House of Commons

Women and Equalities Committee

Oral evidence: Menopause and the workplace, HC 602

Wednesday 16 March 2022

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Watch the meeting

Members present: Kate Osborne (Chair); Elliot Colburn; Carolyn Harris; Kim Johnson, Bell Ribeiro-Addy.

Questions 138 - 179

Witnesses

I: Maria Caulfield MP, Minister for Patient Safety and Primary Care, Department for Health and Social Care; Michael Warren, Director, Labour Market at Department for Business, Energy, and Industrial Strategy; Paul Scully MP, Minister for Small Businesses, Consumers and Labour Markets, Department for Business, Energy and Industrial Strategy; and William Vineall, Director, NHS Safety Investigations, Department of Health and Social Care.

Written evidence from witnesses:

Examination of witnesses

Witnesses: Maria Caulfield, Michael Warren, Paul Scully, and William Vineall.

Q138 **Chair:** Welcome to the final session of the Women and Equalities Select Committee inquiry into menopause and the workplace, which I am delighted to Chair in the absence of Caroline today. I would like to welcome our witnesses, and can I please ask you to introduce yourselves, if we could start with Michael, please?

Michael Warren: Thank you very much, I am the director of labour market policy in BEIS.

William Vineall: I am the director of NHS quality, safety and investigations at the Department of Health and Social Care.

Maria Caulfield: I am the Minister for Primary Care and Patient Safety, and women's health comes under my brief.

Paul Scully: I am the BEIS Minister for covering the labour markets in this instance, also consumers and small business.

Q139 **Chair:** Thank you all and welcome. Can I start with the Minister Caulfield, please? Despite menopause being a natural part of ageing, the Committee has heard that there is still huge stigma attached to discussing menopause, and often women's health more widely. Can you start by telling us what the Government are planning to do to challenge these taboos in relation to menopause and women's health overall?

Maria Caulfield: Thank you very much for inviting us this afternoon. It is great that the menopause is being investigated and held to scrutiny. The Government are taking the issue of the menopause very seriously, with Carolyn's debate in October. The issue of the menopause being taboo and not being spoken about is widely accepted. For generations the menopause has just been seen as something that happens secretly to women as they reach a certain age. Historically it has been called "The change" and people do not talk about it amongst families, in the health service, in society as a whole. It is often just seen as women get a few hot flushes and their period stops, and that is it.

The attention that Parliament has given to the issue and having debates in the main Chamber, debates in Westminster Hall, having the inquiry here, has really helped open up that debate and start to tackle some of the taboos. Just talking about the menopause, whether it is here in Parliament or in the wider society has really helped. So many women have contacted me, and I am sure many other MPs as well, to say thank you for speaking about it. Many women did not realise they were going through the menopause and thought that the symptoms such as not sleeping at night, brain fog, joint aches and pains, depression and mood swings meant that they were not coping with life. Many of these women are going through very busy periods of their life. They may have teenage children, they may be looking after other family members, they may be

at the peak of their career and trying to juggle all these things. Many of them felt they were not coping, when actually when you stop and say to them, "Could you be going through the menopause?", it is like a light bulb moment, so we are taking this very seriously.

Since the October debate we have set up the Menopause Taskforce, which met for the first time in February, where we have BEIS, DWP, Education and Health all coming together to see how we can improve the experience of the menopause, which all women will go through and which has such significant effects on their life, whether that is in their health, in their jobs, at home and with their families. How can we work together to get best practice out there, to try and eradicate some of the taboo and stigma around going through the menopause? We are also in the process of appointing a women's health ambassador. We have interviewed candidates, and we hope to be able to make that announcement very soon. That is someone who will lead on women's health issues, and the menopause will be a significant part of that role. There is a huge amount that they will be doing to push the message out there, but also to try and change the experience of the menopause for many women.

We also have a huge amount of work that we are doing on HRT, because that is a key issue with the menopause. Many women are not aware that they can have HRT; many GPs are not aware that they can prescribe HRT and the impact that can have for women. There is a huge range of workstreams specifically about the menopause that the Government are really pushing—women's health is very high on the Government's agenda, but the menopause in particular is high within that priority area.

Q140 **Chair:** During our inquiry we have heard about particular challenges for some groups, such as ethnic minority women, younger women, LGBT+ people. We have heard that raising wider awareness through translating materials into different languages would help, as well as normalising conversations about women's health and tackling harmful attitudes. If I can ask you again, Minister, how will the Government ensure that those groups are included in your work?

Maria Caulfield: While we did get over 100,000 responses to our call for evidence for our women's health strategy a year ago, we are very conscious that the voices we did not hear from are equally important. There are groups of women, whether from ethnic minorities, homeless, the travelling community, particularly those women who are self-employed or work in very male-dominated professions, who often struggle. We are getting lots of feedback from businesses about how they want to improve the workplace environment for women. But not all women are lucky enough to work for such an understanding employer and for some women, if they work for themselves, having time off to go and see a GP or chase up about trying to get HRT is not easy. There is a group of women from a variety of backgrounds whose experiences of the menopause we want to make sure are heard. Ensuring that they have equal access, whether that is to their GP to talk about their menopausal

symptoms, getting access to HRT, or support in the workplace so that they can stay in the workplace, is really important.

The women's health ambassador will have a key role in that. Certainly when we have been interviewing candidates we have asked questions about how you reach those communities, those women where the menopause is either more difficult because of their circumstances, or where they feel that they are not able to access the support that is there to help women get through a life-changing experience. I would definitely say the women's health strategy, which is due to be published this spring, will focus on this, and the women's health ambassador will have a key role to play in that. The NHS also has a workstream around menopausal pathways that they set up last year. One of the key pieces of work that they are doing is looking at how the NHS can support women from different communities that may not feel able to approach and ask for help, or where the menopause is particularly difficult for them. The NHS has taken on the responsibility of leading on key pieces of work on that itself, so I think we are live to that issue. That there were 100,000 women was great, and in the over 40s the menopause was the biggest issue that they raised, but it is the women who did not respond that we also need to hear from.

William Vineall: It was the third highest issue raised in the call for evidence, overall highest for those in the 40s to 60s age group. When we produced the vision at Christmas, we said that we needed to make access to services equitable, including for those women who have additional barriers. We need to focus on that in the vision, and secondly, we have to get the right data so we can actually understand the groups that are being missed—something that we learned from the call for evidence—which we need to pick up.

Chair: Thank you. Carolyn.

Q141 **Carolyn Harris:** Can I just ask around that data. Have you any plans to actually get in touch with the communities who are not responding? You can see my inbox if you like, but in general I am thinking about people on low pay, women who are actually in the workforce who cannot afford to give up, they do not know the menopausal, they have no messaging. How do you intend to actually reach those groups?

Maria Caulfield: Through working with the women's health ambassador, that is a key part of the ambassador's role. It is not just about raising awareness of the menopause generally or encouraging women to push for HRT if they are not getting it or working with healthcare professionals to improve their knowledge and management of the menopause, but it is really to look at those groups of women from a wide variety of backgrounds, to make sure that their circumstances are taken into account. There are women who are maybe sleeping rough or are homeless, who just cannot access healthcare services easily anyway, and so particularly for the menopause, are less likely to go and see a GP or be able to access HRT. Women who do work in smaller companies that may

not have a menopause policy at work, may not have a menopause champion at work. It is really important that those women have equal access to help and support. We want to make sure that they are included.

Q142 **Carolyn Harris:** How are you going to get that message to them? Is there a proactive way whereby you would physically get that information to those women?

Maria Caulfield: *W*e will be using a number of workstreams, which we will set out in the women's health strategy. It is about raising the profile of the issue nationally, so that women become more aware of it. If they are from a community that struggles to access healthcare services, that they are aware that there is help and support available. Having menopause champions in the NHS is helpful too, which is part of the work that the NHS menopause pathway is setting out. Whether it is at a GP surgery, with a group of healthcare professionals, whether that is in a hospital in A&E, having menopause champions in those departments, so that every opportunity where you meet a woman who might be going through the menopause, you are able to say to them "Are these symptoms part of the menopause? Have you spoken to your GP about HRT? If you have and it has not been successful, have you gone back to them?" Having that wider network of people who are skilled and able to know and give advice about the menopause, we will reach as many women as possible.

William Vineall: As the Minister said, the menopause pathway improvement programme, has a specific engagement group which is trying to reach out to these communities. In a sense, obviously part of what that programme is doing is making a reality of NICE guidelines and checking it against all of the different groups, so that is a component of that work being carried out by the NHS.

Q143 **Chair:** Can I just ask you about the education of young people on this issue? Nadine Dorries responded to a parliamentary question that state secondary school pupils would be taught about menstrual health and the menopause as part of relationships, sex and health education. Other witnesses have told us that, whilst the inclusion of menopause on the curriculum has been welcomed, some were concerned that it is not in itself sufficient and stressed the need for a whole school approach. Can I ask you how the Departments of Health and Education are working together to ensure medically accurate, good quality resources are available to those teaching RSE?

Maria Caulfield: It is a very important point, because we hear from women all the time that they never learned about the menopause at school. The only time that they ever really come across it is when a family member or themselves start to go through it, which is not the ideal way to learn about the menopause. Knowing about it at a young age, to know the signs, the symptoms, the support, the treatment that is available, is really key. It is part of the curriculum now, but it is difficult for teachers if they themselves have not had the training. Part of the NHS

menopause pathway is to look at how we can work with Education as well. Education is included in the taskforce because we recognise it is not something that the Health Department, the NHS, can do on its own. If we are going to improve the outcomes for women and improve the services and the pathway through the menopause, it does need to involve other Government Departments. Training is available for teachers so that they can learn about the menopause themselves, and the up-to-date information about what help and support is available. What we want to do is to make sure that is then happening in practice.

Part of the taskforce will be looking at where best practice is happening in schools, how the teachers feel supported in delivering those lessons, whether there is more that we can do to make that consistent across the country and whether there is more we can do to support teachers as part of that role. It is starting to happen. We need to make sure it is happening consistently, and that the teachers have the right material and support and training themselves to be able to update younger women, and younger men. It is vital that it is not just something that girls go off in a classroom and do, it has to be joint learning so that the menopause becomes a normal part of life for everyone.

Chair: That is a really important point, and something that has been mentioned throughout our inquiry. If I can bring in Bell Ribeiro-Addy.

Q144 **Bell Ribeiro-Addy:** All my questions are for you as well, Minister Caulfield. We have heard about a disparity of access to specialist menopause clinics, and it is generally a postcode lottery when it comes to making sure that every NHS trust has some sort of access to women's health specialists. What are the Government's plans to level up access to these services?

Maria Caulfield: You are absolutely right. Within NICE guidelines women should be able to get support from their GPs, but if women are going through symptoms that a GP does not feel that they can manage—maybe are going through the menopause early, they have been started on HRT and it has not worked for them, or they have quite severe symptoms—they should be able to access a menopause specialist service.

Now that is not as widespread as we would like, and it is something that we will be looking at as part of the taskforce to see where there are gaps in service, but also that women know to ask for that: if women have gone back to see their GPs and are not being put on HRT, HRT is not working for them or they are of a young age, that they know to go and ask for a specialist referral. Once we see the numbers coming through, local commissioners will have to look at the number of women needing that support, and then there will be a demand to set up those services. We will work with local commissioners to see whether there are areas of the country where those specialist services are not set up, and see what we can do to support them in establishing them.

Part of the issue is that there are not huge numbers of specialists in menopause care, and so some of the work that we want to do is around educating and training healthcare professionals. The NHS menopause pathway wants to look at how we can upskill professionals to be able to provide that specialist supporting care. It is not just about where in the country we need them, what is the demand for them, but also making sure that we have the healthcare professionals there to deliver that. There is a huge piece of work going on to make sure that that is happening.

Q145 **Bell Ribeiro-Addy:** Just going back to something that you said, are you waiting on women to say that they need the specialist services from their doctor? Because I would have thought that when we go to the doctor, it is for the doctor to tell us what it is that we need, as opposed to the onus being on the woman.

Maria Caulfield: No, we are not saying that women have to kind of club together to try and request this. We are trying to empower women, so that if they go to their GP and the GP does not offer HRT, they will have the confidence to go back and ask for HRT. If they are experiencing symptoms that their GP cannot manage because they have severe menopausal symptoms, or what they have been offered is not working, they will have the confidence and support to say, "Go back, because there is specialist help available there", it is not saying that the onus is on women. We are obviously going to be supporting GPs and improving their training, because many GPs say to us that they do not always have the skills and knowledge to be able to adequately manage menopausal symptoms—it is a combination of both. We really want women to feel confident in going back if their first response is not dealing with their symptoms, to know that specialist menopause clinics are available and to ask for a referral.

William Vineall: The confidence issue came up more broadly in the call for evidence, which women said was not just about the menopause—that sometimes you had to either self-advocate or ask a lot of questions or go somewhere else for the information. What people actually want is for those three things to be answered when they first go and see the professional.

Maria Caulfield: That is why there are particular groups of women left behind, because some women are better and more confident in asking for help, others less so, and it is important that all women have that support available to them. What we see is where that has been asked by women, it does generate access to services and it then improves access to services for all women because GPs get into the habit of knowing that there is specialist provision available and referring women on and signposting them to that.

Chair: Can I just bring Carolyn Harrison on this point, please?

Q146 **Carolyn Harris:** First of all I need to declare an interest as co-chair of

the Menopause Taskforce, so it is something I have looked at before. But, Minister, from what you have said, it is very much a postcode lottery. All too often it is women who are identifying other women's problems. Is there anything more that we can do to stop women who can ill afford to pay having to see a private doctor? Because that is what is happening now. We are asking GPs to be better trained, but we do not have the time for that; we need someone in those surgeries now to be proactive, whether it is a pharmacist, a women's health nurse, when women are having their smears, when women are having postnatals, those conversations should be happening now. Are the Government thinking along those lines in the pathway, of actually making this a subject that is talked about throughout a woman's life so by the time she gets to perimenopausal age, she is not reliant on a doctor second guessing or, as we know too well, sending her for maybe six or seven different appointments with different specialists with different conditions when, if they were looked at in the round, it would be discovered that it was menopause?

Maria Caulfield: The NHS pathway that was set up last year is specifically looking at how they can establish menopause champions in all clinical settings, so that, as you say, throughout the lifespan of a woman, whether they are going for smear tests, mammograms, they turn up in A&E, there is someone thinking, "Do I need to have that conversation with this woman?", so that it becomes a natural part of a routine health check. When you go and see your GP, they will often ask, "When did you have your last period?", and a series of very common health questions. Having the menopause as one of those routine questions is something that will get women thinking and prepared for it, whether or not they are perimenopausal, which many women can be for five or 10 years before they go through the menopause.

Establishing menopause champions in those settings, not just for colleagues to make them be champions of ensuring that all colleagues in their healthcare setting are aware of the menopause, are up to date with the information, know what services are available, but are also champions for the women themselves that are coming through those healthcare settings, to make sure that they feel that if they have questions or symptoms, that it is okay to ask about the menopause and okay to talk about it—that is happening now, so we will start to see a change in culture, a shift in the dialogue and conversation, so that the menopause becomes a natural part of any healthcare consultation.

Q147 **Bell Ribeiro-Addy:** Just going back to when we were talking about HRT, there is still a lot of confusion amongst women and medical professionals about the safety of this. What do you think is the Government's role in improving understanding about how safe it is?

Maria Caulfield: HRT was more probably more widely prescribed 15 years ago than it is today. There was a period when some medical research came out that had concerns about relationships between HRT and, say, breast cancer that really put healthcare professionals off from

prescribing it and women from taking it. That research has since been debunked, but the fear is still embedded with some clinicians, and with some women who are very nervous about taking it.

Part of the work that we are doing is around making sure that women and healthcare professionals know that HRT is a safe, effective treatment for some of the symptoms of the menopause, and there is a lot of work going on. The NICE guidelines, although not mandatory and just guidelines, do advocate the prescribing of HRT for women going through the menopause. If GPs are concerned, if they look at the NICE guidelines, it will say that for women going through the menopause, HRT should be offered. Women should be monitored for the first three months, then if they are clinically stable and doing well on HRT, that can be rolled out for a longer period of time. The NICE guidelines themselves should be a reassurance both to women and to GPs that HRT is a safe product to give.

That said, there will be some groups of women it is not applicable for—maybe women who have a history of breast cancer or a history of blood clots—but that is a discussion women should be having with their GP for their own specific medical history. If they both feel it is clinically safe after those discussions, HRT should then be prescribed. HRT does not work for everyone, and some women need to try a number of types of HRT to find one that works for them and their symptoms, but for some women HRT just does not work at all. It is about making sure that women are offered it and have that conversation with their GP who knows their own medical history and can then advise them accordingly. In the vast majority of cases, HRT is a very safe and effective treatment for managing the menopause.

Q148 **Bell Ribeiro-Addy:** Recently the Government agreed to work with NHS England to bring down the cost of HRT. What was the justification for bringing down the cost, rather than exempting HRT from prescription charges?

Maria Caulfield: It is a difficult balance. Around 89% of all community prescriptions are free of charge anyway, so the vast majority of people who get NHS prescriptions do not have to pay for them. For those women who do, we are looking at a scheme right now to issue what is called a pre-payment certificate specifically for HRT. This is different to pre-payment certificates for other medications that are in existence now. We had to consult with the various organisations—the pharmacy bodies and Royal Colleges—around the practicalities of rolling this out, but we are in the process of doing that and expect to be in a position where women will be able to get these pre-payment certificates from April next year. This will mean that a woman will pay £18.70 a year for as many HRT products that that certificate will cover. If they are on two or three hormone products, that one certificate will cover all of those for the 12-month period. This will make a substantial saving for those women who are getting maybe two products every month at the moment; they can pay

for this pre-payment certificate and be able to get all their HRT products paid for in the one year. We are working out the technical details at the moment about how we roll that out in terms of dispensing—not so much about the prescription, but about how the products are dispensed within those 12 months.

Q149 **Bell Ribeiro-Addy:** As well as that you were going to look at ensuring that oestrogen and progesterone were not charged separately as part of that process. Carolyn Harris has done a huge amount of work on this and many guarantees were made to women across the country last year. We would have thought that by the beginning of this year this would be in place, or at least by the beginning of this financial year. I know you have explained about what is going on, but why is it going to take so long?

Maria Caulfield: Initially we were going to go through an electronic dispensing method called eRD, which would have enabled women to be prescribed their HRT, and then every month it would just be dispensed without having an additional cost every month. Technically to do that just for HRT, we were told by NHSX or NHS Digital that to work up a specific scheme for that could take 18 months to 2 years, which was far too long in our view. We have opted for a bespoke HRT pre-payment certificate, which will still just be £18.70 for the whole year whether women are on one product or two products. That still needs a technical solution in terms of IT and digital to get that system in place, which we anticipate will be by April next year.

In the meantime, because NICE guidelines allow GPs to issue 12 months' worth of HRT after the initial three-month period, which would just involve one payment, that can happen now. We are working with the Royal Colleges to issue advice and guidance to GPs, both on NICE guidance and to update them about the system that we hope to bring in by the end of the next financial year so there is a huge piece of work. Some of the technical detail is out of our hands, but we have spoken to NHSBSA to make sure that it is in place for April next year. I know it is still 12 months away, but considering the systems that have to be put in place to make that happen, that is—

Bell Ribeiro-Addy: I am handing over to Carolyn in a second because I am sure she has something that she wants to ask.

Q150 **Carolyn Harris:** If I can just say on the record, this is the first I have heard about that time deadline, and as the person who fought for this, I am really annoyed at that time, because there are women out there who are struggling. There is an op-ed today in *The Times* written by Penny Lancaster and myself where we talk about suicide—women taking their lives because they cannot get HRT. What the Minister has just said fills me with no hope that we are anywhere near getting any solution.

Maria Caulfield: A GP can issue a 12-month supply today. If a woman has been on HRT for three months and is stable, and they are both happy that the clinical indications are that that woman is going to stay on that

HRT, they can prescribe 12 months' worth of HRT now, under NICE guidelines. It would be through a physical paper prescription, but it is possible, so that is in place now.

Q151 **Bell Ribeiro-Addy:** At the reduced cost?

Maria Caulfield: Yes, they would be paying one charge for the 12 months.

Bell Ribeiro-Addy: What is the charge?

Maria Caulfield: If they are on one prescription, it would be the price for one item, and if they are on two it would be the double cost.

Bell Ribeiro-Addy: But you are saying it is not until next year that they can get this £18.75?

William Vineall: Yes.

Bell Ribeiro-Addy: So it is not the reduced cost?

Maria Caulfield: It is the reduced cost; it would be one charge now. But what the new system will do is that the GP will issue a pre-payment certificate for £18.70, which will be logged with the pharmacist, and instead of having to go back to the GP to get that prescription issued every month, the pharmacist will be automatically able to dispense it. It is a digital system that is in place to enable the prescription and the pharmacist to tally so they can just automatically dispense it, rather than having to go back to the GP each time. At the moment a GP can issue a 12-month prescription, one cost for that 12 months. If you are on two products it will still be £18.70, but it would be a paper version rather than the digital one, which we are working up at the moment.

William Vineall: I know it seems a long way away, but we met with the BSA recently, who have said that they can deliver this procedure by next April—they have prioritised it within their workload. They are the experts on this work because all the prescriptions work is done within the BSA, and we are pushing as hard and as fast as we can to get this done.

Maria Caulfield: One of the other factors that we had to consider within this is the supply of HRT. With the new system from next April, because it can be dispensed monthly from a pharmacist without that monthly prescription charge, suppliers can manage that supply. Since the debate in Parliament last year, we are already seeing that the number of women being prescribed HRT is going up, which is really encouraging news, but suppliers are starting to struggle to keep up with some of that demand. With the current system, with the 12-month prescription that can be issued today if a woman goes to her GP, all 12 months of that HRT have to be dispensed at one time, and there is potential for pressure to be put on supplies of HRT.

The new system will be much better in terms of managing stock of actual product. One of the things I am hoping to do in the next few weeks is to meet with manufacturers and suppliers of HRT, to see how we can make sure that that stock is kept available for women for the next 12 months until the new system is in place. Because manufacturers obviously want to manufacture HRT, but they need to be confident that that demand will continue.

Q152 **Chair:** I will just come in, thank you. From what you are saying, it sounds like suppliers and IT issues are massively letting women down, and I just wonder how many GPs are aware, or are actually issuing, more than one month or three months' supply at one time. I do not claim to know as much about this issue as my colleague Carolyn, but that is the first I have heard that GPs are able to issue, and from what I have heard, they do not. Do you think a public health campaign would help improve the understanding around HRT, and specifically around these certificates, when the issues have been ironed out?

Maria Caulfield: Absolutely, and it is our plan to do that but we have to have the system in place first to make sure that we can accurately update women about what they can expect when they get a prescription of HRT. We are in the process of working with the Royal Colleges to issue a bulletin to GPs to encourage them to follow the current NICE guideline, so that if a woman has been on HRT for three months and she comes and asks for a 12-month prescription now, that they are aware of that. Many GPs have not been aware that they can issue a prescription for the whole 12 months at one prescription charge for the women. We also do need to update them that there is going to be a digital system in place to enable them to prescribe HRT with pre-payment certificates from next April, so we are in the process of working with the Royal Colleges to update GPs.

I have had lots of women come and see me and say that they have been to see their GP and the GP was not aware that they could do that, but it is under current NICE guidelines, and NICE are updating their guidelines as we speak as well. It is important that we support GPs and primary care to make sure they are aware of what they can do now, and they are aware of the changes that will be coming in April next year.

Chair: Okay, thank you. I am going to bring in Kim Johnson.

Q153 **Kim Johnson:** Good afternoon panel and I apologise but my questions are again for Minister Caulfield. Picking up on GP issues, we have heard evidence and concerns that GPs are not very good at diagnosing and treating women with menopause; the Royal College of GPs has said that the resources for women's health and menopause is very limited. What will the Government do to ensure that GPs are adequately trained?

Maria Caulfield: Part of the work that we are doing is around helping and supporting healthcare professionals, who in many cases will be the first to admit that they have not had the experience of managing the menopause and welcome the provision of specialist services so that if

they are struggling to manage a woman's symptoms, they have a local resource to refer women on to. It is not just about training GPs, it is about practice nurses and a whole range of professionals that work in primary care, because women do not always see the GP. Whoever they see should have that training and feel confident in being able to give support about the menopause, whether they need a prescription for HRT or they are referred on to the other therapies to help with their symptoms. A key plank of the NHS menopause pathway is around support and training but not just one-off training, because the support that is available will change as new evidence comes through, so that is an ongoing process. Particularly in primary care, which is the most likely place a woman who has menopausal symptoms will be seen.

Q154 **Kim Johnson:** Can you say a little about how GPs are monitored in terms of the type of work they do around supporting women in the menopause?

Maria Caulfield: GPs will have frequent visits from bodies like the CQC, who may not look specifically at diagnosis, particular conditions or things like the menopause, but what they will do is look at the policies that they have in place. For example, does a GP practice have a menopause champion in place, and have they got a policy in terms of how they offer support? We do also get patient feedback, so there is a range of systems in place to monitor the provision in primary care for menopause support. But it is something that we probably need to look at because, as Carolyn said, there is definitely a postcode lottery, and it really does often depend on the interest of a GP in that area of work. There are some practices where there are superb GPs and have a particular interest in the menopause and will be able to offer a range of support and services. There will be other practices where they specialise in other areas, who then should be referring on to a specialist menopause clinic. The taskforce definitely needs to look at the provision of healthcare and the range of services that are available in different parts of the country.

Q155 **Kim Johnson:** Just picking up on the taskforce, the first question that was raised was looking at some of those groups that are often unheard, so how are you working to make sure that the diverse voices are included in this taskforce?

Maria Caulfield: The taskforce met for the first time in February, and Carolyn is the co-chair of that. Although health is a devolved matter, it is a United Kingdom wide taskforce with the Health Ministers from Wales, Scotland and Northern Ireland as well. We have a range of stakeholders there, and it involves other Government Departments too. Although Health will obviously lead on it, the menopause is more than a health issues, as we have touched on already. It is about educating young women so that whatever background they are from, if they are learning the signs and symptoms of the menopause from a young age, when it happens to them they will be much more aware of the fact that they are going through the menopause, and will know how to access the support and services that are available. It is also about the workplace and

bringing in businesses. We have seen a huge uptake in interest from businesses in wanting to have a menopause policy at work to support women going through the menopause, whether that be time off work to see their GP, offering flexible working, being able to have that open discussion with the employer if a woman feels that she is not coping with the symptoms. Having workplace support is vital, as is having community champions in place as well. Women in communities where traditionally access to health services is not great are going to struggle to get the healthcare support they need going through the menopause. We do have a wide range of stakeholders on the taskforce, but we are going to be doing some bespoke pieces of work.

Areas we are looking at are around health provision for the menopause, education of women, healthcare professionals and the workplace. At our next session we are doing a deep dive on the evidence behind the menopause, to talk around the point made by Bell, to bust some of those myths around things like the safety of HRT, and to look at the body of evidence about what best practice should look like. At the moment it is a bit hit and miss; if you have an area in the country where there is a particular group of professionals who are very interested in HRT and the menopause, you will get a very different service to other parts of the country where that is not happening. We want to know what best practice should look like, and how we can then make sure that is rolled out to everywhere in the country to ensure that no matter where you live, you should still have access to those services.

Q156 **Kim Johnson:** You mentioned the women's health strategy being published in the spring, I think you said, which is now. You also mentioned menopause and menopause ambassador and I just wanted a bit more information about that. How well resourced is that? How long will that post be in place? How do you expect it to work across the country, given the issues you have raised, and that, particularly in disadvantaged areas, some people do not even have access to a GP because of the difficulty in recruiting?

Maria Caulfield: We are interviewing for the women's health ambassador at the moment and will probably announce who has been appointed to that role in the next few weeks. The menopause will obviously be a big part of the role in making sure that they lead on some of the key issues, whether that is access to HRT or whether that is raising awareness about the menopause. One of the areas that we have asked them to particularly focus on is the hard-to-reach groups of women, whether that is women of different ethnic backgrounds or whether that is women who traditionally do not engage with the health service for a variety of reasons, such as they are not registered with a GP or because poor provision of health services in their area mean it is difficult to engage.

They will be working with a range of women to try and get access to them and to see what some of the barriers are that they are facing.

Literally, within a few weeks we will be announcing who the ambassador will be and they will be supported by the Department. They will have resources available to them from the Department to be able to manage the post and support it.

We will be publishing the women's health strategy this spring and, again, that is only a few weeks away. We are currently looking at the key areas that we announced in the vision document in December. We want some concrete wins in that strategy so that we can say to women of all ages, and obviously the menopause is a big issue for women who are 40 plus when they are perimenopausal and going into the menopause, but for younger women as well. We want to focus on areas like endometriosis. We want to look at fertility and baby loss. We want to look at osteoporosis and dementia. We want to support women and girls who are experiencing violence. In each of those strands that affect a woman's lifespan we want some concrete goals that we can achieve through the strategy and for the menopause, there will be some concrete goals there and women will be able to say, "This will make a difference for me."

Kim Johnson: I look forward to some feedback on that post in maybe a couple of months' time. Thank you. They are all my questions, Minister.

Chair: If I can bring in Elliot Colburn, please.

Q157 **Elliot Colburn:** Minister Caulfield you can rest your voice for a moment as I want to move on to Minister Scully. If we can start by talking about women in the workforce and in the labour market, the evidence that we have collected as part of this inquiry suggests that women at the peak of their careers are either scaling back on the amount of work they undertake or leaving the workforce altogether because of the menopause. Do you think in today's society that such a cost to the economy is acceptable?

Paul Scully: No. We really appreciate your interest in that particular area because you are absolutely right, it is essential to keep older people from all backgrounds in the workplace, not just because of the experience that they have gained, but the resource and the investment that their employers have put in. Therefore, it makes sense—and there is an absolute business case there—for employers to have flexibility to be able to keep them in the workplace. Prior to the pandemic, women over 50 represented the fastest growing segment of the workforce, and that is very much to be welcomed. We know that around one in 100 women experience the menopause by the age of 40 but, none the less, we need to be able to make sure that we can lean in and keep people over the age of 50. That is why the 50Plus Choices Employer Taskforce came up with their report for the menopause and employment. There is no way of quantifying the impact on individuals and employers. We want to make sure that we have a wraparound approach to it for employers to support people in the workplace.

Q158 **Elliot Colburn:** You touched on a little bit there about what BEIS is doing

to try and prevent this happening, but could you expand on that? What is the Department doing to try and ensure that employers understand the business case for supporting menopausal women whilst they are in work?

Paul Scully: First, in terms of the impact to the employer, we always make the point that the business case for employers is absolutely overwhelming. It is really clear that businesses lose out when older workers drop out of the labour market and that age diversity can bring huge benefits to businesses as well as the experience and expertise that I was talking about. Lots of employers value the experience and loyalty that older workers inevitably bring, as well as the balance between the fresh perspectives coming in from younger people.

We use case studies. We showcase the best practice from companies like ASOS, for example, who have—not only within menopause—life event flexibility within their work practices. Indeed, yesterday I signed off on a letter congratulating the Royal Mail on the work that they are putting in for their employees. They estimate they have about 16,500 female employees who are likely to be going through perimenopausal and menopausal symptoms at the moment. They are talking about how they can lead management empathy and raise awareness and understanding within their workforce, exactly as Maria Caulfield was talking about earlier on. They have signed a wellbeing of women menopause workplace pledge as well, which is a national pledge supported by Her Royal Highness, The Countess of Wessex.

Talking about their examples really showcases and leverages a lot of goodwill to other employers to say, "You know what? It doesn't all have to be a cost to business. It doesn't have to be onerous or bureaucratic. It's just the right thing to do because that business case is strong."

Q159 **Elliot Colburn:** Thank you very much, Minister. If I can talk about bureaucracy, though, in a bit more detail? One such body, of course, is the Health and Safety Executive, and we have heard from witnesses who have expressed concern that the HSE does not produce any guidance for menopause in the workplace from a health and safety perspective. Are the Government doing any work to encourage HSE to fill that gap?

Paul Scully: Clearly, guidance is a useful tool. It is a really good way of not having to reach for legislation first; it is just reminding businesses what their duties are. That is something that the TUC agreed with when they were giving their evidence that, "Actually, let's start by enforcing, first of all, what's there, but also tell employers what is there as well." That guidance is very useful.

What we have looked at is lots of external organisations that provide guidance and how we can bring it together. That includes ACAS as well because it provides a lot of guidance on wider issues, such as how to manage the effects of the menopause, how to support staff through the menopause, talking with the staff, encouraging those conversations, but

importantly on the law itself. I have Mike on the line if you want to specifically talk about the HSE work.

Michael Warren: We have discussed the question of specific guidance on menopause with HSE. Their position, at the moment, is they do not hear enough from people looking for that sort of guidance to, in their eyes, justify producing it. That goes back to a point that a number of people have made during this session about the nature of the problem and if people are nervous about coming forward or embarrassed about coming forward then, of course, the problem as it appears to an organisation like HSE may not represent the reality.

It is true, though, that HSE has worked quite closely with ACAS to promote ACAS's guidance, so it would be wrong to conclude that HSE has stayed out of the guidance question altogether. They do not see a case at the moment for a specific piece of HSE guidance on menopause, but they are very happy to work with others. A number of organisations do produce very helpful guidance for employers on dealing with menopause in the workplace. Perhaps the question for us is how do we make the guidance landscape look coherent and accessible to employers rather than having what might appear to be many different conflicting sources of guidance on the same set of challenges and problems?

Paul Scully: It is interesting, and I would just add that HSE has had 13 inquiries in their Concerns and Advice team over the last five years. Again, it is that chicken and egg because as we are talking about it more, clearly, there are going to be more approaches. As Mike says, we are working closely with ACAS, and ACAS is providing guidance on a range of issues. In my opinion, people are approaching ACAS more than HSE. By corralling all the advice that is out there into one coherent stream through guidance, then I would think ACAS is more likely to be fruitful.

Q160 **Chair:** Can I just come in briefly here? How can businesses ask for guidance if they are not even aware that they need it?

Paul Scully: We are providing the guidance insomuch that we know the evidence that we are seeing and the conversations that we are having in places like this. By encouraging more conversations, you are then going to start getting businesses asking for more guidance because they will be aware of it. Again, it is chicken and egg. How do you actually start the conversation in the first place? Maria Caulfield talked about a women's health ambassador rather than a menopause ambassador because it is actually starting off with women's health in general, of which menopause is a major part. Similarly, within the workplace there are a number of issues which will affect older employees and older women; again, menopause is a large subset of that, but not the only subset.

Q161 **Carolyn Harris:** Have you done any work with unions to talk about menopause in the workplace? A lot of unions work to actually encourage employers to make workplaces menopause friendly. What proactive work are you doing about actually getting into workplaces and talking to the

women on the shopfloor, on the factory floor, who are living through the experience where very often there is a policy in place that they do not even know exists?

Paul Scully: I totally agree with that, about policies being in place that nobody knows exist. I have seen that on a number of issues, not just this, whether it is domestic abuse or whether it is other areas that employers need to be aware of. Bear in mind, of course, ACAS is made up of a range of people within that, including some notable trade union members. That is another reason why I think that is a fruitful avenue to go down because they are the ones that have that balance between employer and workers. Mike, does the Department have direct liaisons in this specific area?

Michael Warren: Not in this specific area. I would have to double check with ACAS on the exact form of their engagement with unions in producing the menopause guidance that they currently have on their website, but knowing how they have approached guidance on other issues I am very confident that they engage pretty comprehensively with trade unions. I am very happy to double check that and confirm in due course.

Paul Scully: The council members of ACAS are made up of trade unionists as a wider range—

Q162 **Carolyn Harris:** I am specifically talking about unions who have campaigns about menopause in the workplace. It seems a bit strange to me that the Department has not had those conversations when there are specific campaigns aimed at the workplace.

Paul Scully: We will certainly write to you.

Q163 **Elliot Colburn:** You mentioned enforcing regulations and rules that are already there. Obviously, one such set of rules comes from the Equality Act, and yet there has been nothing from the EHRC about employers' legal obligations under the Act when it comes to the menopause. Is the Department doing anything with the EHRC to make sure that they are making employers aware of their obligations under the Equality Act?

Paul Scully: Yes, but not necessarily in the way that you describe. Menopause is not a protected characteristic, but we believe that—

Elliot Colburn: Should it be?

Paul Scully: No, I don't think it necessarily needs to be because, first of all, we need to remind people of what is there and, in our opinion, there is sufficient—with sex and age and disability—to be able to encompass all of that. I know you can make the argument that if you hear the word "disability" you are further stigmatising the work. There is a really specific definition within the Equality Act which talks about impairment. It talks about impairment to go about your daily business in the workplace and obviously the menopause, especially severe menopause, does exactly

that, which is why we need to move towards greater flexibility. What we have not talked about yet is flexible working, which is probably the biggest tool in this beyond guidance. We are doing a huge amount of work through the flexible working taskforce and, indeed, our manifested commitment is to make the right to request flexible working a default option.

Q164 **Elliot Colburn:** Obviously, menopause may in itself be too specific to add in as a protected characteristic, but you mentioned—and we will come on to a question a bit later—language around disability for example. Would there not, therefore, be an argument to update the Equality Act, either to include a protected characteristic around health or update the wording around disability to make the language more up to date and easier for employers to implement?

Paul Scully: I have some concerns about adverse impacts if we were to introduce changes to the Equality Act because, first of all, it may well provide an unhelpful distraction for employers from what they actually should be doing, which is complying with the existing law, and familiarising themselves with the guidance. Again, I have heard the debate around implementing the dual discrimination provision—section 14—but again, for the same reason as I said before, it is not something that we are particularly looking at doing because employees can already bring a discrimination claim on two or more of the grounds that the courts can then consider consecutively where appropriate. I think that is sufficient for people to be able to tackle these claims.

Q165 **Elliot Colburn:** I hear what you say about claims. We have received evidence that there is a relatively low number of tribunal claims due to numerous barriers to claimants. What is the Department's understanding of why this is the case and what is being done to ensure that genuine claims are not being deterred?

Paul Scully: First of all, it is making sure that people know their rights so they can actually feel that there are no barriers to bring a tribunal hearing. Frankly, that is the case beyond the menopause, that is the case in workers' rights in general, but we know there is a backlog which Covid has proliferated in tribunal work. We want to make sure that anybody raising a complaint can get action sooner rather than later, and not have to wait. That is why we are also looking at employment tribunals to see what more we can do to speed up the process and to have alternative resolutions so that they are not having to wait for a court process which can take some time. They want action now. If someone is suffering from severe issues with the menopause and suffering discrimination and detriment, they want action now. Mike, again, is there anything else that you wanted to raise about tribunals?

Michael Warren: Only that—with sincere apologies for sounding like a broken record—it is indicative of the nature of the problem that although there are a number of characteristics under which you can bring a menopause-related discrimination claim, we do not have exact data on

the number of menopause-related employment tribunal claims. We think the numbers are very low, but they are rising; the signs are there. The awareness of the problem, both amongst employees and employers, and then the tribunal business that goes with the rising awareness that is happening, is starting from a very low base. The challenge for Government across all of the work that it does in this area is that this problem cannot be solved through one particular lens or by focusing on one particular part of the problem. It is a broad range of activities across a broad range of aspects of the menopause that creates societal change that will bring everything along with it.

Paul Scully: One of the problems with this is that there is no one size fits all. There are certain areas of detriment where it is a real clearcut case and there is a clearcut resolution, but different women will have different effects on their ability to work in the way that they would like to, which is why flexible working is there and why reasonable adjustments are there for people to take.

Q166 **Chair:** If these claims are brought about in different ways and not specifically tagged to menopause, how do you know that you are capturing the numbers correctly? You say there is a low number, but how do you know how many there are?

Paul Scully: The low number are the ones that have specifically raised that as an issue. You are absolutely right that we need to improve people's ability to raise these issues and enable employers to understand this better, which is why the "Health is everyone's business" response from the Government said that we had developed the national information and advice service on health, work and disability, and that is in live testing at the moment. That will improve the data that is coming in.

Again, as Minister Caulfield was talking about, the Menopause Taskforce that I sit on, together with the work that Carolyn and Maria are doing, is trying to better understand the research and data, which includes effects in the workplace, not just the wider health issues that you were describing in the first half of this session.

Q167 **Elliot Colburn:** I want to come back to this issue around language. We have heard, both anecdotally and in evidence that we have gathered, that some women have had to compare their experience of the menopause to men's physical sickness or, indeed, refer to themselves as having a disability whereas it is something that over half the population experience. How do we get the right support and adjustments into the workplace if this culture of language does not change?

Paul Scully: It is an interesting point. I readily admitted earlier on that the definitions within the Equality Act talk about disability, but the way that they define disability is far wider than that. I admit that there is potential to stigmatise, but it is important—

Q168 **Chair:** It is not helpful, though, is it, the fact that it comes under a disability?

Paul Scully: No, but there are a lot of different things. First of all, it comes under potentially more than one of those areas—sex, age, and disability—so it will depend again on the circumstance of the individual. That is why I am not sure it is helpful to start introducing a lot more things because you will start to put extra layers on the Equality Act, which distracts the employer from tackling the duty of care that they have in the first place to make reasonable adjustments. Frankly, before all of that, it goes back to what you were saying at the beginning, understand the business case of just doing the right thing because it makes sense for the employer just as much as it does by doing the right thing for the employee in this case. There should be no sense in them ending up at tribunals because what they are doing by doing the right thing, by having reasonable adjustments, by having flexible working, is keeping those people within the company, within their organisation that they have invested possibly decades' worth of resource into.

Q169 **Chair:** Is part of the problem that a lot of these companies have policies and it is a tick box exercise that they write them, they stick them in a drawer somewhere? They do not advertise or publicise or educate their workforce to the fact that these policies exist, including their management team, and then a certain amount end up at tribunal that maybe would not have had the employees and the managers known that that was in place. Is that part of the problem?

Paul Scully: I think that is a fair accusation for some employers, and that is why I come back to showcasing more all-encompassing, proactive approaches like ASOS, like that life events-type of flexibility, because then you are not actually encompassing, "Right, there's a menopause policy, there's a domestic abuse policy, there's an adult care or childcare policy." You are actually wrapping it up into what is valuing the employee, the worker. That is essentially what the likes of ASOS are doing. By doing that, clearly, you do not have to reach for one of a number of policies; you have one. Similarly, the employee knows that there is a people promise to them which they can approach. Digitising this—as I described earlier about the "Health is everyone's business" response—will help that. Also, by having conversations within the workplace that destigmatise this, in the first place through the Department of Health's work, will really help people have this approach.

William Vineall: The second prong of the NHS menopause pathway improvement programme is about the NHS as an employer with 77% female employees. Part of the motivation for that programme is that sometimes the diagnosis is not efficient and, as we have discussed, there are more lost workdays. You would not call it a business case in the NHS, but there is a time case for better provision of menopause care for those women as employees as well.

Elliot Colburn: My next set of questions was going to be on the Equality

Act but I think we have covered off all of those so, Chair, I will hand back to you.

Q170 **Chair:** Mr Scully, you briefly mentioned flexible working a couple of times. In their submission to the inquiry, the Government pointed to a number of steps they were taking to support women to stay in work whilst managing personal needs or health conditions, including consulting on flexible working. I understand that that ran from September to December. The website says that the Government are currently analysing responses. Can you update us on the Government's response to the flexible work consultation, please?

Paul Scully: We are reviewing those responses and will report back in due course, but I can say that we had 1,600 responses to it. It was a really well sought-out consultation, which is absolutely at the heart of all of our work around flexible working in the labour markets, because it is something that encompasses so many things that we are discussing, some of which I have highlighted today beyond the menopause.

We have also reinstated the flexible working taskforce which was originally instituted in 2017 under the previous Prime Minister. We have been able to reflect flexible working in terms of Covid and what we have learned from Covid. We are now going back to business as usual—the right to request flexible working—which does not mean working from home, as so many of us have been doing for the last two years. It can be about compressed hours. It can be about annualised hours. It can be about flexitime or, indeed, job sharing because, and I come back to this, whether it is stress, mental wellbeing, domestic abuse or menopause, or any of these really important issues that we are tackling about workers' rights and labour markets, there is not a single response approach that can be taken by employers to cover all of the possibilities, and nor would employees want there to be. They may need just a couple of hours in the morning, they may need the ability to leave the workplace, obviously in menopause, to attend appointments or whatever it is.

Q171 **Chair:** I am pleased to hear that you have had a good return. It shows a what big issue it is and how important it is. You say, "in due course", and it has been three and a half months since the consultation ended. What does that mean?

Paul Scully: To be fair, I would love to be more specific but I cannot. The 1,600 is a lot of responses to go through and clearly, we want to bring that—

Chair: Do you have a target date?

Paul Scully: We want to bring the legislation forward as quickly as possible because obviously the right to request flexible working is a day one right. We want to make sure that we get that dead right, so we will get those responses back in good time.

Chair: Thank you.

Q172 **Carolyn Harris:** Have you done any work on the rising incidence of domestic violence for a woman who is menopausal? Has anyone looked at that?

Paul Scully: I cannot tell you, no, but it is a really interesting point so I will go away and find out.

Q173 **Carolyn Harris:** Any work on women committing suicide because of menopause?

Paul Scully: I do not know if that has been done in wider government. Not specifically in terms that reflect on the workplace.

Q174 **Carolyn Harris:** Minister Caulfield, testosterone being available on prescription?

Maria Caulfield: Testosterone is a very topical issue around the menopause. At the moment, it is not licensed for the menopause by the MHRA and so it makes it difficult to advocate the prescribing of it for the menopausal setting. There are many doctors who prescribe it for the menopause out of licence, but we need the MHRA to license it.

Carolyn Harris: You have to pay for it, then, when you buy it? I am on testosterone and I had to go private to get it, but it is something that we really need to be thinking about.

Chair: It might be worth speaking to the MHRA as a Committee to look at what evidence they need in terms of licensing testosterone for the menopause. It is not a Government decision. They are an independent body, and they look at the scientific evidence before coming to that decision, so we are very much guided by them.

Q175 **Carolyn Harris:** Can you understand where I am going with these questions? You have not done anything on suicide, you have not done anything on domestic violence. You have all these reviews going on. We hear today that women who thought they were going to be able to get their prescriptions paid annually—and are constantly writing and emailing me—still cannot afford to go on HRT, if they are lucky enough to get a doctor to prescribe it in the first place. Surely, you must be able to understand the frustration of the 51% of the population who have been waiting very patiently to go to a chemist to pick up their prescription and have it for free or pay just once. I suggest that there is going to be a bit of an outcry today after that bombshell.

Maria Caulfield: Can I just clarify? Women today, after they have been on HRT for three months and are stable, and the GP is happy from a clinical point of view that they can continue on that, can ask their GP for 12 months' worth of HRT and will pay one prescription charge. That is in place now.

Carolyn Harris: GPs do not do it. We know that GPs do not do that.

Maria Caulfield: We are doing two things for this immediate situation. We are working with the Royal Colleges to issue a bulletin to GPs to remind them of the NICE guidelines—and they are perfectly free to do that now—that women can pick up one prescription for the whole 12 months and pay one prescription charge with a significant saving compared to what they have been paying. In April next year we are introducing a pre-payment certificate which will make that process far easier both from the pharmacists' point of view and from the women's point of view so that they can pay upfront for a whole year's worth. Instead of having to go and see their GP, they can just pick up their prescription from the pharmacist having paid for it already. The change in April is really a kind of digital—

Paul Scully: It is going on to digital, is it not?

Maria Caulfield: Yeah, it is a digital kind of a result. Also, it makes it much easier for women to ensure if their GP has been a bit reluctant to prescribe 12 months, they can say, "Well, I've got a pre-payment certificate specifically for HRT," and it will enable—

Q176 **Carolyn Harris:** May I respectfully suggest you put a public message out explaining the rationale behind that decision?

Maria Caulfield: We are working with the Royal Colleges on a bulletin that will go to GPs.

Carolyn Harris: It is the public who needs to know. It is the women who need to know.

Maria Caulfield: I very much take that onboard and I get enquiries from women all the time saying, "When is the change coming?" and we say, "Actually, under NICE guidelines it can happen now." We also need to communicate that to GPs because women are going to their GPs and the GPs are saying, "I don't know anything about this." We do need to do both of those things. Very happy to do a public awareness update, both on what women can do now and what the changes will be in April, but we do also need to make sure that GPs are aware of the ability they currently have.

Paul Scully: The pertinent questions you were asking about suicide and domestic abuse are essentially that's exactly what the Menopause Taskforce—that you guys are cochairing—is there to deal with, and to bring all of this together. I cannot answer that because I am the Business Minister so I can only ask about support of domestic abuse in the workplace. That firmly sits with the Home Office.

Carolyn Harris: It is in the workplace if you are menopausal and it happens.

Paul Scully: Exactly. My stakeholders see the end result of it. They do not see what is happening behind closed doors. Tying it together is absolutely right.

Carolyn Harris: What I am trying to say, Minister, is you cannot decompartmentalise all these different things.

Paul Scully: I totally agree.

Carolyn Harris: It is one thing. The menopause is one thing, and we have to regard it as one thing.

Paul Scully: I could not agree with you more. That is exactly what I am saying. The taskforce is a brilliant initiative to be able to bring all those things together to show it is, indeed, one thing.

Q177 **Chair:** Could I just go back to Minister Caulfield? I am looking for clarification on a point that has been mentioned a couple of times on oestrogen and progesterone. I do not mind sharing my personal experience of receiving both of these things within the same foil, within the same box, and being charged for two prescriptions. That is happening. Why is that happening? How can we get the message out to GPs and pharmacists that this should not be happening?

Maria Caulfield: Under the prescription rules that exist you have to pay per item. Under the rules, progesterone is seen as one item and the oestrogen is seen as a second item. Although, from a woman's point of view it is HRT, it is one thing, from a prescribing point of view they are two separate medicines that are being used together.

Q178 **Chair:** It just looks like a con, does it not? You have two tablets in the same foil in the same box.

Maria Caulfield: Paying two prescription charges every month is huge, and Carolyn is right, we do need to get that public message out that after you have been on it for three months you can now just pay for two items, so £18.70, but you can get a 12-month prescription right now from your GP.

Chair: If your GP is willing to give it.

Maria Caulfield: Yes, and we do need to do work on that in terms of updating and letting GPs know about the NICE guidelines—which are not mandatory—and encouraging them to use them. The pre-payment certificate next April will also be a gamechanger because women will be able to request that pre-payment certificate. It will be £18.70 but it is for 12 months. It is £18.70 now for 12 months if your GP will prescribe it, and I recognise there is work to do to encourage that.

We also do have some slight concerns about supply. The difference between the system now that women can take advantage of to April is for the GP to prescribe 12 months today, you will pay £18.70 for your two items, and that is it, so you do not have to pay every month, but you will be given the whole 12-month supply. Our concern is that may put pressure on supplies overall. If all the women on HRT suddenly get a whole 12-month supply next month, could the stocks cope with that?

With the new system in April, although it is a 12-month supply, you can pick it up every month from the chemist, so that will take the pressure off. We are also seeing—thanks to Carolyn's work and the debates in Parliament—that there is already an increase in women accessing HRT, which is also putting some increased pressure on supply.

The temporary measure we have at the moment using the NICE guidelines will work for women. They can get a 12-month supply and pay one prescription charge now. They will get the whole 12 boxes for the whole 12 months. We will have a better solution in April, which will still keep the costs down, but it will make it easier for women and easier for GPs to feel confident in issuing those 12 monthly supplies and keeping that cost as low as possible.

Q179 **Chair:** Minister Scully, the menopause and employment report was announced late last year by the business champion for older workers. When should we expect a response from BIS and the DWP to that report? Can you set out how you plan to implement some of the recommendations, please?

Paul Scully: Mike, can I come to you? The Minister for Employment could not be here and a representative could not be here, but let me find out a little bit more detail. Mike, have you got anything?

Michael Warren: I am afraid it's another "As soon as we can".

Paul Scully: Forgive me, we will have to come back to you.

Chair: Okay. Do Members have any other questions? If not, can I thank you all very much for attending today?