



CAN DO
HEALTH & CARE



Inclusivity in Menopause Transition Report

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Executive summary

This report explores the amount and extent of staff diversity within Suffolk and North East Essex (SNEE) and Hertfordshire and West Essex (HWS) Integrated Care Systems (ICSs). NHS Staff Survey data from the SNEE and HWS Trusts surveyed 41,353 staff. An average response rate of 56% means data from 19,771 staff are included in this report. However, there is less data for GP practices, County Councils, professional body and voluntary agencies within the ICS (see Table 1 for all ICS organisations). The quantitative demographic data mirrors other research on the menopause which concurs that there is an increasing number of working women in the UK aged 45 and older. This equates to about 1/3 of the entire female population but in the SNEE and HWE workforces this could amount to 2/3 of the female workforce (64% aged 41-65). 22% of staff have a disability or long-term condition. One in five staff (20%) are from an ethnic minority background and 4% identify as LGBTQ+ (with a further 6% who prefer not to share this information).

Using a small sample of eight women from diverse backgrounds and a range of ICS staff groups, this report explores how menopause knowledge and transition affect staff health, well-being, and retention. The report draws heavily on the narratives of these participants to ensure their voices were central to its findings. Issues raised have been supported by the wider literature on menopause transition in the workplace. It is acknowledged that the two ICS were already undertaking a wide range of measures to support staff with the menopause transition. However, these initiatives were not always or widely known, therefore there was a discrepancy between what the ICS were offering and what staff knew/ said. Additionally, policies to support staff were not compassionately enacted or followed and there was some evidence of differential access to reasonable adjustments in the workplace.

The report summarises ten recommendations.

- 1: Continue to increase awareness and education for all staff of the diverse range symptoms of menopause
- 2: Co-produce infographics and other display materials that individuals feel relatable to staff from diverse ethnic and LGBTQ+ backgrounds
- 3: Increase promotion of support packages that already exist including menopause advocates for education
- 4: Co-produce further support networks for those experiencing, about to experience or supporting those experiencing menopause.
- 5: Promote existing training for healthcare professionals and line managers to understand menopausal symptoms and the potential consequences for working
- 6: Support staff to have two-way conversations around the menopause
- 7: Co-produce local policies around uniform, heating and toilet facilities to ensure all feel comfortable but ensuring standards are maintained.
- 8: Further promotion of training for staff in their roles, especially primary care and managers to support the workforce and general population
- 9: Discuss policy changes in flexible working, for those experiencing menopausal symptoms (and more broadly)

10: As UK's largest employer lobby government for menopause to be a protected characteristic and extend the NHS staff survey to include ICS staff.

Introduction

The menopausal transition (MT) is defined as the time between the beginning of irregular menstrual cycles (usually appearing with some menopausal symptoms) and menopause (Santoro *et al.*, 2021). Menopause is the absence of menstrual periods for one calendar year. Reports indicate that the average age of menopause in the UK is 51 years. However, 10% of women can have early menopause below the age of 45, and 1% can have premature ovarian insufficiency below the age of 40 (Coulam *et al.*, 1986).

Although the average age for menopause is 51, many factors influence the start of menopause, such as ethnicity, body mass index (BMI), cultural beliefs, synchronized medical or gynaecological health conditions, socioeconomic background, and general health issues: diet, exercise levels and smoking status (Gold, 2011; Schoenaker *et al.*, 2014).

Menopausal Transition Symptoms

Studies demonstrate that symptoms associated with the menopausal transition affect more than 80% of women, and about one-third of this population experience severe symptoms (O'Neill and 2017). The main symptoms include mood fluctuations, vasomotor symptoms (hot flushes and night sweats), exhaustion, disturbed sleep, increased anxiety, palpitations, vaginal dryness, dyspareunia, and bladder symptoms (frequency, urgency, and incontinence). Also, many menopausal women experience brain fog, joint pains, thinning of nails, dehydration of skin or eyes, and changes in skin and hair (Paramsothy *et al.*, 2017).

In addition to physiological symptoms, many psychological and cognitive problems associated with MT affect women in every life and in their workplaces. The Study of Women's Health Across the Nation (SWAN) revealed an association between poor sleep and hot flushes, anxiety, depressive symptoms, and low oestrogen levels with menopause transition (Vivian-Taylor and Hickey, 2014). Some research has revealed that some symptoms are more persistent beyond the menopause transition (Karlman et al., 2017). Additionally, some research indicates that a more extended menopause transition is related to depression, likely due to an increase in symptoms (Kravitz *et al.*, 2003). Furthermore, some studies suggest that cognitive function weakens during the menopause transition, usually explained as brain fog, and returns to standard towards the end of the transition process (Santoro *et al.*, 2021).

Ethnicity and menopause

Various studies have revealed that although the nature of menopausal symptoms is common to all women; however, there are significant ethnic differences which influence the prevalence of specific symptoms (Im, 2010; Richard-Davis, 2013). These facts are important because most NHS staff in England are British. However, about 16.5% are from other ethnic backgrounds, and about 220,000

staff report as non-British nationality, nearly one in six of NHS staff with a known race. Between them, these staffs hold over 200 different nationalities. Over 95,000 are Asian nationals (7.2%), while over 70,000 are EU nationals (5.3%) (Baker, 2021).

Menopause and work

There is a two-way relationship between menopause and work. In other words, menopause symptoms, at pre- or post-menopause stages, can make the working situation more difficult for women and work can increase symptomology (Atkinson *et al.*, 2021). According to the NHS England, they employ over 1.3 million people, 76.5% of them (over 1 million) are females. Further, females between the ages of 45 and 54 make up 19.1% (over 260,000) of the entire NHS workforce (NHS Workforce, 2020).

44% of women believed that their ability to work had been affected by menopause-associated symptoms (Bazeley *et al.*, 2022). 61% said they had lost work inspiration due to their symptoms and 52% acknowledged that they had lost their confidence at work. The same report revealed that 10% of women who were employed had left their jobs due to menopause symptoms, which, based on the current UK population, would be about 333,000 women leaving their jobs due to menopause-associated symptoms. In comparison, 14% had reduced their hours, 14% had switched to part-time, and 8% had not applied for promotions. While many women have been affected widely by menopausal symptoms, many employers are not taking any action to support those staff. Bazeley *et al.* (2022) argue that a mix of appropriate interventions by employers may help women at work, such as culture change, training, menopause advice, adapting absence policies, flexible work, and environmental changes. Also, reports show that disabled women are more affected by menopause symptoms, of which 22% stated that they had left a job due to menopause symptoms, compared to 9% of non-disabled women (Bazeley *et al.*, 2022). Additionally, women believe that the taboo around menopause extends to sick notes; some studies show that only 30% of those that had to take time off work due to their symptoms reported menopause as the main reason for their sick notes (Bazeley *et al.*, 2022).

Aims of the study

This research is conducted to support NHS and care staff across two Integrated Care Systems (ICS), Hertfordshire and West Essex (HWE), and Suffolk and North-East Essex (SNEE), in managing their health and well-being more proactively by ensuring menopause support is provided in a way which will reflect and support the diversity of their workforce.

The current study explores the amount and extent of diversity within SNEE and HWE staff using data provided by the two ICS. Utilising focus groups, it also explores the impact of menopausal transition on the health and well-being and retention of staff. This research has provided various recommendations to improve health and wellbeing of staff and ensure that all staff feel included, by having a voice to address any issues identified.

This study aimed to examine the social construction of menopausal transition among a sample of staff currently working in clinical or non-clinical roles within the ICS. It explored how exclusion may

impact staff health and wellbeing. As the study aimed to gain a thorough understanding of menopausal transitions and women's lived experience of menopause while working within the ICS; the researchers used a 'generic approach' to reflect this and did not set out to design the research using any specific theoretical perspective or frameworks (Smith, Bekker and Cheater, 2011).

Evaluation approach

Design and Procedure

The evaluation is a concurrent, exploratory, mixed-method project (Creswell 2009). The study was conducted in two separate, quantitative and qualitative, phases commencing in September 2022. The weighting of the two elements was intended to be equal (Creswell 2009). However, the quantitative data, which we knew would be secondary data, had already been analysed and as such it was not possible to perform the statistical analyses we initially intended. Therefore, the rich qualitative research carries more weight in this final project, supported by the descriptive statistics of the ICS's workforce demographics.

Table 1. Summarising the organisations within the two Integrated care systems

Suffolk and North East Essex Integrated Care System	Hertfordshire and Essex Integrated Care system
Two acute hospital providers East Suffolk and North East Essex (ESNEFT) Foundation Trust West Suffolk Hospital	Three acute hospital providers: East and North Hertfordshire NHS Trust Princess Alexandra Hospital West Hertfordshire Hospitals NHS Trust
	Three providers of community services: Hertfordshire Community NHS Trust Central London Community Healthcare NHS Trust HCRG Care Group
Mental health services Norfolk and Suffolk Foundation Trust	Four providers of mental health, learning disability and autism services: Hertfordshire Partnership University NHS Foundation Trust Essex Partnership University NHS Foundation Trust North East London Foundation Trust HCRG Care Group
One emergency and urgent care provider East of England Ambulance Service NHS Trust	Two providers supporting emergency and urgent care: East of England Ambulance Service NHS Trust HUC (NHS111 Service)
104 GP surgeries	135 GP Practices working in 34 Primary Care Networks
	Six Professional bodies: Hertfordshire Local Medical Committee Essex Local Medical Committee Hertfordshire Local Pharmaceutical Committee Essex Local Pharmaceutical Committee Hertfordshire Local Optical Committee Essex Local Optical Committee
Suffolk and Essex County Councils	Hertfordshire and Essex County Councils

**And multiple Voluntary, Community, Faith
and Social Enterprise Sector Organisations**

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Enterprise Sector organisations**

Phase 1. Quantitative Approach

The evaluation used quantitative methods to assess the demographic makeup and inclusiveness of the ICS workforce in relation to the level of menopausal tendencies of the workforce. This was undertaken to support or corroborate the outcomes of the qualitative focus group and interview findings.

Quantitative Data Collection

The quantitative approach involved the use of secondary data from a range of sources across the ICSs. Specifically, the evaluation retrieved two datasets from the NHS staff surveys available at <http://www.nhsstaffsurveys.com> entitled “Benchmark report excel data 2017-2021” and “Detailed spreadsheets” datasets (by OE). These datasets comprised of NHS staff surveys including those in the two ICS. The datasets identified and retrieved were from previous NHS surveys that were already reported. Some datasets were from a census survey where all the staff of the organisations were invited to partake in the study and there was an average return rate of 56% across the SNEE and HWE organisations. However, there were no robust data sets for the smaller providers or social care within SNEE and HWE.

In addition, the researchers retrieved reports on Equality, diversity and inclusion from the organisations’ websites titled “Inclusion strategy and action plan”, “WDES report”, “WRES report”, “EDS2-2019”, “GPG report”, “Website Equality Report 2020”. These reports and others were freely available on websites. The Public Sector Equality Duty (PSED) annual compliance report, and the Gender Pay Gap Report 2022 by the Equality & Inclusion Committee of NHS East and North Hertfordshire were used for comparison during the data analysis and presentation to ascertain if the demographic makeup of the ICS in this study were consistent with those from previous studies across the NHS.

Statistical Analysis

The datasets provided did not require data cleaning or any validation processes. As the datasets were already processed, contained aggregated data and not raw data from individual staff of the ICS, it did not permit for deeper statistical analysis like correlation and regression or statistical testing of differences between groups, through cross-tabs, t-tests, and analysis of variance. Therefore, data analysis employed for this phase comprised of the use of simple percentages and averages providing descriptive statistics which are presented in tables and charts (OE).

The procedure for the data analysis and reporting is as follows:

- i. the researchers identified the SNEE and HWE organisations.
- ii. the data for the ICS of interest were extracted into a different excel sheet.
- iii. the researchers identified the specific variables or questions in the dataset that related to the workforce makeup, diversity, and inclusion.
- iv. the average responses to each question for each organisation were computed.

- v. the results reported showed the overall demographic makeup of the ICSs of interest. They also show comparison between SNEE and HWE organisations.

To complement the statistical data, individual reports, initiatives and policy guidance provided by the ICS were reviewed. These included the HWE (2022) Menopause Overview Peppy and SNEE (2022) Evaluation of Menopause for NHSE PowerPoint Presentations. These PowerPoints summarised a portfolio of activities and resources provided by the ICS. These included awareness campaigns for employees, training events for managers and advocates, menopause awareness, inclusivity, and check in sessions, as well as £55K spent on licences for a menopause support app for employees. Additionally, a recent mixed methods study of female ambulance staff experiences of menopause transition (CESSATION) (Prothero *et al.*, 2022) was used as the participants worked within the two ICS.

Phase 2. Qualitative Approach

Focus groups were used to collect data to develop an in-depth understanding of participants health and wellbeing at work in these organisations during menopause transition. The ICSs were keen to understand the impact of MT on staff feeling included/ excluded. Therefore, the language used in the invitations, introductions and questioning was actively chosen to be as inclusive as possible. This was to encourage participation from any staff member whether they were experiencing menopause transition or not. The research team and gatekeeper had had several discussions about the terms we used to recruit to the study, recognising that staff may not conform to gender stereotypes or traditional identities, and that any staff member was welcome to participate.

Initially, research team members (SCM, ZA, CP) reviewed the related literature to enable agreement on core principles and the identification of focus group questions to ensure they are representative of the ICS's workforces.

The focus group invitations were sent (in September, October & November 2022) to the gatekeeper, the SNEE Inclusive Health and Wellbeing Project Manager, who disseminated them. They were advertised in various groups, including MyPause check-in and chat sessions, HWB Collaborate group, SNEE HWB Working Group, LGBTQIA and Network and Menopause training events. The focus group dates and times featured in eight newsletters run fortnightly from September 6th, 2022, to November 30th, 2022. They were also discussed verbally across the ICS when networking.

Despite having a plan for conducting seven focus groups, only four were achieved, consisting of eight participants in total (in four groups: 3,1,2,2). Additionally, the researchers interacted with the gatekeeper to follow up on the invitations as fewer candidates than expected participated in focus groups; the last two focus groups in November had no expressions of interest. Winter pressures, the health and social care staffing crisis, and pay disputes leading to national strikes may have contributed to lower than hoped participation. That said, in qualitative research relatively small sample sizes as low as four focus groups, such as this project, can achieve saturation (Hennick and Kaiser 2022). This is where no new themes emerge, and the data collected is deemed sufficient.

Participants and Recruitment

A convenience sampling technique was used to recruit the potential participants. The study protocol did not contain any exclusion criteria, and there was no age restriction to participate in the study. To maintain anonymity, they had the freedom not to disclose their age, but from those that shared their age, they were in the range of 46-58 years and pre-, during, or post-menopausal. They were all employed by the ICS in clinical or non-clinical roles. Also, four were menopause advocates. They were from various ethnicities, including Caucasian, Caribbean, black African and Asian.

Data Collection and procedure

As the primary source of data collection in the qualitative phase, the focus group was used to encourage discussion and empower the participants to react and build on other women's responses and talk freely about their lived experiences of menopausal transition (Stewart & Shamdasani, 1990). Focus groups were conducted on the Microsoft Teams platform and recorded for transcription, and field notes were taken during the discussion by both researchers as needed. Each focus group lasted approximately 60 minutes and was run by two researchers (SCM/ZA or SCM/CP). The principal investigator was present in all four focus groups.

The focus groups were held online allowing the participants to be in familiar environments of their choice, in non-threatening settings, and to reduce the geographical restrictions thus increasing scheduling flexibility for both researchers and the participants. In addition, like face-to-face focus groups, the researchers had access to the participant's visual cues through their screens, except for one participant who was blind and wished her camera to remain off. Therefore, this method facilitates the collection of verbal and nonverbal information (Irani, 2019). However, even the participant with visual impairment commented upon the nonverbal communication that she experienced. Thus, our approach seemed inclusive.

The focus groups commenced with the introduction of the research team and the focus group participants, followed by preliminary questions, which were asked to stimulate participants' experiences.

Key questions included:

- What motivated you to participate in this study?
- Are you/ people you work with or those that you are close to experiencing menopausal symptoms? Could you please share what these symptoms are?
- Who do you or your colleagues/ personal contacts speak to about menopausal experiences? If you don't, why not?
- Do your symptoms affect you in the workplace? In what way do they affect you?
- What support is available to you or others with menopause? Are you able to access it? Are you willing to access it? What are your perceptions of the support? Prompts: inclusivity, universal, understanding, organisation-wide, dependent online manager
- If you are unable or don't want to access it, can you explain why including the barriers and perceptions of the support?
- What would you like to see from your employer in relation to menopause support?

- Is there anything else you would like to add about menopausal support?

Data Analysis

The study employed Braun and Clarke (2022) six-step thematic analysis approach and NVivo 12 software to identify themes related to menopausal transition while working within the ICS, capturing participant understandings, and lived experiences and allowing an in-depth analysis of the data. This method consists of six phases: (1) familiarizing oneself with the data, (2) generating codes, (3) constructing themes, (4) reviewing potential themes, (5) defining and naming themes, and (6) producing the report. All the focus groups were recorded. Transcription was undertaken using Trint online software (<https://trint.com/>) with each transcript checked and corrected manually (by CP).

The research assistant (NAJ) first familiarised herself with the data by reading the transcriptions several times whilst coding the data on NVivo12. Following the initial set of codes, five themes were produced and sent to the principal investigator for validation, and minor changes were made. The research assistant then re-read the codes and themes to ensure that data from a range of participants sufficiently supported all the themes.

Ethical Considerations

The ethical approval was received from the University of Suffolk in August 2022 (RD22 002). Prior to the commencement of the focus groups, all the participants received an information sheet with clear language explanations of the research aims, process, participant involvement, and expectations. They had the right to decline to participate, answer questions, or withdraw without explanation or penalty. Then they were asked to sign and return the consent form. The participant's data were anonymised at the earliest possible stage to protect their privacy, and pseudonyms were used throughout the study instead of participant names. All data is only accessible by the researchers, and the recordings and transcriptions of the focus groups are stored on the university cloud-based server on password-protected work-allocated computers. The raw data will be deleted after the study's publication and will only be used in this project.

Results

Review of ICS and HWE activities to support menopause transition

There is existing support in Suffolk and North East Essex for menopausal staff working in health and care, the menopause network called 'MyPause' has over 400 members from across the system including GP's and Consultants. The network has been externally evaluated by Niche Consulting and MyPause continues to do its own evaluations demonstrating that those who have engaged with the network have benefited from the support. In a snapshot survey with 31 responses over 80% of staff said that menopause symptoms had meant that they had considered reducing their hours, changing their role or resigning. In qualitative feedback from staff some stated that they would have left without the support of the network.

MyPause provides awareness sessions, training for managers, training on menopause and diversity, and training for colleagues, including safe spaces for men. The menopause policy created by MyPause which includes a risk assessment for staff and recommendations regarding reasonable adjustments is on the NHSE Futures page as an example of good practice. It has been shared with multiple organisations within SNEE and adopted as a policy or guidance by many. The training slides for diversity were presented to the HWE BAME network before being used and include infographics that MyPause hopes many minorities can identify with, they are designed to demonstrate that the support is for everyone within our diverse workforce which includes diversity beyond the protected characteristics. MyPause also has posters and has shared on social media posts in support of inclusivity and images in support of our LGBTQIA+ community. MyPause refers to menopausal people and menopausal women in recognition that not everyone who suffers symptoms identifies as female, and also being mindful that some women value the reference to their femininity. MyPause has been assessed by Henpicked who offer menopause friendly accreditation to organisations that can demonstrate a high level of staff support. They were assessed according to 6 standards, these being:

- Culture
- Training
- Policies and Practices
- Engagement
- Facilities
- Evaluation

MyPause has been awarded a national accreditation. There are currently 45 advocates in the SNEE system who have been trained over three sessions and work to support staff within their organisations. This number will be built on to achieve sustainability. MyPause has also connected with Carolyn Harris MP who co-chairs the national task force, the founder, Debs Crelly has met with Carolyn to lobby on menopause being a protected characteristic, and Carolyn has also met with the menopause network and discussed the progression of this work and the work to reduce the cost and improve the availability of HRT. Many MyPause sessions were made available for HWE staff as well as SNEE.

The communications strategy by MyPause has included; a dedicated Twitter page @MyPause1, a podcast which is on Spotify and the Healthwatch Essex website. Regular communication to its members including a monthly check in and chat on the same third Thursday of the month at 15:30 which is usually attended by around 40 members. There is also a newsletter which is distributed to 500 leaders across the system including voluntary and charitable sector, and MyPause has been in the Voluntary and Statutory Partnerships sector newsletter and is doing a podcast with VASP this year and with the regional ambassador for physician's associates. MyPause was interviewed by BBC Radio Suffolk in December 2022 regarding its support and achievements. Presentations regarding the support of MyPause have been to many organisations and partners across the system and to the SNEE ICS People Board, the SNEE ICS Integrated Care Partnership and an interactive workshop at the SNEE ICS launch on 1st July 2022. It is now the ambition of NHSE regionally that all its systems are menopause friendly accredited and MyPause has presented at regional and national events on how this was achieved.

Phase 1: Quantitative Results

The data below is from the 2021 annual national NHS Staff surveys. It is a comprehensive dataset, one of the largest staff surveys in the world. Its questions are aligned to the NHS People Plan (2021) and The Promise (NHS England no date). This promises that the NHS will be positive, compassionate and inclusive, this aligns with the project's aims.

Table 2: Summary of NHS Staff survey 2021 Data: NB. total staff derived from response rate and number of responses Base/response rate

Trust Code	Trust Name	Trust Type	Sample Type	Survey Mode	Total Staff	Base (no. of responses)	Return Rate
RDE	East Suffolk and North Essex NHS Foundation Trust	Acute / Acute & Community Trusts	Census	Mixed	11,184	5033	0.45
RGR	West Suffolk NHS Foundation Trust	Acute / Acute & Community Trusts	Census	Mixed	4,334	1907	0.44
RQW	The Princess Alexandra Hospital NHS Trust	Acute / Acute & Community Trusts	Census	Mixed	4,774	2244	0.47
RWG	West Hertfordshire Hospitals NHS Trust	Acute / Acute & Community Trusts	Census	Mixed	3,431	1681	0.49
RWH	East and North Hertfordshire NHS Trust	Acute / Acute & Community Trusts	Census	Mixed	5,983	2513	0.42
RMY	Norfolk and Suffolk NHS Foundation Trust	Mental Health & Learning Disability, Learning Disability & Community Trusts	Census	Online	5,244	2622	0.50

RWR	Hertfordshire Partnership University NHS Foundation Trust	Mental Health & Learning Disability, Learning Disability & Community Trusts	Census	Mixed	3,460	1730	0.50
RY4	Hertfordshire Community NHS Trust	Community Trusts	Census	Online	2,071	1408	0.68
06K	NHS East and North Hertfordshire CCG	CCGs	Census	Online	276	229	0.83
06L/06T/07K	NHS West Suffolk CCG; NHS North East Essex CCG; NHS Ipswich and East Suffolk CCG	CCGs	Census	Online	421	278	0.66
07H	NHS West Essex CCG	CCGs	Census	Online	175	126	0.72
	Total				41,353	19,771	
AVERAGE RETURN RATE							0.56

Interpretation of data from NHS Surveys

The SNEE and HWE NHS organisations according to Benchmarking Group of Organisations are five Acute / Acute & Community Trusts, two Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts, one Community Trust, and three Clinical Commissioning Groups (CCGs). A total of 41,353 staff were surveyed with 19,771 responses returned.

The sample type for all the organisations was “census” implying that all the staff of the organisations were invited to the survey. There was an average return rate of 56% across the eleven SNEE and HWE NHS organisations. However, the range was 42-83%, with larger Trusts (those with over 3,000 staff) having typically lower response rates (circa 50%) compared to the smaller organisations (2,000 or fewer staff and response rates above 66%). Whether this is symbolic of a sense of belonging to the organisation is unknown. If we had been able to cross tabulate the raw data, we may have been able to determine this.

The mode of survey was “online” for five of the organisations and a “mixed” approach of online and physical was used for the other six SNEE and HWE organisations. No explanation was given for the difference in use of mixed or online surveys. Using the online only version seemed to increase the response rate, however, these may have had a higher response rate due to being smaller organisations and the mixed method may have been used to increase participation in the survey.

Demographic Data from NHS surveys

Initially, we reviewed the data headings, variables, codes, etc. to help us understand the data and which specific questions we could use to answer the objectives of the study. This was the amount and extent of diversity within the two ICS but also the impact of exclusion on staff health and wellbeing. We intended to cross tabulate the demographic data in gender, ethnic group, sexual orientation, religion, years worked for the organisation and whether recruited from the UK and staff group with staff retention, staff health data (including feeling safe and healthy) and inclusion. However, it was apparent that the datasets were summarised percentages of the staff survey results and not the raw data. For instance, we could not see the data for individual respondents that selected male/female for gender and yes/no for gender identity so we could not identify how many *females* selected *yes/no for gender identity* (crosstab), and so on.

This meant that we did not have access to the raw data on responses from individuals, rather we had the overall summarised data from each NHS organisation. Therefore, we were unable to compute crosstabulations due to limitations of data format available. However, the descriptive data is still valuable and contains a large dataset of staff demographics from the two ICS.

Analysis Results for SNEE and HWE NHS Organisations

Due to the peculiarities of the data described above, the average values were therefore computed for each of the questions across the organisations and reported to generate the general description of the workforce demographics across SNEE and HWE organisations that are of interest to the present study.

Occupational groups

Figure 1 presents the occupational groups in the ICS NHS workforces. Many of these are reflected in the wider ICS workforce (The state of the adult social care sector and workforce in England, 2022) where there are regulated professional roles, registered managers, nursing assistants and care workers.

Our qualitative data was gathered from the largest groups: registered nursing, healthcare support staff, central/ corporate services and administrative as well as a minority groups- social work and community care. Therefore, while not its purpose, it was representative of the occupational groups within the two ICS.

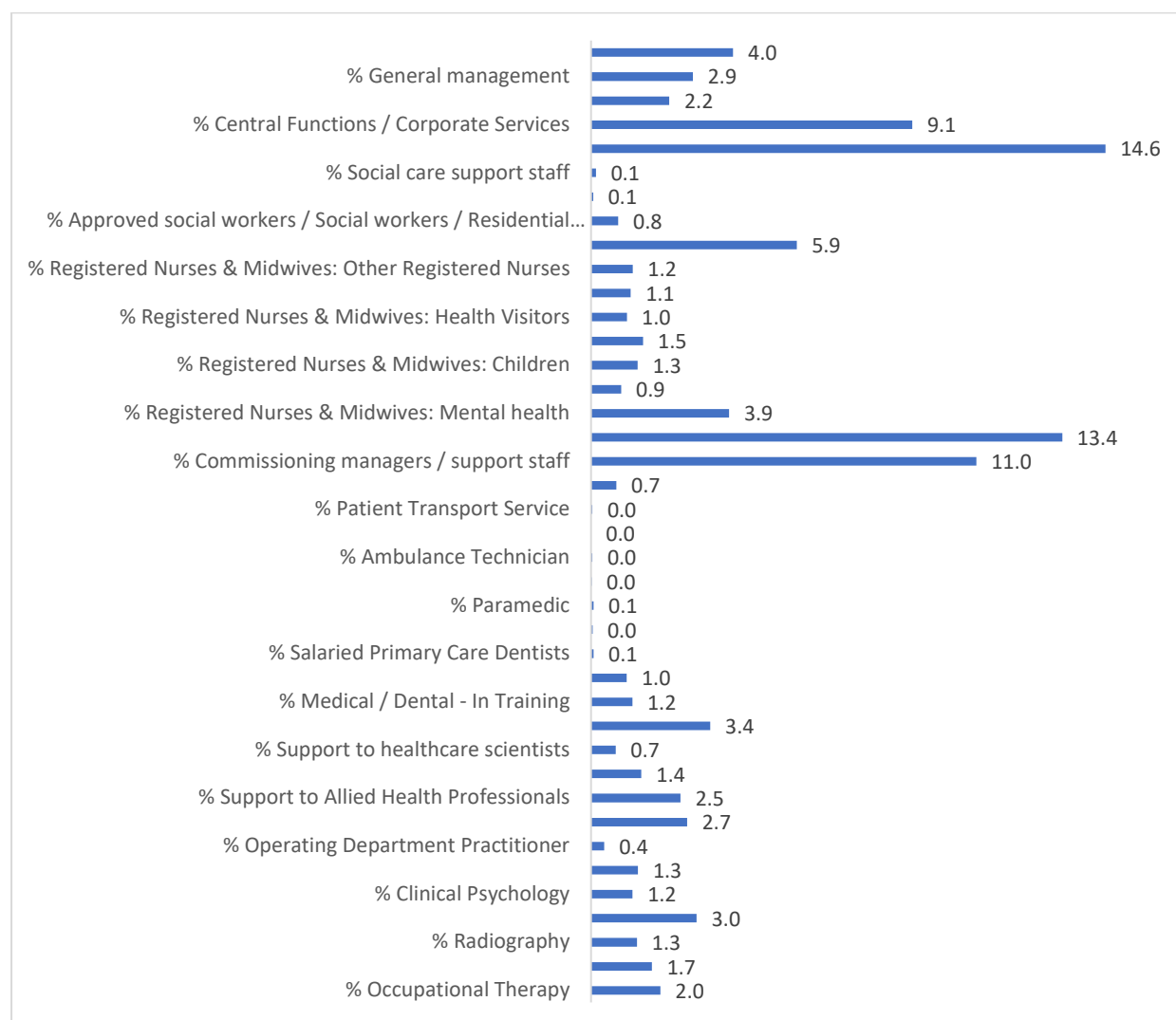


Figure 1: What is your occupational group?

Length of service with the organisation

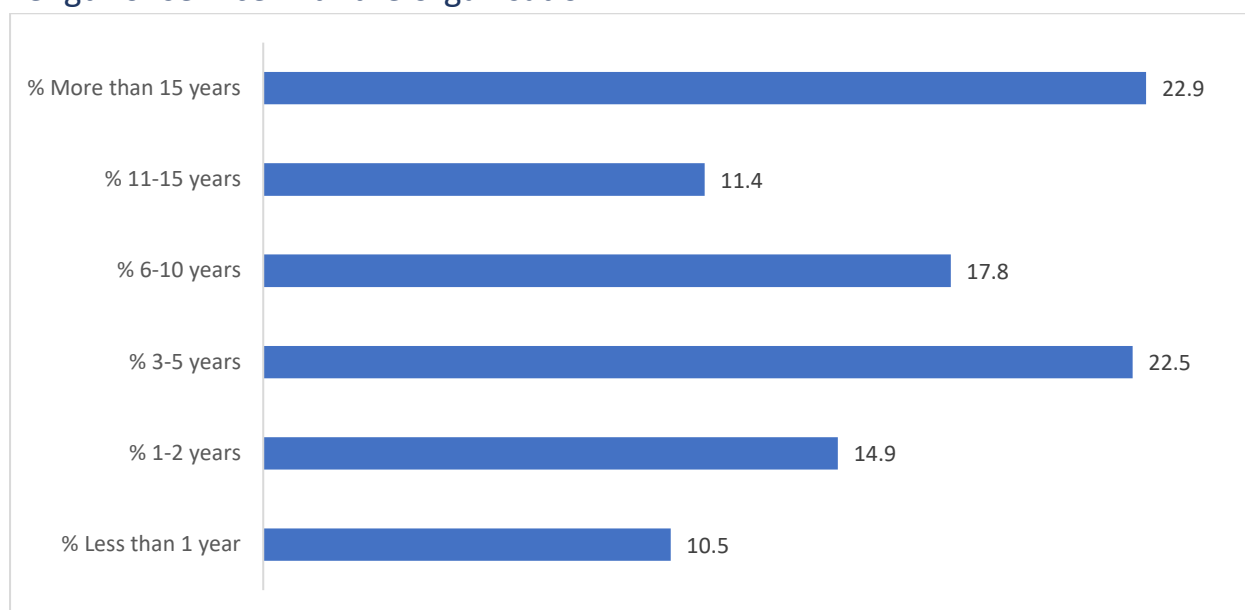


Figure 2: How many years have you worked for this organisation?

There was a wide span in the employment history of staff. This was also noted on the focus group participants with one participant who had been at the organisation for just over a year and another for more than four decades and the others in between. Within other organisations in the ICS, 43% of the ambulance service staff has been in their organisation for less than 10 years (Prothero 2022). This is significantly lower than the NHS Trusts where 65% had served less than ten years' service. 25% of the ambulance service had been employed for less than 5 years compared to 47.9% in the NHS table above. This may be due to the higher percentage of women in the NHS (77%) compared to ambulance service (31-60%). This could potentially imply that there is significant variation across the ICSs in longevity of staff, whether this is associated with inclusivity is not known. However, some of the participants in the focus groups made an association between gender and age regarding feeling valued. This will be reported further.

Gender and gender identity

The key statistic from the NHS staff survey 2021 data is that a 77.4% majority of the workforce in SNEE and HWE NHS organisations are female. In social care this percentage is reported to be higher at 80% of the workforce (Skills for Care 2022). However, in other organisations within the ICS, the ambulance service for instance, the percentage of women is lower (35-56% of female staff in 11/12 UK ambulance Trusts) (Prothero et al 2022). Regardless of the exact percentage, most of ICS staff are female.

The majority (96.8%) of the workforce reported that their gender identity is the same as the sex they were registered at birth, implying that a vast majority of the females would still be identified as females except for a possible 3% who either no longer identifying as females or prefer not to say if they identify as females or not.

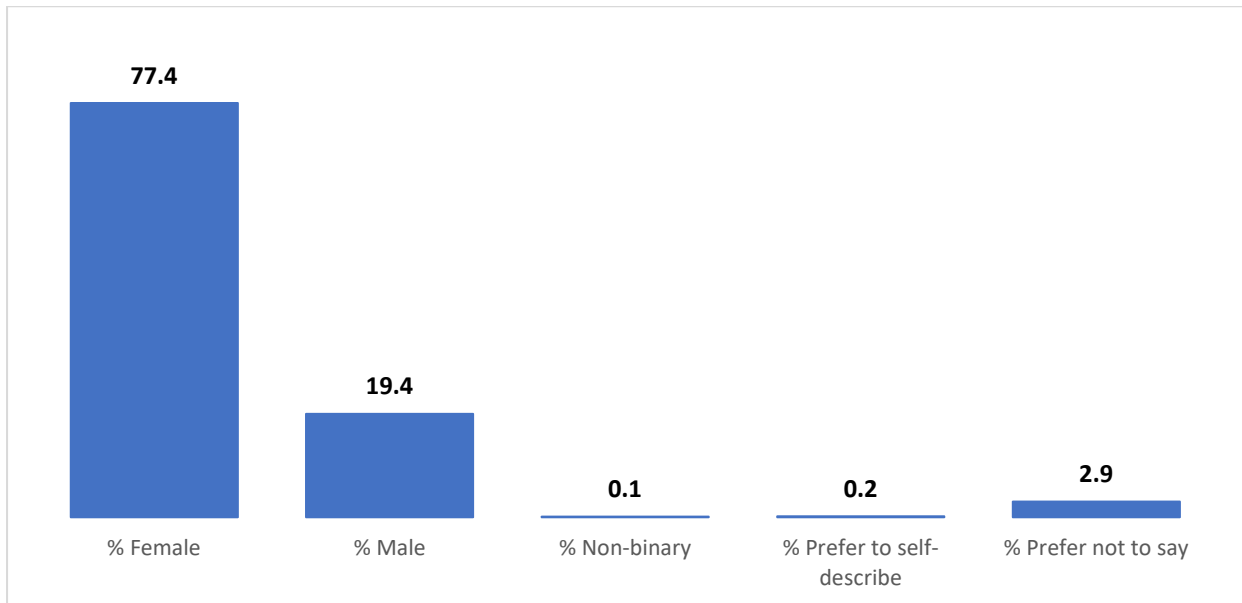


Figure 3: Gender (Combined)

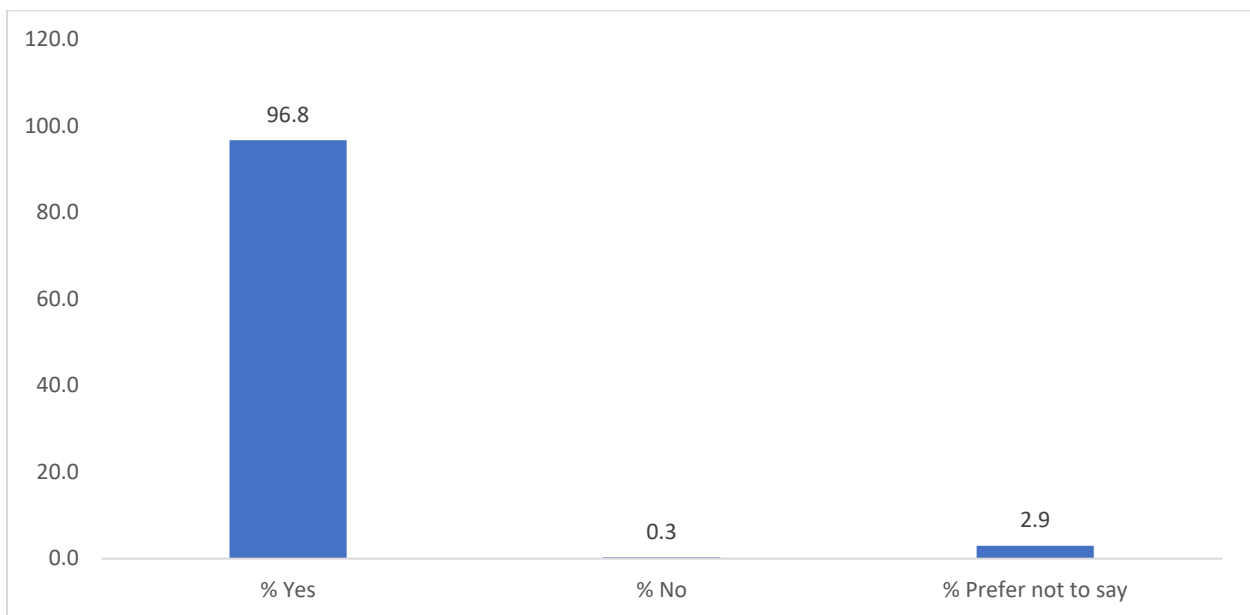


Figure 4: Is your gender identity the same as the sex you were registered at birth? (Combined)

In other words, we can suggest that females make up 77.4% of the respondents for all the variables/questions. The combined results are corroborated by the individual results from SNEE and HWE organisations respectively as shown below.

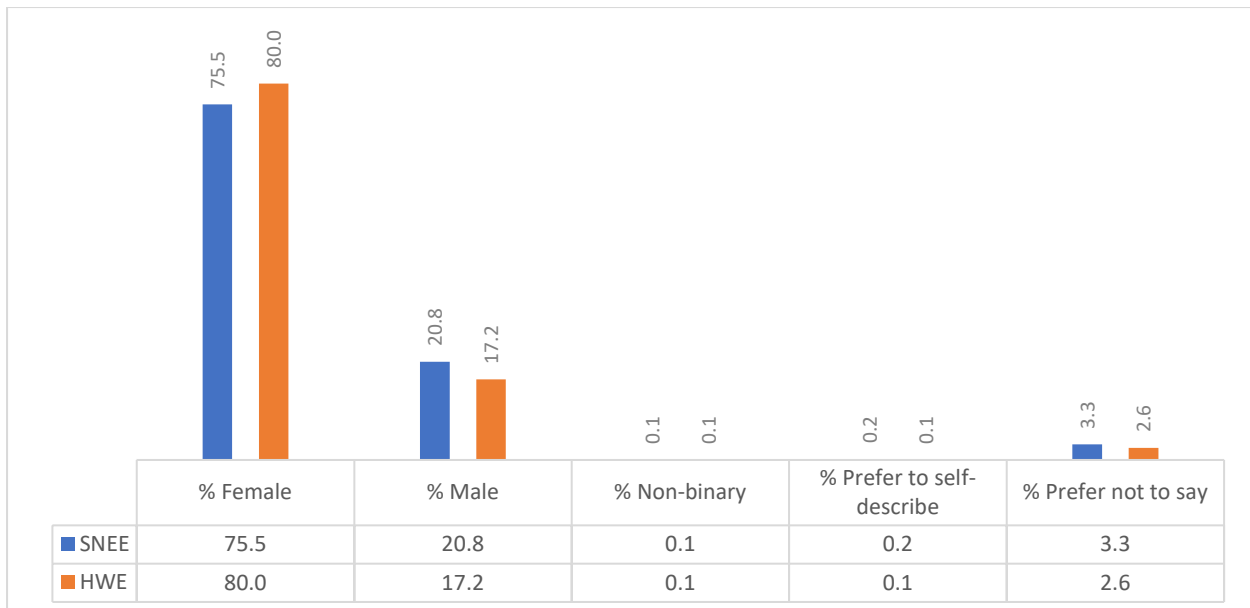


Figure 5: Gender (SNEE and HWE)

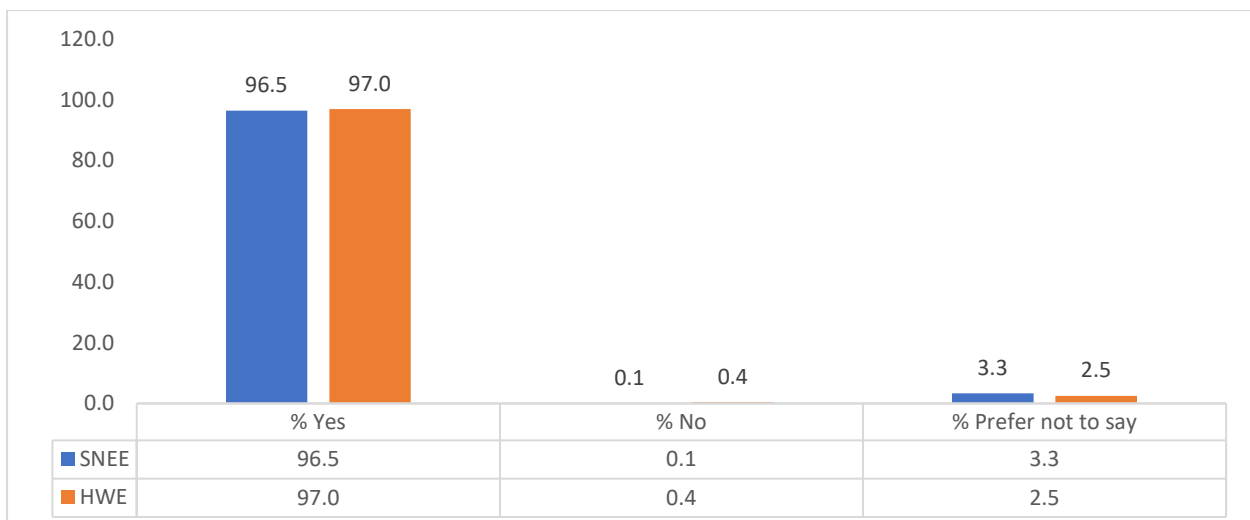


Figure 6: Is your gender identity the same as the sex you were registered at birth? (SNEE and HWE)

When the data was separated for SNEE and HWE NHS staff respectively to show comparison, it can be observed that females still make up over 75% of the workforce across the organisations with over 96% in both ICSs agreeing that their gender identity is the same as the one they were registered with at birth. ONS (2023a) data from England and Wales on gender identity has just been published. The national findings indicate that 93.5% of the census population stated their gender identity was the same as their sex registered at birth (6% preferred not to say). Therefore, the number of staff reporting their gender identity matched their sex at birth is slightly higher in the ICS (96.5-97%) but there were fewer staff who preferred not to say (2.5-3.3%). This could be interpreted to say that the ICS are more inclusive than the perception of the general public in England and Wales. All participants in the focus groups identified as women. One participant had a child whose sex at birth was not the same as their gender identity. This will be reported later.

Age demographics

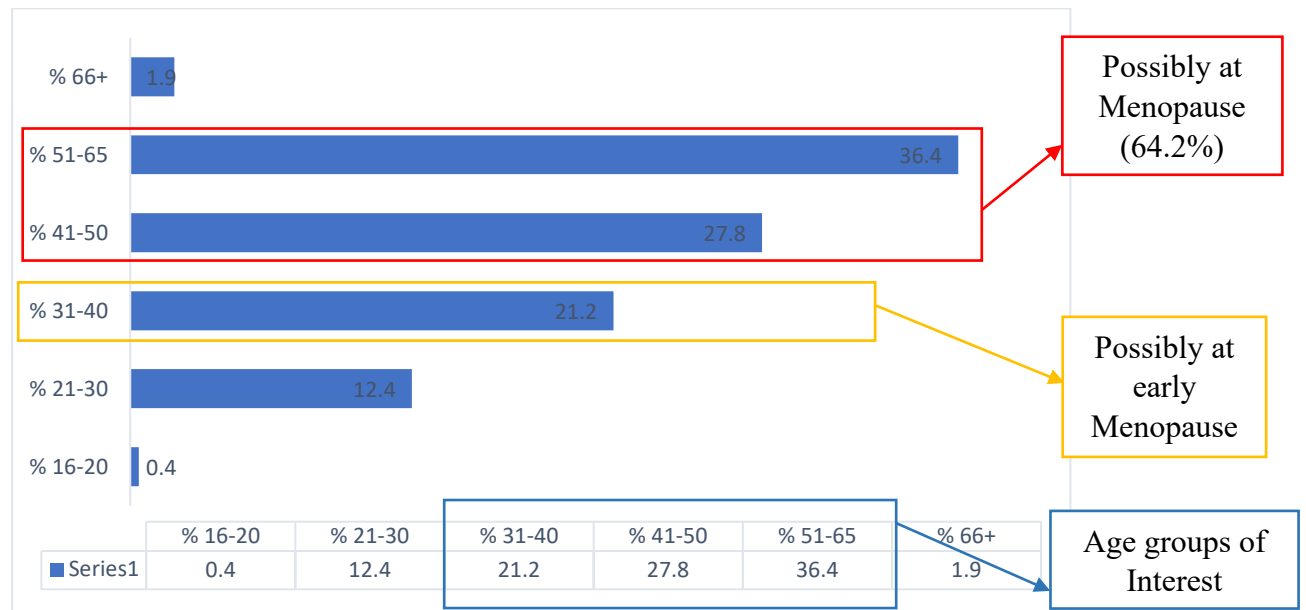


Figure 7: Age (Combined)

On age demography, the data shows that 84.4% of the SNEE and HWE workforce (combined) are between the ages of 31 to 65 years, among which 77.4% are likely to be females already experiencing menopause (64.2% who are 41 and above) or in early menopause (21.2% who are 31 to 40 years old).

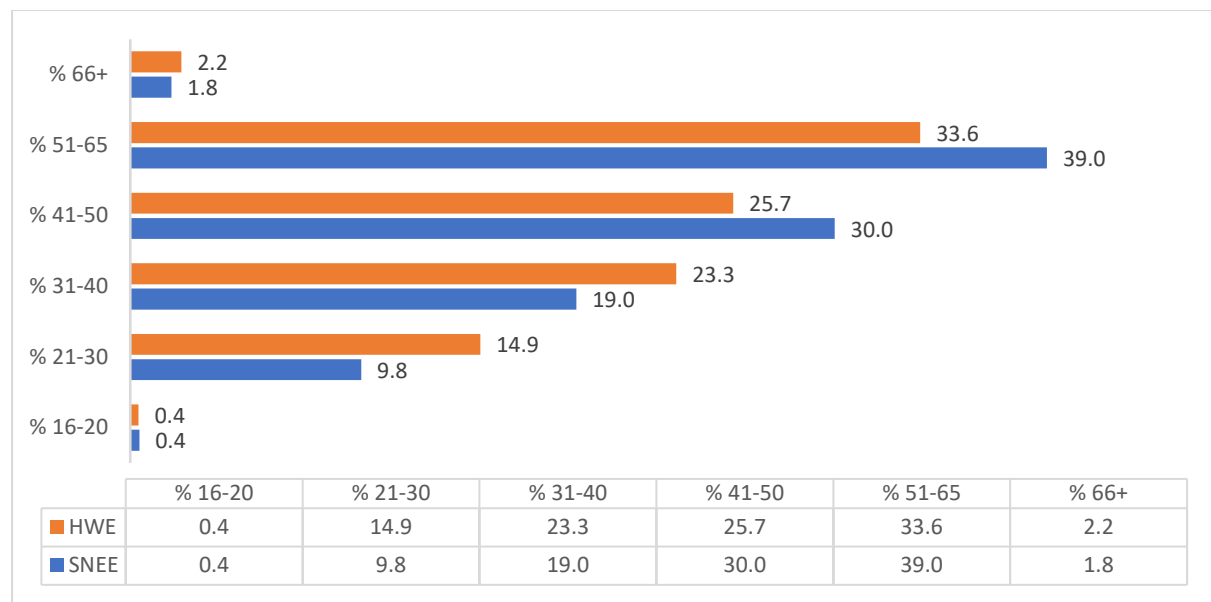


Figure 8: Age (SNEE Vs HWE)

Comparing the data for SNEE and HWE organisations, it can be observed that most of the workforce (of over 60% across the two ICSs) is within the “possibly already at menopause”

age groups of 41 years and above, while about 19-23% are between 31 to 40 years old of who are possibly at early menopause.

The number of staff under 40 years of age in HWE is higher (38.6% compared to SNEE 29.3%). Due to this slightly younger demographic at HWE NHS organisation the number of staff in the 41-65 age group is also slightly reduced but still the largest demographic (59.3%). At SNEE it is higher (69%). Therefore, most of the workforce, who are also women, may have experience or are likely to soon experience menopause transition. This is a larger percentage than in the ambulance service. Across the UK, 31-60% of female ambulance staff were over 40 (Prothero *et al.*, 2022).

Physical or mental health conditions

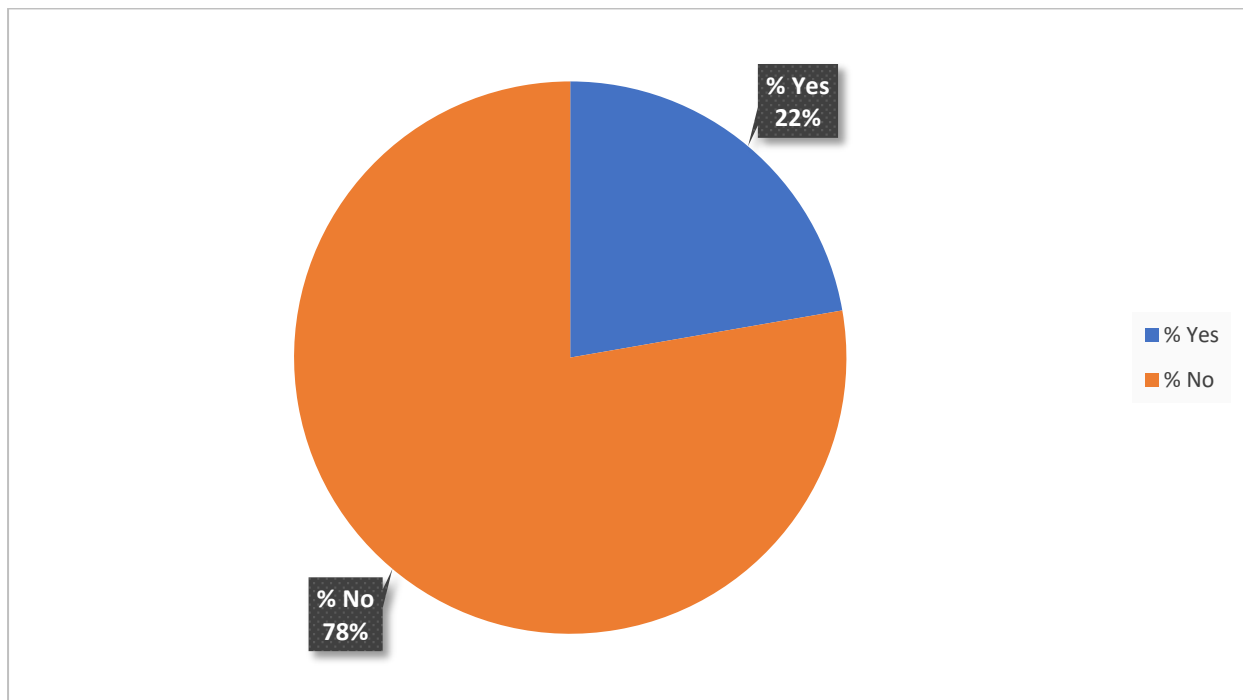


Figure 9: Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?

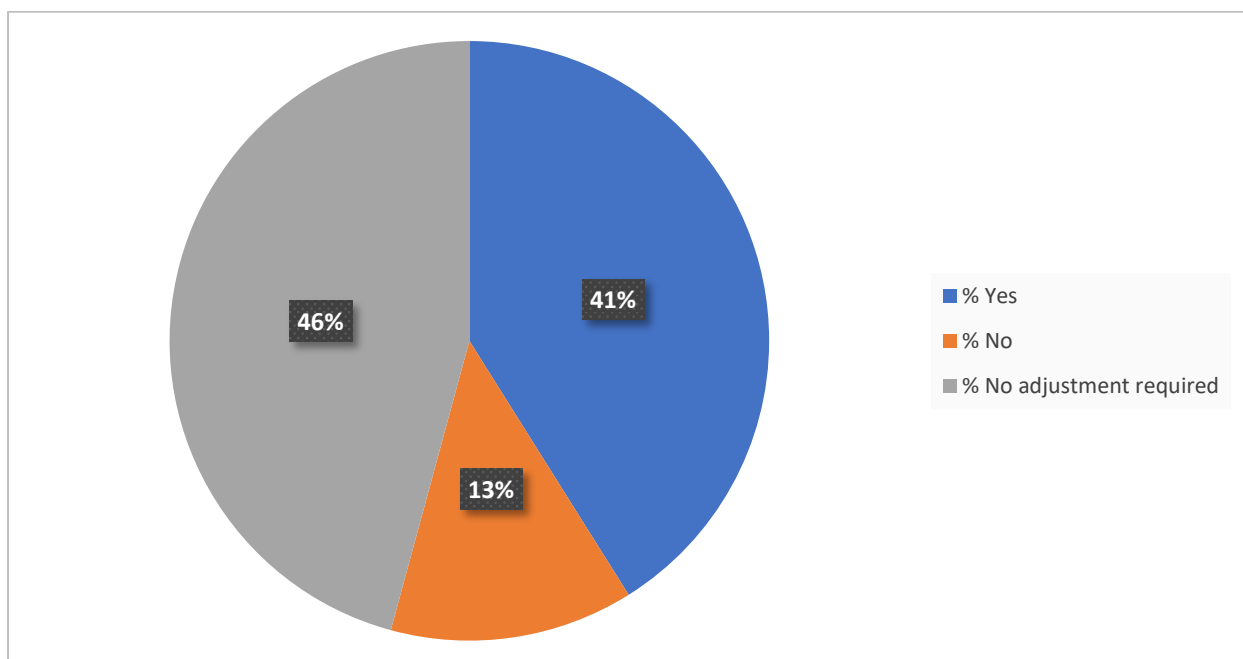


Figure 10: Has your employer made adequate adjustment(s) to enable you to carry out your work?

It would have been interesting to know whether the 22% of the workforce who declared that they had a longstanding disability was age related through cross tabulation. However, we did not have this raw data. In the focus groups there were several participants who had

long term physical or mental health conditions. One had reasonable adjustments, but others found it difficult to access/ negotiate these.

Ethnicity

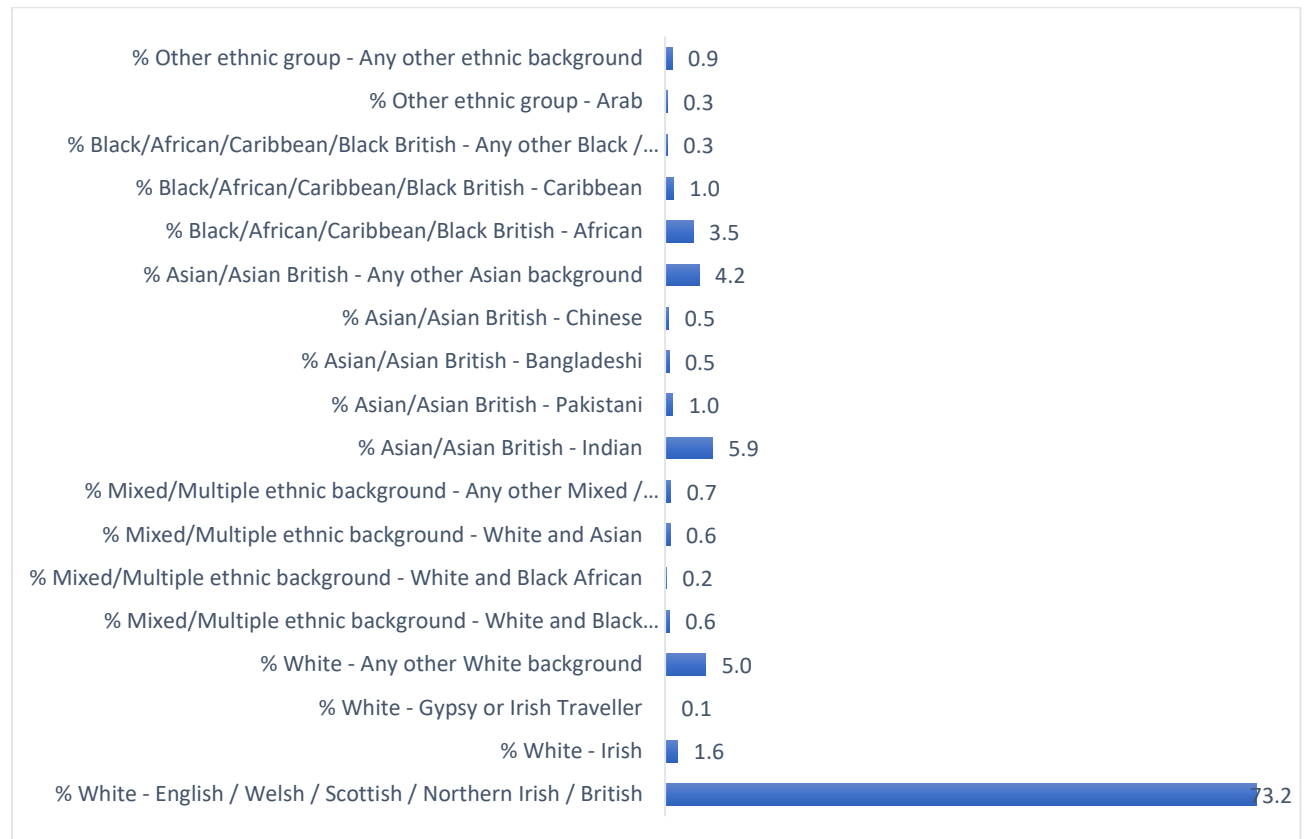


Figure 11: What is your ethnic group?

The results show that the workforce majority are about 80% white staff (which would likely be mostly women), followed by 12% Asian, 5% Black and 3% multiple, mixed or other ethnic group staff respectively who would also likely be mostly women due to the overall workforce gender distribution. In the ambulance service a higher proportion of staff were white 93% and a further 5% white other. Only 1% of 1909 participants (n=26) were from ethnic minority groups (Prothero *et al.*, 2022). This means that some areas within the two ICS may have significantly less diversity than the overall NHS staff demographics.

This could also mean that the NHS workforce majority could be white women of 31 years and above (also based on overall workforce age distribution). The implication of this data for menopause could be that the women at greater risk of early menopause or are already experiencing menopause would be women who fall under the white ethnic group, followed by the Asian and Black staff respectively.

Sexual orientation

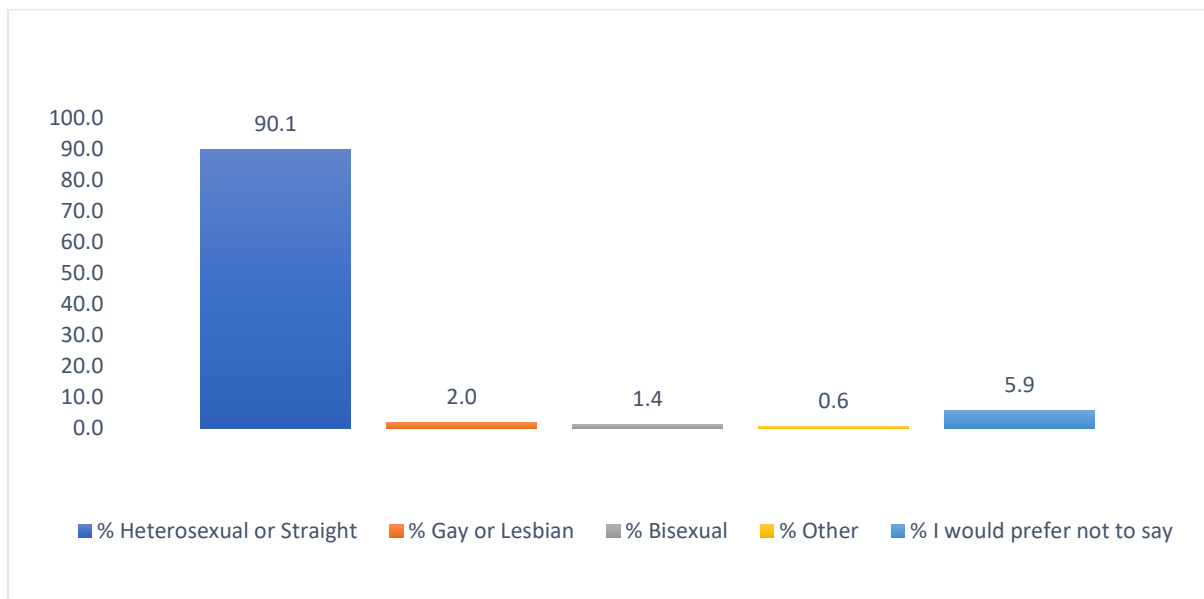


Figure 12: Sexual orientation

The latest ONS Sexual orientation: England and Wales: Census 2021 (2023b) asked a new voluntary question on sexual orientation to those aged 16 and over. 92.5% of respondents answered the census question, which is comparable but slightly lower than the SNEE/HWS NHS staff response rate of 94.1% seen above.

In England and Wales 89.4% of the population identified as straight or homosexual compared to a slightly higher rate of 90.1% for SNEE/HWS. However, the regional ONS (2023b) data for the East of England was 90% straight.

The percentage of staff identifying as LGBTQ+ was also slightly higher in the ICS populations (4%) compared to overall data for England and Wales (3.2%). The ONS (2023b) data had more categories (six) than the NHS staff survey (four). The ONS included gay or lesbian, bisexual, pansexual, asexual, queer and all others. Overall, the data seems to support the hypothesis that staff in the two ICS are slightly more willing to share their sexual orientation and this could be interpreted as positive for inclusivity. The majority of ICS staff are heterosexual but 4% of staff identify as LGBTQ+ and a further 5.9% prefer not to say.

Religion

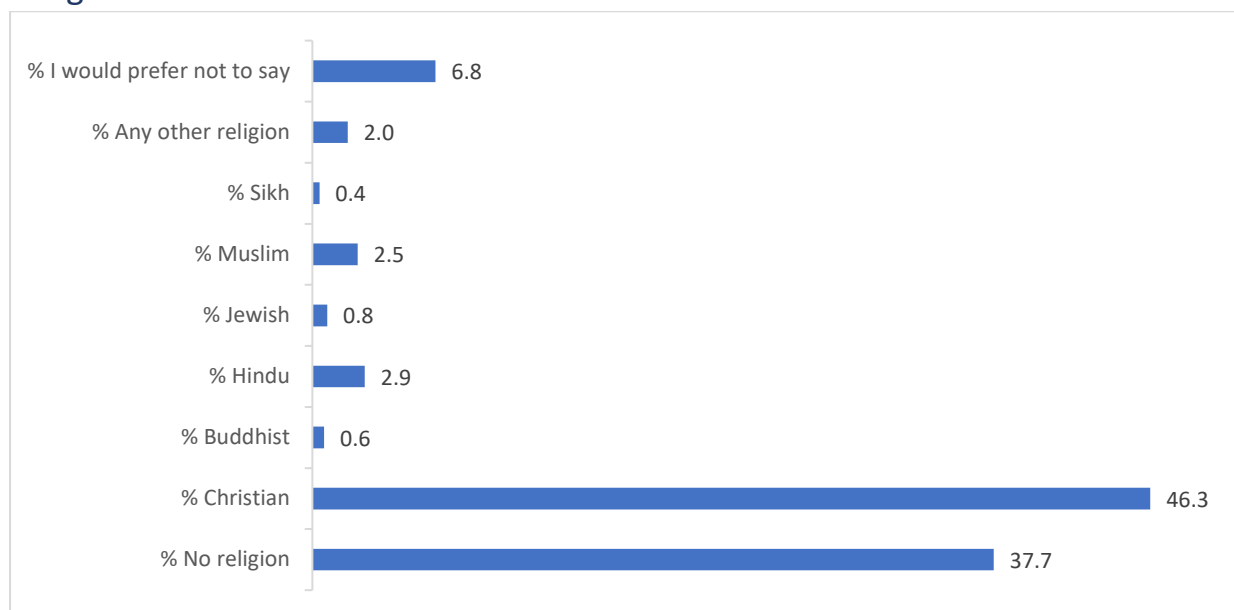


Figure 13: What is your religion?

As expected, the ICS has a range of staff with different religious beliefs, including no religion. It was interesting that more staff preferred not to disclose their religion (6.8%) than sexual orientation (5.9%). We have included this data, but no reference was made in the focus groups to religion, nor was any specific question asked.

Dependents and caring responsibilities

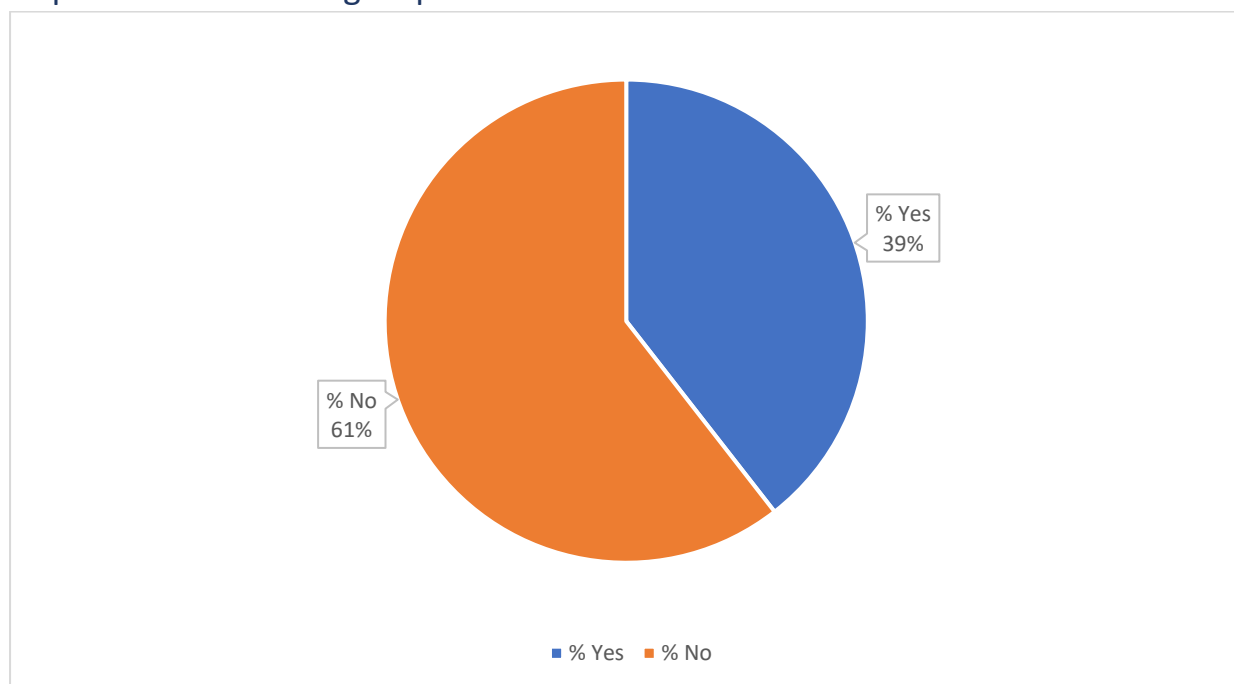


Figure 14: Do you have any children aged from 0 to 17 living at home with you, or who you have regular caring responsibility for?

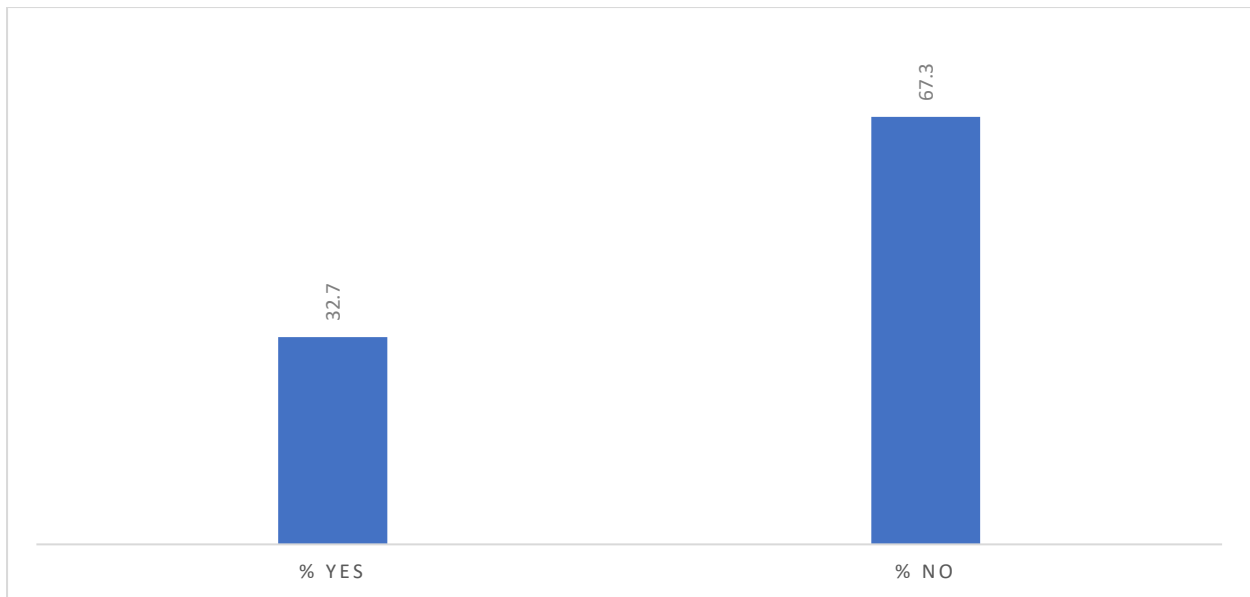


Figure 15: Do you look after, or give any help or support to family members, friends, neighbours or others because of either: long term physical or mental ill health / disability, or problems related to old age?

The majority of the workforce did not have caring responsibilities, whether this was children or family members. In the focus groups, participants spoke about their children but not in relation to caring for them while working. Therefore, dependents did not seem to be a barrier to work or a burden during the menopause transition in our small sample.

Recruitment to NHS from abroad

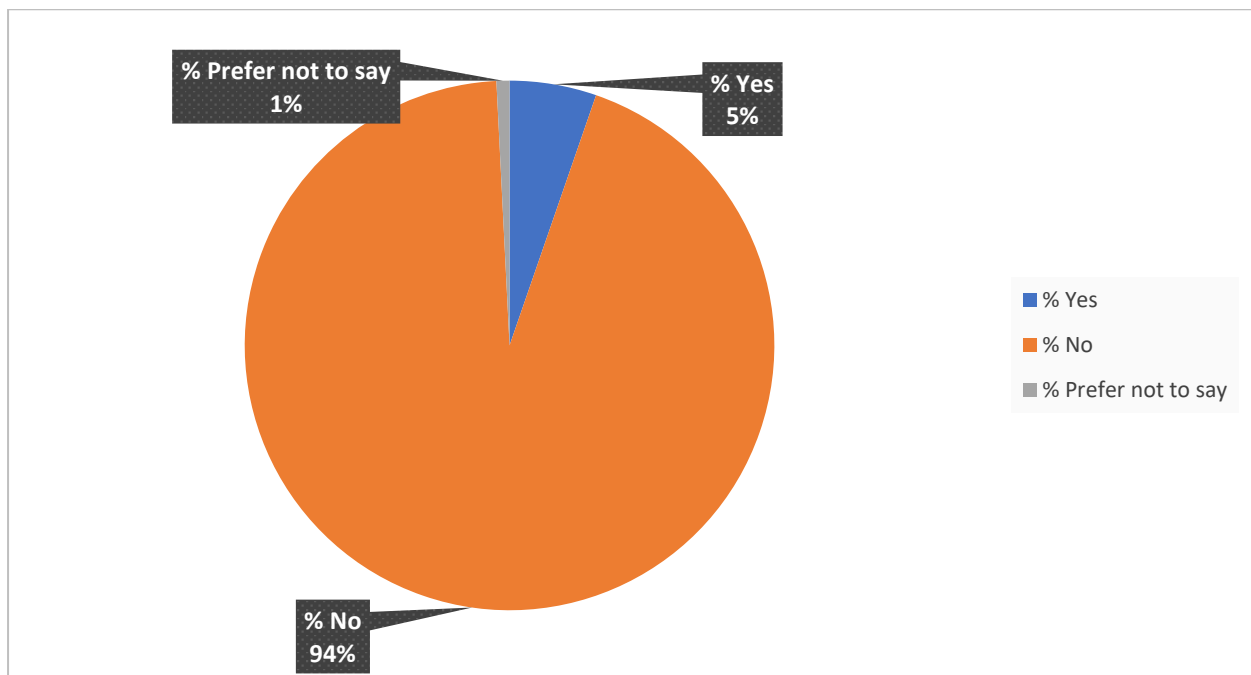


Figure 16: When you joined this organisation, were you recruited from outside of the UK?

Many staff (94%) stated they were recruited from the UK. No participants in the focus group said they were recruited from outside the UK, but some were born outside the UK.

Phase2: Qualitative Results

Description of participants

Eight women, employed in the ICS within the NHS and social care, participated in four focus groups. To maintain their anonymity and to be as inclusive as possible detailed demographic information was not requested; however, many participants shared this spontaneously. It was interesting that those whose ethnicity was not white British explained, in some cases, in detail where their families were from. The other participants, who appeared white, did not. This phenomenon has been called white normativity, when the assumption is that the white culture is the standard and has been linked with white dominance (Bell, 2021). This was not how it came across in the focus groups, but the researchers were mindful of this phenomenon.

Table 3 Focus groups and demographic information where shared

Focus Group	Pseudonym	Age	Role	Ethnicity	Disability/ long term condition	Dependents
1	Anna	58	Community Matron, 40 years of nursing experience		Five years with significant arthritis, needed surgery and 3 months off work. Gynaecological surgery 10 years previously	
1	Katherine		Working in the ICB with a focus on equity. Menopause advocate		Multiple disabilities, sensory neurodiverse and some physical ones	2 children
1	Jill		Senior technician for training and education Menopause advocate			
2	Susie	51	Nurse		Periods of depression in the past, traumatic stress Significant personal traumas	Transgender child
3	Sharon	46	Health Care Assistant, for just over a year			
3	Amara		Social worker	African		
4	Susanna	48	Nonclinical role Menopause advocate	Mixed Caribbean		
4	Salma		Nonclinical role Menopause advocate	Asian		

The thematic analysis of the focus groups identified five main themes and several sub-themes (Table 4) which will be discussed in detail below.

Table 4. Thematic Framework for Focus Group

Themes		Sub-theme
1	Menopause transition and the experience of ICS employees	Physiological symptoms Psychological symptoms
2	Lack of knowledge on menopause transition	Individuals/families Organisations/managers/colleagues The health professionals
3	Discrimination and equality	
4	The ICS as an employer during menopause transition	
5	Recommendations	Societal level: Menopause should be a protected characteristic. Societal need for MT knowledge. Organisational/ managerial level: Primary care knowledge, managerial support, flexible working patterns and environments (access to water, ventilation), signposting to services. Individual level: Support women (people with MT), individual MT knowledge.

Theme 1. Menopause transition and the experience of ICS employees

The women discussed various **symptoms** from pre- or post-menopausal stages, **affecting them physically and psychologically** in their daily life and in their working roles within the integrated care systems. Symptoms most frequently mentioned included hot flushes, night sweats, brain fog, tiredness, memory loss, difficulty sleeping, joint pain and lack of energy. Additionally, some women stated long struggles and confusion with the source of symptoms for several years.

The effects of sleep disturbances were discussed extensively in the focus groups, and women were eager to share their **negative experiences** of working as nurses **with shifts**.

Each participant was unique, some preferred working in the mornings, others later in the day. They shared how they are striving to cope with **working patterns**:

"Because I don't sleep very well at night, and I'd rather just get up and do the early shift time. I get home, say midnight. Then I have to take a couple of hours for me to unwind and then get to sleep... I just don't sleep at all. And then my day off is just messed up. I'm groggy, my head, and I've got no energy "(Sharon, Group 3).

"... I always find it hard to get up in the mornings and a lot of people say they can't sleep. Mine (is) sort of the opposite. I find it really, really hard throughout the day.... it's being permanently fatigued" (Jill, Group 1).

Some physiological symptoms meant women felt embarrassment at work with symptoms such as excessive sweating or an urge to use the toilet constantly:

"You obviously relate to this. It's just awful..... it's ridiculous, embarrassing, humiliating. And you just want to run away from it because you just need this internal heat to stop as quickly as possible" (Anna, Group 1).

"[my teenage child] ... thinks it's hilarious that I pee permanently. I'll go somewhere and I'll wee when I get there. And I'll wee when I leave. She's like a little camel. And wherever we go, it's like, find the toilet, find the toilet. And apparently that's because my oestrogen's dropped as well. So that's said about my other symptoms. That's one of them..." (Susie, Group 2).

In addition to physiological symptoms, women talked about their **psychological symptoms**, such as **depression, anxiety, and memory loss**.

"I'm from an island culture. Lots of people suddenly, like finding themselves sensitive to shellfish and stuff like that. So, it just seems. In some ways I feel sympathetic towards GPs because any one of us could go and present go, oh my God, I feel like if I'm losing my mind and they start going, well, you know, it's been covered, you're stressed, you have teenage children, maybe you're depressed, here's some antidepressants. And then you turn up and you go, hey, I used to love eating. You know, nothing I like more than paella. And then suddenly, I can't have it. And I go, all right, you know, there's more. You know, it might be an intolerance. So, let's send you to the allergist. I could see how they'd be like none of this. We're just we're describing very different symptoms, and it would need somebody to go, okay, if you if people present with this range of symptoms at this age, maybe the first thing I think is menopause. It changes how GP's work. Really. I like yes. So, when I think about it, I feel I do have some sympathy for them. I know it's been hard for a lot of women and in my reports when people share about their frustrations with going to a GP, not going, ah, why don't you think about menopause? I can understand why they don't think about it. Because it's such a wide range of" (Susanna, Group 4).

Many participants had tried to vary their diets by limiting caffeine, alcohol and confectionary before they sought the help of others.

"...during the lockdown...I want to grab myself and get hold of things...so I took hold of myself by the food parts and lost four stone through diet alone. But I don't call it I call it a

way of eating, and that's a whole another story. And I get a bit evangelical. However, in the spring of 21, just after the significant weight had started to come off. Lots of things are improving in terms of my physical and mental health.... "

Some participants said because of their severe symptoms; they had to be off **sick from work**:

"My period of sick leave. I think I was off for about three months when I was off for depression.... I suddenly had that light bulb moment. But my depression and everything was because I kind of nosedived into being perimenopausal. And then I had lost all my hormones...." (Susie, Group 2).

Another participant talked about her **memory problem and embarrassment** among her colleagues when she forgot that she was the chair of a meeting and the topic that was supposed to be discussed. Participants talked about **losing their identity** as they feel they are not as cognitively competent as before

"... I've arranged a meeting one time and went into the meeting and everybody's just chit chatting five minutes into the meeting, nobody's taking it forward. So, I ended up asking who was chairing this meeting and they said you! You called the meeting! So, I think...I would just be honest enough and tell them I'm very sorry... But I forgotten that I'm the one who has actually set up the meeting. Can somebody remind me what we were talking about...and then when they jogged my memory" (Amara, Group 3).

"... I think the biggest one (menopausal symptoms) for me was brain fog. I have to say that I identify very strongly with what I can do, what I can do with my brain. I'm not a particularly great cook. I'm not great with lots of other things. But to me, my brain, and my ability to speak and stuff is me is what I consider my thing! So, when I struggled to remember people's names or I was sending out emails that had errors in it, or I would be in the middle of a conversation and not be able to recall a fact. It really affected me because I kind of like, this is the only thing I'm good at. Like if I lose this, I have nothing else! So... I was aware very quickly and struggled with that idea" (Susanna, Group 4).

One participant stated that she could not cope with her new symptoms and the long shifts, and her daily work as a nurse makes life chaotic, so **she is looking for a new job**. She feels **other jobs have more flexibility** which would benefit her.

"I am already looking for other jobs to go elsewhere. I don't understand my role's because it is hectic. A 12-hour shift on the road. You can't be flexible like you would another workplace, but it's just a little bit a consideration. Just wouldn't go amiss really." (Sharon, Group 3).

Theme 2. Lack of knowledge on menopause transition, or being a taboo

This theme consists of three sub-themes:

- 1) Individuals/families
- 2) Organisations/managers/colleagues

3) Health professionals

Individuals/Families: In the first sub-theme, most women stated that they had **limited or no information about menopause symptoms and how they may affect them** before their journey into the menopausal transition started and affect them directly.

"And I must admit, when people used to talk about having hot flushes and they'd sit there and fan themselves, my image prior to entering the menopause was the hot flash. You sat there and came over all hot went 'phew I'm hot' and cooled straight down when actually you like a little glowing away, and 20 minutes later you're still glowing way and it's going nowhere. And then you eventually doze back off to sleep because you've cooled down and then you wake up again because you're cold. Because you've pulled all the covers off..." (Susie, Group 2).

The other participant said that her tiredness at the age of 45 was attributed to pre-menopausal symptoms by a menopause advocate, which surprised her.

"... But also, the very first time I knew that I'm in the perimenopause or was aware of it because [an advocate] diagnosed me. So, I went to meet heras part of my induction. And when she said, 'How are you?' I just said to her, 'God, I feel so tired and like I don't feel myself...." (Susanna, Group 4).

Some women talked about their **cultural barriers** and their families' restrictions to discussing menopause or sexual terms as taboo topics, which has **limited their understanding of menopause** and prohibited this topic.

"So pretty much like what has been said that in my culture I don't remember when my mum reached menopause. I don't remember when my grandma reached menopause. So, it is not really widely spoken, and everyone is different...." (Susanna, Group 4).

Also, another Asian woman was shocked when for the first time, she heard her mother's recommendations about a specific **diet for menopausal transition**, which has always been a taboo topic in their family.

"... very recently my mum said to me that... you need to start looking after yourself because when the change happens, you'll struggle ...that is the first time I ever heard my mum say something ...she actually used the word like..., menopause and I was like, oh my gosh, I didn't even know..." (Salma, Group 4).

Organisations/managers/colleagues: For the second sub-theme, participants widely talked about **the stigmas around menopause** at their workplaces. Some participants stated that they feel **uncomfortable disclosing their menopausal status** to their managers or colleagues, especially male ones.

"(I) Find sometimes when you talk to people and go through the menopause. You can see their faces...They don't want to. They try and get out the conversation with you. They don't know how to talk, to, approach or ... especially men. They sort of like, oh, God, you know, the

highs and lows of your temperament... you can be quite fiery one minute and the next minute you are nice. And they sort of tend to stay away from you..." (Sharon, Group 3).
"So, I wanted to say the same to my boss. He's just retired actually, but he was very supportive. But obviously he didn't really, he was a bit embarrassed about all the details. I did try to tell him some way he didn't really want to know..." (Anna, Group 1).

"...I think there are barriers and more taboo and stigma around it because not many people understand it. And even I as the menopausal person and there are certain terms that I probably feel a little bit weird, ..." (Sharon, Group 3).

Health professionals: Within the third subtheme, the **participants expressed their frustrating experiences visiting their GP or other primary care organisations** either in pre-menopausal or menopausal stages. Dissatisfaction was expressed spontaneously in all four of the focus groups. Some participants believed they had a more profound knowledge of menopausal interventions than healthcare professionals.

"[the GP] ... Didn't want to give me HRT or the full thing of it, and I'd done a lot of research on it because I lost my sister to breast cancer But typical experience of doctors going, oh, you've got a family history of breast cancer. You can't have HRT. So, lots of quoting the research to her and saying, my life is unbearable. I would rather take the risk. And eventually she gave in..." (Susie, Group 2).

"... I think primary care is the big gap really in knowledge out there in primary care. They're still working on this misbelief that women can't have HRT for more than five years maximum and it almost feels like GPs will try anything to stop you having HRT, are they not aware of the whole amount of benefits from it. And that if you've had conditions or you've got family history of certain things, that doesn't preclude you from taking it." (Susie, Group 2).

Some other participants expressed their dissatisfaction with the approaches of their GPs and a lack of knowledge on the investigations on HRT interventions.

"... I think the research was done in America was that they tend to give the HRT that has oestrogen and progesterone but don't actually have testosterone, which is another hormone that needs to be replaced. But when I tried to bring that subject up, the GP was not interested in having any discussions along that." (Amara, Group 3).

"That that's how you felt... keep having infections after infections down below, and they just give me antibiotics. Nothing's been followed up. I know that is part of the menopause as well. But instead of doing bloods to see where my hormone level is, that just put me straight on HRT ..." (Sharon, Group 3).

"Oh, I was saying when I went to see the GP that they would be trying by all means to talk me out of being on HRT. As a doctor, it's their responsibility to show me both sides. Yes, any medication has got side effects. But there was more emphasis on just concentrating more on

the negative things that the side effects, ...But it's almost sounded like, you know, you don't want me to be on HRT..." (Amara, Group 4).

Theme. 3 Discrimination and equality

The analyses of the focus groups revealed that **women at various levels within the ICS felt discrimination or inequality**, which has affected their menopausal transition directly or indirectly. Some women stated that there is **systematic gender discrimination**, as menopause has been kept unrecognised, or there are limited interventions for it as it is related only to females.

"As I know there is an MP. I can't think of her name that's kind of battling for. Better rights for women around the menopause but. Unfortunately, most politicians are men. I do wonder if it was something that affected men. We'd have probably got a more satisfactory outcome a long time ago "(Susie, Group 2).

Also, someone talked about the availability of medication across genders and implicit socioeconomic barriers to accessing required medicines.

"... the other day came up in menopause group actually was around testosterone. And somebody on there was going to was being seen at the menopause clinic and was going to ask for testosterone. And this MP lady apparently pays for her own testosterone and finds it really beneficial. But it's not available on prescription widely. I think we should have available to us whatever we needed. My child is trans and they're non-binary, but if they were trans female to male, they would be prescribed testosterone..." (Susie, Group 2).

The other subject that women expressed concern about and felt they had been discriminated against is the **lack of government support and legislation to protect females** until retirement.

"And then they've created this situation. The government have created this situation because we have got special status for very good reason. I'm 58 - had I been able to go [retire] at 55, the timing would have been spot on, but instead, I'm forced to carry on working because I can't get my state pension until 67. So, you know, they're going to have to put structures in place to support..." (Anna, Group 1).

Some participants expressed their worries about associating menopause with **ageing and decline** in many organisations; they thought **menopause needs to be normalised**, so women feel comfortable talking about this stage of life to their managers and colleagues.

"(I) have had a few interactions with managers..., there was a lot of support, which is great. But I think what happens and, in that situation, certainly that and this is goes back to my point making people feel comfortable because as soon as you talk about menopause, then it becomes like, you know, oh this person is old, you know, that type of stuff. So, if we make it a topic which is, you know. It doesn't matter. That's not what it says that you think that is old! Yet the managers were very supportive in terms of changing their roles and adjusting the roles. The colleagues were supportive. However, the individual themselves are very

uncomfortable with the situation and felt like, you know, it was because of their age that they were being treated that way. So, there's a like a pros and cons to these situations. But the only thing I would say is it's about communication" (Salma, Group 4).

Another participant who has long term multiple disabilities, including sensory neurodiversity, talked about her worries. She was concerned that as a blind menopausal woman with **minimal work options**, she might be forced to return to an unpleasant workplace that could harm her mental health.

"But interestingly, with my earlier story about the weight loss and sort of grabbing my health by the short and curliest and sorting out myself a bit, that also gave me a confidence in the workplace to apply for other jobs. And that's how come I'm on the second one. And it is a promotion. Secondment which is a real privilege. But I'm a bit scared because it's coming to an end. There is no more funding for another extension of it, and I've got to go back to that place that perhaps had contributed to my mental ill health and weight gain and general symptoms and continue my perimenopausal journey in a workplace that isn't necessarily as supportive as the one I found myself in at present. And I got myself here because I managed to turn a lot of things around. And I have also gained the confidence to at least say some of that to my substantive manager, because he's already had that sort of getting in touch today with me. But I'm scared of going back. You know, I have had to adjust how I behave, and yet I'm more me in this job. And I don't want to stop being me" (Katherine, Group 1).

Another participant, who has recently started a health care assistant job, expressed her emotional and psychological difficulties as experiencing her pre-menopausal symptoms while **feeling discriminated against by the NHS hierarchy**, which left her powerless and mistrustful.

"I find on the ward, the nurses tend to give you a lot of jobs to do because you're a health care assistant where it can be both the jobs and (that I'm) not a nurse said to me the other day, because she's done all jobs, and I said have you, done the rounds. And she went, Oh, no, that's an HCA job. Well, no, isn't this everybody's job? You do get looked down on more as an HCA from nurses than you would of other people.... that's where my anxiety has gone higher since working on this ward, my anxiety and being very paranoid. So that doesn't help with the menopause either." (Sharon, Group 3).

There was the camaraderie between the women's shared experiences. In response to Sharon, Amara shared that she had left her professional NHS career for one in social care due to the NHS hierarchy.

"But that is one of the things that were comparing social care and NHS, which is quite mind-blowing that you know, in the NHS, we talk about looking after other people, but we are not very good at looking after each other...in the NHS, they don't seem to be able to apply the nursing skills that they apply to patients to their colleagues, and the hierarchy doesn't help" (Amara, Group 3).

Some participants from minority backgrounds stated that they feel disconnected from the training and education on menopausal transitions as nothing or **little has been paid to minority ethnicities and how they may experience this transition differently** from Caucasians, the dominant race in the UK.

"There's some really good infographics that have like a, a woman's body with the different symptoms. But I've only ever seen one with somebody who is Caucasian. I keep meaning to ask one of my friends to do like, you know, do like a mock up. So, with, you know, different skin tones to kind of think, you know. One of the things I've been thinking of that we needed with different women, because the symptoms you can listed, but you almost need a picture of somebody looking like you to kind of make you think, my goodness, that could be me\" (Susanna, Group 4).

One of the participants was off work for a few months due to her complicated physical and psychological status due to complex life trauma and the menopausal transition.

"My period of sick leave. I think I was off for about three months when I was off for depression.... Because I'd have, I'd be had periods of time off work in the past and...." (Susie, Group 2).

One of the participants, a mother of a transgender teenager, expressed her **worries about non-binary individuals and how their health could be neglected if they change their gender status** within the health system registration.

"It's not related to menopause, but what is tending to happen now is people of all ages are transitioning to a different gender. So, you get especially female to male transitions. If their records are then changed and they're recorded as male, they don't get called for cervical screening, they don't get called for breast screening, and they're missing out because they're no longer included in that cohort. I see more and more of that as more and more people. Are becoming more gender fluid with where they start and where they end up" (Susie, Group 2).

Case studies: Discrimination and its effects

Case Study 1:

A community nurse with forty years of experience in the NHS talked about her long-term physical and psychological challenges due to her poor health condition. She expressed her worries that long-term health issues are now combined with post-menopausal symptoms and how her managers have disregarded her and left her helpless at this age.

"I'm good at my job. I commit I give 110% all the time... I've been so committed and dedicated for years. And last year when I was really struggling. I worked full time until...and I dropped today so I could do two days, have a day off, recover, go back and do the other two days. And my then manager said, I wonder if we could do like a return to work reduce your hours in advance of your surgery. And so, we decided to speak to H.R. about it and OCC health and got involved. And I had this meeting and talk about being thrown under the bus. And the H.R. woman was clearly just ticking boxes. She wanted to redeploy me. And it was it was a meeting that she didn't have the answers to. And then it ended. And then they'd obviously been off and had a cosy chat, called me back and said, can you come back on the meeting? This is all on teams. And she said we'll redeploy you and I thought about it that night and I was in shock and I told my boss the next day I said, over my dead body, would you redeploy me.

And it was all over resus, really, because obviously I've got two knees with arthritis and this hip and said If you can't kneel to resuscitate, you can't be in a clinical job. So I said, Well, you know, try me out. The OCC health were useless, bless her, you know, very nice but useless. And in the end, I found a very sympathetic, sensible, grounded, manual handling guy. And he assessed me. And if I threw a pillow down and most of my patients are DNAR are anyway. But if I threw pillow then I could do quite a good resus because I could lean on their chest to take them off my knees. So, I stuck the finger up to work and said, you know, I'll stay in my job and he supported me?

*But it was it was awful. I cried. So many tears. And I felt so. Disregarded. and, you know, is that an age thing or is it what is it? But. And then ironically, I'm going through this again now because they've now used the time that I had off with my hip... surgery was great, you know, good three months off, I'm back at work. And I'd had one sicker. And so of course it kicks off on the **Bradford Score** and they've not given me any, you know, under the **Disability Act policy**, you know. So, I've got a meeting and I've brought my **RCN member** in for that. But it's been I've felt in terms of management, I felt not just lack of support. I've used the words. **Harassment** with this one, because I do feel that if you don't if you have a problem and they can't fit it in a box. They just don't want to support you."*

Case Study 2:

A 46-year-old Health Care Assistance with only one year of experience working in an NHS hospital expressed her struggles to cope with her MT and her load works, which has made her think about leaving her job and looking for a new position with more flexibility and understanding of the managers.

"I'm HCA at been they're just over a year. Don't think there's enough out there for support, especially on the wards. I haven't seen any support on my ward, and I've gone to someone telling them I'm through the menopause. I'm struggling and she's just turned around and said, well, you've got another 10- 15 year for this.... That was the support I had!... No so she hasn't I looked on the Internet and saw the Wellbeing Hub and I've gone through the consultant route at the hospital, but I got an email yesterday saying she's left. There's no support up there with the menopause nurse. Go back to GP. That's all I got....

But there's one shift that I just can't cope with, ...(My manager said:) Well, if I take you off, then that shift and I'll have to do for everyone else. The like long shift where you start at 11:00 in the morning and finish up at 11 at night. Because I don't sleep very well at night, and I'd rather just get up and do the early shift time. I get home, say midnight. Then I must take a couple of hours for me to unwind and then get to sleep. It's just I just don't sleep at all. And then my day off is just messed up. I'm groggy my head, and I've got no energy....

Yes, there's a lot of favouritism where I work as well, which doesn't help... it's got they've got their little clicky groups and I don't go into all that.... I can't deal with all that. It's a lot of sorts of favouritism... So, there's like four or five sections where we work on my ward and you know, if certain team is on that, you'll get picked or you won't. And the sort of the nice click team always get the easiest sections some people say hello to, some don't. So, matrons can walk past you and blank you. There's just some staff lazier than others, and they get away with... that's where my anxiety has gone higher since working on this ward, my anxiety and being very paranoid. So that doesn't help with the menopause either...I am already looking for other jobs to go elsewhere. I do understand my roles because it is hectic. A 12-hour shift on the road. You can't be flexible like you would another workplace, but it's just a little bit a consideration. Just wouldn't go amiss really. Looking at going into what my friend works where you go and go to the wards and take blood all the then not 12-hour shifts and no night shifts. Not because night shifts might my symptoms...It can get me very depressed after nights... ([I feel] If your face doesn't fit, you haven't got a chance. they want to be friends with you on Facebook but then they can't talk to you on the ward. Just amazes me.

I've done the Wellbeing Hub to give to the menopause nurse up the hospital, but obviously they've left yesterday, and I don't get much support for my GP surgery for instead of doing Bloods and they've just put me on HRT patches and left me.... Find sometimes when you talk to people and go through the menopause. You can see their faces.... They try and get out the conversation with you. They don't know how to talk, to, approach or talk about, especially men. They sort of like, oh, God, you know, the, the highs and lows of your temperament. And yeah, you can be quite fiery one minute and the next minute you are nice. And they sort of tend to stay away from you. Yeah. [There is a lack of support from the GP] That that's how you felt. Yeah. Look, keep having infections after infections down below, and they just give me antibiotics. Nothing's been followed up. I know that is part of the menopause as well. But instead of doing bloods to see where my hormone level is, that just put me straight on HRT purchase.... also, I did demand to go and see the nurse and she just said that I need to go and see the mental health team. That was her answer!"

Theme 4. The ICS (but mostly NHS) as an employer and menopause transition

The participants had diverse experiences working in the ICS, mainly in the NHS, in clinical and non-clinical roles. However, most women expressed that psychosocial and physical aspects of clinical or non-clinical jobs, or **their working environment, impacted their symptomology, worsening or alleviating menopausal symptoms** experienced in the ICS's workplaces.

One of the participants, with forty years of service as a nurse, stated her negative experience working in the community. She was concerned about the menopause transition as an isolated and solitary subject in her workplace.

"I'm in the community... there aren't any considerations made for it... it doesn't really get acknowledged in the workplace and the working conditions..." (Anna, Group 1).

"You know, we wear hot uniforms, we work in hot cars. There's no water; I work for a GP surgery still... some of the biggest sites they've got maybe more staff support. My office conditions are appalling...we have to use the facilities at the surgery, which are shared with the patients. And I could go on and on, really. ... there's a lot of other women... the nursing workforce is an ageing population...the workload has gone up and up. So, there isn't time to give any consideration to people's personal issues. I think in reality, the community experience is less positive because obviously, we're at workplaces in patients' homes, which is really uncontrolled and often poor" (Anna, Group 1).

The same participant shared her painful experience of her menopausal transition, which was associated with other health issues, and how her **non-supportive manager** in the community made that experience more challenging for her.

"Some other thing happens, so I'm still on it. I had a hip replacement last year, which was brilliant, but I've experienced an awful workplace environment ... this makes me cry...I don't think the community management has caught up with supporting its staff in the same way that maybe the hospital has. I believe that it's great that HR And OCC health are coming on board, and you just thought they'd be taking the lead in all of this. But at least they're coming on board now and workplace they're looking at uniforms...So through COVID also, obviously the heat wave, I think people were wearing scrubs and they realised that it was a better working condition for people. So, they are looking at phasing those into all areas. The community last again, and the community is always last, unfortunately forgotten. I feel if I'm honest and. That's sour grapes, but it's reality as well" (Anna, Group 1).

While most participants had painful experiences of menopausal transition at work, some women shared satisfactory experiences when they disclosed their problems to their managers. For instance, one participant who works in a managerial position found her **manager empathetic and collaborative**.

"I do feel supported in the workplace. Yeah. That's right... I'm in a middle management... And they want to support their staff too" (Jill, Group 1).

Also, another participant shared her positive experience of menopause and working as a social worker. Her **managerial support helped her adjust her working hours and allowed her to have more autonomy in her working hours** so she could tackle her sleep deprivation better.

"[I feel supported] I suppose partly because of the way that I work. I'm more autonomous in what I do, so, and my manager, but I've spoken to my manager and supervisor about, you know, menopause; she's much younger than me..... And she was quite happy for me to start work late because one of the symptoms was that I didn't sleep very well. So, as you would say... So, it's not like, you know, we come 8:30 to you must be at your desk if you haven't slept well the previous night, have a lie in and then log in and then just give you time back towards the end of the day" (Amara, Group 3).

Another woman found that **flexibility with working hours and remote work helped alleviate her menopausal symptoms** and better handled her new lifestyle.

"I can't afford to reduce my hours. So, what I did was (what) everybody else in the team had flexible working around their personal lives. So, I now do a nine-day fortnight, which gives me that extra day off a fortnight, which gives me an extra day to do what I want to do or just to rest. And that has made a difference! My hours are now more, although I work longer days. If I'm really struggling, then homeworking is quite good because you can. Go away and do something else to try and refocus you and make the time up another day" (Susie, Group 2).

Those participants who work long **nursing shifts** talked about their struggle to keep up with the work demands and **lack of flexibility and adjustments**, making them **willing to leave the job for a more flexible role**.

"I am already looking for other jobs to go elsewhere. I do understand my roles because it is hectic. A 12-hour shift on the road. You can't be flexible like you would in another workplace. ...but it's just a little bit a consideration. Just wouldn't go amiss really" (Sharon, Group 3).

Most women talked about the **support groups in their workplaces**. They expressed the need to provide more awareness and support for women at this stage.

"So, the only thing we've had. Back in the old days of normally being in the office when we were (named an earlier iteration of the organisation), they did get somebody from the Menopause Society to come, and they did some briefings to make people more aware. But I think it was predominantly attended by people that were menopausal. And had that interest rather than everybody. And the [names] ICS well-being. People have just set up some, or I don't know how long ago they set them up there, like monthly on a Thursday drop-in session. So, I joined my first one of those last weeks. And it was quite good, but it was monopolised by one lady who seemed to have a lot to say issues. And I know the CCG or the ICB, as we are now, are kind of saying about having a policy. And they talked about having people that were menopause champions. And apparently, some people have done some training to do

that. But it was the first I'd heard about it, and I've not actually seen them doing anything yet, so" (Susie, Group 2).

Also, participants talked about the **lack of formal services to support the ICS staff in their menopausal transition locally.**

"I don't think there's anything within [names county] unless maybe I've not looked hard enough...But I was thinking maybe I should start a group. A support group in [names county]?" (Amara, Group 3).

In all focus groups, women spoke about their line managers and their significant role in making the menopausal transition more satisfying or challenging and how **poor communication or lack of their awareness has made this transition more complicated.** For instance, one of the participants expressed her concern about the need for a holistic approach and managers' knowledge to support them during this transition.

"The management rules are not well designed for that holistic opinion sort of approach that I was talking about earlier...usually women, going through complicated experiences of different diagnoses and managers just not understanding how to handle it" (Katherine, Group 1).

Also, women found their **male managers more reluctant to speak explicitly about menopause,** and this lack of communication and awareness can cause further difficulties for menopausal transition.

"My substantive manager, who's been my manager [for the last five years] in my role as the ... is an [an Asian race] man, and I'm not about to be racist or sexist, but he's also got very strong religious beliefs, and he does not cope well with any kind of biological language in the workplace. He once reprimanded me quite significantly for the fact that I use the word willy. When we were discussing ... [a political issue]50% of us go through this. He's got a wife and daughters, and a mother. We've all got bodies. And why can't we just talk about them?" (Katherine, Group 1).

".. I wanted to say the same as my boss. He's just retired, actually, but he was very supportive. But he didn't really, he was a bit embarrassed about all the details. I did try to tell him some way he didn't really want to know, but he said, you know, do what you have to do. And I also went to Occupational Health, and at the time, they were very helpful. And since then, they brought into place certain things like I can't do the workplace, like stand for long periods and things like that because of my knees. So, I do feel that" (Jill, Group 1).

Themes 5. Recommendations from focus groups

Most participants stated how **certain aspects of the work environment do not benefit women with menopausal symptoms or make the situation worse**. Throughout the discussion through all four focus groups, they made some suggestions and recommendations for different levels to improve this transition.

At a wider societal level, some women suggested considering menopause as a **Protected Characteristic**, besides age, gender, and other topics.

"You know, 50% of us are female. So why are we not having more noise made about, you know, whether it's periods of menopause, obviously pregnancy, maternity protected characteristic, but not 50% of us go through that? 50% of us probably have all the other stuff going on and it's not a protected characteristic!" (Katherine, Group 1).

Also, some women asked to **improve general awareness** by making more TV programmes and advertisements in the most popular hours.

"And I've always thought, why don't we even do something as far as BBC look east or if something just before EastEnders or just before Coronation Street or during a make a football match break. Kind of like, you know, catch the most people that you can so that they can hear the message" (Amara, Group 3).

Another participant expressed her worries about the requirements of the nursing workforce as an ageing population and the efforts that should be in place to maintain and protect this valuable expert group.

".... In this is my experience and there's a lot of other women because, you know, the, the nursing workforce is an ageing population and, and I don't think, you know, and the, the workload has gone up and up. So, there isn't time to give any consideration to people's personal issues" (Anna, Group 1).

At an organisational and managerial level, women had various suggestions for organisations and managerial groups and mostly suggested that general awareness should be improved and staff experiencing MT should be **signposted to services**, including by male colleagues and especially those in managerial positions.

"...like I said, signposting to that group really. But what as HR more, more or less like sort of the responsibility that lies on us would be educating our managers. So, I must say that we tend to talk very openly, not making assumptions because that's something we wouldn't do. And menopause doesn't actually have a specific age so. We shouldn't automatically assume if someone is a certain age and X, Y or Z. But at the same time, our responsibility is to educate our managers and to make sure that they feel comfortable having those conversations.... Because, you know, I don't think a lot of male managers in certain age of their life feel comfortable having those conversations. So that's the aim that I personally would like to get to, to make the topic quite comfortable to talk about and, again, not make

assumptions because that's not what we are saying. Ask questions and listen and listen.”
(Salma, Group 4).

“...another thing I would like to do is training for managers. So that's again, her team have offered and something I just need to personally get some time to look into. So those are the things that I'm very keen on taking forward in the ICB. “(Salma, Group 4).

“... I think it's just talking more and more about the symptoms. I leaflet that has all the symptoms on there. Like online leaflet or physical leaflet that that, you know, say there's something you have to talk to anyone” (Salma, Group 4).

Some participants wanted to **improve the knowledge of primary care professionals, including practice nurses and GPs** around menopause transition.

“As we manage or will be taking over commissioning of primary care? I think primary care is the big gap really in knowledge out there in primary care. They're still working on this misbelief that women can't have HRT for more than five years maximum. It almost feels like GPs will try anything to stop you having HRT, are not they They're not aware of the whole amount of benefits from it. And that if you've had conditions or got family history of certain things, that doesn't preclude you from taking it...And if there is a GP that's not experienced any problems, then they might find it more difficult to. Comprehend somebody that is having problems and everybody's different, what symptoms they do get” (Susie, Group 2).

Participants stated that they found **flexibility at work very beneficial**, such that women could work flexible hours and take breaks when required and wanted to make it more accessible for this group of women—they also suggested **more facilities** such as cooler temperatures, water and other facilities at work when possible.

“... I think actually in that whole being positive, an inclusive space, we need to think more about flexible everything, not just flexible working, but even the stuff that we provide for wellbeing” (Katherine, Group 1).

“... What I often do with [names male line manager] is kind of go some days I'm not up to working my full seven and a half hours, but it's about outcome-based working so is like I have this task to finish. So, if I get up at 3:00 in the morning, I can't go back to sleep and I work on it then. Then, you know, it's done, and you don't need to know. When I worked on it. But that I know it's hard if it's a team. And you're working shifts and stuff but is being able to have the awareness to have those sorts of conversations and understanding as well”
(Susanna, Group 4).

“We have lots of conversations about temperature. In the old building, we work in the main hospital, but I work in one of the modern buildings and it's the temperature is centrally controlled and issues around that. So, there's been a lot of talk about do we need to have discussions around what it should be set at as opposed to just being centrally set” (Susanna, Group 4).

“Heat is the biggest problem because the car situation and everything is so hot, and our working conditions are uncontrollable in many instances. And we’ve, we’ve seen improvements in the offices in that manual handling have come in and got new chairs and things. But, you know, we’ve been working in broom cupboards for years, the community nurses and just accept it” (Anna, Group 1).

Also, they suggested **educating staff about individual differences and their cultures and how it may affect their menopausal transitions.**

“.... different cultures, different background, women, they get they don't have all the symptoms they have feeling, you know. So, it's not it's not just changing the skin tone. I think it's also about having those authentic symptoms on there by doing research or survey or whatever needs to be done, whether it's the hospitals, you know, what are the difference? What is the difference? What are women experiencing in different cultures?” (Salma, Group 4).

Finally, at an individual level, **participants wanted to empower women** and give them voice to improve their situation.

“I think it's all about educating and hence, you know, those are groups like Menopause Group that [names menopause advocate] have. I'm sure that is actually a really good way to have those discussions” (Salma, Group 4).

“Like a group once a week or once a month meet up to meet everybody else so we can give each other ideas to actually sit down with someone and chat with someone about what you're going through and the support out there. Just bounce off each other with ideas or anything that helps with the symptoms” (Sharon, Group 3).

Some participants, talked about **the significant role of communication** between employers and their staff.

“But the only thing I would say is it's about communication.... So, if the individual decides, no, they're fine in the role that they are in, they've been offered all the support help, OH, reasonable adjustments, X, Y, Z, but they still wish to continue in that role and still actually, not, performing well there. Then, you know, we have no other choice but to start taking other sort of alternative options. But if we have explored the options to provide that support very quickly, I would just add that a few years ago I must say menopause in my life wasn't as widely spoken as it is in the last six months. I did have a case where I sat on a one, a panel for an individual, and they were it was due to a lot of sickness because of the menopause, and they were going through perimenopause anyway. So, Manager was quite in favour of, you know, terminating their contract because they had gone through the processes, and we didn't. Obviously, we wouldn't have because if someone had a disability, for example, would we do that? No, we wouldn't. Then we would try to support them as much as we can say

that that's. Now, thinking back to it. It was then seen as, you know, all this person struggling. What kind of support do they need instead of all you know; is why they're making a fuss about something like this type of thing. So yeah, but I'm sure we've moved from a moved a little further from, from that. But yeah, I had a quite a bit of challenge with the, with the manager or on that one because they couldn't understand why I wouldn't support a termination for that contract" (Salma, Group 4).

Discussion

The demographic makeup of the major employers in the two ICS have been presented above. The data for the SNEE and HWS NHS workforces are known, however, there is less data for GP practices, County Councils, professional body and voluntary agencies (see Table 1 for all ICS organisations). The quantitative demographic data mirrors other research on the menopause which concurs that there is an increasing number of women in the UK aged 45 and older (Harper *et al.*, 2022). This equates to about 1/3 of the entire female population (ibid) but in the SNEE and HWE workforces this could amount to 2/3 of the female workforce (64% aged 41-65). 22% of the workforce had a long term physical or mental health condition. One in five staff (20%) are from an ethnic minority and 4% identify as LGBTQ+ (with a further 6% who prefer not to share this information). It is, therefore, imperative that the ICS consider inclusivity in all they do to support staff. Especially with the menopause transition.

The SNEE and HWE ICS already offer a range of inclusive activities for menopausal staff. However, there is a mismatch in what is available and what staff know. It is clear from excerpts of the narratives presented above that the menopause transition and experiences are hampered by symptoms that affect staff in individual ways and sources of support are not widely known, despite four participants being menopause advocates. Focus group 1 and 4 included participants who were menopause advocates. Much of the information shared by these advocates was work that is planned and raising awareness of the services available. Such as:

We had a meeting the other day and we was talking about making sure that we're going to be giving that advice to HR making sure there's a menopause advocate in HR, making sure that is one that they know what information to give in occupational health as well. We're going to put it in the Trust newsletter as well as a person going around doing their little clinics to ward managers as well (Jill, Group 1)

I haven't had anybody come and chat to me yet officially, but I mentioned this (the advocacy) a lot.....I know that 'names another advocate' had been working on a policy so and I think it's been approved, but it's about raising awareness training, as Suzanna said, but also giving people the confidence to ask for some reasonable adjustments (Salma, Group 4)

When staff engaged in these activities, such as the check in and chat they found them beneficial and shared experiences.

The first time I went along, I couldn't believe how many other people were in the same boat and doing the same things. Also, it's not just these physical things, so we've got our children growing older and it and getting their problems as they're, you know, have other children or teenagers. And then our parents and my dad's already passed away and my mum's quite poorly and disabled. We've also got all of those things as well going on (Jill Group 1).

The advocates also promote awareness.

It is about awareness. So, the more we put it in the newsletter, we've put posters up for menopause world menopause day and month. We had stands and in time out and you know, we work in a hospital. So there was a lot of throughputs and even if people didn't always stop and talk to us, the stand was out. On our intranet site, the those of us, I think there's six of us now who are menopause advocates. So our pictures and a little bio is up so people can know who you are (Susanna, Group 4).

Despite the menopause work and services offered by the ICS, there was a lack of knowledge about the menopause at all levels, individual, managerial, organisational, despite the prevalence in the workforce. Cultural barriers were raised, some of this was about knowledge acquisition too. The need for supportive services, such as menopause advocates and groups, was stated. Staff usually commenced self-help, diet, exercise, prior to seeking professional support.

Being a menopausal woman in the workforce did not appear to be valued and staff spoke about some discrimination. Individuals needed different types of support, reasonable adjustments to their working pattern: all 'earlies' or all lates, shorter shifts or reduced hours, others wanted to be able to prove they could still undertake their role and not be forced to reduce their contracted hours. Support for managers to initiate these person-centred conversations is needed. The environment needed consideration too. Staff preferred access to toilets that were not shared with service users, ventilation, and cooler uniforms. This period is a precarious time as some staff have considered leaving their jobs.

The symptoms, sickness from work and effect on women is well documented in health and social care settings and other workplaces (BMA, 2020; Griffins, MacLennan and Hassard, 2013; Harper *et al.*, 2013; Prothero *et al.*, 2022). Women across all sectors experienced physical and mental health effects of menopause transition and this affected them in the workplace (*ibid*). Barriers to reporting menopause symptoms remain an issue, with participants sharing their experiences of cultural barriers, relationships with managers and colleagues and a lack of perceived reasonable adjustments available to them either in their working patterns, environment, or role (BAM, 2020; Griffins, MacLennan and Hassard, 2013). Some of these barriers relate to the continued stigma of embarrassment, and not knowing where to access support or the right information. These factors are widely reported by influential organisations such as the joint response to the government's Women's Health Strategy by the Royal College of Obstetricians and Gynaecologists, British

Menopause Society and the Faculty of Sexual and Reproductive Health (RCOG, FRSB and BMS, 2021). Therefore, these issues are a national rather than local ICS issue.

A large survey of 896 women employed in 10 UK-based organisations participated across a range of sectors reported symptoms and needs (Griffins, MacLennan and Hassard, 2013) which were very similar to those points raised in our focus groups. They were based on four physical and psychological needs: access to information and support, attention to working environment, flexible hours, and greater managerial awareness. A salient point about the large survey (and relates to the aim of this current work) is the number of participants (n=351) who were excluded from their study. These included participants whose symptoms/age were classified as premenopausal (100), undefined (223) or were experiencing premature menopause (7). They may not have met the criteria for the study but there was a high level of interest in participating in the survey. Griffins, MacLennan and Hassard (2013) noted that there is a debate as to whether symptoms such as depression or poor memory were attributable to menopause. The participants in their study, like ours, had no such doubt. Whether or not their depression was new or pre-existing our participants said its emergence/re-emergence was linked to their MT.

Participants shared mental health conditions openly, which was encouraging as this used to be stigmatised. But were less likely to attribute these to menopause- either through a lack of knowledge or due to continued stigma. Participants needed to be able to disclose troublesome symptoms. Where studies have explored participants disclose to co-workers and line managers, their support was highly valued (Griffins, MacLennan and Hassard, 2013). Where our participants expressed feelings of being excluded it was with colleagues and or managers who were not receptive to listening to their menopausal symptoms whether these were physical or psychological. These could be attributed to sexism and or ageism in the workplace. Atkinson (2020) cite the double jeopardy of discrimination due to the intersection of age and gender. In another study, of what 137 working women wanted. Hardy, Griffiths and Hunter (2017) noted the importance of good communication skills as essential to enable helpful conversations about adjustments and support.

Web based support, such as the uptake of the Peppy training (80% of the 306 licences had been used within 48 hours) demonstrates that staff were looking for menopause support. Many of the participants in the focus groups had already tried to modify their lifestyle by changing their diet and or exercising to limit symptoms. This uptake not only implies that women are receptive to web-based interventions but coupled with the incorrect or non-specific advice they sometimes received from their GP or Occupational Health service, this filled that void/ need for information (RCOG, FSRH and BMS, 2021). Lack of menopause knowledge in healthcare professionals was stated in our findings and in other studies (Munn *et al.* 2022). This survey of 738 women reported, like our findings, that there was misinformation and misdiagnoses by healthcare professionals (Munn *et al.*, 2022). Munn *et al.* (2022) found that women were reluctant to seek professional healthcare support. We did not find this, however, there was disappointment that professional help was insufficient.

The evidence on web-based support for menopause suggests that participants benefit from reduced symptomology including anxiety, depression and vasomotor symptoms and increased quality of life (Im *et al.*, 2017). Web based support can also be used for decision making, whether this is for participants alone or for shared decision making with health care practitioners. The web-based support has also been shown to increase women's knowledge, support communication with others and can be tailored to individual circumstances (Im *et al.*, 2017). This evidence supports the continued use of Peppy Licenses that have been trialled in the ICS.

Cultural barriers reported in our study were around menopause knowledge, but this was not solely related to the women from ethnic minorities. In fact, there was a distinct lack of knowledge about the menopause transition and its effects in the participants, their managers and health professionals. This finding is not new. It is widely reported in the literature. Harper *et al.* (2022) online survey of 3150 women, of whom 947 were perimenopausal found that more than 90% of these women had not had formal education on the menopause at school and 60% did not feel informed about this transition. The participants also reported a gap in the knowledge of their GPs, with confusing pre-existing symptoms and potential side effects from medications (Harper *et al.*, 2022). Most of the participants in the Harper *et al.* (2022) survey were white women. Our in-depth focus groups included women from different ethnicities but had similar findings, and with such a widespread lack of knowledge even from the clinicians and health researchers in our study (before they commenced the research) this finding of menopause being a hidden phenomenon with a lack of knowledge is supported regardless of the participant's ethnic background. This is also echoed in the RCOG, FSRH and BMS (2021) document.

Previous studies on MT show that more distressing symptoms are noted in cultures where speaking of menopause is taboo; for example, Asian and African women are hesitant to seek medical help for their menopausal symptoms because menopause is personal and private (Grubb, 2002). In line with those studies, the current study's findings revealed that participants from African or Asian backgrounds stated that menopause was taboo within their families, even being prohibited by their mothers or grandmothers. Also, some studies show that in some male-dominated societies, MT is more prohibited, and women may not feel valued when they reach the menopause stage (Aaron, Muliyl and Abraham, 2002). And, in line with the previous study, in the current research, several participants stated that their male managers (from some specific ethnic backgrounds) were not supportive or reluctant to engage in any discussions about MT, making this transition even more challenging for those women.

Managers are widely cited in the literature as sources of support and frustration. In a sample of 896 women aged 45–55 in ten UK organisations with professional, managerial, and administrative (non-manual) occupations found most women were unwilling to disclose menopause-related health problems to line managers, most of whom were men or younger than them (Griffins, MacLennan and Hassard, 2013). In the ambulance service, half of the

menopausal women had not disclosed this as the 'real' reason for having time off work (Prothero *et al.*, 2022). Support in the workplace was seen as minimal, especially in front line roles, and there was a lack of knowledge of policies or guidance to support menopausal workers (*ibid*). There are a range of NHS resources that have been published recently to support organisations and managers. These include the Supporting our NHS people through menopause: guidance for line managers and colleagues (NHS England 2022). This includes registering menopause symptoms in e-roster so that this information can be collected more systematically by organisations.

Adjustments to the working environment are possible but not well known or easily accessed. In a study of British working doctors, 38% of the 2000 respondents to a survey wanted to make changes to their working lives but were unable to (BMA, 2020). Only 16% of these doctors had discussed their symptoms with their manager. This is echoed in the ambulance service respondents (Prothero *et al.*, 2022) where only half the women who had time off work had disclosed the 'real' reason to their manager. The managers were surveyed in phase 2 and most of the 631 managers (of whom 42% were female and 24% females above 40) reported a lack of knowledge on menopause training. Only one in ten participants in East of England ambulance service trust had received training and of those.

However, if the level of knowledge in managers in how to respond to these disclosures remains impaired this may be an underlying cause of staff feeling excluded. Hardy, Griffiths and Hunter (2019) measured 62 managers knowledge, attitude, and confidence after a 30-minute online training session on supportive conversations. The participants were mostly white women, in their mid-forties from public sector or private sector organisations. They reported statistically significant improvements in the manager's knowledge, attitude, and confidence. This suggests that a brief training session may be an effective tool to enable them to support MT in the workplace (Hardy, Griffiths, and Hunter, 2019).

Participants stated that they only needed small adjustments, and as menopause is a transition, these will not be required for the duration of the staff members working life, unlike a disability. There were areas where reasonable adjustments were considered more difficult to accommodate, such as front-line staff within the ambulance service (Prothero *et al.*, 2020). In our study, status (or lack of it) was seen as a barrier to accessing adjustments. The staff member was a health care assistant who felt powerless to ask for changes and that her role and relationship with others meant she was looking for a new job. This is significant as the ICS cannot afford to lose staff from the workforce. Atkinsons *et al.* (2020) suggest that education, class, and employment type are hidden but significant factors in menopause research and human resourcing. They contend that higher levels of education and work status are attributed to fewer menopausal symptoms. Given that the ICS NHS quantitative statistics demonstrate that 5.9% of the workforce are HCA and 14.6% administrative or clerical, who it could be argued have lower educational attainment and work status, and this figure could be higher in the social care organisations. It is important that these groups are not overlooked. It may be more difficult to adjust the working patterns of the former group than latter.

It is well documented that there are staff shortages in the NHS (Rolewicz and Palmer, 2021) and social care (Palmer and Rolewicz, 2022). It is, therefore, vital that the ICSs retain their existing workforce. As the majority of staff are women, and most are over 40 years of age, and are likely to experience menopause or are already experiencing this. This evaluation is timely. The number of hospital and community health staff leaving the NHS has peaked at 12.5%- the highest level since records began (Rolewicz and Palmer, 2021). Staff leaving social care are estimated to be lower at 3-4% (Palmer and Rolewicz, 2022).

Interestingly although support services do exist, such as the menopause advocates and MY Pause groups, they were not as well-known as we expected. So, despite the two ICS offering these activities to individuals and managers, the organisations need to continue to do more to signposting affected staff to these services.

Recommendations

All staff need to know more about MT. This will support people who experience menopause individually with knowledge, colleagues, managers, health care professionals and the ICSs. Therefore, we recommend mandatory menopause education. This includes non-clinical roles, young and male staff. E-learning for Health has a package for GPs, but it is accessible and could be introduced easily into the ICSs. Educational materials should be accessible to all and should relate to the diversity of the workforce e.g., infographics/posters should include representative images across different ethnic groups.

Recommendation 1: Continue to increase awareness and education for all staff of the diverse range symptoms of menopause.

Recommendation 2: Co-produce infographics and other display materials that individuals feel relatable to staff from diverse ethnic backgrounds.

Recommendation 3: Increased promotion of support packages that already exist including menopause advocates for education.

Recommendation 4: Co-produce further support networks for those experiencing, about to experience or supporting those experiencing menopause.

Managers: need to initiate individual tailored conversations about working conditions and patterns with staff. Ascertaining when staff are struggling so they can be signposted to health and support services is essential. Also, in depth conversation about symptoms and whether these are likely to be associated with menopause even if pre-existing condition reoccurs. Record absences from work due to menopause according to NHS guidelines. Encourage staff to register their menopause symptoms as a disability if they last for 12 months. This will mean they are more likely to be able to access reasonable adjustments in

the workplace to support them to remain at work. While work can exacerbate MT symptoms it can also help staff to have a purpose. So meaningful individual conversations are needed so staff feel valued. Managers will need further training to feel knowledgeable to do so.

Recommendation 5: Promote training for line managers to understand menopausal symptoms and the potential consequences for working.

Recommendation 6: Supporting staff to have two-way conversations around the menopause.

Recommendation 7: Co-produce local policies around uniform, heating and toilet facilities to ensure all feel comfortable but ensuring standards are maintained.

Organisations need to consider MT more proactively as part of workforce planning. This includes training for managers and health professions (more than that stated above), signposting to services that already exist but are not as well-known as they should perhaps be, more advocates, more accessible flexible work patterns and places. Posters and infographics with diverse images of affected staff should be displayed in staff areas across the ICSs. While there is an inclusive programme of events already available these are not always well known.

Recommendation 8: Further promotion of training for staff in their roles, especially primary care and managers to support the workforce and general population.

Recommendation 9: Discuss policy changes in flexible working, for those experiencing menopausal symptoms (and more broadly).

As the ICSs will be the largest employers in the UK (the NHS currently is, and the ICSs include more organisations) they should **lobby the government** to include menopause as a protected characteristic and implement the women's health strategy so that women are truly supported to remain in the workforce and realise their societal, economic, professional and personal potential. The government considered whether menopause should become a protected characteristic in January 2023 and unfortunately this recommendation (number 12) was not accepted (Women and Equalities Committee 2023).

The ICSs should also suggest that the NHS survey, as the largest in the world is extended to the staff within their organisations. Lastly, this survey should include specific questions on menopausal symptoms and support within the workforce. This is the largest demographic, and the ICSs cannot manage without these staff, their specific experiences should be captured within the staff survey.

Recommendation 10: As UK's largest employer lobby government for menopause to be a protected characteristic and extend the NHS staff survey to include ICS staff.

Limitations

This study offers useful information and recommendations regarding the amount and extent of diversity within SNEE and HWE staff by using data provided by the two ICS. It considered how exclusion may impact staff health and wellbeing; however, the study has limitations. First, the study includes secondary data in the quantitative phase relying on the overall summarised data from the NHS organisations. There is also a need for robust primary data for non-NHS organisations within the ICS.

There were a limited number of participants in the qualitative phase. Also, half of those participants were menopause advocates or were in managerial positions. It is assumed that these participants are more aware of MT and have better workplace flexibility and options. Other non-advocate ICS employees may have even lower knowledge and understanding of MT or be affected more by MT. Finally, there was a lack of LGBTQ participants to hear their viewpoints. Future research involving those with various sexual backgrounds, and more from the non-professional/ management levels of the ICS and from diverse cultural and ethnic backgrounds would be beneficial to ensure that MT recommendations apply to a broad range of staff.

Conclusion

The relatively recent public interest in menopause and its effects on women generally and specifically on them in the workplace is heartening. Continuing to raise awareness is necessary to ensure the right information is accessible to staff, managers, and organisations in order to support menopause transition in the ICS. Not just the staff experiencing this but those working alongside them and managing them. Without this knowledge the menopause transition remains hidden, and women feel stigmatised. When such a large population of the two ICS are women over the age of 40, it is imperative that all staff acquire more knowledge so that they can support their colleagues by listening or initiating conversations, understanding the temporary needs (although these can last 4-8 years) of others in the workforce and be accepting of their need for reasonable adjustments, flexible or reduced working patterns or hours and more supportive environments. Not doing so is discriminatory and risks losing this valuable asset, people, from the workforce.

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