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‘Suffering in silence’: Menopause postcode lottery

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The Drum Online Media Awards Winner 2020

What's the story?

Spend on common menopause drugs in England

Women experiencing symptoms of the menopause say they have been left to "suffer in silence" due to a disparity in spending on drugs across England.
Analysis of NHS prescription data shows some local health areas spend three times the amount per woman on Hormonal Replacement Therapy (HRT) than others.
Experts said the treatment options offered by some local health boards were "very limited".
The NHS said it had increased training for clinicians.

Experts said the decision-making of local health boards had contributed to a postcode lottery and that some women were not being offered the full range of options because their local health board did not fund them.

Diane Danzebrink, of the Menopause Support charity, said GPs "hands were tied".

"Often we will hear from women who are being prescribed oral tablets as a first line, and they're not being offered options," said Ms Danzebrink.

"Sometimes that is because those options are purely not available on their local CCG formulary. So that sort of ties the hands of their doctors to be able to offer them choices. But we do definitely see that it seems to be in some parts of the country rather than others."

Other reasons cited for the disparity include cultural differences. Menopause expert and GP specialising in women's health Dr Anne Connolly said different ethnic groups could "experience symptoms differently or manage them differently", while Ms Danzebrink added that cultural barriers such as language could cause problems for some groups of women.

The NHS said it had increased training for clinicians.

HRT replaces hormones that are at a lower level as you approach the menopause. Not every patient will need or want HRT, and clinicians advise against it in some circumstances - including for patients with a history of certain types of cancer or blood clots.

The BBC's Shared Data Unit analysed how much Clinical Commissioning Groups spent on common HRT treatments between April 2021 and June 2022.

- In West Suffolk, £14.10 was spent per woman aged 45 to 60 compared to the £5.56 spent in Leicester City.
- Some 79 of the 106 CCGs were spending at least 20% less on common HRT treatments than West Suffolk

Menopause clinics:

Patients who seek out treatment for menopause symptoms can be referred to specialist NHS clinics for further care.

But BBC analysis of British Menopause Society data shows 59% of Clinical Commissioning Group areas (CCGs) in England have no NHS clinics, including all of Devon and Cornwall and large areas in the North. The data also showed almost a third of existing NHS clinics are either in London or Surrey.

The Department of Health and Social Care said it will consider a recent Women and Equalities Committee target to provide at least one NHS menopause clinic or specialist in every CCG by 2024.

Of the 199 clinics in England, 75 are run by the NHS, with 124 operating on a private basis.

In Wales there are nine NHS clinics and three private clinics - with none at all in two of the country's seven health boards: Powys Teaching Health Board and Swansea Bay University Health Board.

Scotland has 14 NHS clinics and five private clinics, spread across 11 of 32 local authority areas.

Northern Ireland has one NHS clinic compared to two private, all located in Belfast or South Eastern Health and Social Care Trusts.

Background

Concerns had been growing over HRT supplies following reports of shortages of transdermal treatments, including popular gels, after an increase in demand following work by campaigning charities and celebrities to raise awareness.

In July this year, Parliamentary Under-Secretary of State for Health and Social Care Maria Caufield told a Westminster Hall debate there had been a 30% increase in demand for HRT products but said only a few products were now affected by shortages.

From April 2023, a flat rate of £18.70 for all HRT prescriptions will be charged across England.

"We have met trade suppliers, manufacturers and pharmacists to discuss the challenges they face and to try to overcome them," said Ms Caufield.

"Of the more than 70 products that are available, we are now down to pressures on three or four, and even with those we are seeing significant progress."

The Department of Health and Social Care said it would consider a recent Women and Equalities Committee target to provide at least one NHS menopause clinic or specialist in every CCG by 2024.

Methodology

The BBC's Shared data unit analysed more than a year's worth of **prescription data** collected by Oxford University. Drugs included in the research were:

- Estradiol and Estriol with Progestogen
- Oestrogens Conjugated with Progestogen
- Oestrogel
- Norethisterone
- Dydrogesterone
- Medroxyprogesterone acetate

For each drug we calculated an amount spent on prescription. This includes repeat prescriptions. We then used ONS population data to calculate a rate of prescription spend by women aged 45-60 in each CCG area.

This could be worded as *"the amount spent per woman aged 45-60 on common HRT treatments in the CCG area".*

The BBC's Shared data unit also scraped location data for every menopause (NHS and private) clinic in the UK, with permission from the British Menopause Society. The link to their online tool that was scraped by us is here: https://thebms.org.uk/find-a-menopause-specialist/

Once we scraped the data, we took the postcodes from each location and used postcodes.io to assign each location a ccg or equivalent health area. We then calculated the number of private and NHS clinics per health area.

Note: CCG areas were scrapped this year in the most recent round of NHS reorganisation. The 106 CCGs analysed have now been converted into 42 Integrated Care Boards.

Link to full data

We have collected data for each home nation **here.**

The data contains:

England:

- **Prescription data by CCG area collected between April 2021 and June 2022**
- **Data on NHS and private British Menopause Society certified HRT clinics, and their locations**

Scotland, Wales and Northern Ireland:

- **Data on NHS and private British Menopause Society certified HRT clinics, and their locations**

Our investigation found:

England:

Spend per CCG:

Some CCG areas spend three times the amount per woman aged 45-60 on Hormonal Replacement Therapy (HRT).

- In West Suffolk, £14.10 was spent per woman aged 45 to 60 compared to the £5.56 spent in Leicester City.
- Some 79 of the 106 CCGs were spending at least 20% less on common HRT treatments than West Suffolk

Full data:

CCG name	Number of women aged 45-60	Money spent	Prescriptions	Amount spent per woman aged 45-60	Percent below the highest spender
NHS WEST SUFFOLK CCG	24642	347315	25938	14.09441	n/a
NHS BRIGHTON AND HOVE CCG	29679	403797	22424	13.60549	3.47%
NHS DORSET CCG	85252	1108155	73055	12.99858	8.05%

NHS LEEDS CCG	74984	974558	63165	12.99688	8.44%
NHS CHESHIRE CCG	87466	1127962	67662	12.896	9.22%
NHS CALDERDALE CCG	24446	310735	17360	12.71109	10.73%
NHS DEVON CCG	134226	1700657	113743	12.6701	11.21%
NHS CHORLEY AND SOUTH RIBBLE CCG	20563	259837	17730	12.63612	11.51%
NHS NORTH EAST ESSEX CCG	36170	456274	34876	12.61471	11.71%
NHS WARRINGTON CCG	24338	306799	18541	12.60577	11.80%
NHS EAST RIDING OF YORKSHIRE CCG	38683	483966	35742	12.51108	12.56%
NHS HEREFORDSHIRE AND WORCESTERSHIRE CCG	90149	1119926	77893	12.42306	13.36%
NHS PORTSMOUTH CCG	20058	249002	15143	12.41409	13.53%
NHS CASTLE POINT AND ROCHFORD CCG	20362	252351	17899	12.39322	13.70%
NHS SOUTHPORT AND FORMBY CCG	13427	165371	8984	12.31631	14.35%
NHS BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE CCG	93612	1132974	81496	12.10287	16.17%
NHS NORTH YORKSHIRE CCG	51630	621387	42477	12.03539	17.01%
NHS NOTTINGHAM AND NOTTINGHAMSHIRE CCG	108809	1308093	92382	12.02192	17.22%
NHS WAKEFIELD CCG	39093	468388	33375	11.98137	17.58%

NHS VALE OF YORK CCG	39905	476977	32128	11.95281	17.87%
NHS FYLDE AND WYRE CCG	23303	277305	14997	11.89996	18.36%
NHS HULL CCG	25325	301286	27730	11.89677	18.47%
NHS WIRRAL CCG	37393	443794	29890	11.86837	18.71%
NHS WEST SUSSEX CCG	98577	1165431	67506	11.82255	19.14%
NHS ST HELENS CCG	20359	240671	16478	11.82133	19.23%
NHS HALTON CCG	14486	170794	10559	11.79027	19.49%
NHS COUNTY DURHAM CCG	59601	699679	49755	11.73938	19.97%
NHS EAST AND NORTH HERTFORDSHIRE CCG	64212	747882	44462	11.64707	20.85%
NHS NORFOLK AND WAVENEY CCG	112139	1304870	94088	11.63619	21.11%
NHS STOCKPORT CCG	32930	382730	26803	11.62253	21.24%
NHS WEST LANCASHIRE CCG	13070	151105	9826	11.56118	21.80%
NHS COVENTRY AND WARWICKSHIRE CCG	96423	1108715	76293	11.49845	22.45%
NHS EAST SUSSEX CCG	64671	742622	49911	11.48307	22.71%
NHS HERTS VALLEYS CCG	67119	769025	48060	11.45763	22.96%
NHS MORECAMBE BAY CCG	37539	429824	28433	11.45006	23.08%
NHS HAMPSHIRE, SOUTHAMPTON AND ISLE OF WIGHT CCG	180229	2061596	133908	11.43876	23.19%
NHS DERBY AND DERBYSHIRE CCG	118334	1347625	98426	11.38831	23.66%
NHS LIVERPOOL CCG	46664	528801	34757	11.33211	24.26%
NHS KERNOW CCG	67770	767164	53669	11.32011	24.48%

NHS BASSETLAW CCG	14005	158481	11403	11.31601	24.54%
NHS OXFORDSHIRE CCG	73032	821724	57541	11.25156	25.12%
NHS SURREY HEARTLANDS CCG	120773	1354703	81108	11.21694	25.57%
NHS SOMERSET CCG	65530	734238	53694	11.2046	25.76%
NHS GLOUCESTERSHIRE CCG	73484	822629	60608	11.19467	25.88%
NHS BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE CCG	104789	1167150	80152	11.1381	26.41%
NHS SHEFFIELD CCG	55977	621670	48256	11.10582	26.83%
NHS NORTHUMBERLAND CCG	38957	432562	28250	11.10358	26.93%
NHS NORTH TYNESIDE CCG	24233	268926	16650	11.09752	26.99%
NHS MID ESSEX CCG	46029	510715	38203	11.0955	27.02%
NHS WEST ESSEX CCG	36004	397876	26856	11.05087	27.43%
NHS TRAFFORD CCG	27128	298475	19644	11.00247	27.98%
NHS BUCKINGHAMSHIRE CCG	62677	688964	45091	10.9923	28.19%
NHS TEES VALLEY CCG	74716	816177	65318	10.92373	28.84%
NHS NEWCASTLE GATESHEAD CCG	47742	521096	35405	10.91484	29.11%
NHS IPSWICH AND EAST SUFFOLK CCG	46455	504457	41565	10.85904	29.64%
NHS DONCASTER CCG	33952	367659	28523	10.82879	30.07%

NHS NORTH CUMBRIA CCG	38285	412147	30590	10.76524	30.74%
NHS GREATER PRESTON CCG	21235	227692	14577	10.72247	31.32%
NHS NORTH STAFFORDSHIRE CCG	24712	261651	17155	10.588	32.70%
NHS TAMESIDE AND GLOSSOP CCG	29605	312541	21197	10.55704	33.41%
NHS SOUTH EAST STAFFORDSHIRE AND SEISDON PENINSULA CCG	25922	273618	17061	10.55542	33.52%
NHS BLACKBURN WITH DARWEN CCG	15200	159892	13043	10.51919	33.87%
NHS BARNSLEY CCG	27986	293539	21940	10.4888	34.28%
NHS SALFORD CCG	23771	248666	23212	10.46089	34.64%
NHS STAFFORD AND SURROUNDS CCG	18358	191383	11700	10.42506	35.08%
NHS BRADFORD DISTRICT AND CRAVEN CCG	60659	631430	39311	10.40951	35.35%
NHS ROTHERHAM CCG	29139	303320	25435	10.4094	35.40%
NHS FRIMLEY CCG	82193	854933	54424	10.40154	35.48%
NHS NORTH LINCOLNSHIRE CCG	19576	203456	16538	10.39312	35.58%
NHS BERKSHIRE WEST CCG	53873	559239	37150	10.38069	35.73%
NHS BLACKPOOL CCG	15671	162584	11150	10.37486	35.83%
NHS WIGAN BOROUGH CCG	37933	393310	32022	10.36856	35.91%
NHS KIRKLEES CCG	47040	486881	32196	10.35035	36.11%
NHS KENT AND MEDWAY CCG	204996	2118483	155281	10.33427	36.33%

NHS BASILDON AND BRENTWOOD CCG	29418	303565	21739	10.31901	36.53%
NHS BURY CCG	21263	218545	17715	10.2782	36.98%
NHS SOUTH TYNESIDE CCG	17533	179631	10854	10.24532	37.45%
NHS SOUTHEND CCG	20365	207120	15933	10.17037	38.30%
NHS EAST LANCASHIRE CCG	42366	430406	31270	10.15923	38.69%
NHS LINCOLNSHIRE CCG	86954	879304	73785	10.11229	39.20%
NHS SUNDERLAND CCG	31256	315655	23371	10.09902	39.51%
NHS HEYWOOD, MIDDLETON AND ROCHDALE CCG	23639	237121	18554	10.03094	40.24%
NHS BIRMINGHAM AND SOLIHULL CCG	112665	1123433	78632	9.971445	41.10%
NHS WEST LEICESTERSHIRE CCG	45340	449693	34218	9.918245	41.88%
NHS EAST STAFFORDSHIRE CCG	14769	145754	11210	9.868939	42.60%
NHS EAST LEICESTERSHIRE AND RUTLAND CCG	40022	392156	28482	9.798498	43.53%
NHS CAMBRIDGESHIRE AND PETERBOROUGH CCG	95713	932142	68270	9.738929	44.45%
NHS NORTHAMPTONSHIRE CCG	83068	801846	60820	9.652891	45.61%
NHS MANCHESTER CCG	43105	411173	34769	9.538871	47.19%
NHS BOLTON CCG	30761	292458	24029	9.507422	48.09%

NHS SHROPSHIRE, TELFORD AND WREKIN CCG	57900	536625	36112	9.268136	50.76%
NHS SOUTH SEFTON CCG	18783	173142	11062	9.21804	52.61%
NHS KNOWSLEY CCG	17526	159810	11139	9.118463	53.98%
NHS OLDHAM CCG	24391	222376	17788	9.117127	54.58%
NHS SOUTH WEST LONDON CCG	160159	1360289	90751	8.493368	61.43%
NHS SOUTH EAST LONDON CCG	184435	1560407	100439	8.460469	66.33%
NHS BEDFORDSHIRE, LUTON AND MILTON KEYNES CCG	100898	849095	66039	8.415377	67.12%
NHS STOKE ON TRENT CCG	26487	217474	17009	8.210595	69.92%
NHS NORTH CENTRAL LONDON CCG	149793	1199285	78433	8.006284	74.15%
NHS CANNOCK CHASE CCG	16030	127716	10561	7.967336	76.53%
NHS THURROCK CCG	18003	137830	12822	7.655948	80.81%
NHS BLACK COUNTRY AND WEST BIRMINGHAM CCG	139957	1036855	87429	7.408384	87.33%
NHS NORTH EAST LINCOLNSHIRE CCG	17683	130278	12377	7.367406	90.80%
NHS NORTH EAST LONDON CCG	180513	1196797	93290	6.629978	101.32%
NHS NORTH WEST LONDON CCG	213409	1402390	101951	6.571373	113.47%
NHS LEICESTER CITY CCG	30125	167756	18467	5.568663	129.74%

Menopause clinics:

Analysis of British Menopause Society data shows 59% of Clinical Commissioning Group areas (CCGs) in England have no NHS clinics, including all of Devon and Cornwall and large areas in the North.

The data also showed almost a third of existing NHS clinics are either in London or Surrey.

Of the 199 clinics in England, 75 are run by the NHS, with 124 operating on a private basis.

Full data (unamed CCGs have no menopause clinics):

CCG	NHS	Private	Grand Total
NHS North West London	5	24	29
NHS Surrey Heartlands	3	9	12
NHS Nottingham and Nottinghamshire	4	5	9
NHS North Central London	5	4	9
NHS South West London	3	5	8
NHS South East London	4	3	7
NHS Bath and North East Somerset, Swindon and Wiltshire	2	4	6
NHS North East London	3	2	5
NHS Herts Valleys	1	4	5
NHS Dorset	1	4	5
NHS Cambridgeshire and Peterborough	2	3	5
NHS Brighton and Hove	2	3	5
NHS Birmingham and Solihull	2	3	5

NHS Oxfordshire	1	3	4
NHS Ipswich and East Suffolk	1	3	4
NHS Bristol, North Somerset and South Gloucestershire	2	2	4
NHS West Sussex	1	2	3
NHS North Yorkshire	2	1	3
NHS Liverpool	2	1	3
NHS Lincolnshire	1	2	3
NHS Leeds	1	2	3
NHS Kent and Medway	3		3
NHS Hampshire, Southampton and Isle of Wight		3	3
NHS Gloucestershire		3	3
NHS Coventry and Warwickshire	1	2	3
NHS Buckinghamshire	1	2	3
NHS Black Country and West Birmingham	2	1	3
NHS Wirral	1	1	2
NHS West Suffolk	1	1	2
NHS West Essex	1	1	2
NHS Stockport	1	1	2
NHS Somerset	1	1	2
NHS Sheffield	1	1	2
NHS Norfolk and Waveney	1	1	2
NHS Mid Essex	1	1	2
NHS Leicester City	1	1	2
NHS Herefordshire and Worcestershire	1	1	2
NHS Frimley		2	2
NHS East Staffordshire	1	1	2
NHS East Leicestershire and Rutland		2	2
NHS Derby and Derbyshire	1	1	2
NHS Wakefield	1		1
NHS Stoke on Trent	1		1
NHS Southend	1		1
NHS South Sefton		1	1
NHS Shropshire, Telford and Wrekin	1		1
NHS Portsmouth	1		1
NHS Oldham		1	1
NHS North Staffordshire		1	1

NHS Newcastle Gateshead	1		1
NHS Kernow		1	1
NHS Hull	1		1
NHS Devon		1	1
NHS Chorley and South Ribble	1		1
NHS Cheshire		1	1
NHS Berkshire West		1	1
NHS Basildon and Brentwood		1	1
Grand Total	**75**	**124**	**199**

Wales:

Menopause clinics:

In Wales there are nine NHS clinics and three private clinics - with none at all in two of the country's seven health boards: Powys Teaching Health Board and Swansea Bay University Health Board.

Full data:

Health board	NHS	Private
Cardiff and Vale University Health Board	2	2
Aneurin Bevan University Health Board	2	1
Cwm Taf Morgannwg University Health Board	2	
Betsi Cadwaladr University Health Board	2	
Hywel Dda University Health Board	1	
Grand Total	**9**	**3**

Scotland:

Menopause clinics:

Scotland has 14 NHS clinics and five private clinics, spread across 11 of 32 local authority areas.

Note: The data is broken down by Community Health Partnership - areas which share the same borders and names as local authorities for reporting purposes.

Full data:

Community Health Partnership	NHS	Private	Grand Total
Glasgow City Community Health Partnership	3	1	4
Aberdeen City Community Health Partnership	2	2	4
Perth and Kinross Community Health Partnership	1	1	2
Argyll and Bute Community Health Partnership	2		2
Scottish Borders Community Health and Care Partnership	1		1
North Ayrshire Community Health Partnership	1		1
Highland Health and Social Care Partnership	1		1
Edinburgh Community Health Partnership	1		1
Dundee Community Health Partnership	1		1
Dumfries and Galloway Community Health Partnership	1		1
Aberdeenshire Community Health Partnership		1	1
Grand Total	**14**	**5**	**19**

Northern Ireland:

Menopause clinics:

Northern Ireland has one NHS clinic compared to two private, all located in Belfast or South Eastern Health and Social Care Trusts.

Full data:

Health and Social Care Trusts	NHS	Private	Grand Total
Belfast	1	1	2
South Eastern		1	1
Grand Total	**1**	**2**	**3**

What do the experts say?

Credit: Dr Anne Connolly

Dr Anne Connolly - GP in Bradford and MBE recipient for services to primary care women's health in 2021:

Q. Are you surprised at the difference in the amount CCGs are spending per patient on HRT?

A. No, I think there's been such a variability for many years in prescribing for women's health generally and more specifically for management of menopause. I think it's disappointing but I'm not surprised.

Menopause management isn't as straight forward as a yes or no. There are lots of factors that play into whether somebody wants to talk about their menopausal issues, and there's huge variability in the impact menopausal concerns will have on different women. So it's not always straightforward as to whether a woman should have HRT or wants HRT.

There are so many myths still on the internet about HRT. Some of those are very concerning. Some women think it's something they really don't want, other women have done more research and found better information and might come and talk more readily about whether HRT is an option for them.

One size does not fit all for menopause management.

Some women experience really bad symptoms which really affect their life, their ability to function in the workplace, home or sexually. They often put off coming to see a GP or prescriber for a while, but then something will happen and they will decide to come and talk about it. Other

women get very few symptoms, they don't last long and they have other ways of managing if the symptoms become more concerning.

Some of it is about symptoms. A lot of it is about choice. Some women feel badly informed or have more concerns, so they put off coming to talk to us.

There are also many cultural factors. We know that different ethnic groups will experience symptoms differently or manage them differently.

Q. Do you think there are still taboos around discussing the menopause?

A. There are still many taboos generally in women's health problems. We're not great about talking about periods, we're not great at talking about menopausal symptoms, we're not great at talking about mood problems around periods. We can't measure how bad my symptoms might be compared to somebody else's, so we think why should I moan about it?

Education is really important, but better information on the internet and access so women can talk to each other and empower each other to ask for help if that's what they need.

We're certainly seeing a big drive through the media to talk about menopause. Some of that is absolutely fantastic because it's allowing women to feel better about asking for support, some of it is a little bit realistic at times. And some of it is actually scary. I was talking to a patient the other day who said she was scared of going into the menopause now, because so many people were saying that it is so difficult. We have to be careful about the messages and information that we share.

Q. What do you think about the media coverage around HRT shortages?

A. HRT access is very variable, particularly at the moment with the big push for transdermal - patches, creams, gels. They have gone out of stock very quickly and have been hard to come by. I know manufacturers have been working really hard to respond to that, so it is being addressed.

But not every woman needs patches, or wants patches or creams. And some women are very happy to take tablets. There is still very good availability with the oral methods. It's an individual discussion with a woman about what her individual needs and choices are.

Q. Does deprivation come into this? If women live in an area with a greater likelihood of certain illnesses, what sort of impact can that have on women?

A. We know there's big variability in HRT prescribing. Some of that is because of patient expectations and patient requests. Some of that is in areas where women don't want to talk about menopausal sympotoms or don't see the need to. It's not just about health provision, it's also about patient demand and patient expectations.

And some of this is about healthcare provision in inner-city, more deprived areas, where we know there are fewer GPs and bigger list numbers. It's very hard to say that this is the answer to all. We have to be better at sharing the right information in the right way and understanding what the local need is.

“It doesn’t all have to be going to specialist care or cost-heavy hospital care. It’s about looking at the local population, working with your local voluntary groups and local women’s groups to work out how we can best deliver the health messages. It’s about self-care too, as healthcare.”

Q. What can the impact be for women who don’t get the right information or treatment?

A. In the short term, some women really suffer with symptoms. We know that has an impact physically, socially, psychologically, sexually. It depends how bad the symptoms are and what those specific symptoms are.

We see big numbers of women leaving work because they feel unconfident to continue because their concentration isn’t the same. They’re tired, they have memory-loss etc. We’re losing women in the workplace because of their symptoms.

The longer term is also very important, because HRT certainly [protects] against osteoporosis which is bones thinning and therefore fracturing. So taking HRT will protect your bones. There’s mixed but still probably very good evidence that if you take HRT at the right time in your life you will have some improvement on heart disease. So some women, and often women already compromised because of their social deprivation and are more likely to have these problems are then compromised if they are not being offered HRT.

Dr Paula Briggs, chair elect of the British Menopause Society

Credit: British Menopause Society

Q. Are you suprised by the postcode lottery revealed when it comes to menopause care in the UK?

A. In relation to deprivation and postcode lotterys I'm aware it depends where you live whether you can access the same products. I think the HRT tzar has looked at that and that there is work in progress to solve those issues. It's particularly frustrating in border areas. For example Liverpool and Manchester will have different local formularies for GPs so if you lived 100 yards either side you wouldn't be able to access the same treatment from your GP.

Q. Why are we seeing NHS menopause clinic deserts across the UK?

A. It is possibly influenced by access to trainers. I think, behind the scenes, there is work going on to try to improve that. The women's health strategy will help with the development of women's health hubs.

Ideally, menopause care should be delivered in the community closer to home. There's no reason why the vast majority of women need to come into a hospital setting.

I work in a hospital in Liverpool Women's Hospital and we would see our service as providing education and research and possibly managing the more complicated cases like premature ovarian insufficiency and women with cancer.

Q. How likely are we to get a women's health specialist in every CCG by 2024 as per the Women's Equality Committee's target?

A. Okay, so we're talking about a women's health specialist in CCGs. But actually CCGs no longer exist in England. We've moved to integrated care services. And that's a really difficult time, because there's no identified funding for these intermediate services.

So what we need is more baseline education for all GPs, if it's part of general practice.

General practice is a really difficult job because you cannot be an expert in everything. So the development of women's health hubs would be an opportunity to provide care for a group of practices.

So in each place, for example, you might have maybe two or three women's health specialists working together. The kind of things that I think that they will be particularly helpful with is heavy menstrual bleeding, which is probably the first sign of the perimenopause, and menopause management. I had a community gynecology service for 10 years, and those were the two highest categories for referral. And I think if we can start managing that better, then that will have a huge positive impact on women's health in general.

Q. Could be anything more be done to support GPs who are interested in becoming more educated about the menopause?

A. For every trainee that I take on for an Advanced Certificate in Menopause, my expectation is that the once they feel suitably experienced will become a trainer and then maybe train another 10 people, and those 10 people train another 10 people. That's how we will improve the current situation and that would be my plan for the next five to 10 years. As the number of trainers grows, access to training will be improved.

I think what we need in secondary care is a lot more flexibility, improved communication. There is quite a big gap currently between primary and secondary care, which doesn't help the patient. And ultimately, that's what we want to do is improve patient care.

Q. Do a lot of NHS GPs turn to private practice after becoming menopause specialists?

A. It's so difficult to access menopause care, that women are going privately where they shouldn't have to. And I speak from a point of view that I deliver mostly NHS Care, but also some private care.

I would prefer for all women to be managed on the NHS. I think there's more information available via social media, newspapers, television, about menopause. And so women who would otherwise maybe not have thought about using HRT are looking for information to make that decision.

I think all of this can be changed by GPS being supported. If one of my trainees gets the advanced certificate and sets up a private practice, that does nothing to improve NHS Care.

And whilst I have no objection to them doing some private practice, I think when it's exclusively private practice that changes the dynamic completely.

Q. Why do clinicians move over to private practice?

A. I think it's a gap in the [private] market that has been identified, and it's not even necessarily doctors, nurses and pharmacists who've got specialist qualifications.

There are all kind of providers of different ways of managing the menopause setting up, and as a vulnerable patient that puts you in a difficult situation.

So some women may access bioidentical hormone therapy, which is not regulated and therefore may not be safe, but they don't know that. And I think it is just so important to ensure that women are provided with the correct treatment.

That goes back to proper training, adhering to guidelines and protocols. For example, if we give women oestrogen, we need to give them enough progestogen to ensure that they don't get excessive thickening of the lining of the womb, which can lead to cancer.

Q. What would you like to see happening in the next three to five years regarding menopause care?

A. What we need is more baseline education for more GPs. The BMS are working very closely with NHS England to produce balanced peer reviewed easy to access patient information, and a campaign for all medical professionals to 'think menopause'.

If you've got a patient in front of you, who is the average age of the perimenopause, and they're, describing menopausal symptoms like heavy menstrual bleeding and hot flushes and night sweats, instead of thinking ‘could this person have hyperthyroidism’, think menopause because that's the most likely thing. And I think that potentially will have a huge, positive impact on the number of women being diagnosed early.

Credit: Menopause Support

Diane Danzebrink, founder of the Menopause Support charity:

Q. What do you make of the figures? Does it chime with what you see day to day?

A. I'm not particularly surprised because at Menopause Support we have a support community of just over 29,000. So, we hear from a lot of women on a daily basis and we notice ourselves the disparity around the country around what types of HRT are being prescribed in different parts of the country.

Q. What impact can this have on patients?

A. It's multifaceted. You have issues around safety. For those who experience migraines, or perhaps have a family history of blood clot, or strokes, those who perhaps have a BMI over 30, those who smoke, the British menopause society would advise that those individuals don't have an oral HRT. They have a transdermal oestrogen.

You also have the patient choice factor. Some people don't like to take oral medication, some people would prefer to have a transdermal medication.

And also the fact that for many people, having HRT they've had to do quite a lot of research for themselves. They've probably come across something that they feel they will be comfortable with, to find out that's not available to them.

Then we have the issues around what suits one person doesn't necessarily suit another. So if you're prescribed it and it doesn't suit you, perhaps the choices in your CCG area are very limited. That can mean that people aren't getting the ideal treatment for them because they don't have the opportunity to try the options.

Often we will hear from women who are being prescribed oral tablets as a first line, and they're not being offered options. Sometimes that is because those options are purely not available on their local CCG formulary. So that sort of ties the hands of their doctors to be able to offer them choices. But we do definitely see that it seems to be in some parts of the country rather than others.

Q. Could more deprived communities be left behind?

A. Well, I guess it all comes down to finances. It all comes down to how much the local CCG have to spend on all the medications and all the treatments that they need to offer across their local population. So if there are cheaper choices, they're the ones that they're going to take. I think it purely comes down to finances.

Q. More broadly regarding the menopause, are there cultural taboos in some communities? That would affect how widely it's discussed, and what do you think needs to be done to help address that?

A. Absolutely. There are certainly cultural barriers. You'll have some communities where there is no word for menopause. So it's quite difficult to discuss it in clinical terms.

Also, in some communities, it is not accepted to talk about women's health. Women aren't encouraged to talk about their health, they're not encouraged to seek help and support. You could also talk about not just the cultural barriers, but perhaps the language barrier. Not everybody has English as their first language. And I think this is sort of part of the wider issue that we have around sharing factual evidence based information and for people to know that there are options for support.

What we need to see is a government led public health campaign. We need to see something that is sharing education with all parts of society. And that might mean being in different languages, it might mean being in Braille.

I think it’s about thinking about all parts of the community, and what we need to do to share the right education and information to allow individuals to make informed choices for themselves.

Q. What impact has the pandemic had on all of this?

A. We've heard a lot about the mental health effects of being isolated. But it also meant really practical things like perhaps it taking longer to get a GP appointment than you might usually

have done, because obviously, their focus was on vaccinating, etc. So I think that certainly had an impact.

I think the other impact is people would have been in the workplace, perhaps talking to their colleagues, they would have been gathering with friends: those things weren't available to us.

What we've certainly seen more recently is that the lists as far as NHS menopause clinics are concerned have just got longer and longer.

Unfortunately, there are still some areas that have absolutely no provision. But where there is provision, because of what happened with the pandemic, we now see that those waiting lists are really significant.

Some waiting lists at NHS menopause clinics are18 months. We're used to them being three to six months, but people can't wait 18 months.

The provision isn't there in terms of quantity, but even where it is there it's forcing more and more people to seek private menopause care. And that can be very costly. You're often talking about several hundred pounds, and that can go up sharply with private prescriptions.

There are going to be millions of women across the country who could never consider the idea of private menopause care and are being left to suffer in silence. In 2022, that's a disgrace.

Right of reply:

NHS England:

An NHS spokesperson said:

“The NHS has a Menopause Pathway Improvement Programme, which includes increased learning for clinicians in how they can best support menopausal women, and working with clinical colleges and menopause organisations to improve awareness and understanding.

“A new Menopause Optimal Pathway will also guide clinicians and help women in the workplace during peri-menopause, menopause and post-menopause.”

Department of Health and Social Care:

A Department of Health and Social Care spokesperson said:

“We have put women’s health at the top of the agenda by publishing a Women’s Health Strategy for England, appointing the first-ever Women’s Health Ambassador, and taking action to increase supply and reduce the cost of Hormone Replacement Therapy.

“We have accepted the recommendations of the HRT taskforce, including the continued use of Serious Shortage Protocols when appropriate to manage shortages, and NHS England continues to work on gathering data on maintaining and updating local formularies in England.

“The UK-wide menopause taskforce is seeking to end the taboos surrounding the menopause and considering the role workplace policies can play in supporting menopausal women, and the government’s Health and Wellbeing Fund is helping expand and develop projects which support women experiencing the menopause to remain in the workplace.”

Background:

- We have received the Women and Equalities Committee’s report and will consider its recommendations.
- The Women’s Health Strategy for England can be found here.
- Specialist menopause clinics are not funded by central government. Instead, they are commissioned and implemented as local services. Integrated Care Boards are responsible for commissioning services to meet the health needs of the local population.
- Prescribers in primary care are already able to prescribe from all licensed products using the British National Formulary (BNF). Prescribers can, and should, prescribe the medicine or appliance that’s the most appropriate treatment option for the patient, using their clinical discretion and after a shared discussion with the patient taking into account the patient’s values and preferences. Therefore, a national formulary is not required.

On support for women experiencing the menopause:

- The Civil Service has signed the Wellbeing of Women UK Menopause Pledge committing to recognise the impact of menopause and actively support women who are affected.
- We have taken action to increase supply and reduce the cost of Hormone Replacement Therapy (HRT) including through the introduction of a pre-payment certificate which could save women up to £205 per year. The creation of a prepayment certificate will mean women can access HRT on a month-by-month basis if need be, easing pressure on supply, paying a one-off charge equivalent to 2 single prescription charges (currently £18.70) for all their HRT prescriptions for a year. This system will be implemented by April 2023.
- To ensure women can reliably access HRT, decisive action has been taken, including the appointment of Madelaine McTernan as chair of the HRT Supply Taskforce, and issuing of serious shortage protocols to even out distribution and provide greater flexibility to allow community pharmacists to supply specified alternatives, where appropriate.

- We are enhancing women's reproductive wellbeing in the workplace through the Health and Wellbeing Fund 2022 to 2025. The fund supports voluntary, community and social enterprise organisations to expand and develop projects to support women experiencing reproductive health issues – such as pregnancy loss or menopause – to remain in or return to the workplace.
- The Department for Work and Pensions has committed £22 million to support older workers, including the appointment of 50 Plus Champions who will help jobseekers over the age of 50 get into, and progress in work, which includes navigating health issues like the menopause.
- The cross-government response to the independent menopause and the workplace report commissioned by the Minister for Employment through the 50PLUS Roundtable co-chaired with the Business Champion for Older Worker is published here: Menopause and the Workplace: How to enable fulfilling working lives: government response - GOV.UK (www.gov.uk)
- The response sets out the government's commitment to helping employers recruit and retain women as they transition through the menopause. As part of this, the Minister for Employment will work with the Government's Women's Health Ambassador Dame Lesley Regan to build awareness and promote better working practices for businesses.
- The Minister for Employment will appoint one or more Menopause Employment Champions to give a voice to women experiencing the menopause at work, by engaging with employers to keep people experiencing menopause symptoms in work and progressing and promote their economic contribution.