House of Commons

Women and Equalities Committee

Oral evidence: Menopause and the Workplace, HC 91

Tuesday 20 June 2023

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Watch the meeting

Members present: Caroline Nokes (Chair); Dame Caroline Dinenage; Carolyn Harris; Kim Johnson.

Questions 218 – 304

Witnesses

I: Helen Tomlinson, Menopause Employment Champion and Head of Talent (UK and Ireland), The Adecco Group; Maria Caulfield MP, Minister for Mental Health and Women's Health Strategy and Minister for Women, Department of Health and Social Care; Mims Davies MP, Minister for Social Mobility, Youth and Progression, Department for Work and Pensions; Natalie Keogh, Deputy Director, Labour Market, Carers, Ethnic Minorities and 50+ Choices, Department for Work and Pensions; Marian Holliday, Deputy Director, Acute Care Policy, Department of Health and Social Care.

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Examination of Witnesses

Witnesses: Helen Tomlinson, Maria Caulfield, Mims Davies, Natalie Keogh and Marian Holliday.

Chair: Good afternoon and welcome to this afternoon's meeting of the Women and Equalities Committee and our follow-up session on the menopause. Can I thank the witnesses for coming? We have Maria Caulfield, Minister for Mental Health and Women's Health Strategy, Mims Davies, Minister for Social Mobility, Natalie Keogh from the DWP, Helen Tomlinson, the menopause employment champion, and Marian Holliday from the DHSC. I am assuming I have got that right. Thank you very much. Members of the Committee will ask you questions in turn, and we are going to start with Kim Johnson.

Q218 **Kim Johnson:** Good afternoon, panel. The first question is to Maria. I wanted to know whether you could give us a brief and concise update of the work of the menopause taskforce to date.

Maria Caulfield: The menopause taskforce was set up to look at all sorts of issues around the menopause. It is cross-departmental, so Mims attends it, as well as Ministers from the Business and Education Departments. Carolyn is its co-chair. It is there to look at all issues related to the menopause. One of the first issues that we looked at was the HRT prepayment certificate. We have looked at issues around the workplace in particular, and we are meeting this week to follow up on progress on those issues.

Q219 **Kim Johnson:** Can I also ask how effective you think the taskforce is, given that it was scheduled to meet every two months? Can you tell us when it last met?

Maria Caulfield: The taskforce was set up on the back of Carolyn's private Member's Bill to meet regularly. I do not think that it was set up to meet every two months. It was a regular meeting. In between, I stopped being the Minister for Women. I am now back as the Minister for Women and intend for it to meet more regularly.

Q220 **Kim Johnson:** Does the frequency with which the taskforce has met inspires confidence that the Government take the menopause seriously?

Maria Caulfield: Absolutely, yes, because the taskforce is one meeting, and most of the work goes on behind the scenes. Carolyn is co-chair and can call a meeting at any time. It is similar to the maternity disparities taskforce, which I also co-chair with the previous chief midwifery officer, who just recently left, so we will have a new co-chair starting quite soon.

No Government have done more on the menopause than this one. If you look at the work that we have done to reduce the price of HRT for women in England, we introduced the prepayment certificate in April. That is currently saving women hundreds of pounds a year on the cost of hormone replacement therapy.

If you look at the work that we are doing in rolling out women's health hubs, women have a one-stop shop to go to for a life-course approach to health, where menopause advice can be given. Look at the work that we are doing on reliable information; we are launching a women's health portal on the NHS website, where menopause will be a feature, so women can go there for reliable information.

Look at the work that we are doing in the workplace as well in terms of introducing flexible working; women going through the menopause in particular will, rather than drop out of work, have more flexibility.

That is just the tip of the iceberg of the work that we are doing on the menopause. I do not think that anyone could say that we are not taking it seriously.

Q221 **Kim Johnson:** Thanks for that update, Maria. I would maybe like to ask Helen some of those questions that I have just asked in terms of the taskforce and how effective you think it has been.

Helen Tomlinson: As the Minister said, it is an aspect of the work that we are doing. In line with the approach that I am taking as the menopause employment champion and some of the work that we plan to do moving forward, there is definitely some synergy there. I am attending the taskforce this week to make sure that there is not duplication and that we are aligning the work we are doing.

Q222 **Chair:** Maria, you just mentioned the introduction of flexible working. What legislative steps are being put in place to do that?

Maria Caulfield: As you know, the Government are taking forward legislation to give employees the right to request flexible working from day one. That does not sit with the Health team, so other Ministers are taking that legislation forward, but we are absolutely the first Government to be able to work towards that. That is alongside our support for the Employment Relations (Flexible Working) Bill as well, which will make additional changes for the right to request flexible working.

Q223 **Chair:** Do we have a timetable for when we expect that Bill to be enacted?

Maria Caulfield: Again, this does not sit under the Health and Care team. It is under a different Department. I can certainly contact the relevant Minister and ask them for an update on the timescale for that.

Q224 **Chair:** Mims, can you help with that?

Mims Davies: I cannot, but I have pushed and I understand that it is when parliamentary time allows. There is a next Session coming at some point, I presume. Like Maria, we are all very keen to see when that is, but it is not under our auspices—if only.

Chair: We are all very conscious here that that was in the Queen's Speech of 2020, and we are still waiting.

Q225 **Carolyn Harris:** Minister Caulfield, when the Minister for Women and Equalities was last with us quite a few weeks ago, she equated menopausal women wanting greater protections in the workplace to people wanting protected characteristics for short people, carers and people with ginger hair. Do you agree with that?

Maria Caulfield: As you will know, I am very passionate about improving the rights and the experience of women, particularly in the workplace. We know that so many women who are going through the menopause drop out of the workplace completely. We absolutely want to make sure that women have a more responsive workplace and that there is flexibility in that workplace, whether that is within hours, whether that is within the working environment, or whether that is taking some time out. We absolutely want to support women and employers to do that. The evidence that we will show under questions shows that we are the first Government to try to introduce those changes.

Q226 **Carolyn Harris:** I will ask again. Do you agree with the Minister for Women and Equalities when she equated women wanting greater protection for menopause in the workplace to people wanting protected characteristics for being short, for being ginger or for being carers?

Maria Caulfield: You have taken her response out of context.

Carolyn Harris: I can read it to you, if you like.

Maria Caulfield: I did watch the session, and my understanding is that she is not supportive of introducing a separate protected characteristic for the menopause. That does not mean that she dismisses the experience of women going through the menopause in the workplace.

Q227 **Carolyn Harris:** She said, "We have so many things that people ask to be protected characteristics: carers, single people, having ginger hair, being short. We have all sorts of things that people ask for as protected characteristics", "That would require far more resources than encouraging employers in terms of changing their work culture and demonstrating where the guidance is and lessons learned", "This is a philosophical perspective that we are arguing over. We can go over it until time ends. You are speaking from a left-wing perspective on creating something. I am speaking from a centre-right perspective".

I ask again. Do you agree that women with menopause asking for greater protections in the workplace is similar to having protected characteristics such as being short, having ginger hair or being a carer?

Maria Caulfield: You have just read out the quote, which confirms the answer that I have just given. The Secretary of State was talking about the issue of protected characteristics. That is not in relation to the experience of women in the workplace. They are two very different things.

Q228 **Carolyn Harris:** Can we go on to the NHS restructure? I am very concerned that the women's health strategy is asking for quite a lot from

the NHS, and yet we know that it is about to reduce its workforce by 30% to 40%. How optimistic are you that everything that you have asked for in the women's health strategy is going to be able to be delivered with a much reduced workforce?

Maria Caulfield: That is not my experience. We are putting extra numbers into women's health. In the Department, we have prioritised women's health, so there are more people working on women's health issues, whether that is on the menopause or on maternity, than has been the case previously. Only yesterday, I met with the chief nurse, Ruth May, to discuss what resources she and her team need in order to be able to roll out the key priorities in the women's health strategy.

We are absolutely committed to delivering on the key priorities. We set out eight for the first year. We are about to announce our second-year priorities as the first Government ever to have a women's health strategy in this country.

Q229 **Carolyn Harris:** So you are not worried about the public awareness campaign that will not be able to be delivered.

Maria Caulfield: There is a public awareness campaign. I strongly disagree. The number of women taking HRT has gone up by 30% in the last year. That is because women are more aware of the availability of HRT. Only this summer, we will be launching the women's portal on the NHS website, which is the go-to place for women to be able to get reliable information and support about their health. We are also rolling out £25 million into women's health hubs. That money is just about to be distributed to every integrated care board in this country.

Q230 **Carolyn Harris:** So you are not concerned at all that this restructure of NHS England will have any impact whatsoever on the rollout of women's health.

Maria Caulfield: Women's health is a key priority of this Government. I have been quite clear that I met with Ruth May, who is the chief nurse and who leads on these issues, to see what extra resources she needs to deliver that. In the Department, we have increased our resources in women's health. There are more members in the Department of Health and Social Care working on women's health issues and on maternity issues than there were previously. They are the key priorities in my portfolio that we are delivering on. If you look at the eight priorities that we announced in the first year, we have delivered nearly every single one.

Q231 **Chair:** Can I just ask a question on the health hubs and the portal? You said the summer for the health portal. We are probably in meteorological summer now. Do you have any specific timescale?

Maria Caulfield: My understanding is that we are going live in July. It is been trialled with women at the moment. The site is ready, but we are doing service user testing to make sure that it has the information that

women want and would find useful. That will be updated on an ongoing basis, so what we start with will be added to as time goes on.

Chair: So that is just going through a testing process and is imminent.

Maria Caulfield: Yes.

Q232 **Chair:** When do you expect the first of the women's health hubs to be open?

Maria Caulfield: I am going to visit Hackney on Thursday of this week, where they already have a women's health hub up and running. There is one already in operation in Liverpool. Every ICB should get its money in the next few weeks. It will then be for each individual ICB to identify what it will provide. Dame Lesley Regan has given them a spec of what she expects a women's health hub to have as a minimum.

Q233 **Chair:** If she has done the spec, it is not like they are being told that they have to model themselves on Hackney, for example. It will be tailored.

Maria Caulfield: No. She has given them some minimum spec, and each local area will decide what they want to do with that. Some will start up a brand new service. Others will have a service that they want to expand. For others, it may be that there are existing services that they will be able to build on. We are not being prescriptive as to what they will look like, and they do not necessarily have to be in a purpose-built building, but what we do know is that, where they are in existence already, they are making healthcare more accessible for women.

Q234 **Carolyn Harris:** Coming to the cost and supply of HRT, how successful was the rollout of the PCC?

Maria Caulfield: It has been pretty successful. It went live on 1 April. We estimated that about 400,000 women could benefit from a prepayment certificate. We made it really clear at the start that, if women had an existing prescription, they should not buy their prepayment certificate on day one, because it lasts for 12 weeks. If they had two or three months left of their prescription, they would lose out on two or three months of their certificate, so we still have more women purchasing these all the time. To date, we have had 253,000 prepayment certificates purchased. Most of those have been online, but we have had nearly 11,000 bought in pharmacies up and down the country.

Q235 **Carolyn Harris:** There was some confusion when it came out in terms of what products were on the list. I know the answer to this, Minister, but could you share with us any updates on products that were not on the list but now will be?

Maria Caulfield: We have been pretty clear that there are some products that have to be on the list in order to be covered by the PCC. They have to be an HRT product licensed for the treatment of the menopause, so things like testosterone, which is not currently licensed

for the menopause, would not be covered. They need to be hormonal in nature as well, so other medicines that may benefit symptoms of the menopause but are not hormonal are not covered. They also need to be licensed and approved.

In May, we had two new products that have come into scope of the certificate, which are Livial and Intrarosa. They were added at the end of May. It is an ongoing process. If, for example, testosterone was suddenly licensed for use for the menopause, it could come under scope. It is not a fixed list; it will move as products change.

Q236 **Carolyn Harris:** I was led to believe that testosterone would go on the list once it was licensed.

Maria Caulfield: Yes, if it got a licence.

Q237 **Carolyn Harris:** There would not be any problem. If it is licensed for menopause, testosterone would be on that list.

Maria Caulfield: Yes, but that was a decision for the MHRA, not for Government.

Q238 **Carolyn Harris:** What steps are you taking around shortages? We know that one particular product is extremely short at the moment, so what work are you doing to ensure enough product?

Maria Caulfield: We are in a much better place than we were this time last year. There are about 70 products in the UK that are available for the menopause. This time last year, we had about 19 products that had what is called an SSP—a serious shortage protocol—which means that we reduce the number of packs dispensed at any one time, stop it being shipped out of the country, and notify pharmacists and GPs about potential replacements that could be issued instead.

A lot of work has gone in since then, working really closely with manufacturers and suppliers, and the medicines team at the Department has been doing huge amounts of work. We are now down to two items that are under an SSP—Progynova, which is a patch, and Utrogestan, which are capsules. We have been working really closely on that with the suppliers. Progynova should be back in supply in September this year. The supplier of Utrogestan is having peaks and troughs in the supply that it is able to deliver. In March, it gave a huge increase in supply. It is in a less good place at the moment, but it estimates that, by September, it should have a more stable supply and that women will not be experiencing that peak and trough of whether it is available or not.

Q239 **Carolyn Harris:** There is not an alternative progesterone product, so do you feel that enough work is being done in warning women that they should not be taking the oestrogen gel without the progesterone tablet? One without the other is extremely dangerous.

Maria Caulfield: We are contacted all the time by women who make the point to us themselves that they cannot take their oestrogen because

Utrogestan is not available. When we issue the SSPs, the alternatives are set out, but we are also looking to give further guidance to GPs around that in terms of the timescales between now and September, when we should have a much more stable supply.

Q240 **Carolyn Harris:** Are you recommending an alternative to oestrogen and progesterone mixed? No woman who has contacted me has been offered an alternative. They are in a situation where they either cannot take their oestrogen, because they cannot get the progesterone, or they are self-medicating by reducing their progesterone, because they do not understand the problems of not being able to take one without the other.

Maria Caulfield: It is clinical advice. I cannot say, here and now, what replacement hormone therapy women should be taking. That is a clinical decision. When we issue the SSPs, the clinical advice that goes with those to GPs and pharmacists states what alternatives could be given, but we are looking at giving further advice to GPs so that they know that, between now and September, that advice needs to be given.

Q241 **Carolyn Harris:** It would mean that a woman would have to come off that regime and go on to a completely different one without the progesterone, because there is no alternative to progesterone, so you have a situation where they cannot take their HRT.

Maria Caulfield: We are working with the manufacturer in between to try to improve that supply. They introduced extra supply in March of this year, and they are now feeling pressure on that as well. The medicines team is working with the supplier, because the ideal solution is to get the progesterone in good supply across the country. The SSP is having an effect. It limits the amount of drug that can be dispensed at any one time and tries to even distribution across the country, but the supplier is very aware of the demand and is trying to improve that before September.

Q242 **Carolyn Harris:** Why not introduce a national formulary, so that every product is available everywhere?

Maria Caulfield: There is no restriction across England for any prescribing GP to be able to prescribe any licensed medicine that is approved by NICE for NHS use and is licensed by the MHRA as a hormone replacement therapy. Some areas have national formularies, and prescribers are encouraged to prescribe from that, but that does not stop any prescriber from prescribing from what is available nationally.

Q243 **Carolyn Harris:** I understand that, and we both know that, but we both also know that doctors do not prescribe from the local formulary. Any doctor who you speak to will say that, if it is not on the local formulary, they do not have the time or the inclination to go off that and to look for alternative products. Given that there is a shortage, why not introduce, even for a temporary pilot, a national formulary so that every product is available to every woman right across the UK?

Maria Caulfield: They are available now.

Q244 **Carolyn Harris:** But they are not being prescribed. We know that. We have been at meetings together, Minister, where doctors have told us that they are not prescribing off the local formulary, so why not make it evident that they are allowed to make more noise about it?

Maria Caulfield: When we have looked into this and NHS England has given advice, it has not felt the need to do that, because it feels that, at the moment, those drugs are available to be prescribed and dispensed. There is no evidence that, when there is a national shortage of something like Utrogestan, a national formulary improves that supply. That is the key. We want to get that drug on to the shelves of pharmacies and dispensed to women. Our priority is working with the suppliers to be able to do that. The information that they have given us is that, by September, we will be in a much better place.

Q245 **Carolyn Harris:** When was the last time that you had a roundtable with the pharmaceutical sector?

Maria Caulfield: We have had five roundtables with suppliers, wholesalers and pharmacists to discuss this. One was held fairly recently, and we have a sixth one in the pipeline.

Q246 **Carolyn Harris:** Do you attend those?

Maria Caulfield: I attend some but not all of them.

Q247 **Carolyn Harris:** When was the last one that you attended?

Maria Caulfield: I would not be able to tell you the exact date.

Carolyn Harris: Thank you. I will come back later on other questions.

Q248 **Chair:** One of the concerns that we heard from Kate Muir when she came in was that women were not getting adequate advice around the problem of not taking progesterone when you were still taking oestrogen. There seemed to be a really mixed picture, with even some medics giving out the advice to just keep taking the Oestrogel. What is the Department doing to make sure that there is a really robust message around the dangers of taking oestrogen without progesterone?

Maria Caulfield: I will turn to Marian, because we are in the process of offering and publishing some more advice to GPs, which will give that message around the importance of taking both together and not one without the other. It also goes to the greater point of better training for GPs, and NHS England is doing a huge amount of work on this. This is why the women's health hubs are so important, because, if a woman is going to a women's health hub, where you have healthcare professionals—not just doctors but nurses and others—trained in areas such as the menopause, they will be able to give that bespoke advice. There is a huge piece of work going on in terms of improving education around GPs.

Marian, did you just want to update on the advice that we are looking to give to GPs while the supply issue around Utrogestan is in place?

Q249 **Chair:** Before you do, Marian, can I just remind everybody that there was a recommendation from this Committee that there needed to be more training for GPs?

Maria Caulfield: We are rolling that out.

Marian Holliday: As the Minister has said, we are talking to NHS England about issuing a bulletin to primary care staff around the importance of reminding women to follow the doctor's instructions on how they take their HRT.

Q250 **Chair:** So there was a bulletin. Is there enough urgency around that? It was March when we heard from Kate.

Marian Holliday: A bulletin can go out pretty quickly.

Q251 **Chair:** It could have gone out in March, when this Committee was certainly first made aware that the advice was not great. I would just make the point that this is women's health. We want there to be an element of urgency to it.

Maria Caulfield: When the SSP is issued, that advice is also given. If we are hearing from women that either that advice is not being passed on or they are not feeling that they are getting the information that they need, that is when we follow up with a bulletin.

Q252 **Chair:** Can I have some clarity? Is the SSP issued to pharmacists or to GPs?

Maria Caulfield: It is issued to both. GPs are given information about what to prescribe in the first place, and pharmacists are then given information about what to dispense. If they do not have the alternative that the GP has just prescribed, or if they feel that that alternative needs reviewing, the pharmacist then has some leeway in what they can dispense to the patient or go back to the GP for clarification.

Q253 **Chair:** Marian, to whom is the bulletin issued—GPs, ICBs or pharmacists?

Marian Holliday: It is a primary care bulletin that NHS England issues. I am not sure of the exact specifics, but it is across its network of primary care providers, which would include pharmacists as well as GPs.

Q254 **Kim Johnson:** Maria, can you confirm whether your Department has been working with the Department for Education to develop high-quality teaching resources to ensure that all pupils are being taught about the menopause? Subsequently, is there any risk that the RSHE review might remove teaching about the menopause from the curriculum?

Maria Caulfield: We are absolutely working with the Department for Education. It is part of the RSE curriculum that boys and girls learn about women's health and the menopause in particular. It is important that boys as well as girls learn about it, because they will learn about mums, aunties, future partners and women in the workplace in terms of the sorts of impact that the menopause has.

I am not concerned that the review around the curriculum on the education will impact that, because the discussion that we are having around women's health with the Department for Education is that we want to expand the teaching on this, and also, with my other portfolio hat on, around mental health. We are having very constructive discussions with DFE.

Q255 **Kim Johnson:** Have you seen any copies of the resources that are used in schools in terms of informing pupils about the menopause?

Maria Caulfield: I have not seen what is being used, but I know that that is very topical at the moment in terms of parents also asking for materials that are used. It is down to each school in terms of the specific material that they use, but guidance is given as to the topics to be covered.

Q256 **Kim Johnson:** Would you be aware of how effective the training is during RHSE in terms of the teaching of menopause in schools?

Maria Caulfield: This is just being rolled out, so we are in the very early days. We hosted a follow-up roundtable in No. 10 with women around the women's health strategy. We had a wide group of women who felt that it was so important that it is taught as early as possible. The women's health strategy is a life course approach, so we do not want to pigeonhole women into the menopause or into starting their periods and having issues with endometriosis.

We want women to be aware of what changes are likely to happen across their whole lifetime. The menopause is an important part of that, but also part of that teaching is what a healthy period looks like, when you should be going to see your GP if you have heavy, painful periods, what endometriosis looks like, and when you should be thinking about pushing back and asking for more help. There are lots of things that we want young women and girls to be aware of. The menopause is just one of those.

Q257 **Kim Johnson:** Mims, are you confident that all areas of Government and other public services are sufficiently aware of the issues affecting women going through the menopause to enable you to work effectively with them in this area?

Mims Davies: Yes, but I am conscious that the Committee is talking about working at pace, and we all feel that. We should all be pushing to do more. Have we got it all right? Have we got all the answers in place? No. In fact, for some areas, some workplaces and some sectors, this is the start of the conversation. The Chair and I were recently at the university in Southampton, and some of the women at the table were in sectors where it is quite a big invention for this kind of conversation to be happening in the workplace.

It really does matter to me and my Department, because 65% of my workforce of not far off 90,000 people are women. Day in, day out, they

need support and good policies. We are seeing too many women slipping out of the labour force at 50-plus. There are lots of challenges in their life—the impact of the menopause, a lack of the right policies or support at work, discussions they need to be having—that might be reasons for that.

Have we got it all right? No, we do not have all of that. There is more to do, but I am very proud of my Department. We have 300-plus menopause champions who work with our teams and with our claimants. In fact, in your own area, we are having awareness events. We have menopause listening circles; we have activities and workshops going on. Talking of emails and bulletins, we have a reach-out message going out to people. We are doing this really practically from our team leaders. Sitting next to me is Natalie, whose title is around carers, ethnic minorities and 50-plus choices.

As Maria said, across the course of women's and girls' lives, different challenges will come, but I want to remind women that, if we get this absolutely right and if, post-50 and perhaps during the menopause, you get the best support, you could then have the best and most fulfilling part of your career. You deserve that, and we want all Government Departments, as well as sectors and employers, to be working together to deliver, so that women and girls can also have the best retirement choices going forward, because they have not had to make choices to leave the workforce.

Q258 **Kim Johnson:** Can I pick Natalie up on issues around ethnic diversity challenges? How is information available in different formats to meet the needs of all people going through the menopause?

Natalie Keogh: We have 50-plus champions across the jobcentre network who are working with our work coaches to make sure that they have all the information and resources that they need to support their communities in the best way that they can. They are the experts on their local communities.

Q259 **Kim Johnson:** Is information disseminated in different languages? If someone has a visual impairment, is anything available in audio, so that all women, regardless of their needs, particularly in terms of intersectionality, have access to this information? We know that black women and those from ethnic minorities are often not accessing this information and are unaware of the menopause.

Mims Davies: I can answer some of that. We have mentoring circles. Most of our job coaches, whether disability employment advisers or any other support in the local JCP, are local. Whether it is help with ESOL or British Sign Language, there are other ways of us getting help. If you want a specific detail on that, we can give more, but it is certainly something that we are very mindful of and are doing more of. In fact, our previous Secretary of State led on the British Sign Language intervention. At DWP, we collate how, across Government, we are communicating with everybody who needs to hear Government messages. That is absolutely

right, and I am sure that the Equalities Office will be hearing this loudly as well.

Helen Tomlinson: As an overview of the work that I am doing to support that, I have been going through a period of due diligence and learning more about different employers and what they are doing, working with sector bodies and so on, and about how that can support employers and women in the workplace going through menopause.

As a key aspect of that, we will go out and build a cross-sector roundtable and then subsequent roundtable working groups that are sector-led. That means that support in particular sectors meets the need of those sectors, whether a woman is working for a large employer that is doing some really good stuff in the menopause space, or working with a small employer that does not necessarily have access to funding or these support mechanisms, and creating a portal where everybody can access that sector-specific support that is meaningful to them. We will look at the implications of that through intersectionality as well, when we get to that point.

Q260 **Chair:** Maria, can I just take you back to the RSHE review that the DFE is doing? Has the DHSC made any formal submission to it?

Maria Caulfield: Dame Lesley Regan, who is the women's health ambassador, is taking part in that review, so she is helping them in terms of the women's health aspect of that. My understanding is that, when that review completes, we will be involved in looking at the material that is provided going forward.

Marian Holliday: We have also formally responded to the review.

Q261 **Chair:** Mims, has the DWP formally responded to that review?

Mims Davies: The one on education? I genuinely do not know the answer to that, and I am not sure whether we would normally be expected to. There might have been some write-round, but I will happily take that away. In terms of my portfolio, I do not think that we have, but let me take that away and write to the Committee.

Q262 **Carolyn Harris:** Natalie, what does the resource that you talked to my colleague about look like?

Natalie Keogh: For 50-plus?

Carolyn Harris: Yes.

Natalie Keogh: In our jobcentres, we have additional work coach time in place for customers who are 50-plus, which is an extra 20 minutes at 13 weeks and some extra time at 26 weeks and 39 weeks to allow work coaches to work with customers to understand the barriers they are facing, which will include menopause for some people.

We also have a network of 37 50-plus champions in every district across the Jobcentre network, who collaborate with work coaches and employers to raise awareness of the importance of supporting older jobseekers and the barriers that they might have, to try to help them into work.

Q263 **Carolyn Harris:** Is there a factsheet about what the menopause looks like that you are giving out to women? Is the ambassador trained on the menopause? Do they have menopause training?

Natalie Keogh: We have a network of over 300 menopause ambassadors across DWP. They work with our champions to raise awareness and to ensure that work coaches are aware of the challenges and the barriers, so that they can support individuals. Obviously, all those conversations will be individual.

Q264 **Carolyn Harris:** But they are trained specifically in identifying menopause, knowing the symptoms and being able to give the correct information to the individual as to what the problems potentially are.

Natalie Keogh: They are trained to help with all issues facing 50-plus people who are coming into jobcentres, including skills and planning for later life, but menopause is part of that.

Q265 **Carolyn Harris:** Is there a specific training module on identifying menopause as a reason why somebody may be thinking about leaving work or be on long-term sick? Do they understand what the menopause is, because they have been trained in a module on the menopause?

Natalie Keogh: I do not think that there is a specific training module, and it varies from district to district.

Q266 **Carolyn Harris:** So they just deal with over-50s and look generally at the issues facing them. Mims, I had the opportunity yesterday to ask you a question about occupational health therapists. Have you had a chance to think any more about the reasons why that would be a good idea?

Mims Davies: Forgive me, but I did not fully hear what you asked me yesterday, so I gave you a slightly limited answer, but I have and I fully expected you to ask me today. You are right, Carolyn, that there is an opportunity here with occupational health to bring those conversations in, in the way that Natalie described.

This might not be fully what is going on in your life. It might be something that you have not thought about. You may be sandwich caring or have other issues going on in your life, so you have not really thought about the menopause point. It might also not be because you are over 50. We know that younger women experience the menopause too, and that is something that employers need to understand.

There is work that we are doing in terms of working well and universal support, which the Minister for Disabled People is leading on. Access to this could help in terms of long-term health conditions, so it is something that we are looking at roundly in the Department at the moment. I do not

have a final answer, but it is absolutely something that we should be putting into the mix.

Just while I have the floor, Chair, DWP has support for schools, where work coaches reach out to schools and link into what is going on in the local labour market. I was just going to say in regard to that that we have cross-Government work that I am leading with Minister Halfon and Minister Andrew in terms of how the system works best for young people to progress and get the support they need, and making sure that, while we do not duplicate, we also give the right support to young people. We have a reach into that area. How far that is, I am not sure, but I can pick that up. We have a cross-Government conversation in July and I am happy to take that forward.

Q267 **Dame Caroline Dinenage:** Sorry, Maria, I am back to you again. I do not doubt that the Government take this very seriously and that the women's health strategy has been really pivotal in bringing together the menopause and a number of other issues that affect women's health, but what concerns me is the extent to which this filters down to the coalface, if you like—to the practitioners, GPs and others who are seeing women on a day-to-day basis.

The reason I say this is that, about a year ago, I asked for a meeting with my local CCG to talk about what provision it had in place to support women going through the menopause locally. Along came one of the local managers alongside a practitioner, who was a gentleman, and at no point during our conversation did this gentleman refer to the menopause as "the menopause". He kept talking about it as "the change" and using other ridiculous ways of describing a medical process that every other human in this country and in this world will go through.

It was such an old-fashioned way of talking about it, which made me think of the point at which the Government rejected our recommendation that each CCG—or ICB, as they now are becoming—should include a menopause specialist. The Government said that it was not within their remit. Whose remit is it in?

Maria Caulfield: Under the Health and Care Act, ICBs are independent, so we, as a Government, are not able to direct them, but we do work very closely with them. We have seen a change, now that we are moving to ICBs and away from CCGs, because there are 42 of them and it is much easier to have a conversation nationwide.

Last week, for example, with my mental health hat on, I met with all ICBs across England to talk about the progress that we are making in terms of supporting patients going through mental health crises across England. It is much easier to have those conversations and also to see what progress is being made across the board.

Without exception, each ICB has committed to introducing a women's health hub. They recognise the need for specialist women's health leads in their areas, but they are doing that on an individual basis for what

suits their local population. I have been quite pleased with their response and their interest in this, and that is why we have £25 million to help this process kickstart.

It will be an ongoing conversation. It is a culture shift. I speak to GPs as well. When they first trained, many of them did not sit down and talk to women about the menopause, even if a woman came to them. We have heard Carolyn tell her own story of how she was put on antidepressants instead of a GP thinking, "Could this be the menopause?" That is a culture shift for everyone. It is about empowering women to understand the multitude of symptoms of the menopause, so that they are better prepared to go back to a GP if they are not getting the answers they want.

GPs are upfront, as well, and say that they need more education and training. From next year, it will be compulsory for undergraduate medical students to do the women's health module. The menopause is part of that and they will be assessed on that, but it takes more than that. It is about a huge cultural shift. NHS England has its menopause rolling programme as well, because it is not just about GPs, but practice nurses and all healthcare professionals.

Hopefully, by the end of the health strategy, when you talk to the leader of your ICB, they will not be talking about "the change". They will be open and honest about the menopause, the wide variety of symptoms it can cause and the devastating impact it can have on women's lives.

Mims Davies: We have spoken about menopause. There is obviously perimenopause. There was reference made to JCPs and what we do there. One of the key bits that our ambassadors do is to start this conversation and make it easier for people in work in any situation. There have been monthly ones with 600 to 850 of our colleagues there, including men who want to know and understand this for their partners. We have come a long way from that stigma point and, damn right, we should be, but we have had to do a lot of work individually.

You are right, Dame Caroline, to highlight helping men. If men in the medical profession find it hard to talk about, there is, frankly, a lot more to do. We are doing it, but there is a blooming long way to go, and thank goodness that we have started that journey to make it easier for women to thrive in the workplace or whatever they are doing, and to have those conversations with their medical professionals.

Q268 **Dame Caroline Dinenage:** When they responded to our report, the Government said that they would be encouraging ICBs to take into account the aims of the women's health strategy. Maria, you have spoken about what that looks like. When it comes to the menopause and other issues, you are, effectively, allowing them, as you said earlier, to design their own spec for how this looks, but what are the measurables on this? How do we know it is working?

Maria Caulfield: The women's health ambassador has set out the minimum requirements, and some places will add to that. Some places will have specific needs in their communities that they will want to see available in their women's health hubs. We are going to evaluate it, because we passionately believe that, if you have a one-stop shop for women's health needs that covers a life-course approach, first, it saves money, because you are picking things up earlier for women. Secondly, it is a better experience for women. Thirdly, it provides a much more joined-up healthcare approach, so a woman is not having to go and get a smear test in one place, contraception advice somewhere else, and then a referral to secondary care for an ultrasound or whatever.

It will provide better joined-up care, so it will help the system, because they are not navigating several parts of it; it saves money, because it is much more cost-effective to treat someone properly the first time around; and it is a better experience for women.

Kim talked about disadvantaged communities, and one of the things that we hear lots about from women who come from different backgrounds is that they have had a poor experience of the health service and are less likely to come forward if they think that they need help and advice. We see that in maternity. When you talk around maternity disparities and the poor outcomes for black women, they have very often had a poor experience of the health service before they ever got pregnant, and then, when they are struggling through pregnancy, they are much less likely to come forward and ask for help. Hopefully, that should improve the experience of women and also make better use of the resources that we have.

Q269 **Dame Caroline Dinenage:** You spoke about how trainee GPs have modules that are specifically focused on this, but to what extent have you been able to engage with the Royal College of GPs, the CQC and the General Medical Council on improving the understanding and training of current GPs? They are largely independent, to all intents and purposes, but to what extent is that something that you can influence?

Maria Caulfield: The royal college is very cognisant of the debate and is improving the training available to its members. NHS England also has its national menopause care improvement programme, which is for all healthcare professionals and all those working within the NHS, to improve the clinical care of the menopause. Part of that is around the training and education of staff, so that they recognise the signs and symptoms of the menopause, particularly, as Mims says, for younger women, because there is an assumption that it happens only to someone over 50, but the whole perimenopausal period can go on for almost a decade before.

The national menopause care improvement programme tries to cover that aspect, but, again, it is going to take time for women to feel that difference so that, the next time they go to see their GP and say that they are not sleeping or are just feeling tired and not coping, the first thing that the GP will say is, "Well, how are your periods? Do you think

that you are going through the menopause? Shall we do a hormone test to see where you are?" Up until now, that has not been the first thing that has come up in the discussion.

Q270 **Dame Caroline Dinenage:** Not only is it not the first thing that comes up in the discussion, but I have friends and contacts who have been actively discouraged from going on HRT by their medical advocate, which is very concerning. On that theme, what has the women's health ambassador done to improve the way that healthcare professionals are educated and trained on this since taking up her role?

Maria Caulfield: She has been working very closely with ICBs. She is also a former president of the Royal College of Obstetricians and Gynaecologists, so she is very well linked into the royal colleges. That is the advantage of having Professor Dame Lesley Regan, because, if I went along to the royal colleges and said, "You must do this" or "What about this training?", I do not think that it would have the same impact as someone who is a clinician who has worked in this field her whole life, who has been a past president of the royal college and who really understands what they are looking for.

Dame Lesley Regan would also say that it is not just about HRT. HRT is really important in the menopause, but there are many women who cannot take HRT, or who have tried HRT and it has not worked for them. It is about the whole approach to the menopause and also trying to get an evidence base for non-medicinal methods of managing the menopause. I am approached by so many women who say, "The prepayment certificate is great, but I cannot take HRT, so what is available for me?" Dame Lesley is really keen to improve the research that we are doing on the menopause to try to look at a wider management of symptoms as well.

Dame Caroline Dinenage: She is a busy woman, though.

Maria Caulfield: Yes, she is.

Q271 **Dame Caroline Dinenage:** I understand that she is still in clinical practice. She is a professor of obs and gynae at Imperial College. How are you ensuring that she is able to devote enough time to the whole of the women's health strategy and to this in particular?

Maria Caulfield: She is extremely passionate. I meet with her fairly regularly. It is fair to say that she goes above her recommended hours for the post, because she is completely committed. She has spent her whole life trying to improve healthcare for women throughout her career. She has particularly driven the women's health hubs, because she has seen the benefit of it when she has introduced it in her local clinical practice, particularly for those hard to reach. She does not like the term "hard to reach"; I cannot remember the one she uses.

Marian Holliday: "Easy to ignore".

Maria Caulfield: Easy to ignore women. If the one-stop shops are accessible enough, they really do reach women who would normally struggle to access healthcare. We always expect women to go to their GPs, to come to the hospital or to go to a formal healthcare setting. Some of these health hubs are set up in community centres; some are on buses. There is a whole range of options for them, and she has found, through her clinical practice, that they are making a difference. Just because she has spent her whole life in this area, she has delivered more than we could have expected of anyone in this role.

Q272 **Dame Caroline Dinenage:** She is fabulous. It is really important that she is backed up by a deputy ambassador who supports her in this work, but I could not see who that is. Who is the deputy ambassador?

Maria Caulfield: We do not have one at the moment. We did consider one at the time, but we felt that it was so important to get the role in place. There is nothing to rule one out in the future, but Dame Lesley has a support team behind her as well, and so, at the moment, we just have Dame Lesley.

Q273 **Dame Caroline Dinenage:** I am confused. I thought that the post was for an initial 18-month period and that she would be supported by a deputy ambassador.

Maria Caulfield: We did consider one at the beginning, but we did not appoint one. We have not found that we need to at the moment, but that option is still on the table, should we consider that.

Q274 **Chair:** Is it a lack of cash?

Maria Caulfield: No, I do not think so, because they are not paid a huge amount at all. Dame Lesley would do more hours than the post was advertised for. There is the capacity to have a deputy, but we felt that it was important, particularly for the first period that the role was in place for, that the women's health ambassador took a full lead in the direction of where it was going. If we needed one in the future, it is not ruled out at all.

Q275 **Chair:** Going from one very busy woman, Dame Lesley Regan, to another, Helen, do you need a deputy?

Helen Tomlinson: I do not believe that I do at the moment. I am still in the fact-finding phase. I feel that I have met with a lot of people and made good progress in the time that I have been in the role, so I do not believe that I do at the moment.

Q276 **Chair:** Has your fact-finding phase enabled you to set priorities and, if so, what are they?

Helen Tomlinson: Yes, absolutely. We are holding a cross-sector roundtable event in July, which will bring together key sector bodies and employers in those sectors to start to talk about best practice. Out of that will come sector-specific roundtables, again with key sector bodies

supporting employers. That will provide best practice sharing across sectors between larger and smaller employers, so that everybody has access to that shared best practice, additionally supported by allyship, because it is really important to have somebody to talk to if there is nobody in your own organisation providing that allyship. We are providing it across sectors, and that will all be hosted on a portal.

Q277 **Chair:** What are your key sectors? If we are looking at how we keep women going through perimenopause and menopause in the workplace, do you have specific sectors?

Helen Tomlinson: Yes. We are looking at hospitality, retail, manufacturing, adult care, and professional and technical.

Q278 **Chair:** Are you ever thinking outside the box and maybe away from the more traditional? They are all sectors that have very high percentages of women in them. What are you doing to make sure that women in construction and engineering are being supported?

Helen Tomlinson: At the moment, we are focusing on those sectors, and then we will overlay the best practice and the model into further sectors.

Q279 **Chair:** What does success look like?

Helen Tomlinson: Success looks like more women being retained in the workforce and going on to further develop their career post menopause. I have seen a lot of women who have had to take a step back or not achieve their full potential throughout their career, because they have not had the support, so success for me would be more women thriving in their careers moving forward.

Q280 **Chair:** What are the measurables? This might be an unfair one for you; it could be for Mims. How are you measuring whether we are keeping more women over menopausal age? I always get into trouble for saying "over 50".

Helen Tomlinson: The guidance and the statistics for that will come from the Department.

Chair: So you are definitely measuring that, Mims.

Mims Davies: Yes. The inactivity rate for women aged 50 to 64 is 32.1%. The average for women is 25%. The female employment rate is now 72.3%, which is up by over 2 million since 2010. The reality is that the fastest-growing group in the workforce are 50-plus. As Dame Caroline said, women in the workplace are going to be experiencing menopause, and there are more of them in more sectors. We need to make sure that we are supporting and helping them. Six out of 10 women say that, if they have been helped to identify them, as Carolyn has pointed out, menopausal symptoms have a negative impact on their work. As Maria said, we know that perimenopausal symptoms can last for a long time—

seven years. One in three women experience them beyond seven years. One in 100 women experience the impact before 40.

I commissioned a report back in 2021. For those watching, it is "50Plus Choices". It was the renaming of "Fuller Working Lives". It is a name that annoyed me very much, because it just sounded like very busy women rather than anything about a choice in that. It showed that we need to be doing more, because women are dropping out of the workforce. If they do not have those great retirement plans and opportunities out there, it really does affect them.

Helen will be producing her six-monthly update in September. She is doing this role voluntarily. I do not think that we could have asked for any more, and I will maybe pre-empt the Committee going, "Well, why is it voluntary?" To me, the point is that I would not want to take any successful woman out of the workplace to do the job, and she is doing it around everything that she does. She has been in place only since 6 March—International Women's Day.

We were ready for that, but the fact that she is doing it voluntarily means that we get more flexibility. There is no payment to worry about here. The fact that she is in the workplace, engaging with stakeholders, and is able to do that, day in, day out, is very advantageous for us at DWP and across Government.

Q281 **Chair:** Have you set her any targets? Sorry to talk about you in the third person as if you are not here.

Mims Davies: No, not yet, other than to focus on those sectors and on women dropping out, and to lean into the 50-plus work that we have around inactivity post 50. I am not saying full inactivity. It is a very indelicate phrase, if I am honest, because many of those women will be doing caring and other responsibilities as well. For us, it is about making sure that, if you can and you want to work, the menopause is not holding you back from having the most fulfilling part of your career.

We will take stock. We had one of those recent roundtables with women locally. The challenges are different in different areas and sectors. Carolyn, we are coming to Swansea, I hope, and we have one lined up for Derby as well. We are also going to be working with football clubs and other areas to get men involved in those conversations as well. We need to regroup in September, six months on, and really start to set the next stage of the agenda.

Q282 **Chair:** From your own stats, about 32% of women over 50 are economically inactive compared to 24.5% for women under 50. Are you measuring that gap and whether this work has had any impact on reducing it?

Mims Davies: Yes, absolutely, because we can drill into the regional employment stats and into the 50-plus stats. We do not know at the moment whether inactivity, which we are seeing reducing as a whole, is down to menopause, but that is why we have our menopause champions.

There is a chance to really take stock of that. What those measurables are, at the moment, I cannot fully answer, because, as Helen said, she is in fact-finding mode. This is a cross-Government commitment to help women reach their full potential. Perimenopause, menopause and employment as a whole are part of that.

Q283 **Chair:** I just wanted to give you two quotes: first, "So many drop out completely"; secondly, "Too many 50-plus women are slipping out of the workforce". We know that. In what way did you perceive a trial of menopause workplace leave as a barrier to prevent women from slipping out of the workforce all together?

Mims Davies: I know that we have had side discussions on this. It is a conversation that Helen and I have had, as well as in some of the roundtables and interactions that we have had. I genuinely think that flexibility and support from employers and sectors are key. If somebody is leaving the workforce because of menopause impact, as we heard from Dame Caroline earlier, it probably could be because they have not had the right support from their GP and the right conversations with their employer.

There will be opportunities for support, as we discussed earlier, whether it is occupational health, wellbeing policies or adjustments in the workplace. We launched Helen, for a want of a better phrase, in chatting with Premier Inn and Whitbread. Having the right kind of uniform, the right flexibilities in work, the right understanding and help, and the right temperature in the office and the workplace really matters.

If we get to that point where people are looking to leave the workplace, we have failed. That leave question is not an area for me to lean into because my job is to get people into work, staying in work and flourishing in work, but, where people need to take time out or get support for whatever reason, employers will have to have policies and best practice to enable that, while retaining them in the workplace. For me, the clue is in my title: "Department for Work". That is what I am here to get more people doing and flourishing in.

Q284 **Chair:** You do not see trialling menopause leave as part of a mechanism that could help people stay in work.

Mims Davies: As we have discussed roundly already, there is no one-size-fits-all for anybody in this scenario. Designing policies and turning them from things that look great on the website into things that work in reality for women or for any employee is what I am about. My job is to help people get into work, progress in work and stay in work. If we are seeing women leave the workplace when we have opened up this conversation, when we have men as allies and when we have support from sectors and from DH, to me it feels like we are not getting it right.

Yes, of course individuals want to trial this. That is fine. For me, my priority is women flourishing, being supported in work and making choices they do not feel pushed into.

Q285 **Chair:** How would the DWP respond if any of your staff wanted to trial it?

Mims Davies: We do have flexibility in our workforce and workplace. We have signed up to the covenant. In fact, we did it in DH. In the civil service we have got it right in lots of areas, whether it is support for people going through domestic abuse, care leavers or other people who need additional support in the workplace or who have additional barriers to progress.

We have that flexibility in our Department. I am very proud. We are getting it right. I challenge every other Department and Minister to make sure they feel confident about that.

Chair: Do you?

Mims Davies: Yes.

Chair: Have you?

Mims Davies: I think so. Given that 65% of our workforce are women and many of them are—

Q286 **Chair:** No, have you challenged other Ministers across Government? The DWP is getting it right. I know you have greater flexibilities than many other Departments. Are you challenging other Government Departments to follow suit and give the flexibilities you would encourage?

Natalie Keogh: There is a cross-civil service menopause in the workplace policy, which is to support the wellbeing of women in the workplace. It enables and supports line managers and employees to have those conversations. It is about creating cross-Government networks on the menopause, where we have forums, events and cafés where people can support each other and create those conversations. It also sets out guiding principles and toolkits for line managers and employees. That is across the civil service.

Q287 **Chair:** I have a really unfair question for you, Natalie. Are you aware whether the Cabinet Office is still pursuing its returnship programme?

Natalie Keogh: I am afraid I am not aware.

Q288 **Chair:** No. Mims, can you go and find that out for us? The last time I asked the question, there were four returnships across the whole civil service and three of them were in the GEO.

Mims Davies: I have been asked to return various bits of feedback. I have really pushed for returnships around 45. I would like to see them a little bit earlier, particularly for those women who have dropped out of the labour market for positive reasons to look after their children. The route back is quite often too challenging.

Chair, you asked whether I have challenged other Departments. I like to think so—for example, around the care leaver covenant and meeting those who work for us who have come through that way. With the focus in my remit, there was no way I was going to push other Government Departments if we were not getting it right ourselves. I recently met with care leavers who have come into our business.

I am always quite happy, being in the Department for Work and Pensions, to work positively across Government and across the civil service on this because we cannot ask sectors and employers to do that if we are not doing it ourselves. That is where we use our national employer partnership relationships and so on. I was at Tottenham Hotspur this morning at an event on the social mobility pledge, EdAct, women and girls, and supporting those in entrepreneurship. I hope, Chair, you will see I am putting my money where my mouth is.

Q289 **Carolyn Harris:** Helen, there is nothing personal in this, but you are not actually voluntary. You work full-time for another company. Is that correct?

Helen Tomlinson: Yes.

Q290 **Carolyn Harris:** You are not voluntarily doing this. Your company is funding the Government's work on this by allowing your time—

Helen Tomlinson: It allows my time, yes.

Q291 **Carolyn Harris:** How many hours of your time does it take?

Helen Tomlinson: I would say I probably spend about 50% of my time. However, that is not all Adecco time; that is my own time as well.

Q292 **Carolyn Harris:** If you want a job done, you give it to a busy woman. Mims, would you agree that, by creating a role that is voluntary, like you say, it is not taking a woman out of the workforce? It is creating a role for a woman to do the job of looking at what other women need. What you actually have is a situation where Helen, who I am sure is doing a wonderful job, is doing the job but being paid for by Adecco, for which the Government are going to gain from Helen's services.

Mims Davies: We are all going to have to disagree on this one, to a degree. I would never tell another woman what to think—far from it—but we discussed this as the "50Plus Choices" group. We have an older workers' champion in Andy Briggs, who does this similarly for older workers. It has worked really well. I could not be prouder of Helen in terms of what she is putting into this.

Q293 **Carolyn Harris:** I am not suggesting anything different. I am just saying that it does not create a position where a woman is being taken from the workforce. Having this as a full-time paid role creates a job, creates a role and creates the message that the Government are taking this so seriously that they are prepared to fund it to make sure they get it right.

Mims Davies: I would then have to go through a completely different process of appointing someone. They would potentially have built their whole career up and be at a fantastic point, and then I would have to ask them to come and do that. I genuinely think there is a way we can do it alongside that.

Is that the long-term answer? I do not know, but at the moment I feel like it is working incredibly well. There is also the fact that Helen has that reach, that network and that confidence that she is bringing to it. We could not get more out of anyone else.

Carolyn Harris: We will agree to disagree, then.

Mims Davies: Yes, indeed.

Chair: I suspect the DWP could not afford you, Helen.

Mims Davies: Exactly, Chair.

Q294 **Chair:** I have a final question for you, Helen. When I say "final question" I mean in this section. Do you feel that businesses are well supported enough to support their staff going through the menopause? You have previously spoken to me about some sort of portal that the DWP, but not the DWP—it is not going to be on gov.uk—is establishing. Can you tell us a bit about what that looks like?

Helen Tomlinson: Yes, absolutely. To the first part of that, there are a lot of organisations that are doing a lot of really good work. It is about making sure all organisations are giving the same opportunity to women in the workplace. I am working with some great organisations that have come forward and said, "We want to be part of this".

It is not about competitive advantage in the workplace. It is about making the world of work better for all women. CIPD has come forward and said, "We will work with you to get your voice out there in a one-to-many strategy". I am only one person and I need to transcend all sectors to be able to get that messaging out there.

With regards to the portal, we are looking at different options at the moment as to where that should sit. I am really conscious that we have already talked about a portal this afternoon. That could be an opportunity so there is not as much confusion. We are still looking at how the best practice will sit on the portal and how we give access to all organisations to be able to work with that information.

As an example of the type of thing that would go on there, the British Standards Institution standard was launched a couple of weeks ago, which is a free standard for any organisation. It is extremely detailed and extremely prolific around the topics of menstruation, menstrual health and menopause in the workplace. There is a formal launch in a couple of weeks, and then they will produce what is called a little book, which is more of an employer-friendly handbook in that regard. All of that

information will be the starting point for that portal, and we will add to that over time.

Q295 **Chair:** It will not be gov.uk-branded.

Mims Davies: There are various options of where we can—

Chair: There was a sigh then, before you started answering.

Mims Davies: Forgive me. It is because there are various landing spaces. We need to get it right. We are in this fact-finding mode, and then we can move into delivery mode.

I met with the BSI, with Helen, on this. It is interesting. The BSI started from one point but it has got bigger. This is the reality of this situation. Where are we going to land it? How does it link into to Maria's work and the wider work we are doing, possibly the help to grow hub that the old BEIS had or others? There are various portals where employers go that we could use to land it. I guess I sighed because I do not have the answer, Chair, but I am happy to be challenged on finding an answer for you.

Q296 **Chair:** On what timescale?

Mims Davies: We are doing the report in September. As we heard from Helen, we have CIPD, ACAS and all sorts of other people coming to the table on this. It is about where that landing space is. It could and possibly should be a gov.uk space. It took me forever to build Job Help, which is a DWP space, and bring everything together. Perhaps my sigh was slightly about that as well because landing things like this is never quite as easy as one would like to think.

Q297 **Dame Caroline Dinenage:** There are some sectors and professions where there are a tiny number of women and the gender imbalance is massive. Mims spoke about landing spaces. Let's choose, off the top of my head, the airline industry as an example. Clearly, there is massive gender balance when it comes to cabin crew, but, when it comes to pilots, there is massive gender imbalance.

For the sake of argument, let's choose British Airways. Let's say it was about to change its uniform—it is—and it was making a range of uniform options available for cabin crew and for male pilots. I am not sure about the exact numbers on this, but it has roughly 4,000 male pilots and roughly 250 female pilots. There are a number of options for the men and one option for the women, which is not at all conducive to retaining women of a certain age in the workplace. Would you be able to offer advice to companies such as that?

Helen Tomlinson: I know exactly what you are referencing. Yes, completely. To be able to give a woman an option as to what uniform should be available to them is absolutely imperative, if they want to retain women in the workforce who are experiencing menopause. It

absolutely is an option to have those conversations and share that best practice from other organisations.

Q298 **Dame Caroline Dinenage:** Mims, do you see an overlap here between supporting women in the workplace and particularly supporting women in the workplace who are already in areas where there is massive gender imbalance? They are already struggling to attract enough women into this workforce, and then are not retaining them with some changes that they could very easily overlook.

Mims Davies: I have a couple of points, if I may. Helen is there to be "not of the Government", as an expert and as somebody who can help and be listened to with authority, engaging with businesses and sectors about things such as uniform.

I mentioned Whitbread and Premier Inn earlier. That is something they have done. If you can imagine, the bedroom staff are changing a heck of a lot of beds and it is blooming hot. If you have a horrible nylon uniform, that is not ideal. They have adapted that.

I know—it might be worth challenging this—anecdotally, for example, easyJet is recruiting a lot of 50-plus women, who have said, "Great, the kids have gone. I am going to do some flying and enjoy that part of my career". I hope they have the uniform to go with it. When I was with the Chair at the roundtable in Southampton, the Ports Group was there—and that is very much an area where there is gender imbalance—discussing what is going on with the uniform, the temperature and other things like that.

Again, we are getting the conversation going with men as allies. Helen has started to do some men-only sessions. We have seen how the number of 50-plus relationships breaking up has been growing. We know that some men do not know how to start that conversation at home, let alone in the workplace.

Helen, you might want to lean into this point. Particularly in those sectors where you have very few women, you might want to chat about it at work, but there is nobody who you can chat to and say, "Something is going on at home, and I would like to know more".

Helen Tomlinson: I have done a men-only session for DWP. I have done them commercially, externally and in the Adecco Group, where I am head of talent and inclusion. That has allowed men to have a safe space to open up the conversation, learn enough and feel supported enough to become those allies. That is a really good starting point. I have been asked more and more to do that so they can understand the experiences and what may well work for women to be able to be supported.

The uniform piece is a really important aspect of it, but individuals have to be able to start that conversation and say, "This is my experience. This is what I am going through. That uniform is not ideal for me", while

managers have to be able to respond positively to that. That cultural piece is really important. Without the reasonable adjustments, you will never get to that because you cannot start the conversation.

Q299 **Chair:** Helen, although you were not physically in the room, you were with Mims and I at the roundtable in Southampton and heard yet another solicitor talking about the numbers and difficulties of women bringing cases to tribunal and being forced to choose the grounds between sex, age and, more commonly, disability. Do you have any views that you would like to share with us about menopause as a protected characteristic in its own right?

Helen Tomlinson: I would only say that it is covered with those three particular protected characteristics at the moment. As was discussed earlier, it is a much bigger piece of work to look at the Act and change those protected characteristics.

Q300 **Chair:** Mims and Maria, are the Government doing enough to support—how can I put this delicately—the woefully small numbers of women we see feeling able to bring a case to tribunal?

Mims Davies: It was interesting to hear the different points of view at the roundtable, from whether people should be able to have menopause leave, what the grounds would be in any discrimination and the concerns about whether this is just another thing that will stop you employing, progressing and supporting women.

It worries me that, in this day and age, people could even be thinking that. It is where you have good adjustments, good conversations, allyship and the support for women all across their careers. We need women to be supported to reach their full potential and support the wider economy. We need good inclusion policies that deliver in the workplace. It is not rocket science.

Q301 **Chair:** We would all agree that women bringing cases to tribunal is a failure of workplace menopause policies and of employment policies. By the time you have got to tribunal it is too late, is it not? Are you content that the majority of women bringing those cases are doing it under disability discrimination grounds?

Mims Davies: I do not think anyone would be content, but the reality is that we are, as Helen and all of us have described, really starting to have these conversations and work out what may be best for women. Have we got the final answer? No. That is part of the work we are doing with Helen and across Government. GEO, Maria and others lead on that area.

We need to watch this space very carefully. For me, it is always about whether we have done the right thing to get people into work, keep people in work and support them in work. It is more than just a pay packet; it is a sense of wellbeing. You need to be having those positive conversations, whatever is going on in your working life, so ideally you do not need legal representation.

Maria Caulfield: It is a failure, if a woman feels that she has to go to tribunal. The work Mims is doing and we are all doing is around setting the expectations for what a woman going through the menopause should be able to expect from her employer. This is about the wellbeing of women. It also includes the menopause workplace pledge that we signed up to across the civil service and across Parliament. Carolyn got that introduced in Parliament.

We need to ensure women know what to expect and employers also know what is expected of them towards their employees. When I talk to employers, they are desperate for experienced women to join the workplace. These are a group of people who usually spend their whole lifetime working. It is great to take on a young person, but you can never replace experience, in whatever field you are working in.

Women will vote with their feet. If there are good employers providing good support—that may be menopause leave for some employers; it may be uniforms; it may be flexible working; it may be better ventilation in the workplace—women will go to those employers. Those that do not take up the mantle will be the ones that struggle to find the staff.

Giving women that empowerment, so they know exactly what they should be able to expect from an employer, gives them the power. In the care sector, for example, where women are often pretty low paid, they will go to a good care employer that will give them a bit more flexibility in their working hours or a bit more support. If it gets to tribunal stage, a failure has happened. By improving the working experience, women will hopefully have a better experience in the first place.

Mims Davies: If I could point out the Parliament issue, as MPs we are employers. There are a huge number of people here watching, sitting at the back and so on. There is a fantastic opportunity for us to get it right as employers and as this Parliament.

I was very proud to be a member of this Committee when it was formed. There is a great opportunity for us all to do that and lead from the front. Perhaps you as a Committee, and we as Members of Parliament and women leaders, should be assisting in this.

Q302 **Chair:** Maria, I just have a final couple of questions—I am not even sure it is a couple of questions—about HRT. I have been approached, as I know other members of the Committee have, by various companies trying to get additional HRT products licensed through the MHRA. There are massively long delays. I appreciate that the MHRA is not DHSC. It is independent of Government. I would like to know what DHSC is doing to make sure products that are specifically for female medical conditions are not disadvantaged in a process that, instead of taking 150 days, is now taking up to 500 days.

Maria Caulfield: I meet regularly with the MHRA around a number of remits, from issues around sodium valproate—this is about those women

who have been affected by that, who got pregnant when they were on sodium valproate— through to medicinal cannabis and the licensing of that as well.

I am very happy to raise this issue at my next meeting with the MHRA, but we also need to be clear that there is a process. I do not know which companies you refer to or what stage of the licensing process they are at. It is quite a robust process.

I met with a drug company recently around vaccines, and they often get frustrated with the MHRA process as well because it is a very robust process to get a licence for a medicine. Certain evidence has to be submitted. It will then do reviews of that evidence and give a yes or no verdict. From a patient safety point of view, we cannot be seen to be bypassing any of that.

Q303 **Chair:** The MHRA will take money from pharmaceutical companies on the basis of being able to come up with a decision within 150 days, so presumably it can do that. It can be a robust process within 150 days. It is currently taking 500 days.

Maria Caulfield: I do not know which particular companies and medicines you refer to, but I am happy to have that conversation with the MHRA. I do not know what evidence they have submitted, whether it is randomised control trials or whether it is drugs that are licensed by the FDA or the EMA that are waiting for MHRA approval. There is a whole range of factors, but I am happy to have that conversation.

I just want to reassure the Committee that it is not just HRT where companies have that frustration. I hear from companies all the time how they want to get their product licence much more quickly.

Q304 **Chair:** Are the Government taking any steps to make sure the MHRA is meeting its target dates? We do not call them deadlines; we call them targets.

Maria Caulfield: Yes, absolutely. We are having conversations about resources for the MHRA as well. Again, it is an independent body. We cannot be seen to be pushing it to make decisions on products when its absolute priority is assessing whether a drug is safe to be licensed and the indication for that drug as well.

It may be that a drug is already being used for a different reason, but it has an indication that might be of benefit for the menopause. It would have to appraise that evidence and dataset as well. We cannot be seen to influence that. I am happy to have that conversation.

Chair: You might have some written questions from me already in the system on that. Can I thank all of the witnesses for their evidence this afternoon? It has been hugely appreciated and helpful.