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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

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Abstract

Objective: This study explores the perceived volume of women affected by peri- or post-menopausal issues that present to primary care clinicians in West Cheshire, plus the self-reported confidence of those clinicians in managing the menopause, and whether or not they feel that they and their patients should have access to a specialist menopause service.

Study design: Completion of an electronic survey.

Population: General practitioners and practice nurses working in West Cheshire.

Main outcome measure: To provide evidence for future local commissioning of menopause services.

Results: Ninety-one clinicians working within West Cheshire were sent an email request to complete the survey with 53 responses received (58%). The majority were general practitioners and were within the 35–54 year age range. The majority perceived that, each week in their clinical practice, they see between one and eight women who are affected by peri- or post-menopausal symptoms. Regarding their self-reported skills and knowledge in managing the menopause, almost half felt they had 'good' knowledge but 'recognised (they) had learning needs'. Seven of the 53 (13%) felt their skills were 'not good'. Two-thirds of those clinicians who completed the survey felt that they and their patients should have access to a specialist menopause service locally.

Conclusions: In the area covered by West Cheshire clinical commissioning group, there is no currently commissioned menopause service. This study has demonstrated that a substantial number of women present each week to clinicians working in this area who are felt to have peri- or post-menopausal symptoms. The clinicians have self-reported learning needs. Qualitative data from the survey would suggest training can be difficult to access. There is a clear need, both ethically and medically, for the commissioning of a West Cheshire specialist menopause service, with the proposed model being an integrated and holistic care model. Menopause care, and post-reproductive healthcare generally, provides an opportunity for collaboration and partnership working within an outcomes-based commissioning model. This study could be reviewed and replicated in other areas for comparison.

Keywords

Menopause, postmenopause, West Cheshire clinical commissioning group

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Introduction

Despite the fact that women's post-reproductive health is becoming recognised globally as an important issue,[1] access to high quality, holistic and accurate advice and assessment regarding the menopause remains variable across the United Kingdom.

The British Menopause Society (BMS) Statement 'Modernizing the NHS: observations and recommendations from the British Menopause Society' highlighted the fact that 'most women are unaware of the impact of the menopause on their health and that simple improvements in lifestyle could protect them from serious health problems later in life'.

The BMS recommended that all women, registered with a General Practice, should be invited around their 50th birthday, to attend for a health and lifestyle consultation where an individualized plan of care for the post-reproductive years could be agreed.

There are no available data on the implementation of this recommendation in the UK though recent public health measures have included the procurement of 'NHS Health Checks' in England[3] for patients between the ages of 40–74 years to those who are not already on the practice registers with a relevant long-term condition. The latter checks for the women are not usually performed by healthcare staff with a special interest in menopause. In West Cheshire CCG, the checks are often performed by health care assistants who are trained to discuss issues such as smoking, alcohol and exercise and include screens for dementia, diabetes, lipid abnormalities and hypertension.

However, 'provision of a truly holistic approach towards the management of the menopause must include at least a discussion of hormone therapy'.[4] This comment was made before numerous papers had been published re-analysing the findings of the women's health initiative (WHI)[5] and the million women study (MWS),[6] the original findings of which had a hugely negative impact on the prescribing of hormone replacement therapy (HRT) across the world, including in the United Kingdom.[7–12]

An individualised care plan for every woman around her menopause with a proactive approach to providing choice of treatment, utilising the 'window of opportunity'[13] for prevention of long-term disease (bone health, cardiovascular system, cognitive function, urogenital system) as well as proactively enhancing the quality of life for women post-menopause would be economically valid with an 'invest to save' principle.

The recently published 'Five Year Forward View'[14] highlights the need for the NHS to change and 'evolve to meet new challenges' in light of an ageing population with increasingly complex needs, increased demand on services with recruitment and retention to primary care an issue together with the predicted NHS funding gap of £30 billion by 2020/21.

The authors talk about 'proactive primary care' and a 'radical upgrade in prevention and public health' and an enhanced focus on patient empowerment.

In order to provide a proactive approach to the perimenopause and post-reproductive health, there is a requirement for general practitioners (GPs) and practice nurses to be up-to-date with evidence in this rapidly developing field and be motivated to engage with their patients on this topic. The BMS campaign entitled, 'Mind the Gap' in 2014 was aimed at closing a 10-year gap of knowledge in how to look after women during the decades after the menopause.

In this study, the aim was to explore the potential demand for menopause care, as perceived by clinicians working in West Cheshire, while also assessing the self-reported confidence and knowledge in managing their patients with menopausal symptoms. In addition, we asked respondents whether or not they felt they and their patients should be able to access specialist menopause services.

West Cheshire demographics

West Cheshire clinical commissioning group (CCG) is made up of 36 general practices, divided into three Localities (Chester City, Cheshire Rural and Ellesmere Port and Neston) serving approximately 260,000 people in total. The age structure of the population overall, reveals a higher proportion of people aged 45 years and over than the England average (42%) with the highest proportion in this age group living in the Cheshire Rural locality (54%).

Slightly less than one third (28%) of the population of West Cheshire CCG live in areas ranked in the 40% most deprived in England.

While the overall picture is one of a well-paid resident population benefitting from a strong labour market, the CCG also contains limited focal areas which rank, for deprivation, within the worst 1% in England.

West Cheshire CCG lies within Chester West and Chester (CWAC) local authority whose unemployment rates are typically lower than the England average overall with a higher than average rate of people working full-time and a high proportion in managerial or professional occupations. Conversely, some areas of CWAC have benefit claimant rates that are double the Great Britain average.

This diverse demographic has prompted West Cheshire to be referred to as 'England in Miniature'. Almost half of patients registered in the Chester City Locality are male (49.4%). However, consistent with the longer female life expectancy experienced in the

locality, the CCG as a whole and in England, there are nearly twice the number of women aged 85+ compared to men.

Method

An electronic cross-sectional questionnaire survey was designed via a freely accessible web-based resource and piloted amongst colleagues who share an interest in menopause care. Feedback was received and minor adjustments were made.

Inclusion criteria were clinicians who were actively working within West Cheshire CCG.

An email list of all in-house practice GP leads for women's and sexual health in the West Cheshire area was available. The survey was emailed out to all of those GP leads along with previous attendees at recently organised contraception and sexual health education events. In addition, randomly selected GPs and practice nurses who work within West Cheshire CCG were also emailed the survey, using nhs.net as a means of finding the email addresses. An internet review of practice clinical staff at randomly chosen practices in the West Cheshire CCG was done using practice website information and then nhs.net email addresses found for those clinicians. Included were salaried doctors, locum GPs and GP registrars together with GP principals and practice nurses. A random sample of GPs involved in commissioning was also included in the survey population.

The survey opened 4 December 2014 and closed 6 February 2015, hence a two-month period. Non-responders were sent reminder emails on up to two occasions.

The survey results were then analysed and conclusions drawn.

Further data regarding West Cheshire were gained via the CCG and Local Authority websites.

In an attempt to determine the number of women being seen at the local district general hospital regarding menopause-related problems, relevant staff in the CCG were contacted who, in turn requested data from the relevant coding/finance department of the hospital. Unfortunately, no data is collected regarding 'menopause' in the patients seen at the hospital currently. There is no specifically commissioned local Chester NHS specialist menopause service.

Results

Survey results

In total, 91 clinicians were contacted via email with a response rate of 58% (53 responses). Three quarters of those who responded were GPs with the remainder being primary care nurses (practice nurses, nurse practitioners or nurse clinicians) (see Table 1).

Table 1. Are you....

Role	Number	%
GP?	39	73.58
Practice nurse?	7	13.21
Nurse practitioner?	5	9.43
Nurse clinician?	2	3.77

GP: general practitioner.

Table 2. What is your age group?

Age of respondent (yrs)	Number	%
25–34	2	3.77
35–44	14	26.42
45–54	30	56.60
55–64	9	16.98

Table 3. How many women, on average, do you see in your clinics whom you believe are affected by peri- or post-menopausal symptoms?

No. of women/week	Number	%
None	0	0
0–3	26	49.06
4–8	23	43.40
8–12	3	5.66
12–5	0	0
>15	2	3.77

Forty-four of the 53 respondents were between 35 and 54 years (see Table 2).

Regarding the average number of women that respondents felt they see in clinical practice who are affected by peri- or post-menopausal symptoms, the majority felt that this was between one and eight women per week (1–3 per week = 26, 4–8 per week = 23). No one felt there were 'None' and two clinicians felt that they saw >15 women per week with menopause-related issues (Table 3).

The survey went on to ascertain the clinician's self-reported skill level regarding the management of the menopause. Only three out of the 53 who completed the survey felt 'extremely confident' though approximately one-third (32%) felt 'fairly confident'.

Almost half (47%) felt they had 'good' knowledge but 'recognised they have learning needs'. Seven respondents felt their skills were 'not good, have lots

Table 4. Please grade your knowledge and skills regarding your ability to manage women in the peri- and post-menopause effectively.

	Number	%
Extremely confident	3	5.66
Fairly confident	17	32.08
Good, but recognize have learning needs	25	47.17
Not good, have lots of learning needs	7	13.21
Not confident at all	1	1.89

Table 5. Have you undertaken any education regarding menopause or its management in the last 12 months?

	Number	%
Yes, several	5	9.43
Yes, one	27	50.94
No	21	39.62

of learning needs' and one admitted to being 'not confident at all' (Table 4).

Survey participants were asked whether they had undertaken any education regarding menopause or its management within the last 12 months. Approximately half (51%) had undertaken one educational activity in this area, while just under 10% had undertaken more than one educational activity regarding menopause. However, 40% had not undertaken any training at all in the past 12 months regarding menopause care (Table 5).

Clinicians were asked to gauge whether, as a general rule, the training they had received made them more or less likely to prescribe HRT in future; 43% felt 'more likely' to prescribe HRT in future though one-third suggested there was 'no change' in their prescribing patterns and almost a quarter were 'not sure'. Only one clinician felt the training they had received made them 'less likely' to prescribe HRT in future (Table 6).

Finally, clinicians working within West Cheshire were asked whether or not they felt they and their patients should have access to a specialist or general practitioner with special interest (GPwSI) in menopause care. Thirty-five out of the 53 survey participants said 'Yes' (66%).

However, a quarter (26%) felt they should not have access to a specialist service, while four respondents were 'not sure' (Table 7).

Qualitative data were available via the option to free text 'further comments' at the end of the survey (see Appendix 1).There was a general sense that further

Table 6. If so, as a general rule, did the training regarding menopause management make you more or less likely to prescribe hormone replacement therapy (HRT) in future?

	Number	%
More likely	23	43.40
No change	17	32.08
Less likely	1	1.89
Not sure	12	22.64

Table 7. Do you think you and your patients should have access to a specialist or GPwSI in menopause care?

	Number	%
Yes	35	66.04
No	14	26.42
Don't know	4	7.55

GPwSI: general practitioner with special interest.

training would be appreciated though some highlighted difficulty in accessing relevant training (e.g. 'I have found it difficult to access training on management and prescribing for patients going through the menopause.')

Other comments suggested that clinicians would like to manage menopause-related issues, but that specialist services may be valuable for complex cases. The point was also made that capacity and time are issues when attempting to manage these patients especially. (e.g. 'I think I would be good at managing these symptoms given enough time to think about it but a GPwSI would be useful for complex cases.

'This is an area I'm really interested in and enjoy managing women in this category as it's challenging, interesting but rewarding.'

> I am Male GP who works with excellent skilled (female) partners who I signpost patients to after identifying menopausal and complex contraception problems. So in effect I have in house GPwSI, the question is do my partners need the back up of a GPwSi/Specialist?

Interestingly, the clinician who had indicated they would be 'less likely' to prescribe HRT following training explained, 'On question 7 less likely because just not confident starting medication happy to review because had no training only updates'.

Discussion

While this is an extremely challenging era for health and social care in England and the UK, it is also a

time of great potential for innovation and opportunity, with an enhanced focus upon integration, person-centred care and empowerment.

The King's fund highlighted the fact that

> An ageing population and increased prevalence of chronic diseases require a require a strong reorientation away from the current emphasis on acute and episodic care towards prevention, self-care, more consistent standards of primary care, and care that is well co-ordinated and integrated.[15]

These themes would be well suited to the optimal care of the menopause and post-reproductive health-care, which has been remarkably neglected over the past decade as a potential focus for significant gains in terms of preventative healthcare. Moreover, the lives of millions of women have been affected by the reluctance of clinicians to proactively treat and advise them regarding how they can avoid the post-menopausal 'relentless loss of vitality, sexuality, cognitive functioning and musculoskeletal symptoms which impair their ability to function normally on personal, social and professional levels'.[16]

The population surveyed in this study were potentially biased towards those clinicians who are most likely to be knowledgeable regarding menopause care and women's health in general, within primary care in West Cheshire. Balance was sought by including randomly chosen colleagues from the wider CCG clinical population. Twenty of the 35 in-house practice leads for women's and sexual health who comprised the mailing list, completed the survey. These are the clinicians who are most likely to be up-to-date with current practice in menopause care and may account for the fact that a large proportion of those completing the survey had undertaken at least one educational activity regarding menopause within the past 12 months. Despite this, almost half recognized that they had 'learning needs' (47%).

Interestingly, of those who had attended training within the past 12 months, 43% felt that, on average, they would be 'more likely to prescribe HRT in future'.

The qualitative data gathered via the survey highlighted the perceived difficulty in accessing appropriate training regarding Menopause care and a lack of confidence in commencing treatment amongst some clinicians. While there is a wealth of high-quality evidenced-based education available via courses run by the BMS/women's health concern collaboration, the Royal College of Nurses and the UK menopause nurse group, not to mention widely available internet-based peer-reviewed resources such as British Medical Journal Learning modules, there are many other clinical areas competing for priority and time.

There is a perception that women are presenting with symptoms related to the menopause to these respondents, on average, 1–8 times per week. Of course, this information does not factor for hours of work (whether full- or part-time clinicians) and does not provide any information on the type of presenting complaints. Nor was it possible to comment from this data whether those more knowledgeable regarding menopause care, were more likely to recognise presenting complaints as being those associated with post-reproductive health e.g. recurrent urinary tract infections in women potentially being related to reduced oestrogen levels in the urogenital tract.

While further, more detailed, assessment via a larger study would be required in order to assess demand and capacity regarding menopause care, this survey provides a guide to the scale of the problem within West Cheshire. If the 53 clinicians who responded were to consult with eight patients per week regarding menopause-related issues, then 1696 consultations per month would be required and 20,352 per year. This is a considerable number while likely to be only a fraction of those required for the total female population of West Cheshire.

The estimated cost of a single consultation in Primary Care with a GP (average duration 11.7 min) is £46 and a 15 min consultation with a practice nurse costs £13[17] giving an estimated overall financial burden of between £265 K–£936 K per annum for those participating in the survey, related to menopause care.

Regarding whether or not there should be access to a specialist menopause clinic, two-thirds of respondents felt there should.

Further analysis of the data did not suggest any associations between numbers of women seen and self-reported knowledge, regardless of their opinion regarding access to specialist menopause care.

Assessment of the qualitative data revealed a keenness to manage patients wherever possible in-house, but that the availability of specialist advice for the more complex menopause cases was desirable.

The capacity within primary care in order to manage these patients appropriately was also raised. This is, of course, most topical with the unsustainable demand on primary care frequently hitting the headlines currently.

A GP in Bolton attempted to show that investing one's time as a primary care clinician specialising in the menopause can reap substantial rewards in terms of efficiency with reduced frequency of attendance in women around this age group following an hour long consultation in an in-house menopause clinic. After receiving a detailed biopsychosocial assessment, women presenting with symptoms that could be attributable to the menopause, a personalised care plan was created via shared decision making which resulted in

extremely high patient satisfaction rates and a reduction, thereafter, in the consulting behaviour of the women, with up to 50% reduction in presentation rates.[18]

Further research would be helpful in strengthening the case for this argument, though the positive impact on the health and wellbeing of those in the peri- and post-menopause by enhancing the current service provision is hard to deny based on evidence currently available. Clearly, such investment of clinician time would need to be adequately resourced if this model were to be replicated widely. In addition, the training needs of those working in primary care must be addressed at pace.

The enhanced focus on integrated models of care provides an opportunity to treat women around the menopause and beyond within an holistic service, with the potential to offer personalised packages of care including traditional medical treatments (specifically HRT), gynaecological investigation as appropriate, contraception and sexual health advice plus assessment of bone density, while also offering advice regarding herbal remedies for those who cannot take or decline hormones, nutritional advice, weight management, exercise and relaxation therapy plus psychological support (e.g. mindfulness, cognitive behavioural therapy, psychosexual counselling) where appropriate. These services could be utilised by the many cancer survivors who have very specific needs post therapy in many cases.

The current trend towards outcomes-based commissioning[19] would surely be well suited to women's health service provision, with the opportunity for CCGs and public health to align budgets and collaborate in order to achieve maximal gains for women, while also resulting in economic efficiency.

Conclusions

An electronic survey of clinicians working within West Cheshire CCG was undertaken in order to assess the potential need for specialist menopause care in the area.

The study demonstrated that a substantial number of women present to clinicians working in West Cheshire who are felt to have peri- or post-menopausal symptoms.

Many of the clinicians who responded have self-reported learning needs and some have reported difficulty in accessing appropriate training. This issue needs addressing at pace.

Two-thirds of the clinicians who completed the survey felt that they and their patients should have access to a specialist menopause service.

This provides evidence for CCG to consider in a proactive manner, the future commissioning of menopause care services. A formal needs assessment and consideration of an integrated care model are suggested with a focus upon commissioning for outcomes across the provider organisations, aligning funding streams as required. Investment in a truly holistic service, empowering women to make positive choices for their post-reproductive health and wellbeing, should be the aspiration. Further studies to investigate the potential economic benefits of proactive management of the menopause are suggested plus a pilot for an integrated model as detailed above.

Conflict of interest

Although I work for West Cheshire clinical commissioning group, this is purely regarding maternity. However, potential conflict exists given my special interest in menopause as I may be a potential provider of services should they be commissioned.

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Appendix

'Comments'

'I would find a series of seminars on menopause useful.'

'In my current role I would not prescribe HRT.'

'I think I would be good at managing these symptoms given enough time to think about it but a GPWSI would be useful for complex cases.'

I' am interested in managing menopausal symptoms, so do read about it.'

'I under took RCN menopause 2 day foundation course in 2011 and I am a member of the UK menopause nurse group'

'Question 1 & 7 I had to tick answers in order to submit (qu.1 ticked GP, but completed other box as trainee, qu.7 ticked not sure but haven't had menopause training in the last year).'

'On question 7 less likely because just not confident starting medication happy to review because had no training only up dates'

'none'

'I have found it difficult to access training on management and prescribing for patients going through the menopause.'

'Local training for this would be really useful- would prefer to feel confident managing this myself rather than referring yet something else!'

'This is an area I'm really interested in and enjoy managing women in this category as it's challenging, interesting but rewarding.'

> I am Male GP who works with excellent skilled (female) partners who I signpost patients to after identifying menopausal and complex contraception problems. So in effect I have in house GPwSI, the question is do my partners need the back up of a GPwSi/Specialist?
> From talking to patients, it seems to me that lots of blood tests are still being done to diagnose the menopause and in general clinicians are not proactive in discussing vaginal oestrogens. Also, there is a wide variety of interest and experience in managing the menopause with some women reporting it difficult to get what they need and others having really good care. I can't comment on secondary care management of menopause.

'Didn't have any training so couldn't answer Q 7 but computer made me go back and answer!'