease outcomes - but where we lack answers - to help focus research, development, innovation and commercial efforts. Specific actions we will take include:

- delivering our commitments on prevention of obesity and smoking
- reducing variation in medication adherence, diagnosis of blood pressure, and management of high blood pressure and cholesterol - including through preventative medications
- best practice digital by default pathways and a focus on including genomic insights in routine care as standard

Action 40: we will improve care for frailty and dementia.

We will publish a modern service framework for people living with frailty and dementia in 2026. These frameworks will ensure women benefit from the best evidenced interventions and more consistent national provision. The first ever modern service framework for frailty and dementia will be informed by phase one of the independent commission into adult social care. The commission is underway and phase one will report this year. We will engage with a range of partners over the coming months to enable us to build a framework which is both ambitious and practical, to ensure we can improve system performance for people with dementia both now and in the future.

Action 41: we will roll out fracture liaison services (FLS) across every part of the country by 2030.

FLSs systematically identify people aged 50 and older who have had a ‘fragility fracture’ and are evidenced to reduce their risk of further fractures (including hip fractures).

When commissioning new fracture prevention services, in line with the 2030 objective, we expect ICBs to prioritise community-based models which align with the three shifts in the 10 Year Health Plan. This will aim to reduce the occurrence of secondary fractures and improve patients’ independence and quality of life.

New community-based services should be local and easy to access to patients, for example through use of community diagnostic centres, neighbourhood health centres and women's health hubs. Services should be integrated with local services, for example rehabilitation and falls and fragility services. All community-based models should be built on evidence-based practice and recognised clinical guidelines and measured against established key performance indicators

across the patient pathway set out in the FLS Database.

Action 42: we will support early diagnosis of osteoporosis and improved bone health by funding 20 new DEXA scanners in priority locations.

This is enabled by £2.6 million investment in 2025 to 2026 on top of the £1.9 million already invested in the financial year ending 2025. This will provide an estimated 60,000 scans per year once fully operational and improve image quality for patients.

Case study: FLSs and the hospital to community shift

Osteoporosis disproportionally impacts women, with more than 1 in 3 women (compared to 1 in 5 men) likely to experience an osteoporotic fracture in their lifetime. West Suffolk community-based FLS delivering fracture prevention at scale, in line with the shift in the 10 Year Health Plan from hospital to community.

The model is nurse-led, remote-first and digitally enabled. Monthly fracture data are digitally triaged to identify fragility fractures. Assessments are primarily delivered by phone, with home allowing the service to reach frail, elderly and housebound patients. The service works closely with general practice, DEXA (bone density) scanning, orthogeriatrics, radiology, rheumatology and community teams. Since 2022 it has delivered denosumab (injectable treatment for osteoporosis) for around 700 patients who would otherwise have been referred to secondary care to receive this treatment.

Action 43: we will improve quality and access to best-practice care in women's health priorities.

NICE has recently updated guidelines for endometriosis, menopause and birth care in and is currently updating guidelines on fertility, ectopic pregnancy, miscarriage, neonatal infection, and domestic violence and abuse, and developing guidance on polycystic ovary syndrome.

NICE continues to drive access to clinically and cost-effective medicines for women. This includes recommending last year a new daily pill for endometriosis and making the first specific treatment for fibroids available. NICE has identified endometriosis and fibroids as a priority to drive uptake of treatment recommendations.

Action 44: we will improve cancer diagnosis in the community.

As set out in our new National Cancer Plan for England, we will roll out breast pain and post-menopausal bleeding clinics nationally by the end of 2026. This will further our wider improvements in community diagnostics, including investing £2.3 billion over the next 3 years in diagnostics transformation. This will include building many more new community diagnostic centres, bringing convenient community diagnostics to more people - and advancing the neighbourhood health service.

Action 45: we will improve access to mammography for women with physical disabilities, using NHS purchasing power to influence the market for accessible machines.

By engaging with manufacturers we will promote the development of accessible mammography machines, reducing access barriers for women with physical disabilities.

Action 46: we will expand genomic testing for the BRCA1 and BRCA2 genes associated with higher lifetime risk of breast and ovarian cancer.

This is part of the expansion of our genomic testing offer set out in the prevention section below, which also includes Lynch syndrome testing for all patients diagnosed with bowel or endometrial cancer, with follow-on surveillance for female relatives at risk.

Action 47: we will accelerate access to new technologies.

Through the new National HealthTech Access Programme we will streamline adoption of innovation and help end the postcode lottery. One of the 4 cancer priority areas for the programme is technologies to improve detection of endometrial cancer in women with postmenopausal bleeding.

Action 48: we will improve support for girls' physical and mental health through a modern service framework.

We will publish a modern service framework for children and young people. This will support the NHS and system partners including public health and local government to ensure children receive timely high-quality care and support when they need it whilst improving performance and efficiency across the system. The modern service framework for children and young people will ensure access to paediatric expertise closer to home, within neighbourhoods, whilst considering the needs of the whole child with parity given to mental health and physical health. This will enable girls to better manage their health throughout life, from increasing access to vaccinations to better support for their mental health in adolescence.

Action 49: we will improve mental health support for women and girls.

We are expanding NHS Talking Therapies with the aim that 915,000 people will complete a course of treatment by March 2029, including through self-referral.

We are rolling out community mental health centres across the country. These centres bring together NHS, voluntary, faith and social enterprise services to provide trauma-informed care. They have particular benefits for women by providing flexibility and convenience and supporting access for the most marginalised women such as those experiencing rough sleeping.

We will accelerate the rollout of Mental Health Support Teams in schools and colleges, to reach full national coverage by 2029.

We will also invest an additional £7 million in the financial year ending 2027 to Early Support Hubs to bolster mental health support for young people- enabling an additional 10,000

interventions, and alongside this, will embed wellbeing support for young people through Young Future Hubs. This will help more women and girls access mental health support in ways that work for them, providing flexibility and convenience around busy lives.

And we will promote collaborative working between mental health and women's health sectors to improve women's knowledge and healthcare professional understanding of the critical relationships between female hormones and mental health. This will help improve care for conditions like PMDD.

We will also improve access to mental health support through the NHS App in the longer term, creating a digital front door to boost access to early support and empower people to take steps to manage their symptoms.

We will improve health and care for female victims of violence and abuse

One in 8 women in England and Wales in the year ending March 2025 experienced domestic abuse, sexual assault, or stalking[49]. Victims and survivors of intimate partner violence can face an increased risk of poor health outcomes[5051] . In the year ending March 2023, over half of female victims of partner abuse in England and Wales reported experiencing non-physical effects (51.5%), with the most commonly reported category being mental or emotional problems[52]. We are committed to halving VAWG within a decade and will work across government to deliver our VAWG strategy to deliver this commitment.

Jess Asato MP has been appointed as the VAWG Adviser to DHSC, advising on how alcohol is linked to VAWG, embedding support for victims and survivors in neighbourhood health services, and improving local commissioning of VAWG services. An NHS that works for women needs to take account of women's health needs as victims and survivors, and we will consider how Ms Asato's recommendations are implemented in due course.

As set out in the Men's Health Strategy, we will also improve our understanding of why pregnancy and the time after birth can be a period of heightened risk for domestic abuse, and evaluate existing interventions for those disclosing early harmful behaviours to health professionals.

Some of the actions set out earlier in this strategy - particularly to support women and girls' mental health - will help improve care for female victims of violence and

[49] ONS. 'Developing a combined measure of domestic abuse, sexual assault and stalking, England and Wales: July 2025' ons.gov.uk
[50] World Health Organization (WHO), 'Violence against women' who.int
[51] Dillon G, Hussain R, Loxton D, Rahman S, 'Mental and Physical Health and Intimate Partner Violence against Women: A Review of the Literature.' International Journal of Family Medicine, 2013;2013:313909.
[52] ONS. 'Partner abuse in detail' ons.gov.uk

abuse. ICBs have an ongoing important role commissioning support services for victims of domestic abuse, sexual conduct and serious violence, including a duty to collaborate with local policing bodies and local authorities under the Victims and Prisoners Act 2024. And we will take additional action, in partnership with others, to improve health and care for female victims of violence and abuse and ensure that whenever a victim or survivor contacts the NHS, they are met by a compassionate culture which treats them with care and dignity:

Action 50: we will roll out a domestic abuse and sexual violence referral service called 'Steps to Safety'.

This will give general practices the tools and ability to identify and refer victims and survivors into support services. Our goal is national provision of this service, and by 2029, any victim or survivor in England will be able to get the help they need by talking to staff at their general practice - ending the current patchwork of services.

Action 51: we will invest £5 million each year for victims and survivors of domestic abuse and sexual violence.

This will sit alongside the £550 million investment in victims' services provided by the Ministry of Justice, reinforcing that healthcare - along with every part of society - has a vital part to play in supporting victims and survivors.

Case study: The Lighthouse

The Lighthouse - England's first Child House, opened in 2018 in Camden as a pioneering, child centred, multi-agency service for victims of child sexual abuse and exploitation. Based on the international Barnahus model, it brings together health, social care, therapeutic and advocacy services, along with the police, judiciary and courts, under one roof, preventing children from having to repeatedly recount their experiences. It serves the 5 North Central London boroughs and supports children aged 0 to 18 (or up to 25 with special educational needs and disabilities).

The Lighthouse provides holistic medical care, sexual health follow up, emotional and mental health assessments, long-term therapeutic interventions (including through the National Society for the Prevention of Cruelty to Children), access to child-appropriate justice services and dedicated Children's Independent Sexual Violence Advisor support. Families benefit from parent psychoeducation and case management.

Action 52: we will invest up to £50 million to transform support for victims of child sexual abuse and exploitation across every NHS region in England.

The Child House model represents a powerful shift in how we care for children and young people who have experienced sexual abuse, placing them at the centre of a compassionate, trauma informed system. By bringing health, justice,

social care and emotional support services together under one roof, the model spares children the trauma of retelling their story and instead surrounds them with specialist multi-agency care when they need it most.

The success of pioneering sites like The Lighthouse in Camden shows just how lifechanging this approach can be when services come together to wrap support around families. Our national expansion is an ambitious but vital commitment: to expand the model across every NHS region, strengthen safeguarding and justice outcomes, and protect the youngest and most vulnerable in our society.

Action 53: we will launch a new safeguarding learning programme for the entire NHS workforce in 2026.

It will cover all aspects of domestic abuse and improving support for victims and survivors across the health system so that all staff have the tools and understanding to act, creating a culture that is supportive, aware, and equipped to do its part to address VAWG.

We will improve health in and around pregnancy

During pregnancy, evidence shows that pregnancy-related disorders are associated with worse long-term health outcomes: women who had high blood pressure in pregnancy have an increased risk of heart failure, coronary artery disease, and stroke at an earlier age[53]. Women who had gestational diabetes have increased risk of type 2 diabetes, with up to half of women with gestational diabetes going on to develop type 2 diabetes within 5 to 10 years after giving birth[54]. Women's birth experiences and outcomes are a fundamental aspect of high-quality healthcare, and we will act to ensure that all women receive the care they expect and deserve. And we will improve support for the common postnatal challenges that many women face, including in their mental and pelvic health.

The maternal mortality rate for women in England from Black ethnic minorities is nearly 3 times higher compared to White women and has increased slightly, comparable to earlier rates from 2019 and 2021[55]. To end this national shame, we will set an explicit target to close the Black and Asian maternal mortality gap informed by the Amos Investigation.

After pregnancy, many women experience mental health and pelvic floor health problems after birth. Postnatal depression affects more than 1 in 10 women within a year of giving birth[56]. Pelvic floor issues are very

[53] Honigberg, M. and others. 'Long-Term Cardiovascular Risk in Women with Hypertension during Pregnancy - PMC' Journal of the American College of Cardiology (2019): volume 74
[54] Kampmann, U. and others. 'Gestational diabetes: A clinical update - PMC' World journal of diabetes (2015): volume 6
[55] MBRRACE-UK. 'Maternal mortality 2022-2024 | MBRRACE-UK | NPEU' npeu.ox.ac.uk
[56] Peterson I, Peltola T, Kaski S, et al. Depression, depressive symptoms and treatments in women who have recently given birth: UK cohort study. BMJ Open 2018;8:e022152.

common: urinary incontinence affects around half of women in pregnancy, with around 1 in 10 affected a year after birth[57]. This has significant impacts on women's wellbeing - but there is evidence that this is normalised and that many women feel too embarrassed to seek support[58]. In the UK, suicide is the leading cause of maternal direct deaths 6 weeks to a year after the end of pregnancy[59]. Breastfeeding provides significant benefit to mothers and babies, and despite increases over the last decade the UK has low breastfeeding rates compared to other European countries[60] and lower rates among more deprived mothers[61].

We have taken action to support women's health at each of these stages. Since 2024 we have:

- updated our preconception indicator scorecard in including wider health determinants, health behaviours, and pre-existing conditions to include data for local councils and ICBs
- improved services and treatments to support women in pregnancy including rolling out 'artificial pancreas' technology to children and adults living with type 1 diabetes, including pregnant women
- launched our first Best Start in Life (BSiL) campaign, jointly with DfE, which brings together all services, offers and support available to help guide and support parents from pregnancy, through their child's journey into childcare, to starting school and beyond. This includes information about pregnancy and caring for babies, including feeding. Since September 2025, we've had over 4.5 million visits to the BSiL web estate and thousands of expectant and new parents signed up to the regular BSiL email programme. We are currently exploring expanding the BSiL health hub to include preconception health and embedding sign up to the email programme at the 10-week booking appointment and within the NHS App
- supported perinatal mental health services which are now available in every integrated care system (ICS) in England, with 66,451 women accessing a specialist community perinatal mental health service or a

[57] Gmelig Meyling MM, Frieling ME, Vervoort JPM, Feijen-de Jong EI, Jansen DEMC. (2023) Health problems experienced by women during the first year postpartum: A systematic review. European Journal of Midwifery. Dec 18;7:42.
[58] Royal College of Obstetricians and Gynaecologists. Written evidence for the Women and Equalities Select Committee Inquiry into Reproductive Health, committees.parliament.uk
[59] MBBRACE-UK. 'Saving Lives, Improving Mothers' Care 2025 - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2021-23' npeu.ox.au.ac.uk
[60] Royal College of Paediatrics and Child Health. 'Breastfeeding in the UK - position statement | RCPCH' rcpch.ac.uk
[61] OHID. 'Breastfeeding at 6 to 8 weeks after birth: annual data April 2023 to March 2024' GOV.UK

maternal mental health service in the year up to November 2025. This is almost double the numbers of women accessing these services than 4 years previously

- supported mothers with postpartum psychosis through mother and baby units. Postpartum psychosis is a serious mental illness which the NHS recognises as a time-critical emergency, and provides risk stratification, escalation and rapid admission where needed into mother and baby units 24 hours a day, 7 days a week. We have improved capacity through new and expanded units alongside work to support consistent access processes as part of our sustained investment in specialist inpatient provision for women experiencing severe perinatal mental illness, including postpartum psychosis
- invested in preventative pelvic health. The most common pelvic health problem for women prior to or following birth is urinary incontinence, affecting 1 in 3 people having a baby. Preventative pelvic floor exercises reduce the likelihood of urinary incontinence if performed correctly, so the NIHR provided the APPEAL (Antenatal Preventative Pelvic Floor Exercises And Localisation) programme £1 million to enable broader uptake of best practices. The programme uses a “train the trainer” approach and has been delivered in 9 trusts with 9 more planning delivery. As of September 2025, more than 200 midwife service leads have been trained, who have then trained hundreds more to provide the service.
- supported perinatal pelvic health services across England to improve prevention, identification, and timely treatment of pelvic floor dysfunction around birth. As of June 2025, 36 out of 42 ICS areas have fully operational services. Additionally, local NHS systems are supporting women to prevent and manage pelvic floor dysfunction at home using digital models such as Dorset ICS rolling out access to the Squeezy App, which delivers guided pelvic floor physiotherapy plans
- extending the National Breastfeeding Helpline to ensure more mothers can access dedicated breastfeeding support 24 hours a day

Maternity and neonatal care in the renewed Women's Health Strategy

In June 2025 the Secretary of State for Health and Social Care announced an independent investigation of maternity and neonatal care across England to understand the systemic reasons behind why so many women and babies are receiving unacceptable care. The investigation is looking at individual services across the country alongside reviewing the maternity and neonatal system nationally, including wide evidence collection and bringing together the findings of past reviews into one clear national set of recommendations.

The Secretary of State for Health and Social Care appointed Baroness Amos to lead the independent investigation. The investigation is currently ongoing and is expected to report in June 2026.

Separately, the Secretary of State for Health and Social Care has launched a National Maternity and Neonatal Taskforce - which he is personally chairing - made up of esteemed experts, including families. The taskforce will address the independent Investigation's recommendations through the development of a new national action plan that will drive improvements across maternity and neonatal care. The taskforce will also hold the system to account for the delivery of this plan, as well as improving outcomes and experiences for women and babies and tackling inequalities. We are ensuring that a wide breadth of views informs the work of the taskforce through the establishment of several expert reference groups, including multiple family groups.

The taskforce will also look at several well-known and entrenched issues facing maternity care in England, including the inequalities facing women from Black, Asian and deprived backgrounds, and wider concerns over a lack of compassionate care and safety in our maternity services.

It is important that this work continues without restriction and that the government can properly respond to the findings. This renewed women's health strategy therefore does not seek to address safety in maternity and neonatal services other than that related to women's health before and during pregnancy and the actions we are taking immediately to improve maternity and neonatal care.

We will go further to improve women's outcomes during and after pregnancy:

Action 54: we will drive fair access to medicines.

We will move towards a single national formulary for medicines within the next 2 years. This will help address inequity and variation in the use of approved medicines, creating a single nationally agreed list of medicines to replace the current local processes, helping to ensure every patient has equitable access to medicines wherever they live. This can help women with conditions like hyperemesis gravidarum where we are aware of variation in prescribing medicines to combat severe nausea and vomiting in pregnancy.

Action 55: we will expand our world leading prenatal genomic testing offer.

We will provide vital information to women during pregnancy and to support reproductive decision making.

Action 56: we will invest £200 million in Healthy Babies to improve perinatal mental health, parent-infant relationships, and infant feeding support in 75 local authorities.

This forms part of a £900 million package for Best Start Family Hubs and Healthy Babies to create a more integrated, accessible system of support for families right in the heart of local neighbourhoods – so it's there when and where families need it.

Action 57: we will reduce the leading causes of maternal mortality and morbidity.

Earlier this year NHS England published the Maternal Care Bundle to set clear standards across all services for implementation by NHS providers and commissioners across England. The maternal care bundle also includes a postnatal toolkit to support ICBs to deliver better care and improve women's experiences following birth. This year we allocated up to £5 million to NHS trusts to buy equipment or undertake works to implement the maternal care bundle.

Action 58: we will improve safety in maternity services.

We have rolled out a new Maternity Outcome Signalling System which systematically collects and interprets data to support trusts identify potential safety issues and take quicker action. This proactive approach supports safer pregnancies and births, helps reduce inequalities in care, and ensures that women across the country receive consistent, high-quality support tailored to their needs.

Action 59: we will invest in improving our maternity and neonatal estate.

As a first step, we have allocated over £131 million through the 2025 to 2026 Estates Safety Fund to address critical safety risks on the maternity estate, enabling better care for mothers and their newborns. The funded works will deliver vital safety improvements and support NHS productivity by reducing disruptions across NHS clinical services.

Action 60: we will improve postnatal support for physical and mental health in the community.

Our refreshed healthy child programme guidance sets clearer standards for health visiting services. This includes the routine assessment of maternal mental and physical health needs at all 5 statutory reviews including the antenatal review, to ensure support is in place, and at the and 6 to 8 week visit where family wellbeing is the primary focus. Those who need it will then be offered more intensive support.

The postnatal period is associated with heightened risk so we have also improved the importance of face-to-face visits in the home, which are key to the early identification of mental health issues.

The 6 refreshed high impact areas for health visiting include both a) maternal and family mental health and b) transition to parenthood, which includes increasing parental confidence and resilience and improving perinatal mental health.

The refreshed guidance also sets out how health visitors should routinely screen for domestic abuse, including coercive control and other forms of harm, to support early intervention and prevention.

To address concerns that fragmented care and poor communication between services were contributing factors in preventable maternal deaths, the refreshed guidance also sets out improvements in transition from maternity and health visiting services, including data sharing.

Action 61: we will improve responsiveness to cardiac risk in new mothers.

Our refreshed healthy child programme guidance sets out that health visitors should be alert to subtle signs that may indicate underlying cardiac concerns, such as breathlessness, fatigue, chest discomfort or reduced functional capacity, particularly when these symptoms are disproportionate or unexplained. This is an important focus because cardiac disease is the leading indirect cause of maternal death in the UK.

Action 62: we will restore the value of Healthy Start from April 2026.

We will increase the value of weekly payments by 10% to £4.65 for pregnant women and children over one and under 4, and for children under one we will increase the value to £9.30, boosting the ability to buy fruit and vegetables for those families who need it the most.

Action 63: we will improve performance of pelvic mesh services.

We are continuing our work to confirm the redress scheme for victims of pelvic mesh. While that work continues, we are driving clinical action - supported by national investment - to improve quality and experience in mesh centres.

NHS England have completed an audit of mesh centres which has informed an implementation plan to address variation between centres and support further improvements in performance, to be delivered through 3 primary routes: update and implement a revised national service specification for mesh centres; commission a review of the clinical evidence and the production of new clinical guidelines for mesh surgery; create a new mesh centre collaborative network to reduce variation and support pathway standardisation and improvements in patient care.

Case study: nurturing maternal wellbeing in Wakefield's Best Start Family Hubs and Healthy Babies

Maternal Journal is a creative wellbeing programme delivered through Wakefield's Best Start Family Hubs and Healthy Babies. It is designed to support the mental health of pregnant women and new mothers through writing, drawing and collage. Founded by an artist and midwife, the initiative offers a safe, nonjudgemental space for mothers to explore the emotional challenges of pregnancy, birth- and early parenthood.

At Best Start Family Hubs, sessions are delivered in groups or 1:1s. The friendly, informal setting encourages open conversation, helping mothers express how they are feeling in a non-judgmental and supportive setting. Journaling can help give mothers a voice on paper for things that may be hard to express verbally during what can sometimes be an isolating time for women. Best Start Family Hubs staff are on hand to listen and offer support, including signposting or referring to other services.

The sessions not only aim to support individual wellbeing but also foster strong peer relationships. Many participants develop long-lasting- friendships that become ongoing sources of support. Some mothers, inspired by the programme, have gone on to join the Circle of Security Parenting programme, motivated to better understand their children's needs.

Transforming NHS performance in services that matter most to women – summary of actions

Commitment	Responsible organisation	Timeframe
Action 28: we will speed up diagnosis by directing women to the right place at the right time.	DHSC/NHSE	0-3 years
Action 29: we will standardise care pathways and remove unnecessary procedural delays and redesign clinical pathways in for the most common clinical pathways including uro-gynaecology and heavy periods.	DHSC/NHSE	0-2 years
Action 30: we will improve productivity and empower women in common clinical areas, helping reduce waiting lists and supporting self-management.	DHSC/NHSE	0-1 years
Action 31: we will develop and test financial models that would encourage the shift of some women's health pathways into community settings, aiming to provide easier access and reduce waiting times.	DHSC/NHSE	0-3 years
Action 32: we will deliver greater transparency on women's health and healthcare.	DHSC/NHSE	0-2 years
Action 33: We will work with NHS Regions to identify local priorities and monitor progress using our new women's health data dashboard.	DHSC/NHSE	0-1 year
Action 34: we will publish an equity good practice guide to enable ICBs to better understand and reduce inequalities in heavy periods and menopause.	DHSC/NHSE	0-2 years
Action 35: we will set out and deliver a new workforce model to underpin neighbourhood health services across England.	DHSC/NHSE	0-1 years
Action 36: We will prioritise menstrual problems (caused by issues such as endometriosis, fibroids and adenomyosis) and menopause as 2 of the first 9 pathways to be established in the new virtual hospital, NHS Online.	DHSC/NHSE	0-5 years
Action 37: We will capitalise on the accessibility and reach of digital health technologies.	DHSC/NHSE	0-3 years
Action 38: We will enhance and expand the NHS App to provide access and advice through a digital front door.	DHSC/NHSE	0-3 years
Action 39: we will improve cardiovascular risk management and care. Later this year, we will publish a cardiovascular disease modern service framework.	DHSC/NHSE	0-1 years
Action 40: we will improve care for frailty and dementia. We will publish a modern service framework for frailty and dementia.	DHSC/NHSE	0-1 years
Action 41: we will roll out FLS across every part of the country by 2030.	DHSC/NHSE	0-5 years
Action 42: we will support early diagnosis of osteoporosis and improved bone health by funding 21 new DEXA scanners in priority locations.	DHSC/NHSE	0-1 years
Action 43: we will improve quality and access to best-practice care in women's health priorities.	NICE	Ongoing

Action 44: we will improve cancer diagnosis in the community.	DHSC/NHSE	0-1 years, 0-3 years
Action 45: we will improve access to mammography for women with physical disabilities, using NHS purchasing power to influence the market for accessible machines.	DHSC/NHSE	Ongoing
Action 46: we will expand genomic testing for the BRCA1 and BRCA2 genes associated with higher lifetime risk of breast and ovarian cancer.	NHS Genomic Medicine Service	0-1 year
Action 47: we will accelerate access to new technologies.	DHSC/NHSE	0-2 years
Action 48: we will improve support for girls' physical and mental health. We will publish a Modern Service Framework for children and young people.	DHSC/ NHSE	0-1 years
Action 49: we will improve mental health support for women and girls.	DHSC/NHSE	0-3 years
Action 50: we will roll out a domestic abuse and sexual violence referral service across ICBs called "Steps to Safety".	DHSC/NHSE	Ongoing
Action 51: we will invest £5 million each year for victims and survivors of domestic abuse and sexual violence.	DHSC/NHSE	Ongoing
Action 52: we will invest up to £50 million to transform support for victims of child sexual abuse and exploitation across every NHS region in England.	DHSC/NHSE	0-3 years
Action 53: we will launch a new safeguarding learning programme for the entire NHS workforce in 2026.	DHSC/NHSE	0-1 years
Action 54: we will drive equitable access to medicines, moving towards a Single National Formulary for medicines within the next 2 years.	DHSC/NHSE	0-2 years
Action 55: we will expand our world leading prenatal genomic testing offer to provide vital information to women during pregnancy and to support reproductive decision making.	NHS Genomic Medicine Service	0-1 year
Action 56: we will invest £200 million in Healthy Babies to improve perinatal mental health, parent-infant relationships, and infant feeding support in 75 local authorities.	DHSC, NHSE	0-1 year
Action 57: we will reduce the leading causes of maternal mortality and morbidity.	DHSC/NHSE	Ongoing
Action 58: we will improve safety in maternity services.	DHSC/NHSE	Ongoing
Action 59: we will invest in improving our maternity and neonatal estate.	DHSC/NHSE	Ongoing
Action 60: we will improve postnatal support for physical and mental health in the community.	DHSC/NHSE	Ongoing
Action 61: we will improve responsiveness to cardiac risk in new mothers.	DHSC/NHSE	Ongoing
Action 62: we will restore the value of Healthy Start from April 2026.	DHSC/NHSE	0-1 years
Action 63: we will improve performance of pelvic mesh services and continue our work to confirm the redress scheme for victims of pelvic mesh.	DHSC/NHSE	Ongoing

We will support all women to lead healthy, prosperous lives

The decline in women's healthy life expectancy is symptomatic of a society where the healthy choice is not the easy choice; of a health system where disruptive preventative innovations like genomics and predictive analytics have not been harnessed; and where the social determinants of health continue to undermine people's lives and livelihoods.

As the 10 Year Health Plan outlined, we need a new approach. One that gives all women the tools and choices to lead healthy lives, through their life course. One where we equally seize the opportunity of the scientific and technological revolution presented by genomic insights, data and new technologies so that women have more agency and control, driving a totally new approach to prevention based on individual risk - with support to act on it where needed.

To do this, we'll act on 5 key areas. We will:

- empower women and girls with information and advice throughout their lives
- support girls and women to live more active lives and improve their diets
- support women to smoke less and reduce their alcohol consumption
- improve access to vaccination and screening
- embrace science and technology for prevention and women's autonomy

This shift to prevention cannot be delivered by the NHS striking out alone. For example, local councils are an important driver of action to improve the health of their population and reduce health inequalities. The role of the voluntary and community sector, and of industry, is also critical. As part of delivering this plan, we expect systems to continue working with local community groups in shaping the design of services, service provision, and ensuring that information and outreach is accessible and appropriate to diverse communities and those who are the most marginalised and experience some of the worst outcomes in society, such as females experiencing rough sleeping. And at national level we will partner with the voluntary and commercial organisations to improve outcomes for women and girls.

We will empower women and girls with improved information and advice

Women and girls consistently report that they do not have enough information about their bodies and their health, and only 1 in 10 women know all the signs of heavy periods[62]. Our engagement with experts and women with lived experience informing this strategy highlighted a lack of information and confidence as a key

[62] Wellbeing of Women. '"Just a Period": Calling time on heavy and painful periods'wellbeingofwomen.org.uk, page 10

challenge with real implications for women's long-term health. These include:

- heavy periods or pelvic pain can signify the early stages of treatable conditions which, if left unaddressed, worsen and become harder to manage[63]
- many women are not aware that menopause symptoms can be effectively managed through treatments such as hormone replacement therapy or overestimate the risks due to misinformation[64]
- misinformation about hormonal contraception and menstrual management leads some women and girls to use unreliable methods, resulting in unintended conceptions, unnecessary pain and heavy bleeding[65]

We are already addressing these concerns. Last summer the Department for Education (DfE) published revised statutory guidance on Relationships and sex education and health education in schools, covering women's health topics including menstrual health, premenstrual syndrome, heavy periods, endometriosis, polycystic ovary syndrome, and guidance for when to seek healthcare advice. To inform the way we provide information and design services so that women can make informed choices about their care, we have commissioned the NIHR Policy Research Unit in Reproductive Health to investigate how attitudes towards hormonal contraception are changing[66]. This is important because currently, it is unclear what is driving the changes in patterns of hormonal contraception use, how individuals weigh up these factors in their decisions or how best to effectively support them in their choices.

Alongside the improvements in access to information and advice via the NHS App set out in the digital services section above, we will go further to improve information and advice at all stages of life.

Action 64: we will launch a new programme to improve education for girls about their menstrual health.

We will invest an additional £1 million to support targeted work in schools and community settings to support girls' knowledge about menstrual health and when to seek healthcare, delivered in partnership with voluntary and community organisations.

[63] National Institute for Health and Care Excellence (NICE). 'Menorrhagia (heavy menstrual bleeding)' cks.nice.org.uk
[64] Barber K, Charles A. Barriers to Accessing Effective Treatment and Support for Menopausal Symptoms: A Qualitative Study Capturing the Behaviours, Beliefs and Experiences of Key Stakeholders. Patient Preference and Adherence. 2023;17:2971-2980.
[65] de Moel-Mandel C, Donnelly A, Bugden M, '"Do You Know What Birth Control Actually Does to Your Body?": Assessing Contraceptive Information on TikTok'. Perspectives on Sexual Reproductive Health. 2025;57(3):358-367.
[66] University College London (UCL). 'Understanding Contraceptive Attitudes and Decisions' ucl.ac.uk

Action 65: we will work with DfE to update the NHS resources for schools.

Updated resources will support young people to navigate the system so that they know where to seek help which can be customised by schools and their local partners.

Action 66: we will partner with voluntary sector and commercial organisations to share health information and advice and improve access to services for women and girls.

As part of this, we have launched our engagement exercise to explore new commercial partnerships with organisations who want to help deliver our vision for women and girls, with over 50 commercial and voluntary sector organisations joining our market testing events.

Action 67: we will introduce a menopause question into routine NHS Health Check this year.

The NHS Health Check is a free cardiovascular health check-up offered to 40 to 74 year olds without certain preexisting conditions. We are extending that to include a question about the menopause, helping benefit 5 million women by enabling them to access advice about the menopause and perimenopause more easily.

Action 68: we have - through the NIHR - launched a new funding call focused on how best to improve communication around women's health across the life course, particularly in underserved or marginalised communities.

This will generate vital evidence on strategies to promote health literacy, improve awareness of available support, and address cultural and structural barriers to engaging with health information.

Action 69: we will partner with women's health charities to provide improved advice and support for women with new diagnoses.

As part of our new Diagnosis Connect programme, women with new diagnoses will be referred to charities who will provide support ranging from provision of trusted information and advice through to more personalised and intensive support. In time, we will partner with charities supporting women with menstrual health and gynaecological conditions such as pelvic pain.

We will embrace science and technology to deliver a new approach to prevention

We are in the midst of a scientific and technological revolution which will transform women's outcomes and experiences. Our investments in genomics, data and artificial intelligence (AI) will offer women power - not just enabling pre-emptive care and informing decisions about treatment options if they fall ill but reshaping the way they can understand and act on their lifetime risk of major conditions so they do not fall ill in the first place.

This represents a wholly new approach to lifelong health. The potential benefit to health is huge, even if solely through empowering patients to manage their own health risks; half of participants in the 10 Year Health Plan public engagement

platform and 45% of a nationally representative survey identified easier access to their health record and personalised risk information as one of the top 3 things which would help them stay healthy[67]. This will particularly benefit women managing multiple responsibilities in their homes and personal lives who struggle to find the time to research their health risks and the ways they can better manage those risks.

Our world leading NHS Genomic Medicine Service supports women across the life course, with a focus on prenatal care and reproductive health, cancer, rare and inherited disease, and medicines optimisation inclusive of pharmacogenomics. We will expand and improve this offer for women, creating an entirely new prevention paradigm as we deliver the 10 Year Health Plan.

Action 70: we will improve cancer outcomes for women through expanding our NHS genomic testing offer.

The NHS will offer all cancer patients a comprehensive genomic analysis and molecular profiling to guide precision treatment decisions. This will include the use of non-invasive testing through the detection of circulating tumour DNA in suspected cancer types. This testing offer will include several conditions that affect women including breast, ovarian and other gynaecological cancers. Genomic testing will play an important role across many haematological malignancies in younger women to facilitate treatment approaches, and where possible, aim to preserve and optimise subsequent fertility.

Action 71: we will improve care for women with inherited diseases through genomic insights.

We will deliver NHS programmes addressing cancer risk: The Jewish BRCA Testing Programme offers testing to individuals aged 18 and over with one or more Jewish grandparents who receive NHS care in England with more than 28,000 delivered to date, identifying over 340 women with a pathogenic BRCA variant.

In addition, the Retrospective BRCA Testing Programme provides testing to women diagnosed with breast or ovarian cancer between 1995 and 2001 who would have met current eligibility criteria had genomic testing been available at the time.

We will continue embedding the Lynch syndrome programme, established to deliver more effective genomic testing and diagnoses through embedding robust testing pathways. Lynch syndrome affects about 1 in 400 adults and predisposes to multiple cancers that disproportionately affect women including endometrial, ovarian, colorectal and a range of other cancers.

[67] DHSC. 'Engagement insight report: 10 Year Health Plan for England, Chapter 5: the 3 shifts - analogue to digital' GOV.UK

Action 72: we will launch a new genomics population health service, building on our world-leading NHS Genomic Medicine Service and research infrastructure.

This service will integrate genomic testing, diagnostics, and AI analytics to identify and manage disease risk years before symptoms appear. This builds on transformation projects that have been funded in recent years to expand genomic testing at population level for inherited diseases that can have a significant impact on women, including BRCA, Lynch, familial hypercholesterolaemia and unexpected sudden cardiac death, and to undertake cascade testing in family members that may be at risk.

Action 73: we will start including genomic insights in common disease prevention and care.

We will use polygenic risk scores in conjunction with other frequently used risk tools such as QRISK to understand the population's risk of several diseases. This will initially be delivered through targeting high risk groups in the population based on the current evidence. We will then expand this to a trial with Our Future Health, focused on cardiovascular disease and - subject to evaluation - expanding to other areas including diabetes, breast cancer, osteoporosis and dementia. This will bring new insights and approaches to managing conditions where women are at higher risk or experience worse outcomes, and can help ensure that AI interventions avoid sex-based bias.

Action 74: we will improve medicines' effectiveness and safety through genomic insights.

Women are historically at higher risk of medicine-related harm due to their underrepresentation in clinical trials. A key part of the genomics population health service will be an expanded pharmacogenomics and medicines optimisation testing offer. This helps to predict how individuals respond to medicines, reducing adverse drug reactions and improving the effectiveness of medicines.

Action 75: we will deliver personalised prevention and risk management through digital tools.

We will develop a unified genomic record integrating genomic data with relevant clinical and diagnostic data. This will be linked to the Single Patient Record. Patients will be able to view a complete account of their risk of major conditions and manage their personal health risks through the NHS App, with the neighbourhood health service and community-based teams providing bespoke support to help individuals manage these risks.

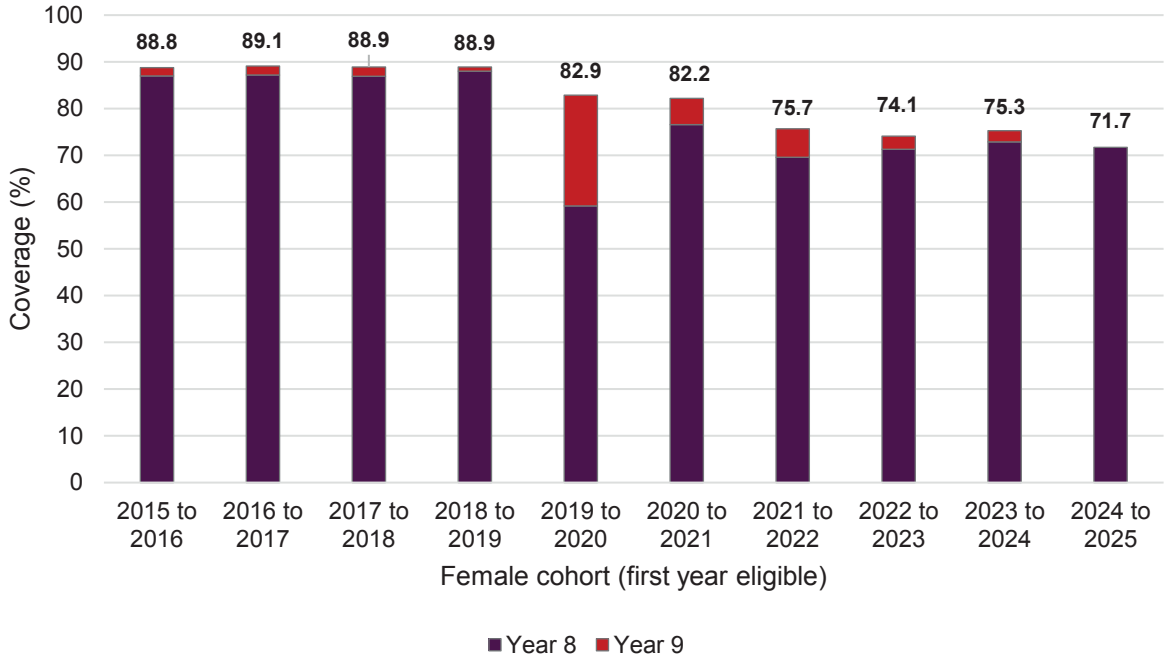
We will improve access to vaccination and screening

Screening and vaccination are some of the most important tools to maintain and protect health. Through our national screening programmes, around 10,000

lives are saved each year[68], while vaccines help prevent serious illness or death from a growing list of conditions including some cancers.

There are concerning signs that these essential preventative services are not reaching women adequately. Breast screening rates are lower than they were 10 years ago[69], while screening rates for breast, cervical and colorectal cancers in England are lower among women from ethnic minority groups[70]. High and equitable HPV vaccination coverage is essential in our aim to eliminate cervical cancer by 2040, but vaccine uptake remains lower than before the COVID-19 pandemic. Coverage among females in year 8 was 88.0% in 2018 to 2019 compared to 71.7% in 2024 to 2025[71].

Figure 3. HPV vaccine coverage for female students by school year of vaccination between 2015 to 2016 and 2024 to 2025 academic years



Note: due to missing data figure excludes year 10 vaccination coverage across all years and year 9 vaccination coverage in 2024 to 2025.

Source: UK Health Security Agency. 'Human papillomavirus (HPV) vaccination coverage in adolescents in England: 2024 to 2025' GOV.UK

[68] NHS England. 'Report of The Independent Review of Adult Screening Programme in England' england.nhs.uk
[69] DHSC. 'Fingertips Public health profiles - cancer screening coverage: breast cancer', fingertips.phe.org.uk. Accessed February 2026
[70] Chief Medical Officer. 'Health trends and variation in England 2025: a Chief Medical Officer report' GOV.UK
[71] DHSC. 'Fingertips Public health profiles - population vaccination coverage: HPV vaccination coverage for one dose (12 to 13 year old) (Female)', fingertips.phe.org.uk. Accessed February 2026

This is because these services are not designed for the diverse needs of women across the country. We will change that, delivering services that listen to women and are designed and led locally under our new devolved operating model, as well as investing in digital tools to improve convenience and agency:

Action 76: we will achieve our ambition to eliminate cervical cancer by 2040 as set out in the cervical cancer elimination plan for England.

This will be achieved though building on what is already working well to drive vaccination and screening uptake and coverage, including a focus on disadvantaged areas and underserved populations.

Action 77: we will make HPV vaccination available through local community pharmacies in 2026 for young adults who missed school vaccinations.

This will improve vaccine coverage and contribute to delivering our commitment to eliminate cervical cancer by 2040. These vaccinations also protect against 6 other rarer cancers that are also linked to HPV.

Action 78: we will roll out home testing kits for HPV this year to people who have never or rarely attended for cervical screening, reducing barriers to access and participation.

This new model is enabled by our reforms to the UK National Screening Committee to enable more targeted recommendations.

Action 79: we will offer all adult screening invitations, appointment reminders and results through the NHS App.

This will allow women to more easily and conveniently attend breast and cervical screening appointments, helping increase uptake and improve early diagnosis of these cancers.

Action 80: we are investing in digital infrastructure and technologies to improve screening performance and insights - beginning with breast cancer.

We will deliver a new a new cloud-based AI research screening platform to enable NHS trusts to securely join AI trials to speed up diagnoses much more quickly, safely and cheaply. The first use of the new platform is in breast cancer, with nearly 700,000 women across the country taking part in a world-leading study.

Case Study: trauma-informed multi-agency outreach and health support for vulnerable women in Peterborough

Peterborough has developed a multi-agency, trauma-informed model to support vulnerable women who are involved in prostitution and face intersecting vulnerabilities including substance use, homelessness, poor physical and mental health, and sexual exploitation. The approach brings together community outreach, a specialist primary care clinic, a women-only wellbeing hub, and dedicated supported housing. These services engage women who are often hidden from mainstream services and frequently cycle between homelessness, exploitation, and the criminal justice system.

The Wildflowers Clinic, launched in 2019, provides GP registration, rapid access to drug and alcohol treatment, harm-reduction interventions, cervical screening, contraception, sexual health services, smoking support, and broader health promotion in a safe, non-judgmental environment. A dedicated colposcopy clinic was later established to ensure seamless follow-up, supported by help to attend appointments and integrated laboratory pathways. Women have shaped service design through continuous feedback and engagement.

This coordinated model has significantly improved outcomes and experiences for women:

- cervical screening uptake increased from 19% in 2019 to 95% in 2024
- improved contraceptive access has resulted in zero unplanned pregnancies since 2020
- trust in services has grown, leading to increased reporting of crimes, including a major case involving a serial perpetrator
- overall engagement with health and support services has strengthened

This case study illustrates how sustained, partnership-based, trauma-informed support can improve health, enhance safety, reduce exploitation, and enable some of the most marginalised women to stabilise their lives and begin recovery.

We will reduce the biggest risk factors for lifelong health

Obesity is a risk factor for multiple women's health problems including increased breast and endometrial cancer risk, particularly after the menopause[72], as well as infertility and cardiovascular disease[73] [74]. More than half of women across all ethnic groups are overweight or obese, with higher rates among Black Caribbean, Black African, and Pakistani women[75]. There are rising levels of obesity in girls, with 2 in 10 year 6 girls now living with obesity, with the highest rates in the most deprived areas[76]. Among adult women, prevalence of obesity increased from just over 20% in the year 2000 to almost 30% of women in 2022[77].

Women are generally less physically active than men[78]. This gender gap begins in childhood, with girls already less active than boys from primary school age (52% of boys are physically active compared to 46% of girls aged 5 to 16 years)[79]. And it continues throughout their lives, impacting negatively on girls and women's mental and physical health. There are notable health inequalities: women from Asian, Black, and other ethnic minority groups are less likely to be active[80], while physical activity levels decline with age and are lower among working-class women and those without employment[81].

Women also face specific health risks as they age. Hormonal changes during the menopause increase the risk of osteoporosis[82], with resistance exercise providing important protection. After the menopause, obesity significantly increases the risk of breast cancer and endometrial cancer due to hormonal changes[83].

High-risk drinking - a risk factor for cancers and liver disease - remains a

[72] Oxford Population Health - Cancer Epidemiology Unit. 'Adiposity in early life, but not adulthood, may protect against breast cancer' ceu.ox.ac.uk
[73] Gautam D, Purandare N, Maxwell C and others. The challenges of obesity for fertility: A FIGO literature review. International Journal of Gynaecology and Obstetrics, 2023, 160(S1), 50-53.
[74] Zhou Z, Parra-Soto S, Boonpor J, and others. Exploring the Underlying Mechanisms Linking Adiposity and Cardiovascular Disease: A Prospective Cohort Study of 404,332 UK Biobank Participants, Current Problems in Cardiology, Volume 48, Issue 8, 2023, 101715.
[75] NHS England, 'Health Survey for England, 2024' Data tables, HSE 2024 Adult and child overweight and obesity tables, Table 8, calculated as sum of women for each ethnicity with a BMI over 25; digital.nhs.uk.
[76] DHSC. 'Fingertips Public Health Profiles - Year 6 prevalence of obesity (including severe obesity) (10-11 years), inequalities split by sex' fingertips.phe.org.uk. Accessed February 2026.
[77] DHSC. 'Fingertips Public Health Profiles - Obesity prevalence in adults, (using measured height and weight) (16+ years), inequalities split by sex' fingertips.phe.org.uk. Accessed February 2026
[78] Sport England. 'Active Lives Adult Survey November 2023-24 Report' sportengland.org
[79] Sport England. ' Active Lives Children and Young People Survey 2024-25 Report' sportengland.org
[80] Raliegh V. 'The Health Of Women From Ethnic Minority Groups In England' kingsfund.org.uk
[81] NHS England. 'Health Survey for England, 2021 part 2, Adult physical activity' digital.nhs.uk
[82] Birmingham Menopause Clinic. 'Menopause and the hidden risk of osteoporosis - Birmingham Menopause Clinic' birminghammenopauseclinic.com
[83] Oxford Population Health - Cancer Epidemiology Unit. 'Adiposity in early life, but not adulthood, may protect against breast cancer' ceu.ox.ac.uk

challenge even though less common in young adults than older adults (a reversal of the situation 30 years ago), and women and girls generally drink less than men and boys[84]. But women aged 16 to 24 and those aged 55 and over are drinking more than they were in 2019[85], with women in the least deprived areas and those aged 55 to 64 most likely to be consuming more than 14 units a week.

While deaths from most major cancers are declining, female deaths from liver and uterine cancers have both increased by over 10% since a decade ago, primarily due to obesity and alcohol use[86].

Fewer than 1 in 10 women now smoke[87], compared to 1 in 5 in 2011, but research published in 2024 suggests smoking rates among more economically advantaged women aged 18 to 45 increased somewhat between 2013 and 2023[88]. Smoking is the biggest cause of cancer[89], and smoking during reproductive age has additional risks to fertility, miscarriage and child health[90].

For some women such as those experiencing rough sleeping, these risk factors may be combined with other causes of harm, leading to some of the poorest outcomes in society. Nine in 10 women experiencing rough sleeping said they had some form of mental health need and 83% had at least one physical health condition in the past year[91] - and the average age of death for women who sleep rough is only 43 years, compared to 45 years for men[92].

Action 81: we will implement the policies within our obesity moonshot.

This includes protecting children from less healthy food and drink, and consulting on proposals to ban the sale of high-caffeine energy drinks to children under-16. And we will work closely with Defra as they develop a cross-government food strategy which will work to provide healthier, more easily accessible food to help both adults and children live longer, healthier lives.

Action 82: we will encourage and support women and girls to move more.

This includes supporting exercise at school age and participation in grassroots sport and continuing to invest in the NHS Better Health and BSiL suite of digital tools, apps and websites which are used

[84] NHS England. 'Health Survey for England, 2021 part 1, Adult drinking' digital.nhs.uk
[85] NHS Digital. 'Health Survey for England, 2024', Adults' health-related behaviours tables, Table 14, digital.nhs.uk
[86] Chief Medical Officer. 'Health trends and variation in England, 2025' GOV.UK, page 52
[87] DHSC. 'Fingertips, Smoking Prevalence in adults (aged 18 and over) - current smokers (APS) fingertips.phe.org.uk. Accessed February 2026
[88] Jackson, S.E., Brown, J., Notley, C. and others. Characterising smoking and nicotine use behaviours among women of reproductive age: a 10-year population study in England. BMC Medicine 22, 99 (2024).
[89] Harker, R and others. 'Statistics on Smoking' commonslibrary.parliament.uk
[90] Action on Smoking and Health. 'Smoking, Pregnancy and Fertility ' ash.org.uk
[91] Ministry of Housing, Communities and Local Government. 'Rough sleeping questionnaire 2025: Expanded findings on women' GOV.UK
[92] ONS. 'Deaths of homeless people in England and Wales: 2021 registrations' GOV.UK

by around 20 million people every year - predominantly women. These actions will build on the Sport England's This Girl Can campaign - the most recent phase of which was launched in late 2025 - to get women and girls moving more, and the Let's Move! campaign by DCMS to help keep families active together all year round.

Action 83: we will support women to smoke less.

We are delivering the landmark Tobacco and Vapes Bill to create the first smoke free generation, as well as cracking down on advertising and sponsorship of vapes and other nicotine products. And we will ringfence all funding for stop smoking services in the Public Health Grant. From April 2026 this ringfence mean at least at least £150 million per year will be protected for these services, providing funding certainty.

Action 84: we will introduce a mandatory requirement for alcoholic drinks to display consistent nutritional information and health warning messages.

This will improve and expand on existing voluntary guidelines for alcohol labelling.

Action 85: we will improve support for women sleeping rough.

We will - led by the Ministry of Housing, Communities and Local Government (MHCLG) - publish an outreach toolkit and a single homelessness and complex needs toolkit to support councils to deliver effective services, including for women sleeping rough, recognising the high levels of physical and mental ill health experienced by this group. These will set out best practice on service design, targeted outreach, accommodation pathways, including housing-led approaches such as Housing First, including guidance on engaging women in locations where they are more likely to stay overnight. We will continue to refine these tools using evidence from sources such as the Women's Rough Sleeping Census[93] and through engagement with multiple organisations.

[93] Single Homeless Project, 'Women's Rough Sleeping Census', shp.org.uk

Case study: an integrated approach to enhanced screening and management of syphilis infection in Manchester

Urban Village Medical Practice is a central Manchester GP practice with enhanced contracts to deliver a homeless healthcare service and contraceptive and sexual health services. The experience and expertise of the team enable it to identify and respond to emergent themes and deliver targeted interventions to some of the most excluded individuals in the city.

The team offers sexual health screening to homeless patients at the practice and in outreach settings. The team identified a 44% year on year increase in positive syphilis tests which disproportionately affects homeless women and women involved in prostitution. Left untreated, syphilis can cause severe and life-threatening complications. It can also be transmitted from an infected pregnant woman to a developing foetus.

Recognising the barriers that this patient group would face to accessing secondary care, the team forged relationships with the Genitourinary Medicine team at North Manchester General Hospital to facilitate consultant led treatment of syphilis in primary care. This relationship enables the team to jointly analyse results, formulate a treatment plan and deliver this in a way that is accessible to the individual.

As a result, 91% of individuals who may not otherwise have accessed screening or treatment have been fully treated for syphilis.

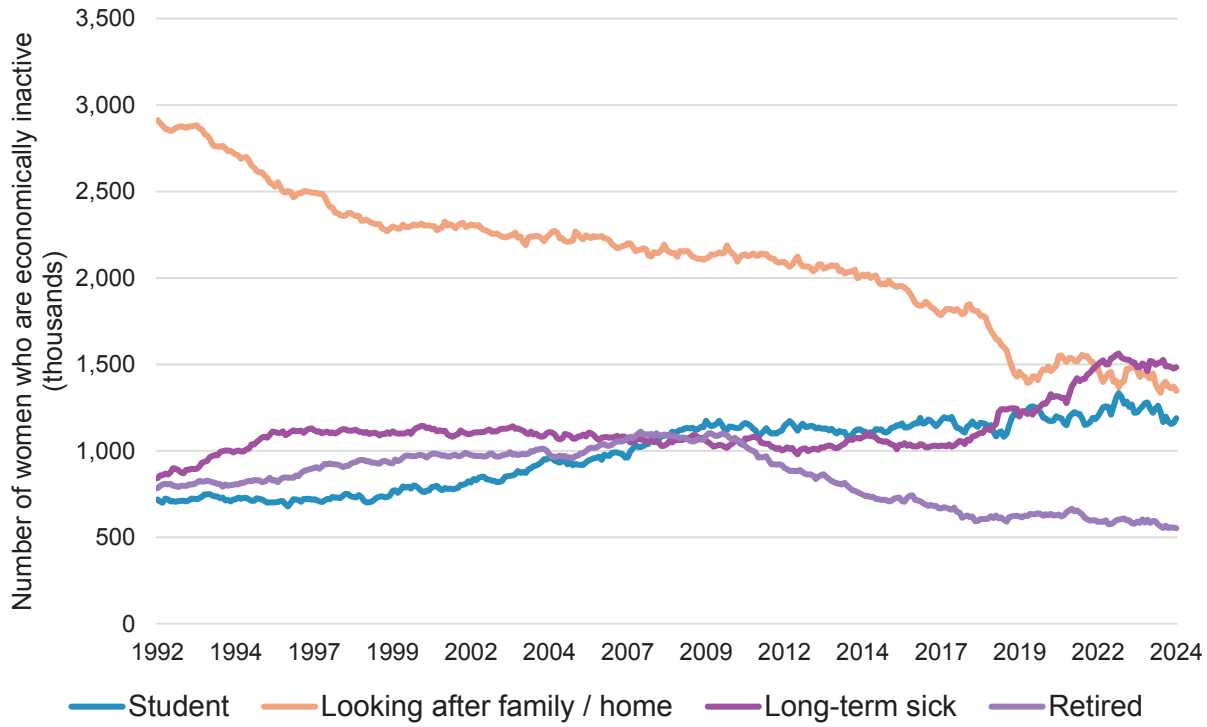
This innovative approach was recognised by the British Association of Sexual Health and HIV in 2025 when the team was selected to present at their annual conference and won the Cathy Harman award for innovation.

We will help more women enter and stay in work

Women face a range of well-known inequalities around work and pay. They are less likely to be in full-time paid work than men. They are more likely to be economically inactive - either because of caring responsibilities or sickness. Indeed, increasing numbers of women find themselves caring for both older relatives and children simultaneously. In turn, these factors contribute to the country's large gender pay gap[94]. Figure 4 below shows that whilst the number of women economically inactive due to looking after their family or home has decreased over the last 10 years, the number of women aged 16 to 64 who are economically inactive due to long term sickness has increased significantly since 2018.

While a health strategy cannot fix all these challenges – government is otherwise acting on the economic disadvantage faced by women through the Employment Rights Act 2025 including introducing enhanced dismissal protections for pregnant women and new mothers, minimum wage increases and expansion of free childcare - we can take far more decisive action on the

Figure 4. Trends in the number of women aged 16 to 64 who are economically inactive by reason, UK 1993 to 2025



Source: Office for National Statistics (ONS). 'ONS labour force survey, economic inactivity (aged 16 to 64 years) by reason' ons.gov.uk, Table INAC01

[94] Trade Union Congress (TUC). 'Equal pay day 2024 - tackling the gender pay gap' tuc.org.uk

significant contribution poor health makes to this inequality.

For example, the Institute for Public Policy Research Commission on Health and Prosperity[95] recently found that improved population health would both make a positive contribution to reducing the gender pay gap but would disproportionately reduce economic inactivity among women. This is indicative of the opportunity to simultaneously improve women's health - and their financial security, labour market experience and incomes. Specifically, we will:

- reduce economic inactivity due to sickness, by preventing the conditions that force women out of work
- act on the financial cost of sickness, by helping more women stay in work if they are diagnosed with a health condition
- take steps to improve the experience of unpaid carers, including through our digital and community shifts

Not only will these actions increase gross domestic product, but - because work is a health outcome - they will also improve population health in their own right.

We will do more to prevent the health conditions that cause economic inactivity

There is now excellent evidence on what health conditions drive economic inactivity. MSK conditions, cardiovascular disease, diabetes and poor mental health disproportionately increase the risk of leaving the labour market. Risk compounds as people are diagnosed with multiple conditions[96].

Women account for much of the recent rise in economically inactivity. They are, as this suggests, also more likely to be diagnosed with conditions that people who are economically inactive report.

- MSK conditions are more common in women than men[97]
- women are more likely to report experiencing common mental health conditions such as depression and anxiety (24.2% compared to 15.4%)[98]
- Prevalence of multiple, long-term conditions is higher in women compared to men[99] - and women are

[95] Thomas ,C and others, 'The final report of the IPPR commission on health and prosperity' ippr-org.files.svdcdn.com
[96] Thomas, C and others, 'Healthy people, prosperous lives: The first interim report of the IPPR Commission on Health and Prosperity | IPPR' ippr.org
[97] DHSC, 'Fingertips Public Health Profiles - Percentage reporting a long-term Musculoskeletal (MSK) problem (2024 version)', inequalities split by sex, fingtertips.phe.org.uk. Accessed February 2026.
[98]NHS Digital, 'Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/24. Chapter1: Common mental health conditions' digital.nhs.uk
[99] Valabhji J, Barron E, Pratt A, and others. Prevalence of multiple long-term conditions (multimorbidity) in England: a whole population study of over 60 million people. Journal of the Royal Society of Medicine, 2024;117(3):104-117..

more likely to have limiting longstanding conditions[100]

Prevention remains the most effective economic response to this challenge. If we can avoid someone falling ill, we can completely prevent the linked health-related economic harm. In tandem, we can boost growth, save the NHS money and prevent more people from relying on health-related benefits.

Action 86: we will deliver prevention accelerators with a focus on the drivers of economic inactivity.

These will be a partnership between the NHS, single or upper tier authorities and strategic authorities to trial new innovative approaches to prevention - supported by mayoral 'total place' powers, and advances in genomics and data. We will support these areas with increased autonomy, including supporting areas through exploring opportunities to pool budgets and reprofile public service spending towards prevention. We will be working with prevention demonstrators across England to scale up action to tackle cardiovascular disease.

Action 87: we will invest a further £25 million in health and growth accelerators in the financial year ending 2027.

These Accelerators trial new ways of working under an outcomes-based approach to reduce the conditions most impacting people's ability to work. Accelerators are focused on conditions which affect both men and women as well as a specific women focus such as the North East and North Cumbria Accelerator focus on reducing gynaecology waiting times, funding one stop shop clinics to speed up access, improve patient experience, and improve women's quality of life so they can participate in daily activities - including employment.

Action 88: we will expand WorkWell across England, backed by up to £259 million investment over the next 3 years.

WorkWell provides early intervention integrated health and work support for people with health conditions, including women's health conditions, so that they can get into work and stay in work.

Action 89: we will expand access to MSK hubs in the community.

We will leverage the leisure and fitness workforce to deliver evidence-based physical activity interventions for people with MSK conditions. This will be particularly beneficial for women given their higher risk of MSK conditions.

Action 90: we will expand the GIRFT MSK Community Delivery Programme.

This proven methodology will be deployed to reduce waiting lists for community MSK services, improve patient outcomes and reduce health related barriers to work.

Action 91: we will support girls' life chances.

Through our modern service framework for children and young people we will improve support for girls' physical and

[100] NHS England, 'Health Survey for England 2024', HSE 2024 Adults' health tables, Table 2; digital.nhs.uk

mental health. Addressing girls' mental health in adolescence is particularly important given the concerning rise in mental health challenges in girls as well as the increased economic inactivity among young women.

We will partner with employers to help more women with long-term conditions stay in work

Our investment in new service models including neighbourhood women's health services and NHS Online will provide easier access and faster action for conditions like endometriosis - which ONS analysis shows have a direct impact on employment and income[101]. We will act on these drivers of economic inactivity that particularly impact women.

On 1 April 2026, Mariella Frostrup was appointed as the government's Women's Employment Ambassador, building on her success over the past 18 months as the Menopause Employment Ambassador. In this expanded role, Mariella will champion women's health throughout their life course, working with employers across the country to strengthen workplace support, raise awareness of key health issues affecting women in work, and highlight the vital economic contribution of women.

We will also act to support women's health in the NHS workforce - where women make up three-quarters of staff[102]. This is crucial for improving staff experience and retention, reducing sickness absence, and addressing gender-specific health needs across the life course of women in the NHS workforce. This will boost productivity, prevent premature workforce exit, and ensure experienced talent remains in the service. And we will support our care workforce through new action on pay. This is particularly important for women as 78% of social care workers are women, representing 900,000 jobs[103].

Action 92: as part of the Keep Britain Working Review, we will partner with Vanguard employers to test how we can better support good health in work - with a focus on women's health across the life course as part of this.

Many Vanguard employers have expressed interest in women's health, so we will work with them to explore how to best support women's health and work outcomes.

Action 93: through the Employment Rights Act 2025 we will introduce new requirements on large employers (those with 250 or more employees) to publish an action plan outlining specific steps to address the gender pay gap and support employees going through the menopause, subject to secondary legislation.

Along with improving gender equality in the workplace, these plans will ask employers to set out how employees

[101] ONS, 'The impact of an endometriosis diagnosis on monthly employee pay and employee status, England: April 2016 to December 2022'. Ons.gov.uk
[102]NHS England. 'NHS Workforce Statistics - December 2025', NHS HCHS Workforce Statistics, Trusts and core organisations- data tables, December 2025. Digital.nhs.uk
[103] Skills for Care. 'The state of the adult social care section and workforce in England' skillforcare.org.uk

going through the menopause are supported, motivating employers to do more to support women going through the menopause to remain in work.

Action 94: we will expand our guidance for NHS organisations on supporting women's health at work

We will build on existing menopause guidance and explore what wider support may be needed for issues such as menstruation and endometriosis.

Action 95: we will make the NHS a more supportive employer.

We will roll out a set of staff standards this spring that will benchmark employers, through the NHS Oversight Framework, on the steps they are taking to promote good staff experience, tackling a range of issues that affect staff welfare and wellbeing including racism, violence in the workplace, sexual safety, as well as promoting supportive line management and working environments. All national policy and guidance in this area will be designed to drive strong local leadership, enabling employers to shape and deliver support that meets the specific needs of their own workforce. As set out in the 10 Year Health Plan, we will roll out staff treatment hubs to ensure access to high-quality support for occupational health including mental health and MSK conditions.

Action 96: we will support career development for the NHS workforce.

Our 10 Year Workforce Plan will focus on supporting staff to stay and thrive in their careers through better treatment, improved training, more rewarding and flexible roles, and a clear, hopeful pathway for long-term progression within the NHS.

Action 97: we will improve employee retention and service capacity in adult social care through the first ever fair pay agreement.

Through new powers introduced by the Employment Rights Act 2025 we are introducing a sector specific, collectively bargained fair pay agreement for the social care sector.

Action 98: we will support flexible working.

We are changing legislation through the Employment Rights Act to make it more likely that flexible working requests are accepted. These changes, which take effect in 2027, will require employers to accept flexible working requests where they are reasonable and feasible. This will particularly benefit women, who are more likely to be balancing unpaid care and domestic labour alongside their careers, and evidence suggests that women managing health conditions such as the menopause particularly benefit from flexible working.

We will do more to improve the lives of unpaid carers, recognising that unpaid and paid labour are linked

Women continue to undertake most of the unpaid care and domestic labour in this country. 61% of unpaid carers in the England are women - and women are

more likely than men to provide 35 hours or more unpaid care a week[104].

This reinforces economic inequality faced by women - pushing them to part-time instead of full-time work, undermining progression and embedding lower pay (including through a career). Research finds that the combined effect of being a carer and being female was over £10,000 a year reduced earnings[105].

The answer is not to create a society where no one cares for each other, or where we cannot rely on the support of family and loved ones. But we do need to reduce the level of unmet need that results in unpaid care; improve the effectiveness with which formal support services meet people's needs; and improve the quality of life for carers themselves.

We are already acting to do so: to support unpaid carers, last year the government increased the Carer's Allowance weekly earnings limit from £151 a week to £196 - the equivalent of 16 hours at the National Living Wage. This represents the largest increase in the earnings limit since Carer's Allowance was introduced in 1976. And through the Department for Work and Pensions we will improve and modernise the way Carer's Allowance operates, making it easier for unpaid carers to combine their caring responsibilities with paid work where they can, and rewarding them more for doing so. In addition:

Action 99: we will set out and deliver a vision for the future of adult social care.

Through the Casey Commission we will build consensus on how to develop a National Care Service that delivers a fair and affordable adult social care system.

Action 100: we will improve the way unpaid carers are involved in care planning.

As set out in the 10 Year Health Plan, we will mirror the inclusive practices of family and group conferencing, which are meetings where family, friends and unpaid carers agree decisions about care together.

Action 101: we will give carers more power and convenience through the NHS App.

When fully rolled out, the new My Carer function in the NHS App will allow people to securely prove they are providing care and access the app to book appointments and communicate with their loved one's care team. This will streamline carers' responsibilities while enabling them to seek advice or reassurance directly from professionals needed. This will be particularly helpful for women caring for older relatives who may struggle to manage this commitment around regular employment.

[104] Royal College of Obstetricians and Gynaecologists. Written evidence for the Women and Equalities Select Committee Inquiry into Reproductive Health, 2024/24. (PDF, 388KB)
[105] Wellbeing of Women. ' Just-a-Period-Calling-time-on-heavy-painful-periods-2025' wellbeingofwomen.org, page 10

Action 102: we will support unpaid carers to balance work and care.

We are reviewing the implementation of carers leave and looking at where any improvements may be needed to ensure that employment rights for unpaid carers are fit for the modern world of work. This review will be particularly relevant to women given their disproportionate likelihood of being an unpaid carer.

Helping women to live healthy, prosperous lives – summary of actions

Commitment	Responsible organisation	Timeframe
Action 64: we will launch a new programme to improve education for girls about their menstrual health.	DHSC/NHSE, DfE	0 to 2 years
Action 65: we will work with the DfE to update the NHS England resource for schools.	DHSC/NHSE, DfE	1-3 years
Action 66: we will partner with voluntary sector and commercial organisations to share health information and advice and improve access to services for women and girls.	DHSC/NHSE	Ongoing
Action 67: we will introduce a menopause question into routine NHS Health Check.	DHSC/NHSE	0-1 years
Action 68: we have - through the NIHR - launched a new funding call focused on how best to improve communication around women's health across the life course, particularly in underserved or marginalised communities.	DHSC-NIHR	0-1 years
Action 69: we will partner with women's health charities to provide improved advice and support for women with new diagnoses.	DHSC/NHSE	0-2 years
Action 70: we will improve cancer outcomes for women through expanding our NHS genomic testing offer.	NHS Genomic Medicine Service	0-1 year
Action 71: we will improve care for women with inherited diseases through genomic insights.	NHS Genomic Medicine Service	0-1 year
Action 72: we will launch a new genomics population health service, building on our world-leading NHS Genomic Medicine Service and research infrastructure.	NHS Genomic Medicine Service	0-1 year
Action 73: we will start including genomic insights in common disease prevention and care.	NHS Genomic Medicine Service	0-1 year
Action 74: we will improve medicines' effectiveness and safety through genomic insights.	NHS Genomic Medicine Service	2-3 years
Action 75: we will deliver personalised prevention and risk management through digital tools.	NHS Genomic Medicine Service	2-3 years
Action 76: we will achieve our ambition to eliminate cervical cancer by 2040 as set out in the Cervical cancer elimination plan for England.	DHSC/NHSE	By 2040
Action 77: we will make HPV vaccination available through local community pharmacies in 2026 for young adults who missed school vaccinations, as part of our efforts to prevent cervical cancer.	DHSC/NHSE	0-2 years
Action 78: we will roll out home testing kits for HPV to people who have never or rarely attended for cervical screening, reducing barriers to access and participation.	DHSC/NHSE	0-1 year
Action 79: we will offer all adult screening appointments through the NHS App to increase uptake	DHSC/NHSE	0-2 years
Action 80: we are investing in digital infrastructure and technologies to improve screening performance and insights.	DHSC/NHSE	0 - 5 years

Action 81: we will implement the policies with our obesity moonshot, including protecting children from less healthy food and drink, and consulting on proposals to ban the sale of high-caffeine energy drinks to children under-16.	Cross government	Ongoing
Action 82: we will encourage and support women and girls to move more, including supporting exercise at school age and participation in grassroots sport.	DHSC/NHSE, DfE, DCMS, Sport England	Ongoing
Action 83: we will support women to smoke less, delivering the landmark Tobacco and Vapes Bill to create the first smoke free generation.	DHSC/NHSE	0-2 years
Action 84: we will introduce a mandatory requirement for alcoholic drinks to display consistent nutritional information and health warning messages.	DHSC/NHSE	2+ years
Action 85: we will improve support for women sleeping rough.	MHCLG	0-3 years
Action 86: we will deliver prevention accelerators with a focus on the drivers of economic inactivity.	DHSC/NHSE	Ongoing
Action 87: we will invest a further £25 million in health and growth accelerators.	DHSC/NHSE	0-1 years
Action 88: we will expand WorkWell across England.	DWP	0-3 years
Action 89: we will expand access to MSK Hubs in the community.	DHSC/DWP	0-2 years
Action 90: we will expand the GIRFT MSK Community Delivery Programme.	DHSC/DWP/NHSE, GIRFT	0-1 years
Action 91: we will support girls' life chances. Through our Modern Service Framework for children and young people we will improve support for girls' physical and mental health.	DHSC/NHSE	0-1 years
Action 92: As part of the Keep Britain Working Review, we will partner with Vanguard employers to test how we can better support good health in work - with a focus on women's health across the life course.	DHSC/DWP/DBT	0-3 years
Action 93: Through the Employment Rights Act 2025 we will introduce new requirements on large employers (those with 250 or more employees) to publish an Action Plan outlining specific steps to address the gender pay gap and support employees going through the menopause.	DHSC/NHSE	2+ years
Action 94: we will expand our guidance for NHS organisations on supporting women's health at work.	DHSC/NHSE	0-1 years
Action 95: we will make the NHS a more supportive employer.	DHSC/NHSE	0-1 years
Action 96: we will support career development for the NHS workforce.	DHSC/NHSE	0-1 years
Action 97: we will improve employee retention and service capacity in adult social care through the first ever Fair Pay Agreement (FPA).	DHSC/NHSE	2+ years
Action 98: we will support flexible working.	DBT	0-2 years

Action 99: we will set out and deliver a vision for the future of adult social care.	DHSC/NHSE	3+ years
Action 100: we will improve the way unpaid carers are involved in care planning.	DHSC/NHSE	0-3 years
Action 101: we will give carers more power and convenience through the NHS App.	DHSC/NHSE	0-3 years
Action 102: we will support unpaid carers to balance work and care.	DBT	1-2 years

We will create an approach to research and development that works for and empowers women

Women have historically been left behind in clinical trials, with lower life sciences investment in some areas including pregnancy and women's health conditions such as heavy or painful periods, endometriosis and fibroids. This inequity harms women[106].

For example, clinicians have had less understanding of how women present with heart attacks[107] and some cancers due to variation in their presenting symptoms which reflect differences in women's underlying biology[108]. Women experience drug effects from Alzheimer medications differently to men and have a 1.5 times greater risk of negative side effects, however 72% of randomised controlled drug trials did not report any sex-specific outcome[109]. Excluding pregnant women from clinical trials due to safety concerns creates gaps in the evidence so that these women cannot access safe and effective treatments[110], or have to make decisions about treatments with insufficient evidence[111].

Women miss out on tests and treatments in a healthcare system that is not designed around their needs. A new and more equitable approach could improve their outcomes and experiences.

This is starting to change, with clinical research demonstrating the importance of reproductive and maternal health to wider health at all ages, including links to cardiovascular disease risk, metabolic disorders including type 2 diabetes, mental health and bone health. We are translating this knowledge into clinical practice and service models, including introducing a menopause question in routine NHS Health Check. But there is more to do to increase our understanding of women's health needs, accelerate the research to evaluate what works, translate that to changes in clinical practice and increase adoption of proven diagnostics and treatments to improve women's experiences and outcomes.

We know too that women's excellence and leadership in science and technology is too often held back by structural barriers and a system that does not reflect their contributions and roles, whether in the lack of career support and sponsorship or the additional challenges they may face raising growth capital from investors. While global investment in FemTech grew rapidly between 2016

[106] UK Clinical Research Collaboration. 'UK Health Research Analysis Report 2022' hrsconline.net
[107] British Heart Foundation. 'Bias and Biology - BHF' bhf.org.uk
[108] Lyratzopoulos, G. Abel GA, McPhail S, an others. 'Gender inequalities in the promptness of diagnosis of bladder and renal cancer after symptomatic presentation: evidence from secondary analysis of an English primary care audit survey' BMJ Open 2013;3:e002861.
[109] Alzheimer's Research UK. 'The Impact of Dementia on Women - Alzheimer's Research UK' alzheimersresearchuk.org
[110] Burrow R, Hinton L, Clarke M. Do pregnant people have opportunities to participate in clinical trials? an exploratory survey of NIHR HTA-funded trialists. Trials 2025;26(1):239.
[111] Vousden N, Haynes R, Findlay S, Horby P, Landray M, Chappell L and others. Facilitating participation in clinical trials during pregnancy BMJ 2023;380:e071278

and 2021, it only accounts for about 4 to 5% of digital health investment in recent years[112]. As with our NHS, this is another example of the system not working for women, holding back their opportunity and power.

To do so we are focused on 3 areas where the UK has particular strengths, in line with our 10 Year Health Plan innovation strategy - our research base, our innovative medtech industry supported by new government action to improve medtech adoption and spread, and our entrepreneurs in tech and life sciences. We will:

- ensure research benefits women from design to delivery
- direct and deploy technologies to benefit all women
- accelerate women's leadership in research and innovation

We will ensure research benefits women from design to delivery

We are investing in a range of areas that matter to women and address their needs.

Through the NIHR, the research funding arm of DHSC, we have been driving further focus on research to include and benefit women including issuing more than 20 funding calls in this government (since July 2024) , ranging from assessments of new therapies for women's health topics including menopause and polycystic ovary syndrome, research to address period poverty and menstrual support, and evaluations of interventions addressing VAWG.

We funded the first ever NIHR Challenge in 2025, focusing on tackling maternity disparities. This funding call, backed by £50 million over 5 years, brings together a diverse consortium, funding research and capacity building, with the aim of increasing the evidence base to address maternity inequalities[113].

Now we will go further to accelerate how we discover and develop new treatments and technologies for women.

Action 103: we will - through NIHR - spearhead the commitment to make research inclusive and representative, ensuring women are not left behind.

NIHR will continue their leadership in inclusive research through applying their new sex and gender in research policy, in addition to the inclusive design requirements already in place. This means that health and care research which should, but does not, take into account sex-based differences will not receive public funding from NIHR. Going forward, research will be representative of our diverse population, so that new diagnostics and treatments will be fit for purpose for women's health.

NIHR will monitor how well studies recruit diverse participants in line with the

[112] Sheffield Olympic Legacy Park. 'FemTech and the Future of Women's Health - Sheffield Olympic Legacy Park' sheffieldolympiclegacypark.co.uk
[113] NIHR. 'The NIHR Inequalities Challenge | NIHR' nihr.ac.uk

new sex and gender in research policy. NIHR is continually evolving its approach to research inclusion, which includes supporting researchers to meet these requirements.

Action 104: we will prioritise unmet areas of need for NIHR funded research.

This year NIHR published a portfolio of women's health research which showcases the range of investments that are unique or relevant to the health of women. This portfolio will help to assess funding gaps across specific topics and enable researchers to align their proposals with areas of unmet need.

Action 105: we will support new research to shape policy.

NIHR recognises the importance of supporting the NIHR Policy Research Unit in Reproductive Health - established in 2024 - to deliver research to better understand contraceptive attitudes and decisions, abortion care, and data for reproductive health. NIHR is extending the initial 3-year contract of the new Policy Research Unit in Reproductive Health until the end of 2028, to continue addressing evidence needs that can shape improvements in reproductive health and care practice.

Action 106: we have launched 2 new NIHR calls dedicated to women's health.

One call focuses on how best to improve communication around women's health across the life course, particularly in underserved or marginalised communities. A second research call considers interventions that support the health and wellbeing of women in the armed forces. Female service personnel and veterans experience a number of gender-specific stressors such as military attitudes towards menstruation and menopause, housing stability, and experiences of violence.

Action 107: we will launch NIHR's R&D Innovation Catalyst to provide wrap around support for high priority innovations, with R&D funding available across all translational phases of research if key milestones are met.

The Innovation Catalyst will connect innovators to appropriate NIHR infrastructure, venture capital funds, regulators, procurement processes and support for commercialisation. We will ensure the Innovation Catalyst considers women's health innovations throughout its operation, both for reproductive and pregnancy conditions, and by ensuring equity in its approach to innovations for any disease.

Action 108: we will make it easier for women to participate in clinical trials.

We will promote 'Be Part of Research' and integrate it with the NHS App, and in future offer automatic matching of patients to relevant studies based on their own health data and interests.

Action 109: we will deliver increased NIHR research funding on prevention, detection and treatment of long-term conditions.

This investment, alongside continued government-funded support for our globally leading research resources will underpin our science and technology enabled transformation and help identify new insights into the causes

of ill health in women. These resources enable research into conditions which affect the lives of millions of women.

This research includes an ongoing genomic epidemiological study of endometriosis using UK Biobank and a project using data from Our Future Health to explore how women's mental health is affected by reproductive transitions like premenstrual periods or the menopause. There is also ongoing research into severe pregnancy vomiting with the NIHR Bioresource, and the ground-breaking Generation Study offered to pregnant women through Genomics England, in partnership with the NHS, to improve our ability to diagnose and treat rare conditions in newborns.

Action 110: we will support development and adoption of new treatments for dementia, the biggest cause of female death.

Through the Dame Barbara Windsor Dementia Goals programme, we intend to set up a new public-private partnership to support the development and adoption of new treatments for dementia. This is complemented by the £50 million NIHR dementia trials network which is delivering a coordinated network of early phase dementia trial sites. This aspires to establish the UK as the go to place for early phase clinical trials by increasing access to early phase trials in an equitable manner, including improving patient and carer experience and joining up and strengthening current early phase trial infrastructure.

Additionally, we are acting on Baroness Casey's recommendations to ensure dementia is appropriately prioritised in research: we are reviewing dementia research and development opportunities and will ensure there is a new dementia leadership role in the new Department of Health and Social Care to drive forward action across the health and care system.

We will direct and deploy technology to benefit all women

In recent years there has been a significant expansion in new technologies aimed at women's health and wellness (FemTech)[114].

As new medicines are developed, improvements to the way NICE and the Medicines and Healthcare products Regulatory Agency work together will speed up access, ensuring that they can be adopted in a more streamlined way. Notably, access to health technologies will be supported through a suite of changes including introducing a new National HealthTech Access Programme and an innovator passport to reduce barriers to spreading proven technologies across the NHS.

However, given the longstanding inequity in access to finance and more widely a lack of focus on women's health as a priority area[115], there are limited

[114] Ellingurd, K. and others. 'Closing the women's health gap' mckinsey.com
[115] College of Sexual and reproductive Healthcare, 'APPG on SRH Report: Reducing Women's Reproductive Inequalities | CoSRH' cosrh.org

FemTech products with sufficient maturity of evidence to enable national evaluation, central funding, or supported rollout. Much of the market is direct to consumer or branded as wellness products, and there is a risk that growth in FemTech will not sufficiently address areas of unmet clinical need, and consumer adoption will exacerbate health inequalities. We will act to direct and support the development and deployment so that FemTech supports our shift to communities, addressing clinical challenges in women's health and reducing health inequalities.

Action 111: we will accelerate the deployment and spread of innovations that benefit women's health.

We will launch a FemTech healthcare challenge, with a pot of £1.5 million to provide grant awards to systems to work with promising FemTech developers addressing areas of unmet need, with a focus on community service models addressing health inequalities. This funding will enable systems and developers to buy products, and critically to free up clinical and management capacity to transform pathways and ways of working to ensure innovations can be adopted to benefit women and support NHS activity. The examples will be evaluated, helping FemTech developers generate the evidence needed to spread their products across the NHS.

Action 112: we will drive new research funding and innovation in women's health in areas of unmet need.

We will identify and set out opportunities for innovation to improve women's outcomes and experiences by transforming care. This 'demand signal' will bring together clinicians, researchers and others to identify and set development and research priorities for innovators and funders such as in wearables for women's health. This will build on our public research focus on unmet need by signalling to commercial developers and funders the specific areas of system interest for innovation and product development.

Action 113: we will support interventions that reduce potential inequalities in AI development and deployment, through the AI Ethics Initiative.

Partnerships, such as with the Health Foundation and other stakeholders, have helped us set standards for AI training datasets, promoting diversity and inclusivity so that technologies benefit all demographic groups - including women - in innovations like breast cancer detection.

Action 114: we will trial wearable technologies for women in areas of deprivation.

In the 10 Year Health Plan, we committed to work with innovators to launch trials for real-world evaluation and development of the next generation of wearable technology and provide devices for free in areas where health need and deprivation are highest. We will ensure some of the first studies evaluating wearables focus on the health of women, particularly in deprived areas, in detecting and monitoring cardiovascular disease.

Case study: women's health innovation in Dorset

In response to the National Women's Health Hubs Strategy, Dorset partners collaborated to transform women's health through integrated services, clinical training and improved access jointly shaping the programme which delivered system-wide and large-scale educational impact, expanded digital support, enhanced clinical pathways, and improved visibility of Dorset women's health.

The programme key impacts include:

- digital innovation driving reach and awareness:
    - the creation of an online resource website supporting thousands of Dorset women with evidenced based self-help, education and support
    - 5 digital apps uploaded to the Our Dorset ORCHA (Organisation for the Review of Care and Health Applications) library
    - 226 downloads from 4 menopause apps
    - 170 registrants adopted Squeezy app licence due to targeted campaign
- strengthened community engagement and support:
    - over 1600 responses to the digital women's surveys
    - 21 groups connected to the work which amplified Dorset women's under-represented voices including women's lived experience stories
    - 28,868 views to the online health resource and 8 podcasts providing support and increasing DWHP awareness

We will accelerate women's leadership in research and innovation

We want to create a system where female leadership in research, entrepreneurialism and technology is taken for granted. As a starting point we will support women's health and technology innovators.

Action 115: we will support female founders in health and care.

Through NIHR we will launch a new accelerator for female founders with innovations addressing women's health priorities. Our new programme will provide funding and support through a programme including mentoring and advice for entrepreneurs, market testing and access, scale-up and commercialisation models. This accelerator will build on the recent NIHR i4i THRIVE pilot for academic entrepreneurs and SBRI Healthcare Female Founders programme, a 6-month, tailored programme to support female founders and leaders in health and social care to be investment and scale-up ready.

Action 116: we will support women to enter, stay and lead in the UK's tech sector through the government's new Women in Tech taskforce.

The Women in Tech Taskforce will identify and dismantle barriers to education, training, and career progression. It will develop practical solutions for government and industry to implement side by side, shape policy that encourages diversity and levels the playing field, and drive sustainable and inclusive economic growth by expanding opportunities for women across the UK.

Action 117: we will collaborate with our international partners to support women's health innovation.

Through NIHR we are supporting development in the FemTech sector, including forming a new collaboration with the Indian Department of Biotechnology on FemTech Research and Innovation.

Creating an approach to research and development that works for and empowers women – summary of actions

Commitment	Responsible Organisation	Timeframe
Action 103: we will - through NIHR - spearhead the commitment to make research inclusive and representative, ensuring women are not left behind.	DHSC-NIHR	1 year
Action 104: we will prioritise unmet areas of need for research.	DHSC-NIHR	Ongoing
Action 105: we will support new research to shape policy.	DHSC-NIHR	0-3 years
Action 106: we have launched 2 new NIHR calls dedicated to women's health.	DHSC-NIHR	1 year
Action 107: we will launch NIHR's R&D Innovation Catalyst to provide wrap around support for high priority innovations, with R&D funding available across all translational phases of research if key milestones are met.	DHSC-NIHR	0-1 year
Action 108: we will make it easier for women to participate in clinical trials.	DHSC/NIHR/ NHSE	Ongoing
Action 109: we will deliver increased NIHR research funding on prevention, detection and treatment of long-term conditions.	DHSC-NIHR	5 years
Action 110: we will support development and adoption of new treatments for dementia, the biggest cause of female death.	OLS	4 years
Action 111: we will accelerate the deployment and spread of innovations that benefit women's health.	DHSC/NHSE	0-3 years
Action 112: we will drive new research funding and innovation in women's health in areas of unmet need.	DHSC/NHSE	0-3 years
Action 113: we will support interventions that reduce potential inequalities in AI development and deployment, through the AI Ethics Initiative.	DHSC/NHSE	Ongoing
Action 114: we will trial wearable technologies for women in areas of deprivation.	DHSC-NIHR	0-2 years
Action 115: we will support female founders in health and care.	DHSC-NIHR	0-1 year
Action 116: we will support women to enter, stay and lead in the UK's tech sector through the government's new Women in Tech taskforce.	DSIT	0-1 year
Action 117: we will collaborate with our international partners to support women's health innovation.	DHSC-NIHR	Ongoing

How we will measure success

As set out at the start of this strategy, we are guided by 3 overarching success measures:

- reverse the decline in healthy life expectancy seen in the 2010s
- improve healthy life expectancy in the poorest regions to a minimum of 61 years
- reduce the time women spend in poor health, especially for women experiencing the greatest health inequalities

We will also measure progress against our ambitions in this strategy through a range of measures reflecting women's access to, experiences of and outcomes from health promotion and health services. In the medium term we will use existing measures which are available and reflective of changes, and in the longer term draw on additional measures which will become available or which are only measurable over longer periods.

Medium-term success will be measured by:

- improvements in screening rates, particularly among the most deprived women
- progress against our target for HPV vaccine coverage (alongside cervical screening) to eliminate cervical cancer by 2040 and protect against several other cancers, including vaginal and vulval cancers
- improvements in women's access to general practice
- reducing the time women spend on gynaecology elective waiting lists
- increasing access to treatments in the community such as intrauterine devices
- reducing the gaps in LARC prescriptions between richer and poorer areas

Longer-term success will be measured by:

- increased confidence among women and girls in managing their own health, using patient reported data collected through the app
- reducing the number of women with unmanaged long-term conditions, poor nutrition, or health behaviours that increase risk, especially pregnant women
- reducing inequalities in maternity outcomes
- reducing time to diagnosis for some gynaecological conditions, for example cancer, endometriosis
- improving outpatient appointment waiting times for women
- improvements in self-reported experience of gynaecological procedures
- reductions in teenage conception rates
- reducing economic activity due to ill health in women

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