HOUSE OF COMMONS

Women and Equalities Committee

Oral evidence: Equality at work: miscarriage and bereavement leave, HC 335

Wednesday 27 November 2024

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Watch the meeting

Members present: Sarah Owen (Chair); David Burton-Sampson; Rosie Duffield; Kirith Entwistle; Catherine Fookes; Christine Jardine; Rachel Taylor.

Questions 1 to 61

Witnesses

I: Dr Jessica Farren, Consultant Gynaecologist, University College London Hospitals; Munira Oza, Chief Executive, Ectopic Pregnancy Trust; Vicki Robinson, Chief Executive Officer, The Miscarriage Association.

II: Rachel Suff, Senior Policy Adviser, Chartered Institute of Personnel and Development (CIPD); Rhea Wolfson, Head of Internal and Industrial relations, GMB Union; Thomas Simons, Chief Human Resources and Operational Development Officer, NHS England; Nicole Basra, Diversity, Equality and Inclusion Director UK and Ireland, Dentsu International.

Examination of witnesses

Witnesses: Dr Jessica Farren, Munira Oza and Vicki Robinson.

Chair: Good afternoon, and welcome to the Women and Equalities Committee. Today, we will be looking at "Equality at work: miscarriage and bereavement leave". In our first panel, we will be hearing from Vicki Robinson, chief executive of the Miscarriage Association; Munira Oza, chief executive of the Ectopic Pregnancy Trust; and Dr Jessica Farren, consultant gynaecologist at UCL Hospitals. Thank you, and welcome today. I am going to start with Christine.

Q1 **Christine Jardine:** Thank you very much. Thank you for coming to join us today. The Government's 2023 Pregnancy Loss Review showed that there was still a taboo, that loss of pregnancy was not spoken about much. The TUC and the NHS have also referred to this. Vicki and Jessica, to what extent do you think the taboos and stigma around miscarriage and pregnancy loss are still a barrier to women and their partners receiving support in the workplace?

Vicki Robinson: Yes, absolutely, the taboo still exists. We are starting to see some changes, but absolutely, for sure, it is there. People who experience this still tell us that they experience a real sense of isolation; they do not feel able to talk about it publicly. They do not feel it is acknowledged; the impact is not acknowledged or recognised. We still have this archaic 12-week rule that is imposed on people that they should not disclose their pregnancy before that time in case something goes wrong. However, if you have not felt able to disclose it, it is very hard to then seek support. It is incredibly unhelpful and, as we are specifically talking about the workplace today, has an implication in the workplace because people do not feel able to disclose their loss at work.

Dr Farren: Time and time again, I meet women who really do not want their workplace to know that they were pregnant and that they are potentially trying for a baby for fear it might have an impact on their career progression if people know that they are soon likely to be having extended maternity leave.

Q2 **Christine Jardine:** We like to think that we have moved away from that sort of culture, but you think it is still quite prevalent?

Dr Farren: Absolutely. For example, whenever I am doing surgical management of miscarriage I will offer patients a sick note. I will always ask patients whether they want me to disclose that it is for miscarriage, or if they want me to put something vague like a gynaecological issue. I would say it is still 50:50 people choosing for me to write a gynaecological issue without disclosing that they were pregnant, in spite of the fact that they are obviously better protected if we disclose that it is pregnancy-loss related.

Q3 **Christine Jardine:** Munira and Vicki, how effective do you think Baby

Loss Awareness Week has been in challenging the sort of taboos and stigma that we have talked about? Is it leading to a more supportive attitude in the workplace?

Munira Oza: Anything that raises awareness among the public is helpful. There is an increased dialogue because of initiatives like Baby Loss Awareness Week, and we would hope that that then translates into the workplace. However, in spite of that, we still come across instances where things do not go smoothly in the workplace, but we would hope that, through initiatives like Baby Loss Awareness Week, the stigma starts to be challenged and barriers break down.

Vicki Robinson: I would agree with all that, but I would also say that that is just one week a year. We are very good at talking about it during that one week in October. What we are not seeing is companies and society generally talking about it much beyond that. As a charity, we are very happy to support businesses that want to raise awareness or have training during that week, but we always say to them, "Please don't just talk about it in October." It is about creating that supportive environment so that it can be spoken about all year round and people feel supported throughout the 12 months.

Q4 **Christine Jardine:** Do you think the balance is shifting at all from businesses being completely unaware to being totally aware, and is it improving?

Vicki Robinson: There are some improvements, for sure. A lot of the businesses that recognise it do a really good job and they have great policies in place. They have training for managers and they have guidance in place, but they are still in the minority. There are still far too many women and their partners who do not have good employers or who are having to rely on an empathetic supervisor or manager rather than there being something systemic in place for them to be able to access and know what their rights are and what they are entitled to.

Q5 **Christine Jardine:** We have heard from women who have been affected that guidance on what mothers and fathers can expect at work is missing. They do not know what the guidance is. They also find that, even though employers might want to be supportive, they do not know what the guidance is either, so guidance for workplaces is also missing. Is that your experience?

Vicki Robinson: Lots of women say to us, particularly if it is the first time they have been pregnant or the first time they have had a loss, that they do not know what they are entitled to. They do not know what a reasonable time to have off work is, or what they can reasonably ask of their employer. Is it sick leave? Is it a bereavement? They just do not know. Because we do not talk about it, and most companies do not have policies in place, there is very little in terms of the bereavement leave policy in general. It barely mentions miscarriage.

It is no surprise that that compounds the experience for people. They are already having a terrible experience. They have already lost their baby; they have been told their baby has died. One of the first questions they often present to us after we have talked about their feelings is, "Well, what do I do about work?" They just do not know.

Dr Farren: Could I add an example to that? You will be aware that the NHS as an organisation was in the headlines in March this year because NHS England had adopted a policy of bereavement leave after pregnancy loss. I have since treated three NHS employees for miscarriage and none of them were aware of any policy related to it. There is also an issue with these sorts of policies being made, but they do not filter down.

Q6 **Christine Jardine:** Munira, what impact has the introduction of formal baby loss certificates had on challenging that taboo and stigma and, if you like, making it a more tangible thing to take to employers or to just break down the stigma?

Munira Oza: That is a very interesting question in the sense that you used the word "tangible".

Christine Jardine: I could not think of another one.

Munia Oza: No, I think it is very appropriate in that, certainly for the gestation of losses that we deal with at the Ectopic Pregnancy Trust, there is very little tangible to remember a pregnancy by. Typically, ectopic pregnancies occur prior to 12 weeks, usually around the six-to-seven-week mark. As Vicki alluded to, some women may not have disclosed that they are pregnant. They may not even know themselves that they are pregnant, and then they find out that they are having an ectopic pregnancy.

The word "tangible" is very appropriate because there is not very much with these certificates. Certainly, from our audience, we have found there was a recognition that there is an experience here, that there is a loss here, and that helps them have something to remember and commemorate their experiences by.

What I would add to that, though, is that it is still in the private sphere. It is up to an individual to choose to have a certificate or not. It is not a legally applicable document and so there is nothing associated with that that would necessarily help within the workplace. It is simply an important recognition for the person of the experience that they have gone through.

Vicki Robinson: Could I come in on that just to give you some context? The last time I checked in with that, over 80,000 of those certificates had been issued and, as Munira said, there is no legal status. To some extent, there is no benefit to having one apart from the fact that it is a validation that you have experienced a loss. Hopefully, you can see from that how important that is to people.

Christine Jardine: That is quite a startling figure, 80,000. Thank you very much. I apologise; I am going to have to leave the session for a bit. I did not want you to think I was just running out, but thank you very much for that.

Q7 **Chair:** I wanted to pick up on that point of the baby loss certificates. Vicki, do you think there is a danger that Government policy is now looking a little contradictory in that they issue baby loss certificates to recognise the loss, but do not allow parents and families the time to grieve?

Vicki Robinson: It feels a little token, "We will make a concession, give you a certificate, give you a piece of paper, but we will not back that up with some policy that says, actually, you can have some time off work." This can be felt as a bereavement by a great many people. It is a really important step, and it has been welcomed by so many people, but it does not go far enough in and of itself.

Q8 **Chair:** Thank you. Dr Farren, you said it was 50:50 between women wanting to disclose the real reasons why it was they were coming to see you for the medically managed miscarriage treatments. Do they say why that is? Is it that they are fearful their employer will treat them differently? Or is it that they are fearful their employer will take punitive steps?

Dr Farren: As a general rule, I do not think they go into the details. There is just a kind of acceptance in the conversation I have that it would be a reasonable attitude to not want your employer to know, which probably gives you an indication as to the problem: that it is understood that you might not want to divulge that, and I am not inclined to ask any more questions about why.

Q9 **Kirith Entwistle:** Dr Farren, your study found prevalence of psychological conditions, including PTSD and anxiety, lasting for months after miscarriage and ectopic pregnancies. How and why do these conditions emerge, and how could the risks be better mitigated?

Dr Farren: It is really important to start by saying that the reactions to pregnancy loss are very diverse and there will be a group of people who are fine after miscarriage and ectopic pregnancy, but a tiny minority who are absolutely not fine. For most people it is something, and for some people it is everything; I think that is an old Miscarriage Association saying. My research very clearly demonstrates that there is a sector of people who meet criteria for one of the most severe psychiatric diagnoses you can come across, which is PTSD. We had a rate of 29% at one month, 23% at three months, dropping to 18% at nine months, which is huge and actually not that much of a decline over time.

What you have to remember is that is just showing the tip of the iceberg. Beneath that, when you analyse the PTSD, you look at a whole host of questions and you have to meet criteria within each of these different sections. However, 70% of people reported symptoms that were having

an impact on their day-to-day life for one month. So, it is not just the psychiatric conditions; it is the people beneath that who are suffering in all sorts of different ways by, for example, having an impact on their relationships at home or at work. The really scary bit is when you think of the potential impact on their family life at large and, potentially, for future generations from the morbidity that is out there.

Munira Oza: On my way to the Committee on the train this morning, an email came into my inbox from a woman who had gone back to work today. She is one month post her treatment for ectopic pregnancy and was asking for help. She had been tearful throughout the day. She is not having the support that she feels that she needs, and she has reached out to us. That happened this very morning.

Q10 **Chair:** Can I just ask a question related to that? Obviously, the first period post-miscarriage can be incredibly traumatic. How are you finding employers are understanding of the ongoing impacts of miscarriage past that initial two weeks?

Munira Oza: It is fair to say we see a range of different approaches. Sadly, the terms "miscarriage" and "stillbirth" are familiar, and they are heartbreaking and devastating in their own ways. With ectopic pregnancy, we have to go a step before that and a lot of people do not even know what the condition is.

With an ectopic pregnancy, it is often an emergency situation and there are lots of things that happen in a very short space of time. The woman herself is just about processing what is going on, and then thinking about work and the sorts of conversations that she might need to be having at work adds another level of complexity—as Jess helpfully alluded to earlier—in thinking about the workplace and what to share and what not to share when you walk in there.

When that experience is shared in the workplace, we have examples where care is good, and you have empathic members of the team who are supportive, and where conversations can be had openly. However, we had an instance where a conversation with her doctor was overheard, and her employer suggested that she might be lying about the extent of what she was going through. Another example: a woman was told, "Oh, you don't need that long after a miscarriage." It is safe to say we hear a mixed bag, and we would hope that an initiative can help with more positive experiences in the workplace.

Q11 **Kirith Entwistle:** What are some physical and emotional impacts of the lesser-known types of pregnancy loss, including molar and ectopic pregnancies?

Munira Oza: Can I start by saying that I am here representing many of the women who speak to us, and I am grateful to them for sharing their experiences to enable me to reference them here? In terms of the physical aspects we hear about, there are three main treatments for

ectopic pregnancy and it is safe to say they are all incredibly difficult in their own way.

Most commonly, because it is an emergency situation, the experience of treatment is through surgery and, of course, that is traumatic for the body and very fast decision making is required to save the woman's life. With non-surgical treatment, there is the ongoing risk of rupture and the worries around that. There are repeated hospital visits which are demanding and they can be triggering for people. Until those hormone levels fall, you are not really fully out of the woods, and that can be a heavy, dark cloud that really overshadows for weeks or months on end.

Touching upon the emotional aspects, certainly there can be the grief that is associated with losing the pregnancy. With ectopic pregnancy, there is often the loss of a fallopian tube as well and there is a grief associated with the loss of part of your reproductive system. There is anger, there is often blame, and there can be very confusing emotions, even a sense of relief that they have had the treatment and they are alive. There are lots of complicated emotions to navigate not just for weeks but, I would say, for months afterwards.

Q12 **Kirith Entwistle:** To what extent does the fact that many employers might not have heard of those types of pregnancies make it more difficult for employees? What more do you think the Government and the NHS could do to try to raise awareness about those types of pregnancies?

Munira Oza: The awareness point is an incredibly important one and, in fact, the MBRRACE-UK report recently repeated the need for awareness among healthcare professionals and clinicians around ectopic pregnancy. This is not the first time the MBRRACE-UK report has referenced that; the prior report two years ago also said the same thing. That message is something that is coming out loud and clear from the MBRRACE-UK team, and which we would fully endorse.

Awareness is very much needed around ectopic pregnancy and, indeed, molar pregnancy. The second part of your question I believe was about employers and the barriers to that. I covered part of that earlier in the sense that not even knowing what the condition is means that there is a level of explanation that the individual has to go into, reliving and going over a very difficult experience and trying to find the words to express that to their colleagues. Certainly, we do our best to speak with employers to try to help them understand where their colleagues have come from in the immediate aftermath and afterwards following an ectopic pregnancy.

Q13 **Kirith Entwistle:** What do you think we could be doing better as the Government, or perhaps maybe the NHS might be doing, to try to help increase that awareness and try to allow employers to access some sort of information that might increase that awareness around these sorts of pregnancies?

Munira Oza: I would want to ensure that the term "ectopic pregnancy" is expressly used through all the narrative around leave provisions. That visibility really counts. A lot of the time, ectopic pregnancy is conflated with miscarriage and I would say they are both heartbreaking, difficult experiences in their own right, but they are different. It is important to recognise that there is a cohort of women who experience miscarriage and their needs need to be addressed. There are also women who have experienced ectopic pregnancy, and they need to be seen and recognised in the narrative and in the communication.

Q14 **David Burton-Sampson:** Thank you to all three of you for coming in today. Vicki, we recently heard from some women who shared their experiences and one thing that struck me was that they all brought up the impact this had on their partners, and we often forget that. From your experience, and from the people you have worked with, what are the emotional impacts of pregnancy and baby loss on partners?

Vicki Robinson: You are absolutely right, and we have not always been great at considering the partners in this. We have talked about ectopic pregnancy. There is a tendency to medicalise miscarriage and ectopic pregnancy, and pregnancy loss generally, which means that it is often seen as being a women's issue and not a couple's or a family's issue.

Partners can be very significantly affected by it on lots of different levels. Jess did some research on this as well, so she might want to come in. Obviously, they have not had the physical loss, but they too have lost a pregnancy or a baby. It can have a very significant emotional impact on them, and it is often a conception that they need time off work to support their partner. But it is not just about that. They will want to be there to support their partner, but it is also for their own mental health and wellbeing that they will need that time to come to terms with what has happened.

We talk a lot to partners who express a whole gamut of feelings, but often they feel quite helpless because they are not able to physically be there, or take the pain and the hurt away from what their partner is experiencing. They also feel that their feelings are invalid, that they did not have the physical loss so they should not be entitled to have these sorts of feelings. Again, as a society, we talk to partners and we will say, "How is your partner doing?" Or, "Here are some flowers for your partner." It is not yet fully recognised that there are two and sometimes more people in this loss.

Q15 **David Burton-Sampson:** Dr Farren, did you want to add anything to that?

Dr Farren: I can give you some statistics from the study we did. We had a much smaller group of partners involved, and perhaps their lack of involvement reflects the sense that they do not necessarily have a right to engage in the research because their response rates were much lower. Generally, the levels of psychological morbidity sat much lower than in

women, and it is not entirely clear why that is. It might be because of societal expectations on them, which I think is the most likely cause, or it may be something different about the physical experience or the hormonal experience that makes a difference. But it is clear that there is impact, and I would echo what Vicki said in terms of that powerlessness being really key. I have met a number of partners over my many years in clinical practice who have witnessed their partner going through a life-threatening situation and, let us not forget, these events can occasionally be deeply traumatic.

Q16 **David Burton-Sampson:** Absolutely. Vicki, what more can be done to recognise the effects on partners and supporting them in the workplace?

Vicki Robinson: It is all the things we talked about but recognising that, for them, it is also a loss; they have had this loss. Employers, in particular, must recognise that they will need time off and to support that time off; again, not just to be there for medical appointments or to be there for their partner, but to start their own recovery process. Often, in an experience like this—as Jess and Munira alluded to—there are an awful lot of follow-up appointments and so employers should be supporting those because there can be lots of invasive tests afterwards, particularly if people are having recurrent loss as well. These can be traumatic experiences for people. We talked about them being triggering, so they should be able to have their spouse with them to support that as well. In any legislation that comes forward, it is absolutely crucial that partners are included.

Q17 **Chair:** We heard from some very brave women who shared their experiences and what happens when they are having to go to these medical appointments by themselves. Jessica, you talked about the medical management of miscarriage. For example, D&Cs or emergency surgeries for ectopic pregnancies will require general anaesthetic; they are not even allowed to leave the hospital alone. As well as the partner's grief, what kind of emotional and physical support do many of these women need following miscarriage, and particularly medical treatment?

Dr Farren: There is an element of practical support which people forget. We had a case last Friday where we had to cancel a surgical management of miscarriage because someone could not find an escort to go home with because their partner was not available and had not had the time off work. That is huge. It varies depending on what the situation is but, as Munira said, we are increasingly managing ectopic pregnancies expectantly with repeated blood tests to monitor the decline in the hormone level over time. People will often be coming back for repeated blood tests, and often they will want either the practical support of their partner or, let us not forget, if they are looking after children at home then they also need the logistics of being able to get to these appointments which are often at inconvenient times.

There is this concept in ectopic pregnancy that you do blood tests at 48-hour intervals—which is never achievable exactly within the NHS—but,

actually, what that dictates is that if people have blood tests at 9am one day, they are expected to come back for a blood test at a similar time two days later, so that can have an impact too.

Q18 **Chair:** We heard testimony from one woman who had to drive herself to A&E and nearly bled to death. You said that in instances of miscarriage it can be life threatening. The difference that could be made if their partners were given bereavement leave at the same time is not just mental and emotional, it is also physical as well. Could you elaborate on that, Vicki?

Vicki Robinson: Yes, you are absolutely right. It is about having that support network in place. There is the physical aspect of it in terms of the practicalities of having someone with you when you are having surgery, perhaps someone with you to go to appointments. There is also that aspect around people going to what they think is going to be a routine appointment and then they are given bad news about their pregnancy and their partner has not been able to be with them. That person can often be in a real state of shock and not necessarily hearing what the clinician is saying to them, or not necessarily taking it in.

It is really crucial that someone can be there with them to try to help them assimilate the information they are being given and the choices they might have to make. They have to make some very difficult decisions very early on. Partners are absolutely crucial in this process and they should not just be seen as a support network; they play a very important part in doing that.

Q19 **David Burton-Sampson:** Munira, the third sector in particular has argued that reliance on sick pay after pregnancy loss can be hugely damaging for women and their partners. Can you explain a little as to why that might be?

Munira Oza: Using the phrasing of sick pay covers over the realities of what is happening for a lot of women and couples when they go through pregnancy loss. It reinforces the stigma. It is not an illness, if I can put it that way. Pregnancy loss is not an illness in the traditional sense that we all know where you get a diagnosis, you get treatment and you get better. That is not what pregnancy loss entails. Using that terminology can be quite restrictive for people not being able to talk openly about their experience of pregnancy loss, and that certainly feeds into the workplace as well.

If you are going into the workplace with a sick note and sick leave, then the approach is quite different to having a conversation around bereavement and loss and all the attendant emotions that come alongside that. Sick leave is quite narrowing and, in some ways, it minimises the experience of pregnancy loss for people. Would you agree with that?

Vicki Robinson: Absolutely.

Q20 **David Burton-Sampson:** Vicki and Munira, are you aware of employers not following the ACAS guidance on recording pregnancy-related absences separately, and are women facing unlawful workplace discrimination as a result of employers not following that process?

Munira Oza: Frankly, yes.

Vicki Robinson: Absolutely. Yes, we have heard it all too often really. We did some research four or five years ago, which we will repeat and share with the Committee. We had about 700 respondents, 49% of whom said they were not aware of pregnancy-related leave, or their employer did not tell them about it and, therefore, their sick record was impacted because it was recorded as normal sick leave.

We have a story of one woman who spoke to us who had been called in for a disciplinary hearing because she had had multiple losses and so her absences were totted up, triggering a meeting with HR. She was so distressed by her recurrent loss and her experiences that she ended up being dismissed while she was on leave because she just did not have it in her to fight it; she just could not. There are so many other people as well. So, 11% of people who responded to us said because of the way they were treated and how their leave was treated they ended up leaving that employer altogether.

These are by no means isolated stories. We hear it all the time from people that even when they have pointed out to their employer that actually this should be recorded separately, the employer does not understand that or does not impose it. It is incredibly difficult for people. As Munira talked about earlier, for lots of people they do not feel sick; they do not see it as an illness. They do not see it should be on their sickness record. Not all the time they have off is to deal with physical symptoms. Recognising it as a bereavement would be really helpful to the people who are going through it. It would also be helpful to HR professionals and employers. It gives a very clear understanding of why that person is away. You would not be calling someone into a disciplinary hearing if they had had a bereavement, and it is the same experience.

Q21 **David Burton-Sampson:** What is the issue here? Is it that employers are not aware of the guidance, or are employers choosing not to follow the guidance? If they are choosing not to follow it, do we know why?

Vicki Robinson: It is both those things, but it also goes back to whether this should be recorded as sickness, or whether it should be something else. Should it be a bereavement? If it is being considered a bereavement, we do not have to worry about sickness rules being rightly or wrongly implemented.

Q22 **David Burton-Sampson:** Munira, did you have something to add?

Munira Oza: I was going to fully echo what Vicki said. I have a few examples here where an employee was told, "If I do not come in to do my shift, I would lose my job." And similarly, somebody went back to ICU

following a complication with their ectopic pregnancy and, again, she was threatened with losing her job. From memory, that was somebody who worked in the health service. We hear of those instances and, sadly, those are just a couple of them.

Vicki Robinson: I have a few more here that I will read out, if that is, OK? So, "My work is such that I didn't feel I could take any time off to manage the miscarriages, so I worked through both of them which was really hard." Somebody here told us that, "I was told, because there was no body, I wasn't allowed compassionate leave. I had to attend a disciplinary meeting because of sickness due to my miscarriage. It was my fourth. I ended up going through an attended management process with my manager and HR because of the time I had had off by the time I had had a third miscarriage. My employer asked for evidence which was really distressing. The evidence went to admin, and I was really embarrassed by this. My line manager ended up monitoring me for a month after my return even though she was great when I first disclosed it. She gave me informal time off, but that made me more depressed and anxious to return. I wish I could have had a formal route to do this." Somebody else said, "I was given a disciplinary for attending the hospital." These are not unusual comments that we receive.

Q23 **Rachel Taylor:** Quite often we hear of women telling us that they feel they are to blame for their miscarriage or their ectopic pregnancy. Jessica, given this sort of attitude from employers, do you think this is partly causing some mental health issues that women are facing?

Dr Farren: That is a really difficult question. Generally, what is causing it is the way society deals with pregnancy loss, rather than employers specifically. We have to go right back to the terminology we use in miscarriage: miscarriage being that the carriage of the pregnancy is at fault. Missed miscarriage: you did not even notice it. There is incompetent cervix thrown in.

It is not just that. On the flipside, when you are pregnant you are constantly bombarded with all the things that you are allowed and not allowed to do in terms of what you eat, how you sleep, not having hot baths, all these sorts of things. It is completely understandable that when you miscarry or have an ectopic pregnancy you turn that on its head and assume that you were responsible for it. It is a huge issue. So it is society at large in terms of the mother feeling that responsibility for the safekeeping of the child, rather than necessarily being in the hands of employers.

Q24 **Chair:** Jessica, obviously, we have talked a lot about partners; we have talked a lot about ectopic and molar pregnancies; but I wanted to talk about losses following IVF, which is incredibly important for same-sex couples and people with fertility issues. Could you talk a bit about that, please?

Dr Farren: It is a huge issue, and actually I am so glad you raised it. I was hoping it would come up because it is really important to acknowledge that failed embryo transfers—which are not classed as pregnancy losses in the traditional sense because the pregnancy test is never positive—are often felt as acutely as any other loss and, indeed, going back even further from that, you now have a situation where people can have unsuccessful egg collections where the results from the egg collection are incredibly disappointing. You guys have a decision to make about what you include within the remit of this Bill, but I would say failed IVF is a really important one, especially in view of the fact that, actually, as you say, some marginalised groups are maybe more likely to be affected by it.

Q25 **Chair:** Could you talk a little about the physicality of that? We have understood and we have heard very much the physical results of pregnancy loss but, in terms of IVF and the specific instances that you have raised, if you could talk a bit about that as well, that would be great.

Dr Farren: The physical impact is less because the point would be that you have not become pregnant, so you might have some marginally heavy bleeding or some pain. However, the emotional impact is immense. A lot of the time people have put their entire life savings or borrowed lots of money behind the hope of this pregnancy and it represents that complete loss of hope from often following many years of trying and miscarriages or ectopic pregnancies. It is a culmination of all this hope and effort and it is absolutely devastating. There was a study that came out earlier this month looking at PTSD in the aftermath of fertility treatment, and it is even higher than my study suggested.

Q26 **Catherine Fookes:** Thank you for all your answers so far, panel, it is really enlightening. Moving on a little now, if we may, to the areas around statutory reform and what we want to change there. Jessica, this question is for you. In their Women's Health Strategy, the last Government said they would look at what more could be done to support families after miscarriage and pregnancy loss. What should the new Government's priorities be in this area?

Dr Farren: As in by the NHS at large?

Catherine Fookes: What should the Government be doing? Do you think we need to see a change to the Employment Rights Bill, for example, to include pregnancy loss and baby loss?

Dr Farren: Yes.

Catherine Fookes: Yes? Okay, thank you. That is really important.

Dr Farren: It was a straightforward answer. It is really important, though, with all the consideration around this, that you do not alienate those people who do not feel that they need that leave because there will be a group of people who deal with this as a reproductive mishap. We

have to be careful in the way we manage these things so that we do not make those people feel like an anomaly or as if they are uncaring or do not deserve to be a mother in the future because they deal with it in a different way. It is also really important just to bear that in mind in terms of how we deal with things.

Q27 **Catherine Fookes:** Would anyone else like to comment? Vicki?

Vicki Robinson: As I understand it, under the proposed Employee Rights Bill we are now looking at a period of bereavement leave for people in general who lose a loved one, so that will be in place. Then, we already have parental bereavement leave for anyone who has a loss from 24 weeks onwards. It now feels like people who are experiencing pregnancy loss are the only ones who are not included in bereavement leave legislation and that feels incredibly unfair. It feels incredibly isolating for the people who are going through it; it feels like it is extending the taboo and stigmatising even more than it is already. We would very much want to see the Employee Rights Bill amended to have specific reference to pregnancy loss before 24 weeks and some rights in there for those people who are very sadly going through it.

Munira Oza: If I may just add that I would endorse that it be up to 24 weeks to cover the entire range of losses that happen, anything from early gestation up to 24 weeks, and not have an arbitrary cut-off somewhere in the middle.

Q28 **Catherine Fookes:** Back to Jessica's point: perhaps including and making sure that IVF is included in the definition, I guess. Munira, you supported Angela Crawley's Bill that would have given three days' statutory paid leave for pregnancy and baby loss before 24 weeks. India gives people six weeks off. Do you think three days is a sufficient minimum standard?

Munira Oza: Not by any stretch. no. It was heartening to have a proposal put forward by Angela Crawley and her team, and to have the conversation around pregnancy-loss leave and for it to be a step in the right direction. Three days is a very short space of time. You are barely managing the physical aspects in that timeframe let alone any of the emotional upheaval that is happening. While it was a step in the right direction, a longer timeframe is more appropriate.

Q29 **Catherine Fookes:** Jessica, would you like to comment on that from a medical perspective?

Dr Farren: I would very much echo what Munira said. A lot of patients with ectopic pregnancy have had laparoscopic surgery, and there is a duration of time needed for physical recovery before they can go back to work. I guess then the question is whether that should be considered sick leave rather than bereavement leave. From the perspective of my research, it only kicked in at one month, and we were seeing such high levels of psychopathology at that stage that three days sounds pretty token in that context.

Q30 **Catherine Fookes:** Vicki, should employers be encouraged to adopt flexible policies to suit individual circumstances?

Vicki Robinson: Yes, 100%. I echo what Jess said earlier as well about not imposing feelings on to people where they might not exist. We talk to employers all the time and it is really important that pregnancy loss is seen as a unique experience. Many things can have brought them to this pregnancy which can then compound that loss or affect how they might feel about that loss. People will need different things depending on their general levels of resilience, how they perceive their loss, how they deal with it, and the support networks they have at home and elsewhere. Any policy that is in place should, hopefully, offer a standard kind of guideline to what people can expect, but we would still want to see a level of flexibility. It may be that the person needs less leave than that; it may be that they need more than that. But it does not just stop at leave. The employers need to have an understanding that somebody being back at work does not mean that it is all over now and they have dealt with it. There are ongoing physical and emotional problems, and there are ongoing trigger points as well that people will experience.

Q31 **Catherine Fookes:** Is there a risk that if you have a prescribed statutory leave period it could potentially dissuade employers from adopting better policies?

Vicki Robinson: I do not think so. I can see why that would be a concern, but good employers will always want to do more because they recognise the value in supporting their employees. Giving them the time off they need to recover and giving them good support back to work means they come back to work in a much better place. They are able to work better to their normal levels, and they work to a much better standard. They are less likely to take more time off overall. There are really good reasons to go above and beyond what the minimum prescribed is, and good employers will not be dissuaded from doing that.

Q32 **Catherine Fookes:** Should the NHS be doing more on research and prevention here? That is probably for Jessica, or perhaps one of the others might want to take it?

Dr Farren: I am going to be very biased in my answers. Of course they should, which is exactly what I am very behind in my day-to-day. Actually, as Vicki was talking, it occurred to me that this whole idea of it being very individualised is so important because, actually, for a lot of people, going back to work is an important step in their recovery, particularly if they can be supported and their duties be amended accordingly.

I sometimes deal with patients who, unfortunately, work in the field that I am in, which is obstetrics and gynaecology. For some people, going back on to a labour ward or into the early pregnancy unit in the context that they have just lost a pregnancy might be especially difficult. Having the employer's understanding in terms of when they are ready and they

want to come back, if they want to do something that is not pregnancy related, that should also be supported.

Chair: Thank you very much. Does anybody else have any questions, any follow-ups? No? Okay. Thank you very much for your time and for sharing all the people's experiences and pain that you have drawn upon. Hopefully we can see progress. At the beginning of this session, we started talking about the stigma and how we need to actually have conversations about people's pregnancy journeys and, sadly, that is part of it for many, many women. Thank you so much for being here and for sharing your experiences in your organisation. Thank you.

Examination of witnesses

Witnesses: Rachel Suff, Rhea Wolfson, Thomas Simons and Nicole Basra.

Chair: Thank you for your time today. We will be hearing from Rachel Suff, who is the senior policy adviser from CIPD, Nicole Basra, the EDI director for UK and Ireland from Dentsu International, Rhea Wolfson, the head of internal and industrial relations at GMB Union, and Thomas Simons, the chief human resources and operational development officer for NHS England. Thank you all and welcome. Before we start, I want to declare an interest that I am a former GMB employer and still a member. I will hand over to Rachel.

Q33 **Rachel Taylor:** Thank you all for sitting through the first section of our evidence and for coming along today. Rachel, the results of the CIPD's 2022 survey showed that there were considerable gaps in employer support for pregnancy loss. What were the key areas of concern?

Rachel Suff: There were quite a few. In our research, we surveyed both 2,000 employers and around 300 people at work who sadly had lived experience of pregnancy and baby loss, so we had both sides of the picture. What it showed overall is that gap in workplace support and understanding that the previous panellists have talked about, including around what the legal situation is.

For example, we found that just 18% of employers record absence related to pregnancy and baby loss outside the normal sickness absence reporting system. People could therefore be subject to the use of triggers, adding to stress and so on. We found that according to employees who have been through this, under half felt supported by their employer. We found that around one in four considered leaving their job, and only around half felt able to tell their employer about their experience.

In terms of employers, just one in three had a policy around pregnancy and baby loss, sometimes stand-alone, but usually part of another policy. It was sometimes part of a maternity policy, which could be unhelpful for some people. We did find stigma and taboo still. I want to emphasise there were good stories as well as some heartbreaking testimony from

people where they had not received support, and that went for partners as well. The support made a tremendous difference in areas such as people's mental health, commitment, loyalty to the organisation, intention to stay, and performance. There is a real mutuality of outcome where support is provided. There were lots more findings, but I will leave it there.

Q34 **Rachel Taylor:** Do you think there is evidence of the situation improving?

Rachel Suff: Slightly. We carried out separate research again in 2022 through our annual health and well being at work survey report. We were interested in looking at pregnancy and baby loss, particularly before 24 weeks, as part of learning what support employers provide for people throughout the employee life cycle, and across the range of reproductive and women's health issues.

What we found in 2022 was that when asking HR professionals whether they provide support around pregnancy loss, miscarriage or stillbirth—not differentiating—26%, around a quarter, said, "Yes, we provide support to a large or moderate extent," and then a further 36% said, "To a little extent." In our last survey, which we published at the end of last year, we saw an incremental improvement. Instead of a quarter providing support to a large or moderate extent, that has gone up to 37%, but obviously that is still a minority.

Q35 **Rachel Taylor:** That covers my next question. Can you provide more recent data? Do you have that in a form that you can submit to the Committee?

Rachel Suff: Yes, we can submit those headline findings. We also have another survey going into the field in the spring.

Q36 **Rachel Taylor:** The next question is for Nicole and Thomas. Beyond your own organisations, do you think the wider HR sector is beginning to understand and provide support for pregnancy loss as a workplace issue? Are you able to give examples?

Thomas Simons: The 2022 survey data from CIPD, showing that 37% have formal processes and policies in place to support, is a good start. We see some really high-profile organisations like John Lewis, Channel 4 in media, and banking—Monzo and so on—stepping forward and saying, "This is a really important issue for women and their partners." That is increasingly so in the conversations that I am in with other organisations. We obviously want to see that translated, and the NHS wants to take, and is taking, a leading role in trying to model what needs to happen in all sectors. My sense of those conversations is it is moving, but we want it to move quicker.

Nicole Basra: Compared to maybe 10 years ago, people are talking about it more and more now. It is definitely in the news and press more. There is definitely a movement here. Maybe I need to give some context,

since not many people potentially know what organisation Dentsu is. We are a global media and marketing agency. We have about 72,000 people globally and just over 4,000 in the UK. Obviously, it is a very young industry, so there are probably many, many people within our industry who experience pregnancy loss. The research shows that one in four people are affected, so the numbers obviously are going to be quite high.

When we thought about implementing a policy like this, we looked externally as well, of course. When you present a business case to your business, you want to know what best looks like, what other organisations are doing. For example, at the time we worked with a charity called Working Families; it has done a lot of research in this space to see what good looks like. We looked at some partners and clients. At the time, it was Co-op and Channel 4 that were leading in this space, and they did 10 weeks. When we launched our policy back in October 2021, and we pulled our business case together, I felt like there was definitely a movement there and other industries would start getting on to that.

Q37 **Rachel Taylor:** You have both touched on some really good examples and employers, but do you think this is happening across the board now or is there still a long way to go?

Nicole Basra: Listening to the panel beforehand, there is still a taboo around the subject. It feels a bit like people are not willingly, openly wanting it to come up. The economy at the moment is difficult, obviously organisations always want to talk about the cost associated with it. There is movement, but there is definitely more that needs to be done.

Thomas Simons: I would concur. It is an area where there is still stigma, and it is not talked about openly by employers or employees. I say that with the NHS still on that journey, as we heard about just a moment ago. We still have more work to do, but the wider economy and different sectors do as well.

Q38 **Rachel Taylor:** Rhea, the next question is for you. What has been the take-up of the GMB's model employer charter?

Rhea Wolfson: We just launched GMB's pregnancy loss charter in October at the last Baby Loss Awareness Week. Already we are engaged in negotiations where we have recognition with a number of local authorities and one very large food manufacturing company. It is positive that it is there, and we are pleased to have presented it, because policies like our pregnancy loss charter, which you can find on GMB's website, are really important to supplement the law. It is really important that we are talking about changing the law to create a much more solid floor for rights, but it needs to be more than that.

We need to talk about organisational culture, we need to talk about how managers are trained, how we speak about these issues, making sure that we are listening to what workers experience, that we allow them to lead. We have put a lot of emphasis in our policy on the experience of

partners and future co-parents, because they are impacted very significantly by pregnancy loss, and it is really important that they are part of that. It is positive, but we have a very long journey to go before we get large employers to reflect anything like the level of rights and wraparound care that we are advocating for.

Q39 **Rachel Taylor:** It is important for our research to see some really good, positive examples of successful implementation of your model of a month's leave for pregnancy loss. Are you able to share some with us?

Rhea Wolfson: We are only in a process, as I say. It takes a long time to promote new policies, and we only launched this charter back in October. I would be really happy to come back and report when we have had some successful landing of that policy and talk about how it has impacted. But there is a reason we are asking for a month, and I did not sit in an office building; this policy was built by our members who had experienced pregnancy loss, and came to us and said, "This is really important. I really want to talk about the frankly terrible experiences I've had at work, because I don't want anyone else to have to go through what I've been through."

I would like to talk about some of that testimony if I get an opportunity. People are being put through processes that we mentioned a number of times, not just dealing with absence triggers—that is very important—but dealing with the basic fact that some people are not paid when they go off sick, and then they go on to statutory sick pay. It is a huge financial burden for some people to be off sick, and to be put into a sickness absence policy rather than a bespoke policy. I would love to come back and tell you about the positive impacts when we have been successful in ensuring this implementation, but it is another reason why we are advocating for it to be a statutory minimum as well.

Rachel Taylor: Thanks for the work that you are doing in this space, it is really important.

Chair: We will have a chance in a bit to explore the NHS and Dentsu's different policies. David, did you have a follow-up question?

Q40 **David Burton-Sampson:** To refer to my declarations of interest, I am a member of the GMB. You would have heard me talk in the first session with the first panel about the impact on partners of a couple suffering from a miscarriage or baby loss. What guidance is out there for how employers should treat partners when they are in that sort of situation, if any? That is for any of you.

Rachel Suff: Yes, we have guidance for our HR members that we produced with the Miscarriage Association and others with lived experience, and Tommy's. We also have guidance for line managers and colleagues, recognising that all areas of support in the organisation are really important. Concern and support for partners come through really strongly, as does a whole focus on inclusion, in terms of how you treat

pregnancy and baby loss, what type of loss, recognising everybody's different experiences and potential family makeup.

In terms of partners, we have provision around that, and it is so important. So often it came through to us that partners' needs were just completely overlooked, and they could be really feeling traumatised; there are mental health impacts as well. We really urge inclusion around partners and proactive support provided to them because they are very likely to be grieving too. That is a really important element, and it runs through all our guidance.

Q41 **David Burton-Sampson:** Rachel and Rhea, do you find many employers putting in provision for partners or following that guidance? Maybe you first, Rachel, and then Rhea.

Rachel Suff: The really great ones. We have worked with Co-op; they have already been mentioned. Yes, its support is just as available to partners, and it gives paid time off to partners to attend medical appointments with the physical birth mother as well. Making that practical support and leave available is really important. We were also really supportive of Angela Crawley's Bill that made provision for partners, and we would be supportive of that statutory leave being made available to partners.

It is very variable. Where employers are doing really good things and providing really good support, then yes, they are being inclusive. They are working with organisations like Miscarriage Association and developing really inclusive policies, but it is not across the board.

Rhea Wolfson: It is not our experience that it is widespread, or even common, to see employers implementing policies that support partners and recognise what they are going through. It is worth pointing out the wider context that we are sitting in: look at the pretty dismal state of affairs around paternity leave and the rights associated with that, never mind going on to talk about pregnancy loss and how it affects everyone.

I have one quote here from a member who works in the NHS. He said, "My wife had multiple miscarriages a couple of years ago now, and the support I got from the trust was none. I had to get a sick note with stress, as the trust policy didn't believe families should have compassionate leave. This needs to change."

What we see is when you do not have proper policies in place, you just push people into another policy. People end up taking sick leave, they end up in a worse physical state, and dealing with mental health issues that maybe would not have happened if they had had a very swift, compassionate and person-led intervention from their employer in the first instance. Those are experiences even in big employers like the NHS, where they should have a much greater awareness. It is very uncommon, from our experience, to hear positive stories of active support from employers for partners and prospective co-parents.

Q42 **Kirith Entwistle:** I wanted to know what more the Government could be doing to try to raise awareness about some pregnancy loss and pregnancies we talked about in the first panel. Also, in your view, how far does the Employment Rights Bill go in providing some support?

Thomas Simons: Well, I can give a bit of a summary of the things that we considered before introducing what we have done in the NHS, which is a policy framework for women who experience loss, but also for their partners. I really welcome that question because it is one of our big learnings. There are three big things that we have considered: what is the impact? What do employees want and need in terms of support? What are the interests of the employer in introducing these supportive interventions? Then there is a question about what the cost is of introducing those measures.

Our assessment on all those three dimensions is that yes, of course it is in the interests of employees, and absolutely the employer. The cost is pretty marginal, and that is even without thinking about things like retention and turnover. For us, that was the right and appropriate decision for the NHS to make. For Government and for this Committee considering it, there will be other broader considerations: the size of the organisation, the type of absence arrangements they have in place already, and more broadly, the kind of modern workplace and type of society we want to be in, really. That feeds into your thinking.

Rhea Wolfson: In terms of the Employment Rights Bill, which is a very positive thing that GMB really welcomes and is excited about so many parts of, we do not cover this issue sufficiently. The basic safety net is not there for people who are suffering pregnancy loss; we class that as miscarriage or termination before the 24th week of pregnancy. Those rights just are not there, they are not included in the Employment Rights Bill, and we need to look at that. Having those statutory rights creates a floor, of course, and it is vital. Sometimes they create ceilings, but that is the way our employment law is set up, so we should not be too scared of that.

It also increases awareness of the issue and helps reduce the stigma. One of the comments we had from a school support staff member was, "There is no support unless you ask for it, so women are just forced to carry on like nothing has happened." That was a really common thread of the testimony we had, "I just picked up and got on with it because I didn't know whether my employer would be sympathetic, whether I would have access to anything, whether I would be told to go home and therefore I'm not paid." That is a very scary prospect for people at work. That floor of rights is absolutely vital. We are talking about people's physical safety, we are talking about their mental health, we are talking about trauma. These are big issues, and we are pretty far away from actually tackling them head-on, and tackling them in statute is really important.

Nicole Basra: Government can really help to raise awareness around the topic as such, because as I said, people still do not really talk about it. I have personal experience and when it hit me, it hit me out of nowhere because there was just nobody really talking openly about it.

Number one is raising awareness, actually having it openly out there that so many people are affected, and doing a bit of an education around the subject. Of course, people need time to grieve, and yes, 24 weeks is a very late time to offer that support because people suffer a lot, much prior to that.

Rachel Suff: It is a really important question. We would be really supportive of putting in place that statutory floor as well, and the Employment Rights Bill seems like a really good opportunity to do that. The clause dealing with bereavement is the ideal place.

As previous panellists have said, and it came through in our research, sickness absence just is not the appropriate, helpful way to deal with this kind of loss and grieving. We would really support provision for a certain number of days' paid pregnancy loss, miscarriage leave, definitely. If that statutory right was there, it would first help to raise awareness of the need for compliance on the part of employers, because still far too many women or partners cannot get that basic leave. It would also help to reduce some stigma around it, because it is there, it is a right. You do not have to go and quibble, or ask or beg, or worry and stress about what you can get, because it is just there, and it is available.

Feeding into that more broadly, in terms of what the Government could do—because again, now is a real opportunity—we have a women's health strategy, I do not know whether that will be revisited with the new Government. We have a women's health ambassador. Having even more focus on the role of the workplace is important because actually a lot of people talk to people at work.

I have had several losses, and sometimes it is really hard to talk to people you are closest to, it can be easier to talk to the people at work, plus people do have real friendships at work. The workplace is such an important place to provide support, reduce stigma and so on. We have seen tremendous progress around menopause, which was so heavily stigmatised. We can do the same for these other really important workplace well being issues.

The NHS can also play a really great role as an employer, as well as obviously your health service. We would be really keen at CIPD. We have really evidence-based research, thorough guidance informed by experts and lived experience. We would be really happy to develop that more broadly.

Chair: Thank you, Rachel and Nicole. I am very sorry for your losses. Rachel, could you share that research with us around the feelings of why sick pay is not applicable or suitable? That would be really useful, thank

you.

Q43 **Rosie Duffield:** It is worth mentioning before I move on to my section that Nicole mentioned creative industries, and Rhea was talking about no pay, but of course a lot of Channel 4's employees, for example, will be creatives who are freelance. They are not going to get sick pay at all if they go through this and then decide themselves how long they need out of the workplace. Perhaps we could look at that in the report as well.

I am going to talk about the NHS miscarriage leave scheme now. Thomas, this section is for you, if that is okay? What proportion of NHS trusts have implemented the miscarriage leave policy since it was introduced in March?

Thomas Simons: The work that we started on pregnancy loss was actually started in Birmingham Women's and Children's NHS Trust in 2021. It started developing supportive policies back then, and it started gathering some momentum. By the time we started responding to the review from 2023, it had already been adopted by about 30% to 40% of NHS trusts already. As you would hope, there was a movement of understanding some issues in the National Health Service and among HR practitioners working in that sector. We introduced it in March of this year. We then introduced planning guidance each year, which is a document that sets expectations and priorities for the NHS as a whole.

As you will know, we made the adoption of the policy one of the priorities for all organisations. We are about eight months into our journey of adopting, and Amanda Pritchard very much led in promoting it as a priority for everyone to adopt. We did a snapshot survey just before joining you, and about 80% of those that responded have adopted or are in the final process of doing so. I hope you do not mind, Sarah, I took a look at your constituency, and Milton Keynes has done it, Bedfordshire has, Luton is just about to launch it. You can really see the evidence of it taking hold. But we are still in the early stages of that.

As colleagues have mentioned, there are cultural aspects, and the really important thing about our policy is it is a national policy, but individual employers in the NHS need to adopt it. That is important. Although really supported by national unions—GMB and Unison and others nationally—we want that conversation to happen locally. This is about the culture change and about the conversations that happen about this issue in the workplace. That is the important part of the adoption.

Q44 **Rosie Duffield:** Do you expect 100% of trusts to implement the scheme and do you have any timeframe about how long that will take?

Thomas Simons: That would be our aim, that is what we would like, and that is very much what Amanda has set out as a priority in the planning guidance. As I said, we are about eight months in. We are going to start a formal evaluation of the work in April next year, both about the level of adoption and whether we have things right in it: the number of days, the type of support. Already there are a few things that we are hearing

about, and ways we are thinking we would like to evolve the policy. We will see where we are, and we would be very happy to share that back with the Committee if it would be helpful at a later date.

Q45 **Rosie Duffield:** Brilliant, thank you. A lot of the questions in this section were really about the feedback that you are getting, but it is at the beginning, it is in the early stages. Have you had feedback yet that implies that partner leave is going to be taken up as well? All these issues that we have talked about, will the NHS try to look at those things?

Thomas Simons: Birmingham Women's and Children's NHS Trust did a fantastic job in 2023 of independent evaluation of its policy, which was quite staggering in terms of its results. It was a group that had not accessed support versus those that had access to support; 85% of those that had felt valued, versus 31%. Those feeling that they were physically supported in the workplace: 73% versus 40%. Being able to talk freely, on a 10-point scale: 6.9 versus 4.1, and so on. We could share that Birmingham Women's and Children's NHS Trust report because it is incredibly compelling.

Q46 **Rosie Duffield:** What have you found have been the key practical and administrative challenges so far? Maybe it is a bit early to tell, but have you come across anything that makes it difficult or that you have learned from?

Thomas Simons: First, there is no practical reason why employers cannot put this in place, okay? From an administrative, HR perspective, that is not a problem, and we have not found it to be so. What we have learned is that local adoption, local culture change, training leaders, managers, overcoming some stigma that we have heard about today, is really at the heart of whether this is successful. We are hearing some really positive stories from staff who have experienced employers, local NHS trusts that are really leading the way in adoption. We are encouraged by where we are. We are not complacent but encouraged.

Q47 **Chair:** Thomas, can I just push on the finances? You said it was a very minimal cost. What is the net effect of the amount of paid leave taken? What are the projected overall costs for the trust? I know that that will be key to actually making sure that this finds its way across the entire country.

Thomas Simons: It is not an easy thing to model, because the evidence we have seen is that women and their partners either come to work when, in essence, they should not be at work—we have heard some really horrific stories from staff about that—or they take sickness leave, as opposed to a more appropriate type of leave, as we have heard happen. However, we have a sense of the number of trusts that adopted it already.

We are obviously at day one sickness, we have sickness provision, payment provisions in place. We looked at what the maximum level of exposure would be across the National Health Service, and we equated it

to something like 0.01%. That was without considering the benefits for retention, turnover, absence, staff engagement, or productivity. Our view, or that of our chief finance officer, Julian Kelly, who spoke about this a while ago, was that it was negligible.

Q48 **Chair:** Thomas, that is going to be huge news, given the fact that the NHS is the largest public sector employer of women, to hear that it is such a minimal cost to implement something such as this, without even factoring in the retention costs, as you say. On this, are you putting a target for individual trusts to have implemented your policy and to have taken it up? You said 80% of the respondents, but that is not 80% of the trusts. How long are you giving them, and are there going to be any extra support or incentives for trusts to join, to make use of this change in policy?

Thomas Simons: The end of this financial year is a good stocktake point for us, because where there is local engagement and real discussion and debate about this sort of policy, that is healthy and good for employers. From my perspective, it should not be a binary game of have you or have you not, this early on. As we move into the end of this financial year and into the next one, we would expect employers to have adopted the policy, and we will have real data about that in April.

Chair: Kirith, did you have a question?

Kirith Entwistle: No, I just needed to declare that I am a member of the GMB and to refer members to my register of interests as well.

Q49 **Chair:** Thomas, I know that you have said to the end of the financial year. Do you have any plans to publish any of the assessments that you make on this policy and the roll-out of it, and the benefits as well as some barriers that you have managed to overcome?

Thomas Simons: Yes. We are not waiting until the end of the year, we are obviously learning a lot about the policy and its adoption already. We want it to be independently assessed in April. We would really welcome sharing any of the learning that comes from that with you, if that was something you would like, absolutely.

Q50 **Chair:** Does anybody have any follow-up questions at all for Thomas on this? No. I am going to move on to the private sector schemes now. Nicole from Dentsu, before we start, the NHS scheme has been outlined, could you just give us a brief summary of what Dentsu's policy is on this?

Nicole Basra: Yes, sure. We implemented our policy back in October '21, so it has been in place for a number of years now. We offer two weeks of paid leave for anybody experiencing a pregnancy loss, but also their partner. It is the same rights for everyone. Of course, in difficult circumstances there is room for additional discretionary leave, if need be.

Q51 **Chair:** What have you seen, in terms of the level of take-up for this by women and their partners since your implementation?

Nicole Basra: We encourage people who experience loss like this to put it in our system as compassionate leave. Of course, at the time we thought about it, but we thought it was a bit insensitive to ask for specific reasons.

If you look at compassionate leave, if you go through a difficult situation like this, people arguably potentially do not even put it into the system. But I had a quick look, obviously, ahead of this meeting to prepare. Back in 2023, we had 238 people who took compassionate leave. The majority took one to 10 days, but we had uptake up to a year. It is very difficult to say what percentage of that could be related to pregnancy loss. This year we had 184 people taking compassionate leave, and as I said we are just over 4,000 in the UK. My assumption is that people do not necessarily put it into the system.

Again, in order to prepare for this, we have an amazing parents and carers community, an ERG that we tap into quite a lot. They helped us to pull this policy together at the time. They have been really crucial in putting it through, because obviously you listen to your people, you listen to their stories. We are very fortunate, there is a very good culture there. We are a Japanese heritage company, and we talk a lot around the sanpo yoshi philosophy, which in essence means what is good for our people is good for business and is good for society. If that all works nicely together, everybody wins.

There is more that we can do, of course, but we are really trying to support our people wherever we can. Our parents and carers community is 600 people strong. Before I came to this meeting, we put a little question out there in terms of how people have utilised it. I thought I would share some comments here with you; I need my glasses because the light is not great in here. I had five people within a week who came forward and said they have used the policies, which is quite good given the very short notice.

One person said, "The support offered by baby loss policy has strengthened my loyalty to Dentsu as an employer. I felt my struggles were heard and validated. Allowing time off to rest and recover allowed me to return to work in a much better headspace, and be more productive as an employee (compared to when I returned to work following baby loss where there was no policy in place)." Another person said, "It was incredible to receive the support. Having time to grieve and openly talk about the loss really helped me get through this difficult time." Another person said, "Not only having to deal with the physical elements of pregnancy loss, but emotional loss, it was great to know that Dentsu understood and supported me. Having time and space you need to grieve in the form or capacity of a pregnancy policy is invaluable."

Then when you ask what benefits there are for a company, we talk a lot around loyalty, retaining talent, doing the right thing—again, at Dentsu we talk a lot about doing the right thing for our people and actually

supporting them in times of need—staff retention. There is also obviously a lot of work that is done around mental health in general. Yes, it is difficult to track how many people have used it, but the culture suggests that it is definitely there to be utilised. Again, to the topic around the taboo, people would take the time off. From a cost perspective, if they need time, it is sick leave. But you are absolutely right, sick leave does not address the issue. For me, addressing and having an open conversation around the topic really helps people to get through those difficult times.

Q52 **Chair:** I know that you said that it is difficult to identify the data split between compassionate leave and miscarriage bereavement leave from the way that it is recorded in Dentsu. Since it has been implemented in 2021, has there been a change in costs? Have you seen an increase, or is it very minimal in the same way that Thomas outlined for the NHS?

Nicole Basra: I would say it is very minimal. As I said, if people need the time off, they probably book it off as sick leave anyway. This is the private sector; we are a multimillion-pound business. From a financial stability point of view, that would not have impacted our financial stability. There is nothing really that we can attribute directly to this. The main thing is from the perspective of culture. As I said, it creates loyalty, and in times when a company potentially is not doing so well, you hope you retain your talent. If you have your employee's back at a time when they need it, you hope that gets paid back eventually. Arguably, you probably are in a better place if you can support your employees.

Q53 **Chair:** I was going to ask about training within Dentsu, which is obviously big and multinational. A policy is only as good as the people implementing it. This will probably be extended to Thomas in a bit as well, about the training that you are giving management. Rhea said about the appropriate language, about how you are using your policies, and how you are there to support your employees in the best way that you can. Did you offer implementation training for this change in policy?

Nicole Basra: Yes, we very much do. To accompany the policy, we also developed some line manager guidelines—which are really, really critical—that go along with the policy. As I said earlier, we are a very young organisation, so the line manager guidelines are actually sensitising your employees around how often it happens, what it means, what an employee potentially experiences going through a loss like this, hints and tips that you as a line manager can do to help your employee to get through this difficult time, then signposting great, helpful resources, like the Miscarriage Association or Tommy's. There is so much out there and actually, if you go through this you do not want to search yourself, so there is lots of signposting done. Definitely, education of line managers and helping them to help their employees is really important.

We offer training because obviously a policy is only good if people are aware of it. We constantly try to reiterate what kind of policies we have to support our employees: pregnancy being one, but we also offer a

fertility policy, for example, we offer neonatal care and premature babies, again, to support people whenever it is needed.

We have a great peer-to-peer support network through our parents and carers community, for example. People share their stories on our intranet internally and put themselves out there to be contacted in case of need. Arguably, the people sharing their stories probably have had time to deal with it, so they are able to talk about this. It is really nice. I shared my story, and on the back of that people came to me and asked me, and I was able to be a good buddy to them.

The peer-to-peer support is really critical. We have mental health first aiders and we have an EAP: an Employee Assistance Programme. Signposting all this available support is important because people do not necessarily come forward when it happens to them. No, they look for confidential people, people they can talk to on a one-to-one basis, rather than talking out loud about what happened to them. Signposting this available support internally is really critical.

Q54 **Chair:** Thomas, did you want to add anything on the training of managers point? Is that part of the policy?

Thomas Simons: Yes, it is very similar. I would say that for the NHS, we have a very active programme around improving the experience of staff in the round. We have something called the People Promise, which has been built from staff comments. One of those is particularly around health and well being. The training of managers is core to all that. We have actually set out manager expectations in the round, around the kind of experience that staff should be having in the National Health Service. Culture and experience are an important umbrella for this work as well.

Q55 **Chair:** I just wanted to ask you, and possibly Rachel and Rhea on this, do all your policies and your guidelines cover terminations for medical reasons at all? They do.

Rachel Suff: And embryo loss.

Chair: Everybody, okay.

Q56 **Christine Jardine:** Apologies for coming back in after you had started. Nicole, what is your view on extending eligibility for two-week statutory parental bereavement leave to employees affected?

Nicole Basra: Going beyond two weeks?

Christine Jardine: Yes.

Nicole Basra: Well, as I said, we have this discretionary support available in any case. We talked about how people have different needs at different times, so it is important to be flexible around this. Two weeks is a guideline. It is the same as we offer for compassionate leave, for example, if you lose a close relative, so it is aligned with that. Anything like that at the moment is based on discretionary leave. As I said, when I

looked at the uptake, there were actually quite a few that went well beyond the 10 days.

Thomas Simons: It is really interesting. The NHS policy is up to 10 days. What we have seen so far from the evidence in Birmingham is where you create a very supportive environment, where managers are trained and the employer is actively supporting this space, what has happened is individuals affected have so far come back in between about five or six days. There is something about the signalling of the leave and the support that is just as important as the number of days specifically.

Q57 **Christine Jardine:** I wonder if there are any key points that each of you would like the Government to bear in mind, or that you have learned that could be important?

Nicole Basra: We did touch on that a little earlier, and it is around awareness and openly talking about it. I was saying earlier; when it hit me, it hit me out of the blue. There is actually not much awareness, unless you obviously go into researching it and then you find all this information. I do not know whether it has changed, but at the time, the NHS would not offer help until it happened to you three times consecutively. Then when you had a baby, you had to have another three miscarriages in order to get help again. Raising awareness first around how it happens a lot, and secondly, what is available; openly addressing it.

Again, when I went through it, my line manager had no idea. It was 10 years ago, so I am hoping we are at a different place now. She called me in the hospital and asked me when I would come back to the office. Even my friends, I love them dearly, but they would come to comfort me, and they would bring their young children, and it would hurt. Raising awareness about the impact it has and how people are suffering is really important. Time to grieve is also critical. I came to the office at 6 o'clock in the morning, because I needed to avoid going into a room full of people asking me how I was, because I was worried I would burst into tears and not be able to stop. Grief takes different amounts of time. There are two things for the Government: definitely help raise awareness around the topic, and encourage organisations to provide leave to grieve.

Thomas Simons: First, definitely addressing the stigma and addressing that front-on is really important. Secondly is probably around this issue of not seeing this as a cost, but seeing this as absolutely vital for healthy workplaces, and in the interests of the employer as well as the employee, and that balance is really important.

Thirdly, the big learning we have had is to David's point about partners and the support they need, as well as enabling them to support the woman. We underestimated how pervasive that was as an issue in the implementation. We have seen that, and men have spoken on a number of occasions to me about that being an important part of the policy change that we have made.

Rachel Suff: I definitely agree with both panellists. Just flowing from that, Government could have such an important enabling role in terms of working with organisations like ACAS, which provides such great advice and has guidance already, but also membership in other organisations like the NHS and trade unions and leading employers in the area. They could raise the importance and understanding that it is a workplace issue, because some employers might not see it as such. We see it with other well being issues, that this is something private, it is intimate, it has no place in the workplace. Yes, we know that some people might not want to talk about it, grief is intensely private and so on, but the onus is still on the organisation to recognise it as a really important workplace well being issue.

Providing practical support is very important, but the second most valued type of support after paid leave, according to people we surveyed was, "Understanding from my manager that it can be a difficult time." It does not cost anything to create that culture, that environment, and open up the conversation so that people can seek support if they want to. It will open up the culture.

Rhea Wolfson: I want to come back to that missing floor of rights, because this is such an important chunk of our legislation that is missing. It brings together how we often misunderstand or do not take seriously enough health issues that women face, and discrimination that women face in the workplace. It brings those issues together, and it is so important. I have testimony from a member who works in the non-profit sector. She said, "I worked throughout my miscarriages and was given the option only to work from home, which was insufficient in my view. The emotional distress and the physically harrowing aspects of a miscarriage, particularly if the pregnancy is advanced. Additional time should be permitted for appointments, D&C procedures and therapy, without cutting into annual leave or other kinds of leave, like bereavement. Pregnancy loss is unique and deserves recognition."

We need policies, if not statute, that take into account that grief is not linear. Anniversaries come about and everyone is different, everyone experiences pregnancy loss differently, but a floor of rights allows us to have a better quality conversation and a minimum standard that workers can expect, and raises that expectation that women can go into work and have their mental and physical health taken seriously.

Just coming back to your question; you talked about two weeks. Well, after two weeks often people are still suffering significantly physically, without even talking about the trauma and the toll on their mental health. Physically, depending on what procedures people have undergone, two weeks is not a long recovery period, and that is when you get into sick leave, which yes, ties up with stigma, but it is really practical. People do not get paid properly, people might turn up to work, and it is a false economy because people take the leave they need to take, they just might have to do it in a way that punishes them financially

or even causes them to potentially lose their employment altogether. That is maternity discrimination packaged up in a different way, that we are just not taking seriously enough yet.

I welcome this Committee hearing and the fact that people here have shared their testimony. I know there will be other people in this room who have not, and that is so important for tackling the stigma. It is also important just to say we are going to take this forward really practically because these issues impact so many people, and we have something really fundamental we need to do.

Chair: Christine, before you come to your last question, I know Rachel wants to come in on the point that has been raised just now.

Q58 **Rachel Taylor:** Yes, you have touched on this, and it is particularly for Thomas and Rachel. A lot of employers and line managers would probably say that they are ill-equipped to deal with these issues in the initial conversations that employees may have. Do you think there is a role for Government, and particularly for organisations like ACAS, or larger employers like yours, Thomas, to push out a package of training to equip those line managers and employers—particularly small employers—with some tools to be able to deal with those situations?

Thomas Simons: It is really important that large employers first work with their trade unions, and work with employees to develop a package that is easy to use, that signposts and creates an environment where people are inquisitive to know more. This is an area where, because it has been stigmatised, people have not talked about it in the workplace, either employees or employers. What we have done in our policy framework is, of course, given the details you expect about how many days and so on, but also said, "This is where you can access more information, this is where the video is that you can see more from Tommy's."

It is for local employers in the NHS context to work that through on the ground with line managers. It may be that a line manager does not encounter that experience, and it could be intermittently, it might be once in a year. It needs to be comprehensive enough that they can take it off the shelf and go, "Okay, what should I be doing here? What are the things that are important?" And then be able to deal with things compassionately.

Rachel Suff: Yes, I completely agree. It is absolutely crucial that line managers feel confident, comfortable and capable of having those conversations. They play such an integral role in terms of supporting people's health and well being in a number of ways. They have the day-to-day contact with people, they will be managing the work, they will be managing absence, return to work, day-to-day. It is true in the NHS as well, that they will have that relationship and be implementing all those policies. Their role is multifaceted, but obviously they are very busy, and

often they are not given enough training or investment, and in terms of issues like this, many will feel unconfident.

That is why we produce specific guidance for line managers. It is really accessible, practical, and breaks it down into knowing what to say. We also have tips of things that might not be helpful to say, because what we find is that silence is stigma, and very often it is because people are afraid of saying the wrong thing, because they might not come across this issue very often. We do not know what line managers themselves are going through either.

That guidance is how you bring the policy to life, and how line managers can bring that policy to life is critical to the support that that person will receive. They will be the ones who should know what policies can come into play, like flexible working and reasonable adjustments. They will know what support should be available, like a gateway for all the management policies, and will signpost where there is an employee assistance programme or advise not to use the trigger system for absence and so on. It has to take place within that context of a trust-based relationship with the individual.

The role of line managers is absolutely critical. But they are not counsellors or medical experts, and that is why they need training, otherwise the risk is that they will stray into trying to fix the problem or give advice, and they should not be doing that.

Q59 **Christine Jardine:** People might suggest there might be an unintentional consequence of extending leave, that it would dissuade companies from, say, the GMB policy charter. It might have a counter effect.

Rhea Wolfson: We need minimum standards. That is how our employment law is set up: minimum standards, whether it is minimum wage, whether it is statutory sick pay, statutory maternity leave. We need minimum standards. We need more than minimum standards, but that is where trade unions and collaborative working come in, where we advocate for stronger policies that have that wraparound support, whether it is guidance around language, or whether it is training or access to counselling, buddy systems, any of that. It is not a strong argument to say there is a risk that if we introduce minimum standards, we will not get more. If we do not introduce minimum standards, we will not get minimum standards.

Q60 **Chair:** Just to be clear, GMB is suggesting, and I have heard across the panel, that you would like to see this written into the Employment Rights Bill, or that that would be a good place to start?

Rhea Wolfson: Yes, we think that. There is more in our charter that is not statutory that is really important to look at and we will be advocating for, but there are basic rights that should be considered in the Employment Rights Bill.

Can I just make one comment, because I have missed it? We have not really talked about the intersectionality around this issue, which is really important. Yes, we have talked about how pregnancy loss affects women and their partners, but it is worth highlighting that some people are more likely to experience pregnancy loss, including black and black mixed heritage women, who experience a much higher rate of miscarriage. Disabled parents may experience more pregnancy complications and impact on their physical and mental health. LGBTQ+ people may have more complicated fertility journeys, in many cases more expensive, and different routes to pregnancy. A policy like this is really important for lots of different communities and that is really important to highlight.

Q61 **Chair:** I am going to ask each of you in turn just to summarise your final points and what you would like to see, or what the benefit has been to your organisation for implementing miscarriage bereavement leave. Rachel, I am going to start with you, and you have about a minute each, if that is possible.

Rachel Suff: I would like to focus on that last question then, around what we would like to see from the Employment Rights Bill and whether there is a case for statutory change. In this case there definitely is. Legislation does not always solve the problem, sometimes it does not always do enough to change employee behaviour. We have talked a lot about the need to change the culture in organisations as well, and that is really important, such as what Tom said about how it is not just the number of statutory days that you are allowed to take in leave, it is everything that goes around that.

However, in this case there is such a cliff edge in terms of that gap in statutory support, that it really needs addressing. Literally from one day to the next you could have experienced a loss, and at the moment it is so stark, and the differential in terms of what you are entitled to by law is so big, that there is a really strong case for improving that statutory floor and giving everyone the right before 24 weeks—no matter what stage, because it can be just as devastating—to some statutory basic provision for paid leave.

Thomas Simons: It would not be surprising for the NHS to say we think what we have done so far is a really good step in the right direction, particularly affecting women and their partners. That is important. It is still really a work in progress for us. Some things you just mentioned, or some areas we are grappling with about things like surrogacy and things like that, we have not been as clear as we want to be. There is definitely work for us to continue to do, and good employers will do this work because it has a positive impact on both employees and their organisations.

The question around whether it needs to have statute to strengthen it is a question really of whether we think employers in the round will take this forward, because of the things I have mentioned: either there is no interest to do so, or we might need a harder lever to make that change

and change the stigma. That is ultimately the question that Government will be considering.

Rhea Wolfson: We want to see a statutory floor of rights that applies to workers experiencing pregnancy loss, which we define as an expected or unexpected end of pregnancy before the 24th week through miscarriage or termination, obviously as a day one right. We want to see employers adopt policies like the GMB charter on pregnancy loss to ensure that wraparound support and guidance, and to ensure that all employers, no matter their size, are best supporting all workers that are experiencing pregnancy loss, directly or through their partners, in whatever role they are playing.

Nicole Basra: What I would like to see is definitely the awareness around the subject and the leave, of course, at any point in time before 24 weeks. As soon as you find out you are pregnant you start imagining your life, and that is a loss. If a company has a compassionate leave policy that is two weeks, why would pregnancy loss be different? For me, it is definitely awareness and the leave benefits.

Speaking as an employee of Dentsu, I feel incredibly proud to work for an organisation that actually puts their employees first, and cares for them and supports them in a time when it is needed the most. From a personal perspective, it would have meant the world to me if I would have had support at a time when I needed it. It is really tricky, and 10 years down the line it is still triggering sometimes. I really applaud you for trying to push this. I know it has been on the radar for a number of years, so I really applaud you for trying to make a change and to make the world a better place for people who experience loss in that way.

Chair: Thank you all, and thank you for all the work that you are doing too, and for coming to share your experiences as well as the experiences of the people who work in your organisations who seek your representation every day. If there is anything that you think you want to follow up on that you did not cover, or any specific research or text that you think we should have access to, please forward that on to the clerks, it would be really useful.

I said in the private session that this was a particularly heavy topic. For anybody watching, and for all the panellists and everybody here, please be kind to yourself today. This has been a really powerful session, but as outlined, incredibly necessary. Thank you very much. That brings proceedings to a close.