NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Menopause

Output: Prioritised quality improvement areas for development.

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Contents

1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for menopause. It provides the committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the committee in considering potential statements and measures.

1.2 Development source

The key development source referenced in this briefing paper is:

Menopause: diagnosis and management (2015) NICE guideline NG23. No review schedule presented.

2 Overview

2.1 Focus of quality standard

This quality standard will cover diagnosing and managing menopause in women, including women who have premature ovarian insufficiency.

2.2 Definition

Menopause is when a woman stops having periods as she reaches the end of her natural reproductive life. This is not usually abrupt, but a gradual process during which women experience perimenopause before reaching postmenopause. The average age of menopause in the UK is 51. However, this varies widely and 1 in 100 women experience premature ovarian insufficiency (menopause occurring before the age of 40 years which can occur naturally or as a result of medical or surgical treatment).

2.3 Incidence and prevalence

There are more than 11 million women over the age of 45 in the UK, and this number is forecast to continue to rise as the population increases. The associated increase in the number of women going through the menopause is expected to result in more

GP consultations and more new referrals to secondary care for women needing short-term symptom control and those who have associated long-term health issues.

Oestrogen depletion associated with menopause causes irregular periods and has many other effects on the body. Symptoms include hot flushes and night sweats, mood changes, memory and concentration loss, vaginal dryness, a lack of interest in sex, headaches, and joint and muscle stiffness. Quality of life may also be severely affected.

Not all women experience the same type or severity of symptoms. Most women (8 out of 10) experience some symptoms, typically lasting about 4 years after the last period, but continuing for up to 12 years in about 10% of women. Prolonged lack of oestrogen affects the bones and cardiovascular system and postmenopausal women are at increased risk of a number of long-term conditions, such as osteoporosis.

2.4 Management

Around a million women in the UK use treatment for their menopausal symptoms and the advice and support available is variable. Treatments include non-pharmaceutical e.g. cognitive behavioural therapy to help with low mood and anxiety and pharmaceutical treatments e.g. hormone replacement therapy (HRT), vaginal oestrogen creams, lubricants and moisturisers for vaginal dryness.

The number of prescriptions for HRT almost halved after the publication of 2 large studies: the Women's Health Initiative (2002) and the Million Women Study (2003). These studies focused on the use of HRT in chronic disease prevention and potential long-term risks rather than considering the benefits in terms of symptom relief.

2.5 National Outcome Frameworks

Table 1 show the outcomes, overarching indicators and improvement areas from the framework that the quality standard could contribute to achieving.

Table 1 NHS Outcomes Framework 2016-17

Domain	Overarching indicators and improvement areas
2 Enhancing quality of life for people with long-term conditions	***Overarching indicator*** 2 Health-related quality of life for people with long-term conditions** ***Improvement areas*** **Ensuring people feel supported to manage their condition** 2.1 Proportion of people feeling supported to manage their condition
4 Ensuring that people have a positive experience of care	***Overarching indicators*** 4a Patient experience of primary care i GP services 4b Patient experience of hospital care *4d Patient experience characterised as poor or worse* *I Primary care* *ii Hospital care* ***Improvement areas*** **Improving access to primary care services** 4.4 Access to i GP services
Alignment with Adult Social Care Outcomes Framework ** Indicator is complementary *Indicators in italics in development*	

3 Summary of suggestions

3.1 Responses

In total 13 stakeholders responded to the 2-week engagement exercise 06/04/16 – 20/04/16, 2 of which did not submit any quality improvement areas.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 2 for further consideration by the committee.

Full details of all the suggestions provided are given in appendix 4 for information.

Table 2 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Diagnosis	CEUFSRH, SCM
Information • Opportunities to give information • Symptoms and treatment options • Contraception • Before treatment that may lead to menopause	Bayer, CEUFSRH, CSCFSRH, EA, Hands, MSD, PCWHF, SCM
Managing short term menopausal symptoms • Individualised treatments • Vasomotor symptoms and HRT • Altered sexual function • Urogenital atrophy • Complementary products	Bayer, BMS, EA, CSCFSRH, NIMH, PCWHF, SCM
Review	PCWHF, SCM
Premature ovarian insufficiency	BMS, CEUFSRH, CSCFSRH, PCWHF, SCM
Referral	BCN, BMS, CEUFSRH, CSCFSRH, MUK, NIMH, SCM
Additional areas • Length of appointments • Research • Training • Service specification	CEUFSRH, Hands, MSD, MUK, NIMH, SCM
Bayer – Bayer plc BCN – Breast Cancer Now BMS – British Menopause Society CEUFSRH – Clinical Effectiveness Unity of the Faculty of Sexual and Reproductive Health	

Suggested area for improvement	Stakeholders
CSCFSRH – Clinical Standards Committee of the Faculty of Sexual and Reproductive Health EA – The Eve Appeal Hands – Hands Inc MSD – Merck Sharp and Dohme MUK – Menopause UK NIMH – National Institute of Medical Herbalists PCWHF – Primary Care Women's Health Forum SCM – Specialist Committee Member	

3.2 Identification of current practice evidence

Bibliographic databases were searched to identify examples of current practice in UK health and social care settings; 581 papers were identified for menopause. In addition, 38 papers were suggested by stakeholders at topic engagement and 9 papers internally at project scoping.

Of these papers, 6 have been included in this report and are included in the current practice sections where relevant. Appendix 3 outlines the search process.

4 Suggested improvement areas

4.1 Diagnosis

4.1.1 Summary of suggestions

Stakeholders suggested improving the diagnosis of menopause in primary care. Stakeholders reported that diagnosis currently relies on blood tests to diagnose menopause in women over 45 and should instead be based on clinical symptoms.

Reducing the number of tests received by women over 45 may save unnecessary investigations for the woman, avoid false negative results and empower clinicians to diagnose menopause based on clinical history alone.

4.1.2 Selected recommendations from development source

Table 3 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 3 to help inform the committee's discussion.

Table 3 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Diagnosis	NICE NG23 Recommendations 1.2.1, 1.2.3, 1.2.4 and 1.2.5

NICE NG23 – Recommendation 1.2.1

Diagnose the following without laboratory tests in otherwise healthy women aged over 45 years with menopausal symptoms:

- perimenopause based on vasomotor symptoms and irregular periods
- menopause in women who have not had a period for at least 12 months and are not using hormonal contraception
- menopause based on symptoms in women without a uterus.

NICE NG23 – Recommendation 1.2.3

Do not use the following laboratory and imaging tests to diagnose perimenopause or menopause in women aged over 45 years:

- anti-Müllerian hormone
- inhibin A

- inhibin B
- oestradiol
- antral follicle count
- ovarian volume.

NICE NG23 – Recommendation 1.2.4

Do not use a serum follicle-stimulating hormone (FSH) test to diagnose menopause in women using combined oestrogen and progestogen contraception or high-dose progestogen.

NICE NG23 – Recommendation 1.2.5

Consider using a FSH test to diagnose menopause only:

- in women aged 40 to 45 years with menopausal symptoms, including a change in their menstrual cycle
- in women aged under 40 years in whom menopause is suspected (see also section 1.6).

4.1.3 Current UK practice

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

4.1.4 Resource impact assessment

Expert clinical opinion from the guideline development group suggests that the list of laboratory and imaging tests in recommendation 1.2.3 were not widely used to diagnose perimenopause or menopause in women aged over 45 years. Therefore this area was not identified as an area that would have a significant resource impact (>£1m in England each year).

The costing template for NG23 estimated that approximately 1 million women in England have FSH tests each year and 70% (700,000 for the population of England) of women who have FSH tests are aged 45 or older. Assuming the average cost of a test is £15, the cost of testing women who are aged over 45 in England, is approximately £10.4 million.

The number of tests for women aged 45 or older is expected to decrease to 15% as a result of the guideline (approximately 53,000 for the population of England) of the total number of tests. Testing 15% of women who are aged 45 or over will cost

approximately £800,000 resulting in a saving of approximately £9.6 million for the population of England.

4.2 Information

4.2.1 Summary of suggestions

Opportunities to give advice

Stakeholders suggested increasing the number of opportunities for GP's and other health professionals to initiate a conversation about menopause awareness in women over 40. For example: part of NHS health check, smear test or women presenting at sexual health clinics. Stakeholders highlighted this may reduce the stigma of talking about the menopause and increase the reach and diversity of women who are aware of menopausal symptoms and the support and treatments available to them.

Symptoms and treatment options

Stakeholders suggested improved provision of accurate and reliable written and online information, increasing a women's understanding of the breadth of menopausal symptoms and ensuring they can make a shared informed decision about their management options. Stakeholders highlighted that currently symptom awareness is focused on the presence of hot flushes. A focused individual symptom assessment could form the basis of a treatment plan from which the effectiveness of symptom relief can be measured. The future risk of breast cancer related to HRT was also highlighted as a specific area where clear information should be provided.

Stakeholders also highlighted that much of the available information on menopause is inaccurate or biased by pharmaceutical company involvement. Statistics are frequently misquoted and it is impossible to gage the quality of menopause information.

Contraception

Stakeholders highlighted that although fertility is decreased during the perimenopausal period, pregnancy is still common. Women may be confused about the timing of discontinuation of contraception and therefore should be provided with information and advice about effective contraception.

Stakeholders reported there has been an increase in the number of unplanned pregnancies in women's aged over 40 years leading to an increase in the number of abortions.

Before treatment that may lead to menopause

Stakeholders suggested that women facing medical interventions affecting ovarian function (such as surgery, chemotherapy or radiotherapy) should be offered information and advice on menopausal symptoms and fertility prior to the procedure.

4.2.2 Selected recommendations from development source

Table 4 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 4 to help inform the committee's discussion.

Table 4 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Opportunities to give advice	No recommendations in NICE NG23
Symptoms and treatment options	NICE NG23 Recommendations 1.3.2, 1.3.3 and 1.5.11
Contraception	NICE NG23 Recommendation 1.3.5
Before treatment that may lead to menopause	NICE NG23 Recommendation 1.3.6

Symptoms and treatment options

NICE NG23 Recommendation 1.3.2

Explain to women that as well as a change in their menstrual cycle they may experience a variety of symptoms associated with menopause, including:

- vasomotor symptoms (for example, hot flushes and sweats)
- musculoskeletal symptoms (for example, joint and muscle pain)
- effects on mood (for example, low mood)
- urogenital symptoms (for example, vaginal dryness)
- sexual difficulties (for example, low sexual desire).

NICE NG23 Recommendation 1.3.3

Give information to menopausal women and their family members or carers (as appropriate) about the following types of treatment for menopausal symptoms:

- hormonal, for example hormone replacement therapy (HRT)
- non-hormonal, for example clonidine
- non-pharmaceutical, for example cognitive behavioural therapy (CBT).

NICE NG23 Recommendation 1.5.11

Using table 3 *(appendix 1)*, explain to women around the age of natural menopause that:

- the baseline risk of breast cancer for women around menopausal age varies from one woman to another according to the presence of underlying risk factors
- HRT with oestrogen alone is associated with little or no change in the risk of breast cancer
- HRT with oestrogen and progestogen can be associated with an increase in the risk of breast cancer
- any increase in the risk of breast cancer is related to treatment duration and reduces after stopping HRT.

Contraception

NICE NG23 Recommendation 1.3.5

Give information about contraception to women who are in the perimenopausal and postmenopausal phase. See guidance from the Faculty of Sexual & Reproductive Healthcare on contraception for women aged over 40 years.

Before treatment that may lead to menopause

NICE NG23 Recommendation 1.3.6

Offer women who are likely to go through menopause as a result of medical or surgical treatment (including women with cancer, at high risk of hormone-sensitive cancer or having gynaecological surgery) support and:

- information about menopause and fertility before they have their treatment
- referral to a healthcare professional with expertise in menopause.

4.2.3 Current UK practice

Opportunities to give advice

A survey[1] by the Royal College of Obstetricians and Gynaecologists (RCOG) looked at the health information needs of older women (women approaching, experiencing or beyond the menopause). Of the 1667 women who answered the questionnaire, 58% were currently concerned with the menopause. Of these women 73% had been to see their GP or practice nurse and the percentage increased with age from 50% in

[1] Royal College of Obstetricians and Gynaecologists (2015) The Health Information Needs of Older Women in the UK

those aged under 45 to 100% in the 55-59, 60-69 and 70 and over age groups. The reasons for not seeing their GP included being able to cope on their own, not being necessary, embarrassment, opinion there is nothing that can be done or being taken seriously as it's an age thing.

Symptoms and treatment options

The survey[2] by RCOG on the health information needs of older women asked women how much they felt that knew about the symptoms of the menopause, 33% of women said 'a lot', 62% said 'some' and 5% said 'nothing'. The percentage of women who said they knew 'a lot' increased with age from 13% in the under 45 age group to over 61% in the 60-69 and 70 and over age groups.

The survey also asked women how much they felt they knew about the treatment options for the menopause, 17% of women said 'a lot', 65% said 'some' and 17% said 'nothing'. The percentage of women who said they knew 'a lot' increased with age from 6% in the under 45 age group to 36% in the 60-69 age groups but then decreased to 30% in the 70 and over age group.

Contraception

Data from the Abortion statistics[3] for England and Wales show that abortion rates for women over 35 increased from 6.8 in 2004 to 7.4 in 2014. In 2014 there were 719 abortions to women aged 45 or over (less than half of 1% of the total).

In 2014 the British Pregnancy Advisory Service looked at contraceptive use of more than 150,000 women aged 15 and over receiving care at its clinics over the past 3 years. They found a third of all women having an abortion reported not using contraception when they conceived. The proportions of women reporting not using contraception when they conceived are lowest among younger women undergoing abortion, with 31% of women aged 15-24 reporting no use, rising to over 42% of women over 40[4].

Before treatment that may lead to menopause

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

[2] Royal College of Obstetricians and Gynaecologists (2015) The Health Information Needs of Older Women in the UK
[3] Department of Health (2015) Abortion statistics, England and Wales: 2014
[4] British Pregnancy Advisory Service (2014) Women trying hard to avoid unwanted pregnancy, research shows

4.2.4 Resource impact assessment

This area was not included in the resource impact assessment for NG23. It was not identified as an area that would have a significant resource impact (>£1m in England each year).

4.3 Managing short term menopausal symptoms

4.3.1 Summary of suggestions

Individualised treatment

Stakeholders highlighted that menopause treatments should be individualised, taking account of discussions with the woman to ascertain her needs and form the basis of an individualised treatment plan.

Vasomotor symptoms and HRT

Stakeholders suggested women with menopause symptoms should have a risk assessment and be offered HRT if appropriate. Stakeholders also highlighted the importance of the correct preparation e.g. oestrogen and progesterone to be used in women with a uterus as exposure to unopposed oestrogen is linked to endometrial carcinoma and therefore not safe to use.

Altered sexual function

Stakeholders suggested the provision of testosterone for post-menopausal women who experience issues with low libido and pro-active screening of women with regard to their sexual function. Loss of libido was highlighted as having an impact on the woman and her partner and can lead to morbidity of mental and physical health.

Stakeholders reported that prescribing of testosterone is poorly understood with variations in its access.

Urogenital atrophy

Stakeholders highlighted that vaginal symptoms are often under reported and not appropriately treated. There is a reluctance to prescribe vaginal oestrogens and when they are prescribed it is for a limited time only. Stakeholders also highlighted that many women are unaware that moisturisers and lubricants can be used as standalone treatment or in addition to vaginal oestrogen and that this information is not being shared by healthcare professionals.

Complementary products

Stakeholders highlighted that there are several complementary products that can be used to treat menopausal symptoms but that women need to be informed about what they are and how they should be used. Concerns were raised about women referring to other sources for information and sources of complementary products, some of which may be low quality.

4.3.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 5 to help inform the committee's discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Individualised treatment	NICE NG23 Recommendation 1.4.1
Vasomotor symptoms and HRT	NICE NG23 Recommendation 1.4.2
Altered sexual function	NICE NG23 Recommendation 1.4.8
Urogenital atrophy	NICE NG23 Recommendations 1.4.9, 1.4.12 and 1.4.13
Complementary products	NICE NG23 Recommendations 1.4.4, 1.4.15 and 1.4.17

Individualised treatment

NICE NG23 Recommendation 1.4.1

Adapt a woman's treatment as needed, based on her changing symptoms.

Vasomotor symptoms and HRT

NICE NG23 Recommendation 1.4.2

Offer women HRT for vasomotor symptoms after discussing with them the short-term (up to 5 years) and longer-term benefits and risks. Offer a choice of preparations as follows:

- oestrogen and progestogen to women with a uterus
- oestrogen alone to women without a uterus.

Altered sexual function

NICE NG23 Recommendation 1.4.8

Consider testosterone supplementation for menopausal women with low sexual desire if HRT alone is not effective.

Urogenital atrophy

NICE NG23 Recommendation 1.4.9

Offer vaginal oestrogen to women with urogenital atrophy (including those on systemic HRT) and continue treatment for as long as needed to relieve symptoms.

NICE NG23 Recommendation 1.4.12

Explain to women with urogenital atrophy that:

- symptoms often come back when treatment is stopped
- adverse effects from vaginal oestrogen are very rare
- they should report unscheduled vaginal bleeding to their GP.

NICE NG23 Recommendation 1.4.13

Advise women with vaginal dryness that moisturisers and lubricants can be used alone or in addition to vaginal oestrogen.

Complementary products

NICE NG23 Recommendation 1.4.4

Explain to women that there is some evidence that isoflavones or black cohosh may relieve vasomotor symptoms. However, explain that:

- multiple preparations are available and their safety is uncertain
- different preparations may vary
- interactions with other medicines have been reported.

NICE NG23 Recommendation 1.4.15

Explain to women that the efficacy and safety of unregulated compounded bioidentical hormones are unknown.

NICE NG23 Recommendation 1.4.17

Advise women with a history of, or at high risk of, breast cancer that, although there is some evidence that St John's wort may be of benefit in the relief of vasomotor symptoms, there is uncertainty about:

- appropriate doses
- persistence of effect
- variation in the nature and potency of preparations

- potential serious interactions with other drugs (including tamoxifen, anticoagulants and anticonvulsants).

4.3.3 Current UK practice

Individualised treatment

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Vasomotor symptoms and HRT

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Altered sexual function

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Urogenital atrophy

Menopause matters[5] most recent survey on vaginal atrophy received responses from 1351 women and found 88% admitted to experiencing vaginal dryness (82% in the premenopausal group, 86% in those undergoing the change and 94% in those who had been through the change). Eighteen per cent admitted to vaginal dryness affecting self-image, 33% affecting confidence, 56% felt that relationships had been affected, and 34% felt that vaginal dryness affected general wellbeing.

Of those that had experienced vaginal dryness, 63% of women had seen a health professional for this reason. Of these, 34% said that the conversation was a little embarrassing but much better than expected, 32% had found the consultation neither embarrassing nor uncomfortable and 11% had found the conversation really helpful and felt much better for having discussed the issue. The remaining 23% had found the consultation unsatisfactory with the main reasons being unhelpful advice or not being taken seriously. In those who did not seek help (37%), reasons given were that 22% were embarrassed and 22% felt that it was part of ageing.

Treatments being used in those that had visited a healthcare professional included HRT (22%), vaginal estrogen (46%), moisturisers (26%) and lubricants (39%). Of the group of women who had not visited a healthcare professional to discuss vaginal dryness, 51% had tried lubricants, 13% vaginal moisturisers, with 9% were using HRT and 2% vaginal estrogen.

[5] Menopause matters (accessed 2016) Vaginal atrophy - the taboo subject

Complementary products

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

4.3.4 Resource impact assessment

At the time of producing the guidance, expert clinical opinion from the guideline development group suggested recommendation 1.4.8 was not likely to lead to an increase in use as it was not licensed. Therefore this area, along with the other above areas, was not included in the resource impact assessment for NG23. These areas were not identified as areas that would have a significant resource impact (>£1m in England each year).

4.4 Review

4.4.1 Summary of suggestions

Stakeholders suggested all women prescribed HRT should have a clinical review at 3 months and then annually to assess risks/benefits, dose and type of HRT. This is important to identify possible adverse effects of HRT, encourage women to participate in recommended national screening programmes and identify when a reasonable duration of treatment has been reached.

4.4.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 6 to help inform the committee's discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Review	NICE NG23 Recommendation 1.4.19

NICE NG23 Recommendation 1.4.19

Review each treatment for short-term menopausal symptoms:

- at 3 months to assess efficacy and tolerability
- annually thereafter unless there are clinical indications for an earlier review (such as treatment ineffectiveness, side effects or adverse events).

4.4.3 Current UK practice

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

4.4.4 Resource impact assessment

Expert clinical opinion from the guideline development group suggests there may be a slight increase in the number of reviews if there is an increase in the number of women who are prescribed HRT. This area was not included in the resource impact assessment for NG23 because an increase in the number of reviews would not be expected to have a significant resource impact (>£1m in England each year).

4.5 Premature ovarian insufficiency

4.5.1 Summary of suggestions

Stakeholders highlighted that premature ovarian insufficiency (POI) is an important condition of increasing prevalence due to improved care of young women with cancer.

Stakeholders reported the diagnosis and management of POI is currently inefficient with delays in diagnosis, misdiagnosis and inadequate specialised services. They also suggested women with POI should be recommended HRT as they have higher morbidity and mortality than women aged over 45. This can lead to poor quality of life and increased psychological and physical morbidity e.g. increased risk of osteoporosis and cardiovascular disease and reduction in life expectancy. Specific reference was made to women from low socioeconomic groups who may have greater social barriers to accessing HRT.

4.5.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 7 to help inform the committee's discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Premature ovarian insufficiency	NICE NG23 Recommendations 1.6.2 and 1.6.6

NICE NG23 Recommendation 1.6.2

Diagnose premature ovarian insufficiency in women aged under 40 years based on:

- menopausal symptoms, including no or infrequent periods (taking into account whether the woman has a uterus) **and**
- elevated FSH levels on 2 blood samples taken 4–6 weeks apart.

NICE NG23 Recommendation 1.6.6

Offer sex steroid replacement with a choice of HRT or a combined hormonal contraceptive to women with premature ovarian insufficiency, unless contraindicated (for example, in women with hormone-sensitive cancer).

4.5.3 Current UK practice

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

4.5.4 Resource impact assessment

This area was not included in the resource impact assessment for NG23. It was not identified as an area that would have a significant resource impact (>£1m in England each year).

4.6 Referral

4.6.1 Summary of suggestions

Stakeholders highlighted the importance of appropriate referral to a specialist healthcare professional. Several different populations were suggested by stakeholders:

- Women who experience menopausal symptoms as a result of their breast cancer treatment should be referred to specialist clinicians who are able to advise them appropriately, including as to options that are not contraindicated by their breast cancer treatment. The menopausal side effects of breast cancer treatment can be severe and can have a significant impact upon quality of life. In some cases, they can be severe enough to cause people to discontinue or disrupt their treatment for breast cancer, thus compromising their survival. Treatment options are available to help people to manage the menopausal side effects of breast cancer treatment but more often than not, people are not made aware of these and/or are not referred to the appropriate specialist.

- Women with premature ovarian insufficiency where there is uncertainty over the diagnosis to ensure they receive an accurate diagnosis and appropriate treatment.

- Women where there's no improvement after trying different treatments.

Stakeholders identified several potential issues when implementing recommendations on referral including a shortage of healthcare professionals with expertise in menopause management, a lack of appropriate services to refer to ensure equitable access across the country and the need for improving the visibility and accountability of menopause services by allocating clear leadership responsibility for co-ordinating delivery of menopause care nationally, regionally and locally.

4.6.2 Selected recommendations from development source

Table 8 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 8 to help inform the committee's discussion.

Table 8 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Referral	NICE NG23 Recommendations 1.3.6, 1.4.20, 1.4.21, 1.4.26, 1.6.5

NICE NG23 Recommendation 1.3.6

Offer women who are likely to go through menopause as a result of medical or surgical treatment (including women with cancer, at high risk of hormone-sensitive cancer or having gynaecological surgery) support and:

- information about menopause and fertility before they have their treatment
- referral to a healthcare professional with expertise in menopause.

NICE NG23 Recommendation 1.4.20

Refer women to a healthcare professional with expertise in menopause if treatments do not improve their menopausal symptoms or they have ongoing troublesome side effects.

NICE NG23 Recommendation 1.4.21

Consider referring women to a healthcare professional with expertise in menopause if:

- they have menopausal symptoms and contraindications to HRT **or**
- there is uncertainty about the most suitable treatment options for their menopausal symptoms.

NICE NG23 Recommendation 1.4.26

Offer menopausal women with, or at high risk of, breast cancer:

- information on all available treatment options
- information that the SSRIs paroxetine and fluoxetine should not be offered to women with breast cancer who are taking tamoxifen
- referral to a healthcare professional with expertise in menopause.

NICE NG23 Recommendation 1.6.5

If there is doubt about the diagnosis of premature ovarian insufficiency, refer the woman to a specialist with expertise in menopause or reproductive medicine.

4.6.3 Current UK practice

There is currently no comprehensive picture of NHS menopause services[6]. Menopause UK attempted to map the number of menopause services in the UK in July 2014 through an internet search and call for information. They found there is currently 1 clinic to every 355,000 women in the UK with 2 clinics in NHS North of England, 6 clinics in NHS South of England, 3 clinics in London, 7 clinics in NHS Midlands and East and 1 clinic in Wales.

4.6.4 Resource impact assessment

The above area was not included in the resource impact assessment for NG23. These recommendations were largely considered to be current practice and were therefore not identified as areas that would have a significant resource impact (>£1m in England each year).

[6] Menopause UK (accessed 2016) map of menopause services

4.7 Additional areas

Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or require further discussion by the committee to establish potential for statement development.

There will be an opportunity for the QSAC to discuss these areas at the end of the session on 2 June 2016.

Length of appointments

Stakeholders suggested longer GP appointments would allow women time to discuss their symptoms fully and any concerns about treatment, potentially reducing the need for repeat visits. It is not within the remit of quality standards to determine the length of GP appointments.

Research

Stakeholders suggested there is a need for good-quality observational studies and clinical case series examining the individualised treatment offered by medical herbalists. Quality statements on research are not within the remit of quality standards.

Training

Stakeholders suggested improved training for primary care professionals on appropriate advice about symptoms and treatment options and awareness of services to refer to. Quality statements on staff training and competency are not usually included in quality standards.

Service specification

Stakeholders suggested a single service specification that could be used locally would be helpful to help local areas set up effective menopause services. It is not within the remit of quality standards to write a template service specification.

Appendix 1: Additional information

Absolute rates of breast cancer for different types of HRT compared with no HRT (placebo), different durations of HRT use and time since stopping HRT for menopausal women

		Difference in breast cancer incidence per 1000 menopausal women over 7.5 years (95% confidence interval) (baseline population risk in the UK over 7.5 years: 22.48 per 1000 [1])			
		Current HRT users	Treatment duration <5 years	Treatment duration 5–10 years	>5 years since stopping treatment
Women on oestrogen alone	RCT estimate[2]	4 fewer (-11 to 8)	No available data	No available data	5 fewer (-11 to 2)
	Observational estimate[3]	6 more (1 to 12)[4]	4 more (1 to 9)	5 more (-1 to 14)	5 fewer (-9 to -1)
Women on oestrogen + progestogen	RCT estimate[2]	5 more (-4 to 36)	No available data	No available data	8 more (1 to 17)
	Observational estimate[3]	17 more (14 to 20)	12 more (6 to 19)	21 more (9 to 37)	9 fewer (-16 to 13)[5]

HRT, hormone replacement therapy; RCT, randomised controlled trial

For full source references, see Appendix M in the full guideline.

[1] Office for National Statistics (2010) breast cancer incidence statistics.

[2] For women aged 50–59 years at entry to the RCT.

[3] Observational estimates are based on cohort studies with several thousand women.

[4] Evidence on observational estimate demonstrated very serious heterogeneity without plausible explanation by subgroup analysis.

[5] Evidence on observational estimate demonstrated very serious imprecision in the estimate of effect.

Appendix 2: Glossary

Compounded bioidentical hormones are unregulated plant-derived hormonal combinations similar or identical to human hormones that are compounded by pharmacies to the specification of the prescriber.

Low mood is mild depressive symptoms that impair quality of life but are usually intermittent and often associated with hormonal fluctuations in perimenopause.

Menopause is a biological stage in a woman's life that occurs when she stops menstruating and reaches the end of her natural reproductive life. Usually it is defined as having occurred when a woman has not had a period for 12 consecutive months (for women reaching menopause naturally). The changes associated with menopause occur when the ovaries stop maturing eggs and secreting oestrogen and progesterone.

Menopausal women include women in perimenopause and postmenopause.

Perimenopause is the time in which a woman has irregular cycles of ovulation and menstruation leading up to menopause and continuing until 12 months after her final period. The perimenopause is also known as the menopausal transition or climacteric.

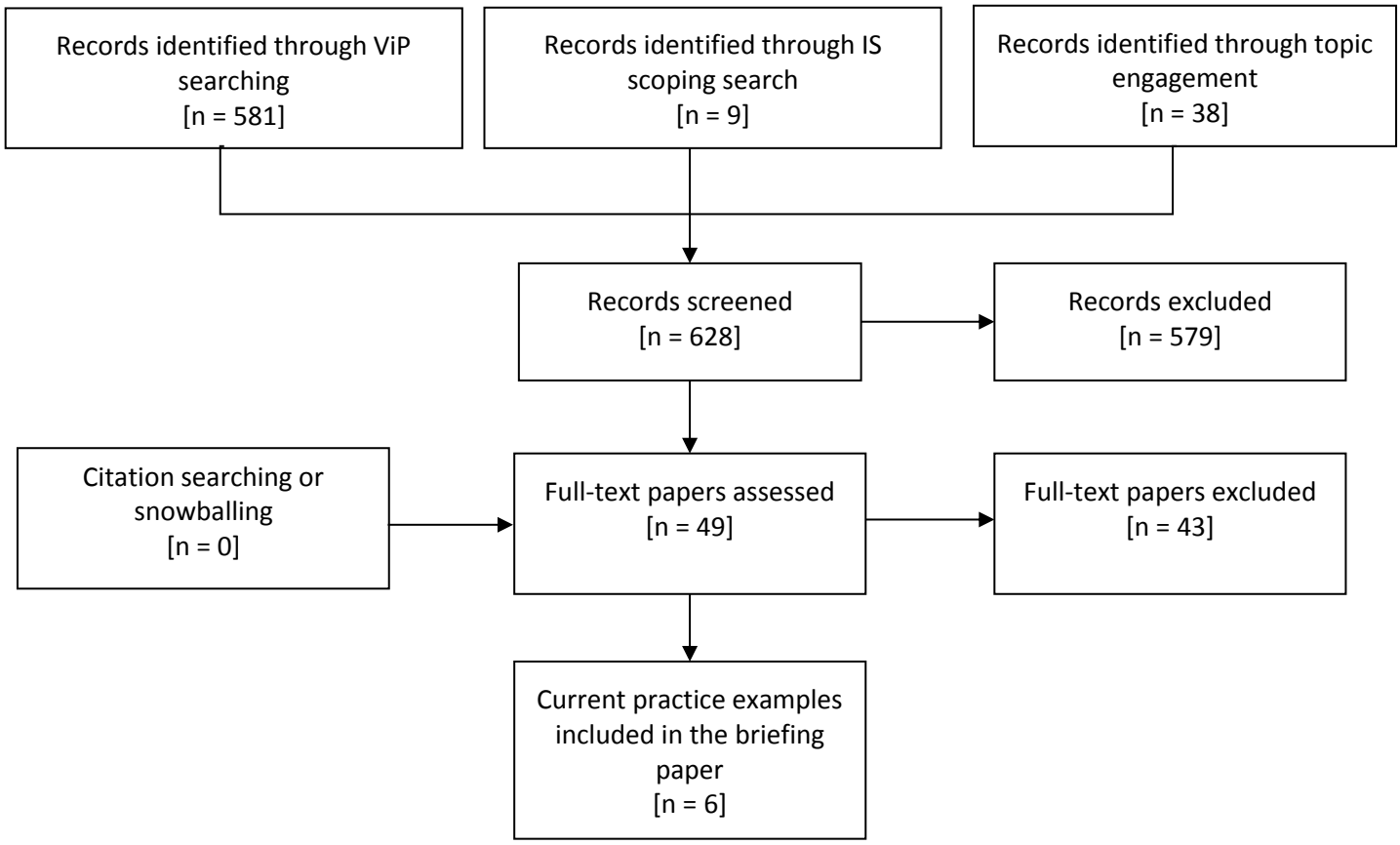
Postmenopause is the time after menopause has occurred, starting when a woman has not had a period for 12 consecutive months.

Premature ovarian insufficiency is menopause occurring before the age of 40 years (also known as premature ovarian failure or premature menopause). It can occur naturally or as a result of medical or surgical treatment.

Urogenital atrophy is the thinning and shrinking of the tissues of the vulva, vagina, urethra and bladder caused by oestrogen deficiency. This results in multiple symptoms such as vaginal dryness, vaginal irritation, a frequent need to urinate and urinary tract infections.

Vasomotor symptoms are menopausal symptoms such as hot flushes and night sweats caused by constriction and dilatation of blood vessels in the skin that can lead to a sudden increase in blood flow to allow heat loss. These symptoms can have a major impact on activities of daily living.

Appendix 3: Review flowchart



Appendix 4: Suggestions from stakeholder engagement exercise – registered stakeholders

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
Diagnosis					
1	Clinical Effectiveness Unit of the Faculty of Sexual and Reproductive Health	Improving the diagnosis of menopause in primary care.	Primary care services often rely on blood tests to diagnose menopause.	In women over the age of 45 years, it is rarely necessary to undertake blood tests to diagnose menopause. This should be a clinical diagnosis as blood tests can give misleading results.	Laboratory services can supply local data on what tests are being done and correlate with those requesting the tests and the indications.
2	SCM2	1.Diagnosis of menopause based on appropriate clinical history for all age groups and without laboratory testing in otherwise healthy women over 45 years. e.g. "a diagnosis or menopause or peri menopause should be made where appropriate"	This is important because a working diagnosis of menopause is required in order to provide relevant information so that the clinician and patient may agree a management plan based on informed choice. Action point: reduce FSH testing from 70 % to 15 % of all tests in > 45 years	Laboratory testing in the form of Follicular Stimulating Hormone blood tests are used widely in order to make a diagnosis of menopause, particularly in those women over 45 years old. Reducing the number of tests received by women in this age group will save unnecessary investigation for the patient, avoid false negative results and empower clinicians to diagnose menopause based on clinical history alone.	Please see NICE costing template regarding FSH testing. https://www.nice.org.uk/guidance/ng23/resources/costing-report-556376653 (I have found very similar initial results when looking at local biochemistry lab figures, Derriford Hospital, Plymouth) Menopause (2015) NICE guideline NG23, recommendations 1.2
3	SCM3	Measurement of FSH in women over 45.	This is a waste of money as it does not affect patient management	Many women have FSH assessed prior to being referred to secondary care. It could be implemented through the Clinical Biochemistry Laboratories.	*No additional information provided by stakeholder.*

4	SCM4	Key area for quality improvement 1 Diagnosis of perimenopause and menopause	In otherwise healthy women aged over 45 years with menopausal symptoms, NICE guidelines recommends diagnosis of the following without laboratory tests: perimenopause based on vasomotor symptoms (hot flushes and night sweats) and irregular periods; menopause in women who have not had a period for at least 12 months and are not using hormonal contraception; menopause based on symptoms in women without a uterus	Clarity regarding diagnostic criteria will prevent the use of unnecessary expensive biochemical or hormonal tests being undertaken. The diagnostic criteria will encourage multidisciplinary professionals without access to biochemical results to have confidence to participate in the care and advice of menopausal women therefore increasing access to information	NICE Guidance concluded. A woman aged 45 years or more may not have an increased chance of being perimenopausal, but being aged less than 45 reduced the chances of being perimenopausal. The same study also showed that a women aged 55 years or more had an increased chance of being perimenopausal but being aged less than 55 did not reduce the chance of being perimenopausal. No other age groups (42 years or older, 46 years or older, 50 years or older, 60 years or older) were found to be useful to distinguish perimenopausal women from premenopausal women. FSH measurements in the perimenopause cannot be considered precise because FSH levels fluctuate considerably over short periods of time during the years leading up to the menopause
Information – opportunities to give advice					

5	Hands Inc	Key Area for Quality Improvement 3 Increase the number of opportunities for GP's, and other health professionals to initiate the conversation about menopause awareness. For example as part of the NHS Health Checks targeted at 40plus adults; smear test for women over 40; women over 45 presenting at sexual health clinics or seeking support for sexual health issues, women over 40 presenting with gynaecological issues	Helps to reduce stigma and taboo around the topic and increase awareness of the menopause as part of a women's natural life cycle. Helps to increase the reach and diversity of women of menopausal age Creates opportunistic support and treatment of menopausal symptoms	The Chief Medical Officer Annual report 2016: Women's Health sites, 'a woman's life course offers multiple opportunities to prevent predictable morbidity and mortality and to empower women with information to take proactive steps towards health.' The report examines women's health in England and makes a range of recommendations to improve it including the menopause. It identifies several missed opportunities for intervention in women's health, and brings attention to 'embarrassment' as a needless barrier to health.	CMO Annual Report https://www.gov.uk/government/publications/chief-medical-officer-annual-report-2014-womens-health Please see The Royal Society of Medicine Journals', Post Reproductive Health article by Grant Phillip Cumming et al called, The need to do better -Are we still letting our patients down and at what cost? (June 2015) http://min.sagepub.com/content/21/2/56 This article explores the importance of the menopause consultation as part of a life course approach as well as the emerging discipline of Health Web Science.
Information – Symptoms and treatment options					
6	Clinical Effectiveness Unit of the Faculty of Sexual and Reproductive Health	Improve the provision of both written and online information available for women when experiencing menopausal symptoms	Much of the available information on menopause is inaccurate or biased by pharmaceutical company involvement. Statistics are frequently misquoted and it is impossible to gage the quality of menopause information. Provision of easily accessible high quality, accurate and consistent information	NICE Menopause encourages women to consider their options and make informed choices regarding treatments. A high quality NHS website on menopause could be developed to give accurate information and treatment options	The independent Menopause Matters website which is clinician-led is often recommended as a resource. http://www.menopausematters.co.uk/ However this still has promotional material on it and an unbiased approach to

			is extremely important.		menopause is essential.
7	Merck Sharp & Dohme	Key area for quality improvement 2 Ensure that women requesting treatment for menopausal symptoms from GPs are given information about, and offered a choice of all methods.	Choice of the most adequate treatment for menopausal symptoms depends upon patient preferences and medical history. General practitioners (GPs) should be able to provide information and appropriate treatment to all women with menopausal symptoms.	Menopausal symptoms can severely affect woman's quality of life. NICE recognises HRT as being highly effective in reducing menopausal symptoms and should be offered to all women, after discussing the individual benefits and risks.1	*No additional information provided by stakeholder.*
8	Merck Sharp & Dohme	Key area for quality improvement 3 Ensure that all menopausal women requesting HRT are given clear information/advice about the long term benefits and risks of this therapy.	There is conflicting evidence in the literature and in the media on the benefits and risks of HRT, which can influence the ability to make an informed decision on the use of HRT.	The advice and support available regarding the long term benefits and risk of HRT is variable according to socioeconomic and cultural factors.1 This is a key area for quality improvement, given that around a million women in the UK use HRT for their menopausal symptoms.1 No other treatment has been shown to be as effective, though the balance of risks and benefits varies among women.1	*No additional information provided by stakeholder.*
9	Primary Care Women's Health Forum	Key area for quality improvement 3 All women should be signposted to reliable patient information so that they can make a shared informed decision about their management options			NICE Menopause Diagnosis and Management Guideline – Information for the Public https://www.nice.org.uk/guidance/ng23/ifp/chapter/about-this-information Menopause Matters http://www.menopausematters.co.uk
10	SCM2	2. Provision of information for patients e.g. "women who are concerned that their symptoms are related	This is important because NICE puts individualised care at the heart of its recommendations.	Clinicians need to be well informed themselves in order to know where to sign post patients for information and advice. For example, HRT prescribing figures reduced	Please see Menopause (2015) NICE guideline NG23, recommendations 1.5

		to the menopause are given appropriate information and advice regarding the potential risks and benefits of Hormone Replacement Therapy."	(Is it a potentially "measurable" quality standard? This might need some more specific parameters in order to consider setting a standard on "provision of information".) Action point: provide standardised up to date patient information in various appropriate forms. Provide more training for health care professionals.	dramatically in the years following the publication of the Womens Health initiative data, 2003. The figures have increased over the past twelve years but suggest an ongoing reluctance to prescribe HRT, which may highlight a training need for health professionals in order to provide better information for patients.	"A knowledge gap amongst some GP's and healthcare professionals could mean that they are reluctant to prescribe HRT because they overestimate the risks and contraindications, and underestimate the impact of menopausal symptoms on a woman's quality of life." Menopause (2015) NICE guideline NG23, recommendations 1.5 (quoted directly from p20) Prescribing data for HRT in Cornwall "fell off a cliff" from 2003 following the Womens Health Initiative findings. (I have some slides regarding this but wonder if the NICE team have access to some more robust supporting National prescribing data?)
11	SCM4	Key area for quality improvement 2 Comprehensive individualised symptom assessment at diagnosis	NICE advise clinicians give an explanation to women that as well as a change in their menstrual cycle they may experience a variety of symptoms associated with menopause, including: • vasomotor symptoms (for example, hot flushes and sweats)	The main focus of symptom awareness is hot flushes. Increasing a women's' understanding of the breadth of related symptoms allows tailored self-care and understanding. Focused individual symptom assessment should form the basis of a treatment plan from which the effectiveness of symptom relief can be measured.	NICE guidance development group 'discussed the findings and decided that menopausal women should be given specific information about the different stages of menopause, the most common symptoms they

			• musculoskeletal symptoms (for example, joint and muscle pain) Menopause Information and advice • effects on mood (for example, low mood) • urogenital symptoms (for example, vaginal dryness) • sexual difficulties (for example, low sexual desire		may experience, how menopause is diagnosed and the associated benefits and risks of available treatments'
12	The Eve Appeal	Information and support for menopausal women.	It is imperative that women are given up to date and complete information regarding how to manage their symptoms. The NICE guidance details that women should be given information on the menopause in different ways to help encourage them to discuss their symptoms and needs.	Women should be referred to specialist menopause clinics when they experience early menopause, either due to risk reducing surgery, premature ovarian failure or treatment with particular medications. Such clinics exist but women are not being referred as a matter of course. This should also apply to women who are experiencing particularly unpleasant menopause symptoms.	The Eve Appeal "Ask Eve" information service, Menopause Matters and The Daisy Network are resources for women to seek peer support and advice from healthcare professionals outside the hospital/GP setting.
13	The Eve Appeal	Breast cancer risk in menopausal women.	NICE guidance on menopause details the change in risk of breast cancer for women who are using HRT.	Reading the information in table 3 (1.5.11)may give women the impression that it is appropriate to use oestrogen on its own if they still have a uterus – it must be made clear that women who have a uterus must also supplement this with progestogen.	*No additional information provided by stakeholder.*
Information - contraception					
14	Bayer plc	Key area for quality improvement 1 Contraception in the	Although fertility is decreased during the perimenipausal period, pregnancy is still common.	Data from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3),1 shows that 5.5% of women aged 35-44 has had a pregnancy with a known outcome in the previous 12	1. Wellings K et al. Lancet 2013; 382: 1807-1816. 2. Department of Health Abortion Statistics 2014

		perimenopause	NICE guideline [NG23] Menopause: diagnosis and management, includes the following recommendation: 1.3.5 Give information about contraception to women who are in the perimenopausal and postmenopausal phase. See guidance from the Faculty of Sexual & Reproductive Healthcare on contraception for women aged over 40 years.	months. Of these pregnancies, 61.4% were planned. 57.1% of all unplanned pregnancies in the survey ended in termination. Abortion data from England & Wales2 shows that abortion rates for women over 35 increased from 6.8 in 2004 to 7.4 in 2014. In addition the British Pregnancy Advisory Service (BPAS) reported that 42% of women over 40 undergoing termination were not using any contraception.3 We believe there is a need for additional education regarding effective contraception for perimenopausal women, which should include long-acting methods as per the NICE LARC guideline.4	https://www.gov.uk/government/statistical-data-sets/abortion-statistics-england-and-wales-2014 (accessed 28th August 2015). 3. British Pregnancy Advisory Service 2014 https://www.bpas.org/about-our-charity/press-office/press-releases/women-trying-hard-to-avoid-unwanted-pregnancy-res/ (accessed 28th August 2015). 4. NICE Long-acting reversible contraception CG30 2005 www.nice.org.uk/guidance/cg30 (accessed 19th November 2015).
15	Clinical Standards Committee of the FSRH	Suggestion 2 The contraceptive needs of peri-menopausal women should be assessed	Women should be provided with information and advice about effective contraception or be referred to an appropriate service for assessment	Women may be confused about the timing of discontinuation of contraception and there has been a significant increase in unplanned pregnancies in women > 40 years old	http://www.fsrh.org/pdfs/ContraceptionOver40July10.pdf
16	Primary Care Women's Health Forum	Key area for quality improvement 1 All non hysterectomised women presenting with menopausal symptoms have a discussion about	Women who are perimenopausal may be fertilie and require contraception.	There are a significant number of abortions required in women aged over 40	Department of Health (DH) (2015). Abortion statistics, England and Wales: 2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/433437/2014_Commentary__5_.

		fertility and contraception with their healthcare provider			pdf FSRH Contraception in women aged > 40 http://www.fsrh.org/pdfs/ContraceptionOver40July10.pdf
Information – before treatment that may lead to menopause					
17	Primary Care Women's Health Forum	2a Women facing medical interventions which will affect ovarian function (such as surgery, chemotherapy or radiotherapy) should be offered information and advice prior to the procedure.	Particularly for elective BSO for high risk genes		NICE CG 164 (breast ca) and 44 (HMB)
18	SCM3	Discussion of implications of menopause with women having surgical treatment with removal of ovaries	Implications should be outlined with the treatment options so women can make an informed choice as some have no idea of what to expect in regard to symptoms	Early removal of ovaries causes symptoms and may reduce health in the long term.	*No additional information provided by stakeholder.*
19	The Eve Appeal	Information for women undergoing risk reducing surgery due to genetic mutation.	Women who are choosing to undergo risk reducing salpingo-oophorectomy as a result of a genetic mutation, should be provided with details of what to expect regarding menopausal symptoms and fertility. These are detailed in the NICE guidance on menopause but not always explained in sufficient detail.	Referrals to specialist menopause clinics and fertility experts should be made when a woman wants to start a family following BSO.	Patients should be signposted to services such as BRCA Umbrella or Ask Eve amongst others.

Managing short term menopausal symptoms – individualised treatment					
20	British Menopause Society	4. Formulary provision of menopause products	Menopause treatments should be individualised to optimise outcomes	Formularies are often restricted to the least expensive treatments – prescribing should be cost effective, not driven by cost alone.	Nice guideline ng 23
21	National Institute of Medical Herbalists	Key area for quality improvement 2	NICE guidelines highlight the need to take an individualised approach in managing menopausal symptoms	Medical herbalists tailor herbal prescriptions to the needs of each individual. Herbal Medicine has a long tradition of use in managing various menopausal symptoms including vasomotor , psychological, urogenital and muscoloskeletal symptoms	http://fampra.oxfordjournals.org/content/24/5/468.abstract?sid=ac553b88-7bb9-41df-a146-0be2a1d4e1ad
22	SCM4	Key area for quality improvement 3 Individualised treatment plan including risk assessment	NICE recommendation 8.2.8 Adapt a woman's treatment as needed, based on her changing symptoms. Discussion with a women is needed to ascertain her needs and choices based on a safe and appropriate treatment for her. Inclusion of choice of preparation and risks associated with their preference of treatment needs to be clear and evidenced based.	NICE guidance suggests a number of considerations for treatment needs and choices and the risks associated with these treatment. Ensuring an individualised treatment plan is devised with the women ensures a safe and effective management approach. However the quality and standard of the knowledge of the clinician she is consulting is of paramount importance.	Key area for quality improvement 3 Individualised treatment plan including risk assessment
Managing short term menopausal symptoms – vasomotor symptoms and HRT					
23	Bayer plc	Key area for quality improvement 2 **Management of vasomotor symptoms**	NICE guideline [NG23] Menopause: diagnosis and management, includes the following recommendation: 1.4.2 Offer women HRT for vasomotor symptoms after discussing with them the short-term (up to 5 years) and longer-term benefits and risks. Offer a choice of preparations as follows:		1. Mirena® Summary of product characteristics. Bayer HealthCare. May 2015 2. Levosert® Summary of product characteristics.. May 2015 3. Levonorgestrel-releasing intrauterine systems:

			• oestrogen and progestogen to women with a uterus • oestrogen alone to women without a uterus. The levonorgestrel-releasing intrauterine system (IUS) (containing 52mg levonogestrel, releasing 20 micrograms/24 hours) Mirena® provides effective contraception (which standard HRT does not) and allows a choice of tailored estrogen therapy whilst protecting against endometrial hyperplasia.[5] It should be noted that the different brands of levonorgestrel 52ug IUS have important differences in both the range and duration of their licensed indications.[5,6] The MHRA recently published a safety notice to bring this to prescribers attention.[7] Mirena® has three licenced indications – for contraception and heavy menstrual bleeding for 5 years, and for protection from endometrial hyperplasia during oestrogen replacement therapy for 4 years. In contrast, Levosert® has a licence for contraception and management of heavy menstrual bleeding for 3 years only, and is not		prescribe by brand name. MHRA Drug Safety Update. https://www.gov.uk/drug-safety-update/levonorgestrel-releasing-intrauterine-systems-prescribe-by-brand-name

			licenced for protection from endometrial hyperplasia. In light of these important differences the MHRA recommended branded prescribing.		
24	Clinical Standards Committee of the FSRH	Suggestion 3	Sometimes it is difficult to find a suitable HRT regime for some women	There are preparations available which are not licensed for HRT usage but are not licenced for this purpose	Appropriately licensed products are not available in the UK e.g. estradiol and testosterone implants and their use should be supported to help meet the guidance of https://www.nice.org.uk/guidance/ng23
25	Primary Care Women's Health Forum	Key area for quality improvement 4 All women with menopause related symptoms should have a risk assessment and be offered HRT if appropriate			BMS http://wwwthebms.org.uk NICE Menopause Diagnosis and Management Guideline https://www.nice.org.uk/guidance/ng23
26	SCM2	3.Management of menopausal symptoms with HRT e.g "progestogenic opposition is essential for all women receiving HRT who have an intact uterus"	It is important to establish a standard for the safest possible use of HRT in order to avoid putting patients at unnecessary risk. Action point: oestrogen and progesterone to be used in women	It is a well established association that exposure to unopposed oestrogen is linked to endometrial carcinoma and therefore it is not safe to use. This is a "measurable" standard as the number of cases of women with a uterus using	Please see Menopause (2015) NICE guideline NG23, recommendations 1.4.2

			with a uterus	unopposed oestrogen should be zero.	
Managing short term menopausal symptoms – altered sexual function					
27	Clinical Standards Committee of the FSRH	Suggestion 1 Provision of testosterone for those with low libido and the pro-active screening of women with regard to their sexual desire	NICE NG23 advice the use of testosterone in post-menopausal women and those with POI but guidance on how to start is lacking for GPs Current access to Testosterone supplements is "patchy" in the UK. Prescribing is poorly understood (In a recent menopause talk to GPs in North London of a poll of 40 none knew how to prescribe or if they were allowed to)	"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" http://who.int/about/definition/en/print.html Loss of libido has a huge impact on a woman-and her partner-and can lead to morbidity of mental and physical health. Post menopausal women and those with POI should be actively assessed and sympathetically questioned about sexual desire	http://www.fpa.org.uk/sexual-health-week/pleasure-principle/sexual-wellbeing-as-you-get-older http://www.fpa.org.uk/sites/default/files/people-over-50-relationships-and-sexual-health.pdf https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/484383/cmo-report-2014.pdf Sexual desire is a taboo often among health professionals who should receive education from undergraduate level on its assessment and management
28	SCM5	Testosterone is suggested as an additional treatment for women suffering low libido (1.4.8) however, anecdotal evidence suggests that testosterone therapy has largely been withdrawn from NHS treatment and is only prescribed off-licence.			
29	The Eve Appeal	Post-menopausal women experiencing issues with libido.	There is evidence that a number of post-menopausal women experience issues with their libido. NICE guidance mentions the use of testosterone supplementation which	There is only anecdotal evidence to support the long-term use of testosterone.	*No additional information provided by stakeholder.*

			can increase libido and minimise sexual dysfunction.		
Managing short term menopausal symptoms – urogenital atrophy					
30	SCM1	Key area for quality improvement 3 Vaginal oestrogen use for women with atrophy – long term	Women with vaginal symptoms are often not given vaginal oestrogen or given in short term ways	Vaginal symptoms are often under reported and often neglected. There is a reluctance to prescribe vaginal oestrogens and when they are prescribed it is for a limited time only.	*No additional information provided by stakeholder.*
31	The Eve Appeal	Use of vaginal oestrogen for women with urogenital atrophy.	There is significant evidence that the use of vaginal oestrogen can help post-menopausal women who have symptoms of urogenital atrophy.	Nice guidance mentions the use of vaginal oestrogen. There are alternatives without oestrogen, and anecdotally has systemic effect, therefore is it necessary to take this point out? take out?	*No additional information provided by stakeholder.*
32	The Eve Appeal	Use of moisturisers and lubricants alone or in addition to vaginal oestrogen for urogenital atrophy.	Many women are unaware that moisturisers and lubricants can be used as stand alone treatment or in addition to vaginal oestrogen. This is detailed within the NICE guidance on menopause and it is imperative that this information is shared with women who are experiencing urogenital atrophy.	Anecdotal evidence from post-menopausal women shows that this information is not being shared by healthcare professionals when women are diagnosed with urogenital atrophy.	*No additional information provided by stakeholder.*
33	The Eve Appeal	Symptoms of urogenital atrophy.	NICE guidance on menopause explains that symptoms often come back when treatment is stopped; adverse effects from vaginal oestrogen are rare; they should report unscheduled vaginal bleeding to their GP.	More emphasis should be placed on reporting unscheduled bleeding to GPs.	*No additional information provided by stakeholder.*
Managing short term menopausal symptoms – complementary products					

34	National Institute of Medical Herbalists	Key area for quality improvement 1	NICE guidelines note that there is some evidence that isoflavones or black cohosh may relieve vasomotor symptoms in menopausal women. However there is concern in consistency in products and possible interactions with other medications. Likewise there is concern on possible drug-herb interactions with St Johns Wort.	Medical herbalists can advise on how herbs can be used safely, taking into account other medications women are taking, they can minimise drug-herb interaction risks There is a vast difference in taking OTC products and seeking expert advice from someone specifically qualified to give that advice. Many women turn to the internet which is full of low quality herbal products and dubious advice. Patients need to know that reliable information is available and how to access reliable information.	*No additional information provided by stakeholder.*
35	National Institute of Medical Herbalists	Key area for quality improvement 5	Managing menopausal symptoms	Medical Herbalists help to improve quality of life, to promote well-being and to encourage a strong resolve to take measures to enhance health and boost their morale.	*No additional information provided by stakeholder.*
36	National Institute of Medical Herbalists	Additional developmental areas of emergent practice	Herbal medicine practice	Herbal medicine may be considered an emergent practice but in reality it is the oldest form of medicine in the world, and still the most widely practised. Treatment is centred on the care of each patient as an individual, with prescriptions dispensed to meet individual needs. There is a growing body of research into individual herbs, which demonstrates their efficacy and their safety. There is a need for good-quality research examining the individualised treatment offered by medical herbalists.	*No additional information provided by stakeholder.*

Review					
37	Primary Care Women's Health Forum	Key area for quality improvement 5 All women prescribed HRT should have an annual review to assess risks/benefits, dose and type of HRT. without 'arbitrary time limits applied' and have adjustments to the dose and type of preparation if appropriate)			BMS http://wwwthe bms.org.uk NICE Menopause Diagnosis and Management Guideline https://www.nice.org.uk/guidance/ng23
38	SCM2	4.Clinical review at 3 months after commencing HRT and then annually.	This is important in order to identify possible adverse effects of HRT, to encourage women to participate in recommended National screening and to identify when a reasonable duration of treatment has been reached. Action point: to set these periods of review as standards for good clinical practice and publicise this.	There is no current recommended standard of practice for HRT checks as for example with the oral contraceptive pill. Therefore follow up is variable. This standard is measurable by audit and would facilitate Primary Care in setting up "recall reminders" as is well established in other clinical domains within Primary Care.	Please see Menopause (2015) NICE guideline NG23, recommendations 1.4.18 1.4.19
Premature ovarian insufficiency					
39	British Menopause Society	3.Diagnosis and management of premature ovarian insufficiency	An important condition of increasing prevalence due to iatrogenic interventions for malignancy. Has implications for qol, fertility and long term health (also see below)	The diagnosis and management of this condition is currently inefficient – delays in diagnosis / misdiagnosis / inadequate specialised services can lead to poor qol increased psychological and physical morbidity e.g. increased risk of osteoporosis and	Nice menopause guideline ng23 Eshre poi guideline Fertility problems (2014) nice quality standard 73. Breast cancer (2011) nice

				cardiovascular disease and reduction in life expectancy	quality standard 12. NICE Guidance CG80: Early and locally advanced breast cancer (2009) ASCO (2015): ACS/ASCO Breast Cancer Survivorship Care Guideline (http://www.asco.org/practice-guidelines/quality-guidelines/guidelines/breast-cancer#/9526) Endocrine Society (2015): Treatment of symptoms of the menopause (https://www.endocrine.org/education-and-practice-management/clinical-practice-guidelines) NAMS position statement on non-hormonal management of menopausal vasomotor symptoms (2015): (http://www.menopause.org/docs/default-source/professional/pap-pdf-meno-d-15-00241-minus-trim-cme.pdf)
40	Clinical Effectiveness Unit of the Faculty of Sexual and Reproductive	Improving the pathways for women experiencing premature menopause following cancer or risk reduction removal of the ovaries.	The NICE Menopause guidance encourages improved management of women experiencing premature menopause.	Cancer services should be better informed to promote good menopause care for young women suffering early menopause as a consequence of their cancer treatment.	Protocols for menopause care in young women with cancer or at high risk of cancer are already in existence in some centres eg Royal Marsden Hospital,

	Health				London. https://www.royalmarsden.nhs.uk/sites/default/files/files_trust/brca_0.pdf
41	Clinical Standards Committee of the FSRH	Suggestion 5 Women from low socioeconomic groups must be able to access HRT equitably	https://www.menopause.org.au/for-women/information-sheets/1030-spontaneous-premature-ovarian-insufficiency There is some evidence that women from low socioeconomic groups are at greater risk of POI (? Linked with smoking) Greater social barriers to women from low SEG accessing HRT	http://www.local.gov.uk/web/guest/health/-/journal_content/56/10180/3510094/ARTICLE http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review those from low SEG may not benefit from reforms within the workplace that support women in the menopause https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/484383/cmo-report-2014.pdf	Osteoporosis and HRT in low SEG Link between Osteoperosis and nutrition and SEG https://www.nos.org.uk/document.doc?id=894 https://www.nice.org.uk/guidance/cg146
42	Primary Care Women's Health Forum	Key area for quality improvement 2 Women with menstrual changes and/or symptoms consistent with menopause age < 45 should be recommended HRT		Women who have premature ovarian insufficiency have higher morbitidy and mortality than those who are menopausal aged > 45	BMS consensus statement – premature menopause http://www.thebms.org.uk/statementpreview.php?id=3
43	SCM3	Premature Ovarian Insufficiency: Diagnosis and management.	This is becoming commoner with improved care of young women with cancer and the diagnosis is often delayed	Appropriate care improves QOL and long term health as well as providing information and support.	NICE MENOPAUSE GUIDLINE NG23 Breast cancer (2011) NICE quality standard 12. ESHRE POI GUIDELINE
44	SCM4	Key area for quality	NICE recommends diagnosis of	There remains uncertainty regarding the	*No additional information*

		improvement 4 POI management	premature ovarian insufficiency in women aged under 40 years is based on: • menopausal symptoms, including no or infrequent periods (taking into account whether the woman has a uterus) and • elevated FSH levels on 2 blood samples taken 4–6 weeks apart	diagnosis and management of women with premature ovarian insufficiency. They can experience the effects of menopause for most of their adult life. This can lead to reduced quality of life and an increased risk of osteoporosis, cardiovascular disease and possibly dementia. The contraceptive requirements of fluctuating levels of fertility is an area of need for improvement in general practice.	*provided by stakeholder.*
45	SCM5	3.1 refers to menopause and menopause deriving from premature ovarian insufficiency. However, it doesn't refer to those women who experience surgical menopause which can be premature. Is this implied within the concept of premature ovarian insufficiency? If not, why not and will this specific experience of menopause be covered by other quality standards?			
46	SCM5	Surgical menopause is not specifically discussed and the suggestion is that these women have the same experience as those with a uterus, however anecdotal evidence and research shows this is not the case.			
Referral					
47	Breast Cancer Now	Suggested area for quality improvement People who experience menopausal symptoms as a result of their breast cancer treatment are referred to specialist clinicians who are able to advise them appropriately, including as to options that are not contraindicated by their breast cancer treatment. Relevant section in the NICE Menopause guideline	The menopausal side effects of breast cancer treatment can be severe and can have a significant impact upon quality of life. In some cases, they can be severe enough to cause people to discontinue or disrupt their treatment for breast cancer, thus compromising their survival. Treatment options are available to help people to manage the menopausal side effects of breast cancer treatment but more often than not, people are not made aware	a) supporting patients to cope with side effects and adhere to their adjuvant treatment regime It has become clear that patients with early invasive breast cancer need support and information to help them to continue to adhere to their adjuvant treatment plan, and therefore have better survival outcomes. Support with managing side effects could play an important role in encouraging adherence. Makubate et al (2013) showed that many women do not take the medication as directed and they stop treatment before completing the standard 5-year duration. The researchers	Makubate et al (2013): "Cohort study of adherence to adjuvant endocrine therapy, breast cancer recurrence and mortality" British Journal of Cancer 108, 1515–1524. McCowan et al (2013): "The value of high adherence to tamoxifen in women with breast cancer: a community-based cohort study", British Journal of Cancer 109, 1172–

		Offer menopausal women with, or at high risk of, breast cancer: Ø information on all available treatment options Ø information that the SSRIs paroxetine and fluoxetine should not be offered to women with breast cancer who are taking tamoxifen Ø referral to a healthcare professional with expertise in menopause.	of these and/or are not referred to the appropriate specialist.	commented that they were unable to examine reasons for non-adherence, but a case note review of the women with an incidence of breast cancer between 1998 and 2007 had 382 women who discontinued medication, reporting they did so owing to side effects (the study comprised 3361 women in total). Over half of the women whose notes were reviewed, reported side effects due to endocrine therapy. McCowan et al (2013) showed that patients with low adherence to their adjuvant medication have shorter time to recurrence, increased medical costs and worse quality of life. They concluded that interventions that encourage patients to continue taking their treatment on a daily basis for the recommended 5-year period may be highly cost-effective. Indeed, they estimated the expected value of changing a patient from low to high adherence as £33,897 (95% CI: £28,322–£39,652). b) signposting to appropriate treatments (which are not contraindicated) We currently lack robust evidence on the availability of appropriate treatments and techniques to relieve menopausal symptoms experienced as a result of breast cancer. This is partly because the issue hasn't received much attention and serious consideration to date. More recently, evidence-gathering in this area has been pioneered by the Symptom	1180.

				Management Working Group, a sub-group of the National Cancer Research Institute's Breast Cancer Clinical Studies Group. They have conducted a survey of healthcare professionals which has shown that awareness of treatments and techniques to relieve menopausal symptoms caused by breast cancer treatment is low. There are options available to women undergoing treatment for breast cancer that are not contraindicated. However, the survey revealed that some healthcare professionals are offering and prescribing contraindications of breast cancer treatment, which is very concerning. Access to appropriate treatments in England is currently reliant on prescriber knowledge of the products, their indications and applications which is patchy across primary care and in oncology.	
48	British Menopause Society	2. Ease of access / equitable access to / availability of specialist menopause services nationally. Provision of adequately trained menopause specialists	A significant number of menopause problems are complex e.g. malignancy, cv risk, severe osteoporosis requiring specialist / mdt management	Complex problems require specialised care – referral to a specialist is recommended on a number of occasions in the nice guideline but specialised services are currently inadequate & fragmented - an increase in education and resources is urgently required to meet the shortfall	Nice menopause guideline ng23 Patient experience in adult nhs services (2012) nice quality standard 15. BMS definition of menopause specialist Https://www.rcog.org.uk/en/guidelines-research-services/guidelines/high-quality-womens-health-care/

					Commissioning for menopause specialist services: A local perspective: An internet-based survey to assess the potential demand for menopause care in West Cheshire and the skills of local primary care clinicians in this field, with a view to informing future commissioning locally. Wilkinson J et al. Post Reprod Health September 2015 vol. 21 no. 3 98-104
49	British Menopause Society	1.Ease of access / equitable access to / availability of menopause services nationally in primary care. Provision of adequately trained multi disciplinary staff	Access to services is currently fragmented and dependent on local commissioning, expertise of gp/nurses resources etc with many women being given inconsistent and often inappropriate advice with effective treatment denied	Prompt diagnosis and management of menopause related problems will improve qol, long term wellbeing and productivity of women and will reduce number of subsequent appointments	Nice menopause guideline ng 23 Patient experience in adult nhs services (2012) nice quality standard 15. Cardiovascular risk assessment and lipid modification (2015) nice quality standard 100. British menopause society council. Modernizing the nhs: observations and Recommendations from the british menopause society.

					Menopause int. 2011 Jun; 17(2): 41-3. Https://www.rcog.org.uk/en/guidelines-research-services/guidelines/high-quality-womens-health-care/ https://www.gov.uk/government/publications/chief-medical-officer-annual-report-2014-womens-health Reinventing the general practitioner menopause clinic – personal experiences Mehra A Post Reprod Health May 20, 2014 2053369114536151
50	British Menopause Society	5. Post malignancy integrated menopause care (multi-disciplinary and multi-professional)	Many women suffer iatrogenic menopause following treatments for malignancy e.g. breast/ovarian cancer	Few specialised menopause services are available and little thought is given to optimising quality of life – even survivorship clinics are not focussed specifically on care of menopause related issues e.g. vms / vva	Nice guideline ng 23 Breast cancer (2011) nice quality standard 12. NICE Guidance CG80: Early and locally advanced breast cancer (2009) ASCO (2015): ACS/ASCO Breast Cancer Survivorship Care Guideline (http://www.asco.org/practice-guidelines/quality-guidelines/guidelines/breast-cancer#/9526) Endocrine Society (2015):

					Treatment of symptoms of the menopause (https://www.endocrine.org/education-and-practice-management/clinical-practice-guidelines) NAMS position statement on non-hormonal management of menopausal vasomotor symptoms (2015): (http://www.menopause.org/docs/default-source/professional/pap-pdf-meno-d-15-00241-minus-trim-cme.pdf) ? worth adding contradictory position statements about use of ospemifene in breast cancer patients? (European Medicines Agency and FDA)
51	Clinical Effectiveness Unit of the Faculty of Sexual and Reproductive Health	Availability of specialist menopause clinics across the UK	The NICE Menopause guidance makes many references to referral for specialist advice for complex menopause problems.	The NHS provision of specialist menopause care is very variable across the UK. Regions with poor provision of specialist menopause care should be supported to develop new services. At the present time, access is not equitable across the UK.	See Menopause Map of services as quoted in NICE Menopause guidance http://menopauseuk.org/resources/map-of-menopause-services/ There is excellent provision of menopause services in Scotland but far fewer clinics per head of population elsewhere.
52	Clinical	Suggestion 4	https://www.nice.org.uk/guidance/q	Royal College of Nursing (2014) Menopause:	https://www.nice.org.uk/gui

	Standards Committee of the FSRH	Referral for specialist fertility consultations for women with POI should not be delayed, neither should HRT be delayed while the patient is being referred to an RMU (Reproductive Medicine Unit)	s73/chapter/Quality-statement-2-Referral-for-specialist-consultation POI can be devastating news for women who have not started or completed their family. Women diagnosed with POI should be offered specialist counselling with regard to their fertility and their options without delay. Commissioners should have an understanding of POI with specialist referral pathways for those with POI into the fertility pathways and a policy for POI patients https://www.england.nhs.uk/wp-content/uploads/2013/02/fertility-facts.pdf	lifestyle and therapeutic approaches Women with POI need HRT and commencement of this should not be delayed while they are awaiting referral to specialist fertility services	dance/qs15/chapter/Quality-statement-8-Asking-for-a-second-opinion Patients should be given the option to speak with a specialist in menopause for a second opinion if they request GP should be able to refer patients to a specialist service for support with POI whether that is a Menopause service or RMU who has knowledge of POI
53	Menopause UK	Key area for quality improvement 1 Identifying local and regional expertise and capacity, to make it easier for women and professionals to access advice and support We suggest:	The NICE guidelines for menopause include a number of points in the care pathway where it is recommended that women should be referred to a specialist, or where practitioners should seek advice on managing women in their care. Currently, care is provided in a number of different settings, by professionals from a variety of specialities (gynaecology,	A mapping exercise conducted by Menopause UK in 2014 identified just 29 specialist 'menopause clinics' within the NHS across the UK. Women consistently report distress arising from: practitioners refusing to refer on; being told there is no specialist locally (and no money for out of area referrals); very lengthy delays in first and follow up appointments; considerable personal expense for long distance travel.	Kings Health Partners conducted an exercise to map mental health provision within their geographical area. This highlighted the extent to which mental health care is delivered by a network of professionals from a variety of disciplines, who may not report into the same service management mechanisms. This is in some

		Creating regional and local menopause service directories that unite the networks of professionals delivering care	endocrinology, sexual and reproductive health) as well as within primary care. This makes it difficult to identify, navigate, monitor or systematically improve services.	These reports suggest that access to services is poor. The North of England seems to be especially poorly served.	ways analogous with menopause care, and the methods used could be adapted to provide guidance for local women's health commissioners to conduct their own mapping exercises. The report can be found here: http://www.kcl.ac.uk/ioppn/depts/pm/research/imparts/Quick-links/Mapping-Report.pdf Menopause UK's mapping project can be viewed here https://menopauseuk.org/resources/map-of-menopause-services/ The findings are discussed here https://menopauseuk.org/2014/10/28/out-of-the-picture-what-we-found-when-we-tried-to-map-menopause-care/
54	Menopause UK	Key area for quality improvement 2 Improving the visibility and accountability of menopause services by allocating clear leadership	Menopause care doesn't fall under specialised commissioning arrangements. Where it is recognised locally, there is no consistency about where it sits (women and children/ sexual and	There is no clear service leadership or responsibility for menopause care.	The guide to whole system commissioning for sexual health is a useful example of how co-ordination can be improved https://www.gov.uk/govern

		responsibility for co-ordinating delivery of menopause care nationally, regionally and locally.	reproductive health/ other). This contributes to a lack of transparency, and excludes practitioners and service users from participating in decisions about service planning and design.		ment/uploads/system/uploads/attachment_data/file/408357/Making_it_work_revised_March_2015.pdf
55	National Institute of Medical Herbalists	Key area for quality improvement 4	The challenge: providing enough specialist services	Medical herbalists are a largely untapped resource In the 2015 Professional Standards Authority (PSA) report to parliament specific mention was made of the benefit offered by complementary medicine for patients, and how the complementary medicine workforce can contribute to achieving the aim of improving the nation's health. Herbal medicine is one such area.	*No additional information provided by stakeholder.*
56	SCM1	Key area for quality improvement 1 Access to specialist menopause services for women with POI	These groups of women have higher morbidity and more complex issues around the menopause.	There is variable access to specialist through out the UK and women with POI not having access to these or given any replacement hormones . without specialist investigations and long term monitoring their long term health in relation to bones and cardio vascular disease has poorer outcomes than peer matched women, leading to additional problems in the future.	ESHRE guidelines on POI
57	SCM1	Key area for quality improvement 2 Access to specialist menopause services for women with hormone dependant cancers	Women with hormone dependant cancers are often unprepared for the effects of the menopause and also the impact that some treatments can have on the symptoms.	There is unequal access to services and some women do not get specialist help	
58	SCM2	4.Referral to Specialist if needed	This is important in those with special requirements e.g. premature	There is a significant shortage and of health care professionals with expertise in menopause	Please see national menopause map to illustrate

			ovarian insufficiency or at high risk of breast cancer Action point: to identify a clinical lead in menopause management with expertise in the field within each Clinical Commissioning Group in order to drive a change in service provision as required.	management. The NICE guidance is clear that onward referral to a specialist is recommended in certain cases. This is simply not available in many areas at present. Without this being developed as a key area for quality improvement there will be a lack of clinical leadership to drive the new guidance forwards.	sparsity of specialists. http://www.menopausematters.co.uk/clinicfinder.php Please see Menopause (2015) NICE guideline NG23, recommendations
59	SCM3	Provision of adequately trained menopause specialists	Menopause problems are often complex and need someone with the time, interest and knowledge to treat them properly	Referral to specialist services commonly recommended in CG 23.	As above
60	SCM3	Ease of access to menopause services nationally in primary and secondary care.	Service provision is very variable and depends on the region and interest of staff. All practices and Trust should have someone with knowledge of menopause	This will enable rapid diagnosis and treatment of menopausal problems	NICE MENOPAUSE GUIDELINE NG 23 Patient experience in adult NHS services (2012) NICE quality standard 15. RCOG and Specialist Society Guidance
61	SCM4	Key area for quality improvement 5 Referral to Specialist Menopause clinics	Women should be referred to a menopause specialist if there's no improvement after trying treatments, and a referral considered if a woman has menopausal symptoms but HRT is contraindicated (for example, in women with hormone-sensitive cancer), or the most suitable option is uncertain.	This key area for improvement implies that all care up to the point of referral, which will be provided in primary care, is of a quality and standard described in this guidance. The lack of specialist services in parts of the UK can provide a challenge for the clinician needing the advice and guidance of a specialist.	*No additional information provided by stakeholder.*

			Refer if there is doubt about the diagnosis of premature ovarian insufficiency		
Additional areas – length of appointments					
62	Hands Inc	Key Area for Quality Improvement 2 Women want more time with GP's to discuss a person centred approach to managing menopausal symptoms	The taboo associated with menopause makes women feel uncomfortable to talk about menopausal symptoms with GP's. Creating a designated time outside of the restrictions of the typical 10 minute GP appointment slot will give women and their health professional the space explore the menopause along with some of the concerns they might have of taking a medical route to treating symptoms such as about HRT It can also reduce repeat visits and the unnecessary cost implications. Women we have spoken to talk of visiting their GP's on average 4-5 times about menopausal symptoms before either giving up or getting some support • Longer appointments may also be inclusive of those with additional needs Longer appointments may also be inclusive of those with additional needs • Evidence shows that adopting a	The Health Information Needs of Older Women in the UK, a survey conducted by the Women's Network (WN) of the RCOG in June/July 2015. Of the 2109 women surveyed the menopause was of greatest health concern (58%). Based on NICE statistics 45% of women experiencing the menopause will find their symptoms distressing. Yet evidence shows that women are not choosing the GP as the place to turn for advice or support. The cost of this is women living with preventable sequelae associated with the menopausal transition. Going to the GP to discuss the menopause can be a daunting task for many women. Especially given the concerns and about HRT. In our 3min audio story Fifi tells about her experience of visiting her GP and why one trip to the GP is often not enough. https://reclaimthemenopause.com/2015/04/21/talking-to-gps-about-the-menopause/ A presentation at the Patient Information Forum (PiF) June 2014 Executive Circle by Mark Britnell, Chairman & Partner of KMPG's Global Health Practice, showed that 'activated patients' can save providers between 8-21% of costs	The Health Information Needs of Older Women in the UK: https://www.rcog.org.uk/globalassets/documents/patients/womens-network/health-information-needs-of-older-women-final-report.pdf Please see KPMG Global Healthcare: Creating New Values with Patients Carers & Communities. Which explores the importance of involving patients with their health management, the associated cost savings and improvements in quality of care http://www.kpmg.com/Global/en/IssuesAndInsights/ArticlesPublications/what-works/creating-new-value-with-patients/Documents/creating-new-value-with-patients.pdf

			more person centred approach to managing symptoms encourages the patient to take a more proactive part in their health management and feel more empowered to make informed decisions		
Additional areas - research					
63	National Institute of Medical Herbalists	Key area for quality improvement 3	Recommendations for research	There is a need for good-quality observational studies and clinical case series examining the individualised treatment offered by medical herbalists	*No additional information provided by stakeholder.*
Additional areas - training					
64	Clinical Effectiveness Unit of the Faculty of Sexual and Reproductive Health	Improve primary care provision of menopause care.	The majority of women will seek advice and help about menopause from their GP or practice nurse. This is an ideal opportunity for primary care staff to give high quality care to women at this stage of their lives.	If a small percentage of primary care staff undergo further training in menopause care they can provide a resource within their own practice or within their GP localities.	The Faculty of Sexual and Reproductive Health offers training in special skills modules in menopause that can be undertaken by doctors and nurses with an interest in this field. http://www.fsrh.org/pages/Special_Skills.asp
65	Hands Inc	Key Area for Quality Improvement 1 Variation in consultation and treatment of menopausal symptoms highlights the need to improve knowledge amongst health professionals supporting peri/menopausal women	If women do not get the correct advice and support they need to manage menopausal symptoms this can impact on their health in both the long and short term, with downstream cost implications on the health economy. The new NICE guideline advocates that health professionals give information and advice based of	NICE has developed the new guidelines and quality standards because it recognises the inconsistencies and variation in treatment. It also highlights the need to improve knowledge amongst healthcare professionals. Hands Inc has been running a Menopause Project since March 2015. The frustration that the women felt trying to get clear person centred advice from GP's led them to recognising there was a gap in health professionals' knowledge about the	The Royal college of Nursing's Menopause: lifestyle and therapeutic approaches looks at skills levels required for nurse in the support of menopausal women. http://www.rcn.org.uk/professional-development/publications/pub-003839

			women's personal needs, including complementary therapies and CBT. But if health professionals are not adequately informed themselves then they will not be able to confidently give the range of advice and support recommended by the NICE guidelines.	menopause. As part of our current programme we surveyed practice nurses across 17 GP practices to explore what they felt their training needs were in relation to the menopause. 35% reported feeling confident supporting women with menopause advice. 82% reported never receiving training around the menopause. 47% of participants reported not being able to advice women in treating the menopause without medication. The other 53% of participants listed the following ways of helping women treat menopause without medication: giving words of comfort and reassurance, having brief discussions and giving advice regarding diet and exercise, suggesting readings and websites to visit, suggesting acupuncture and herbal remedies to help and advising GP appointments We asked the practice nurses what their training needs were to support peri/menopausal women and 82% of participants want training about HRT, 71% want general training about the Menopause, 76% want training about the impact of hormonal changes during the menopause, 65% want training about the key menopausal symptoms to be aware of, 88% want training about services to support women's needs, 88% want training about the psychosexual impact of the menopause, 82% want training about the new NICE menopause treatment guidelines and 88%	Also see RCN Competences for nurses working in the field of menopause https://webcache.googleusercontent.com/search?q=cache:k6rZ0ZX8qx8J:https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2011/october/pub-003528.pdf+&cd=5&hl=en&ct=clnk&gl=uk Hands Inc asked the women who took part in our Menopause programme a series of questions to get a sense of what was important to them and what sort of changes they would like to see within healthcare to make things better for peri/menopausal women. See the link; https://reclaimthemenopause.com/2015/05/05/how-can-gps-better-support-women-through-menopausal-transition/

				want training about holistic menopause treatments available. We also asked the practice nurse what training they felt able to offer in this area and 12% felt able to offer training about HRT, 23% can offer general training about the Menopause, 18% can offer training about the impact of hormonal changes during the Menopause, 23% can offer training about the key menopausal symptoms to be aware of, 6% can offer training about services to support women's needs, 6% can offer training about the psychosexual impact of the menopause and 0% can offer training about the NICE new menopause guidelines or training about available holistic menopause treatments	
66	Merck Sharp & Dohme	Key area for quality improvement 1 Ensure that primary care practitioners receive adequate training on the management of menopause.	Healthcare professionals (HCPs) need to be able to support women to make an informed decision about the treatment of menopausal symptoms. A knowledge gap among HCPs can mean that they are reluctant to prescribe hormone replacement therapy (HRT) because they overestimate the risk and contraindications, and underestimate the impact of menopause symptoms on a woman's quality of life.1	There is currently a lack of specialist services with expertise in menopause, and their availability varies nationally.1 Primary care practitioners are therefore best placed to support women experiencing menopausal symptoms; and should therefore receive regular training on the management of menopause.	Please see: 1. National Institute for Health and Clinical Excellence (NICE). Guidelines. Menopause: diagnosis and management (NG23). London: NICE; November 2015.
67	National Institute of Medical Herbalists	Key area for quality improvement 6	Improving knowledge among healthcare professionals	There is a need for education of healthcare professionals who may be unaware of the potential benefits of existing services, and	*No additional information provided by stakeholder.*

				consequently not offer access or referral to them and of patients who may be unaware of the existence of services that might help them. The 2015 PSA report to parliament specifically mentions the benefit offered by complementary medicine, and how the complementary medicine workforce can contribute to achieving the aim of improving the nation's health. At a time when the NHS is under stress for a variety of reasons, it makes sense to provide patients with all treatment options available.	
68	SCM1	Key area for quality improvement 4 Development and protection of specialist services and development of education in primary care , and pathways for each CCG	This is based on anecdotal evidence from practice.	Too often women are given a HRT and then if this does not suit are not given other options or switched to non-hormonal. Women are often not given HRT in primary care due to perceived risk.	*No additional information provided by stakeholder.*
Additional areas – service specification					
69	Menopause UK	Key area for quality improvement 3 The development of local service specifications for menopause care, supported by provision of a model service specification for a primary care based menopause service	Menopause care has lacked consistency in the absence of guidelines and the persistence of misinformation and controversy. The NICE guidelines are very helpful, but it will be inefficient for every local area to respond by developing their own service specifications from scratch.	Individual staff face considerable barriers to initiating a menopause service. We have been contacted by NHS professionals seeking examples of service models from other areas, to assist them in case making and service design.	We can provide contact information for professionals who have successfully established menopause clinics in their localities and who are willing to share information about the design and operation of these services.
70	NHS England	Thank you for the opportunity to comment on the above QS I wish to confirm that NHS England has no substantive comments to make regarding this consultation.			
71	Royal College of Nursing	This is just to let you know that there are no comments to submit on behalf of the Royal College of Nursing in relation to the stakeholder engagement exercise for the menopause quality standard.			