

Joint BMS / RCOG / RCGP / RCN / FSRH framework for restoration of menopause services in response to COVID-19

Version 2: March 2021

The surge in COVID-19 cases over the last few months has resulted in a significant increase in the demands on NHS services and disruption to all aspects of healthcare provision across the spectrum of women's health, including menopause care. This was further compounded by the general winter pressures and increased workload for both primary and secondary care as well as the reduced staffing levels due to illness or self-isolation. As a result of these pressures, and as we saw in the earlier months of the pandemic, a number of non-urgent services including menopause services have been restricted to divert staff to support the critical care and emergency services.

We recognise the ongoing provision of menopause care is likely to help many women control their often difficult menopausal symptoms. Many women are significantly affected by the menopause, and with the additional stress some women may be under in view of the strains of the current situation on society, the impact of the menopause should not be underestimated. In addition, General Practitioners' surgeries have also been put under additional pressure, with consultations and advice prioritised to dealing with serious and potentially life-threatening medical issues as well as the significant service provision demands that have resulted from primary care involvement in delivering the COVID-19 vaccination programme. As a result, many women may be suffering with menopausal symptoms without feeling able to approach their General Practitioner, due to concerns of not over-burdening an already busy service, and may feel they should simply endure the different symptoms they are experiencing.

As we begin to exit the critical phase of the recent wave, attention moves again to the recovery phase and the assessment and planning of the steps required for resumption of clinical services.

Delivery of many healthcare services was modified to limit patient visits to healthcare services to an absolute minimum. In the earlier part of the pandemic, this resulted in services in both primary as well as secondary care offering virtual menopause consultations by telephone or web-based video consultations, or increasing this where such virtual consultations were already previously offered. The latter approach to the provision of menopause care was maintained by most services during the recent wave of the pandemic. This structure of service delivery is likely to continue for the foreseeable future, particularly during the restoration phase of services given the restrictions imposed by the pandemic and the uncertainty surrounding the trajectory and impact of the pandemic in the coming months.

Restoration and maintenance of menopause services is essential not only for treating menopausal symptoms, but also to optimise women's health during the menopause transition and beyond, given that appropriate strategies promoted and instituted at midlife such as lifestyle, diet, exercise and hormonal therapies have significant primary prevention benefits including bone and cardiovascular health and may potentially have a protective effect on the impact of COVID-19.

The objective of this updated joint document produced by the British Menopause Society (BMS), the Royal College of Obstetricians and Gynaecologists (RCOG), the Royal College of General Practitioners (RCGP), Royal College of Nursing (RCN) and the Faculty of Sexual and Reproductive Healthcare (FSRH) is to provide updated guidance to clinical practitioners on the resumption and running of menopause services in the next phase of restoration of planned clinical services. It is essential, in this phase that the impact of the menopause and the importance of menopause services is fully recognised to prevent a setback in this vital aspect of women's health. We need to ensure that the many women who may be being unduly affected by their menopausal symptoms are able to access appropriate help and advice, so that they are not shouldering the dual burden of coping with a pandemic and experiencing what may be distressing and uncomfortable menopausal symptoms.

This updated document covers guidance on the following aspects:

- 1. Impact of menopause on quality of life and women's health: Access to information**
- 2. Menopause services and menopause consultations**
- 3. Prescribing HRT and HRT shortages**
- 4. Unscheduled bleeding on HRT: assessment and management during the COVID-19 pandemic**
- 5. Menopause training**

1. Impact of menopause on quality of life and women's health: Access to information

- **Women should be encouraged to seek help for managing their menopausal symptoms and should be advised that the COVID-19 pandemic should not be a reason for them to discontinue HRT or withhold starting HRT if required.**
- **Management decisions should be made on an individualised basis after discussing the benefits and risks with each patient and should be considered in the context of the overall benefits obtained from using HRT including symptom management and improved quality of life as well as the cardiovascular and bone protective effects associated with HRT.**
- **Women should be made aware of resources available for guidance.**
- **Advice should be provided to women on how they can access menopause consultations remotely to discuss their management options and the local pathways available for having HRT prescriptions issued or renewed.**

The impact of the menopause on women should not be underestimated. More than 75% of women experience menopausal symptoms, and a quarter of such women describe their symptoms as severe. Although symptoms on average last 7 years, a third of women experience long-term symptoms. Hormone Replacement Therapy (HRT) is the most commonly used treatment for managing menopausal symptoms and has been shown to be the most effective intervention in this context.

A national survey by the British Menopause Society in 2016 showed that women reported on average 7 menopause related symptoms with 79% experiencing vasomotor symptoms, 22% experiencing unexpected sleeping problems / insomnia, 20% experiencing difficulty with memory / concentration and 18% experiencing unexpected joint aches. 42% of women indicated that the symptoms were worse or much worse than suspected. 50% of women said their symptoms had impacted their home life and 36% said the menopause impacted their social life.

HRT intake is likely to help many women control their often difficult menopausal symptoms. This is particularly relevant at present given the additional stress some women may be under in view of the strains of the COVID-19 pandemic on society, whilst also experiencing what may be uncomfortable or distressing menopausal symptoms.

Women should be encouraged to seek help for managing their menopausal symptoms and should be advised that the COVID-19 pandemic should not be a reason for them to discontinue HRT or withhold starting HRT if required. Women should not feel that they may be “overburdening” healthcare providers and should feel that their need for appropriate help and advice will be recognised.

In addition to its effect on managing menopausal symptoms and improving quality of life, HRT has been shown to have beneficial effects on bone and cardiovascular health and this should be discussed as part of the benefits / risks assessment when counselling women about HRT.

HRT has been shown to have a significant protective effect against osteoporosis and related fragility fractures. Osteoporosis is estimated to affect more than two million women in England and Wales. It is estimated that 1 in 2 women in the UK will suffer a fracture after the age of 50 and the International Osteoporosis Foundation reports that a 50 year old woman has a 2.8% risk of death related to hip fracture during her remaining lifetime. The National Osteoporosis Guideline Group (NOGG) estimates there are 536,000 fractures every year in the UK caused by osteoporosis and mortality rates with femur fractures are estimated to be 20% within the first year.

Cardiovascular disease remains a leading cause for morbidity and mortality in women. The British Heart Foundation has indicated that 24,000 women die from coronary heart disease each year in the UK. Given the potential cardiovascular beneficial effects reported with HRT initiated in women under the age of 60 this is a further aspect that should be considered as part of the benefits / risks assessment when counselling women about HRT.

Women should be made aware of resources available for guidance. Links for such information are included

below:

<https://thebms.org.uk/>

<https://www.womens-health-concern.org/>

<https://thebms.org.uk/publications/videos/bms-tv/>

<https://www.menopausematters.co.uk/>

www.managemymenopause.co.uk

<https://pcwhf.co.uk/resources>

In addition, women should be advised how they can access menopause consultations remotely to discuss their management options and the local pathways available for having HRT prescriptions issued or renewed.

2. Menopause services and menopause consultations

- **Ongoing current advice to minimise hospital visits will result in a significant proportion of menopause consultations being provided remotely (by telephone or web-based video consultations) for the foreseeable future, and potentially beyond that.**
- **The structure of remote menopause consultations should largely follow that used in face to face consultations with assessment of symptoms, bleeding patterns, background medical history and risk factors and changes in weight.**
- **Services providing remote consultations should have defined pathways that address consent and confidentiality issues and in keeping with GMC guidance.**

- **It is essential that access to face to face consultations remains available where a physical examination is needed (e.g. pelvic or breast examination) and access to endometrial assessment (pelvic ultrasound / endometrial biopsy / hysteroscopy) for women for ongoing unscheduled bleeding on HRT.**
- **Menopause services should aim to offer, where feasible, email / telephone advice and guidance to support primary care.**
- **Consideration should be given for multi-disciplinary menopause clinics (MDTs) to run virtually as video MDTs and email MDTs.**

General Practitioners' (GP) surgeries have been put under ongoing additional pressure during the COVID-19 pandemic and the recent second wave over the winter months, with consultations and advice prioritised to dealing with serious and potentially life-threatening medical issues as well as the significant service provision demands that have resulted from primary care involvement in delivering the COVID-19 vaccination programme.

As we move into the recovery phase for resumption of menopause services, it is necessary to continue focusing on different ways of delivering services that takes into consideration:

1. The demands that clinical services are likely to face in the coming months during the recovery phase and the months beyond.
2. The need to offer services while minimising hospital visits and patient travel and maintaining social distancing where feasible.
3. Changes to staffing levels, with a proportion of staff continuing to be redeployed to the COVID-19 services and the potential for some staff continuing to shield due to their medical background.

The majority of menopause consultations that took place in both primary and secondary care since the COVID-19 pandemic started were conducted remotely by telephone or web-based video consultations.

The ongoing demand to minimise hospital visits will mean that a significant proportion of menopause consultations are likely to continue to be provided remotely (by telephone or web-based video consultations) for the foreseeable future, and potentially beyond that. However, virtual menopause consultations are also likely to offer women more flexibility, less need for travel and result in less disruption to women's family and work life.

The structure of remote menopause consultations should largely follow that used in face to face consultations with assessment of symptoms, bleeding patterns, background medical history and risk factors and changes in weight.

The GMC guidance on remote consultations including the principles of good practice in remote consultations and prescribing should be followed by healthcare professionals offering remote menopause consultations:

<https://www.gmc-uk.org/ethical-guidance/learning-materials/remote-consultations-flowchart>

<https://www.gmc-uk.org/ethical-guidance/learning-materials/remote-prescribing-high-level-principles>

<https://www.gmc-uk.org/ethical-guidance/ethical-hub/covid-19-questions-and-answers#Remote-consultations>

<https://www.england.nhs.uk/outpatient-transformation-programme/video-consultations-in-secondary-care/>

In addition, RCGP has provided guidance on the principles on remote consultations in general practice. This can be accessed through the following link:

<https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0479-principles-of-safe-video-consulting-in-general-practice-updated-29-may.pdf>

Services providing remote menopause consultations should have defined pathways that address consent and confidentiality issues and in keeping with General Medical Council (GMC) guidance and should aim to do within the principles set by the Academy of Medical Royal Colleges:

[https://www.aomrc.org.uk/wp-content/uploads/2020/05/COVID-19 Principles for reintroducing healthcare services 0520.pdf](https://www.aomrc.org.uk/wp-content/uploads/2020/05/COVID-19%20Principles%20for%20reintroducing%20healthcare%20services%200520.pdf)

The nature of menopause consultations lends itself well to virtual consultations as a significant majority of consultations are conducted without the need for a physical examination. It, however, remains essential that access to face to face consultations remains available where a physical examination is needed (e.g. pelvic or breast examination) and access to endometrial assessment (pelvic ultrasound / endometrial biopsy / hysteroscopy) for women for ongoing unscheduled bleeding on HRT. The latter is discussed in more detail later in this document.

In addition, menopause services should aim to offer where feasible email / telephone advice and guidance to support primary care. This is likely to further support menopause management in primary care and minimise the number of secondary care clinical appointments that patients require.

Further, in services where multi-disciplinary (MDT) menopause clinics take place, consideration should be given to running such joint clinics virtually including video MDTs and email MDTs.

Setting up remote menopause consultations may require additional technical and administrative support including having web cameras and microphones linked to the PCs used by the clinical service, identifying secure software for remote video consultations that maintains patient confidentiality, and having administrative support to allow the communication of the clinical and prescribing plans to patients and GPs, which should take the form of a letter to the patient, summarising the discussion and agreed plan with a copy to the referring healthcare professional.

HRT implants require a face to face outpatient visit to have the implants inserted. Both estradiol and testosterone implants have been in short supply over the last decade due to the discontinuation of implant production for commercial reasons. Further, during the COVID-19 pandemic most clinical providers that offered implant insertion withheld these services as part of the overall suspension of non-urgent planned care.

Women on HRT implants could consider switching to alternative HRT preparations either on a temporary basis until the resumption of face to face outpatient services that offer implant insertion, or on a long-term basis should they wish to do so. Alternative HRT options can be identified through the BMS website through the following link:

<https://thebms.org.uk/wp-content/uploads/2019/11/HRT-alternatives-04.11.2019.pdf>

3. Prescribing HRT and HRT shortages

- **Healthcare professionals and prescribers should develop pathways on how advice is communicated to women regarding how HRT prescriptions are issued and collected and to provide similar information on how to request and obtain repeat HRT prescriptions.**
- **Prescribers can access information on the availability of HRT preparations through the BMS website where updates are provided on the current availability of HRT products.**
- **Where shortages of a particular HRT preparation are experienced, consideration should be given to prescribing an equivalent alternative HRT preparation.**
- **Patients should be advised that for most HRT preparations there are usually a number of equivalent alternatives that can be considered if they are unable to obtain supplies of their HRT preparation.**

- **Guidance on suitable equivalent HRT preparations is available on the BMS website and it also provides advice on alternative HRT preparations that can be considered where there is difficulty obtaining a preparation.**

We recognise that many women are likely to experience difficulties in obtaining HRT supplies due to the current COVID-19 pandemic. We also appreciate that continuing HRT intake is likely to help many women control their uncomfortable or distressing menopausal symptoms, which is particularly relevant if they are under additional stress due to pressures arising from the current pandemic.

Healthcare professionals and prescribers should develop pathways on how advice is communicated to women regarding how their HRT prescriptions are issued and collected and to provide similar information on how to request and obtain repeat HRT prescriptions.

The joint BMS, RCOG, RCGP and FSRH statement in March 2020 recommended that General Practitioners and healthcare providers consider having HRT prescriptions available on repeat order (especially to women who have been on HRT and have not been experiencing any problems with their intake). This will minimise the need for many women to visit their GP surgeries and assist with obtaining repeat prescriptions.

The burden of the COVID-19 pandemic on the health service and resulting difficulties in obtaining clinical appointments and accessing pharmaceutical services is likely to have resulted in many women have been experiencing difficulties in obtaining HRT supplies.

The BMS has continued to issue regular updates on the current availability of HRT products to provide guidance to BMS members and clinical practitioners. These can be accessed through the BMS website through the following link:

<https://thebms.org.uk/2021/03/british-menopause-society-further-update-on-hrt-supply-shortages-25th-march-2021/>

The advice remains that where clinical practitioners are unable to offer a certain HRT preparation, consideration should be given to prescribing an equivalent alternative preparation to the ones their patients are using.

Patients should be advised that for most HRT preparations there are usually a number of alternatives that can be considered if there is a need to change an HRT preparation or if they are unable to obtain supplies of their HRT preparation. For example, there are several 50 microgram estradiol patches available such as Evorel 50, Estradot 50, Estraderm 50, Progynova TS 50 that a patient can consider switching to if required. A similar concept would apply to estradiol gel preparations (using Oestrogel or Sandrena) and with oral HRT preparations.

Generic prescribing of estradiol patches where feasible (for example prescribing estradiol 50 microgram patches) may allow pharmacists more flexibility in offering patients supplies of available preparations rather than being restricted to a specific brand.

Consideration should also be given to prescribing estrogen and progestogen separately to make the closest match or find a suitable alternative. Different brands for the same medication may vary in appearance or excipients. However, they would provide equivalent amounts of hormones when used in similar doses.

Switching to such alternatives where indicated, allows patients to continue with their current preferred route of HRT administration (transdermal: patch, gel, spray or oral in the form of tablets) and with the same dose of their HRT intake.

The BMS has produced a document on alternative HRT preparations to provide guidance to BMS members and clinical practitioners on suitable equivalent alternatives that can be considered. This document can be accessed on the BMS website through the following link:

<https://thebms.org.uk/wp-content/uploads/2019/11/HRT-alternatives-04.11.2019.pdf>

In addition, BMS members can post prescribing queries on the BMS forum if any clarifications are required.

4. Unscheduled bleeding on HRT: assessment and management during the COVID-19 pandemic

- **Unscheduled bleeding on HRT can initially be assessed through remote consultation and medical advice offered where appropriate.**
- **For the majority of cases modifying progestogen intake would often control the bleeding especially in women who experience unscheduled bleeding in the first few months after commencing HRT.**
- **Women who continue to have unscheduled bleeding beyond 6 months despite modifying their progestogen intake or where there is a concern about the clinical presentation or bleeding amount / pattern should consider having pelvic ultrasound scan assessment and endometrial biopsy or assessment of the endometrial cavity by hysteroscopy.**

The RCOG, British Society for Gynaecological Endoscopy (BSGE) and British Gynaecological Cancer Society (BGCS) have released joint guidance on the management of abnormal uterine bleeding including postmenopausal bleeding to guide clinical practice during the Coronavirus (COVID-19) pandemic.

The guidance recommends carrying out assessment and advice through remote consultation in the first instance and offering medical advice where appropriate to minimise the need for women to visit their healthcare providers and to limit the risk of person to person viral transmission. The document can be accessed through the BSGE website:

<https://mk0britishsociety8d9m.kinstacdn.com/wp-content/uploads/2020/03/Joint-RCOG-BSGEBGCSguidance-for-management-of-abnormal-uterine-bleeding-AUB-in-the-evolving-CoronavirusCOVID-19-pandemic.pdf>

Similar management principles can be applied to women who experience unscheduled bleeding on HRT beyond 3- 4 months from commencing HRT as referred to in the BMS guidance on the management of unscheduled bleeding on HRT ([https://thebms.org.uk/wp-content/uploads/2020/03/BSGE-document-HMB31.3.20final .pdf](https://thebms.org.uk/wp-content/uploads/2020/03/BSGE-document-HMB31.3.20final.pdf)).

An initial assessment could be carried out through a virtual (telephone / web-based video) consultation and consideration should be given to modifying women's progestogen intake as an initial management step.

For the majority of cases modifying progestogen intake would often control the bleeding especially in women who experience unscheduled bleeding in the first few months after commencing HRT.

Progestogen intake could be modified as follows:

- For continuous combined HRT regimens the dose of progestogen could be increased (e.g. go up from Utrogestan 100 mg daily to 200 mg daily on continuous basis). Those on continuous combined HRT regimens that contain a progestogen in a combined preparation or have the Mirena IUS, could have Utrogestan / medroxyprogesterone acetate or norethisterone added to their HRT regimen. If they continue to experience ongoing unscheduled bleeding, the HRT regimen could be changed to a cyclical intake of progestogen.
- For cyclical HRT regimens: Increase progestogen dose (e.g. Utrogestan 300 mg for 12 days a month instead of 200 mg) or increase duration of progestogen intake (can take progestogen for 14 days a month or for 21 days out of a 28-day HRT intake cycle).

- Women who continue to have unscheduled bleeding beyond 6 months despite modifying their progestogen intake or where there is a concern about the clinical presentation or bleeding amount / pattern should consider having pelvic ultrasound scan assessment and endometrial biopsy or assessment of the endometrial cavity by hysteroscopy. Assessment timelines should aim to adhere to the recommendations set in the RCOG prioritisation framework for care in response to COVID-19:

<https://www.rcog.org.uk/globalassets/documents/guidelines/2020-06-26-restoration-and-recovery---priorities-for-obstetrics-and-gynaecology.pdf>

- If breakthrough bleeding occurs following the switch to continuous combined HRT and does not settle after three to six months, then the woman can be switched back to a sequential regimen for at least another year.

The risk of endometrial cancer in women with unscheduled bleeding on HRT is significantly lower than that with postmenopausal bleeding in women not on HRT especially in women who had not been experiencing bleeding before commencing HRT and who are taking progestogen.

5. Menopause training

- **The Covid-19 pandemic has resulted in a detrimental impact on menopause training as well as training in various other medical specialties.**
- **Modifications to the way menopause education and training are delivered are likely to be required.**
- **An increasing proportion of educational meetings are likely to be delivered virtually. In addition, online educational resources and webinars may offer additional educational resources that can be accessed remotely.**

- **Any adaptations to the structure of menopause training that may be required in the coming months is likely to be in line with that followed by other national educational bodies.**

The COVID-19 pandemic has resulted in significant disruption to menopause education and training, as well as menopause care. Prior to the COVID-19 pandemic, the majority of menopause education and training was delivered through face to face meetings and in person attendance of trainees at clinics with patients present. The implementation of social distancing requirements meant that such options for carrying out menopause education and training were significantly restricted.

While changes in service provision have brought many challenges, they also offered an opportunity to review and introduce adjustments that offer positive and workable change compared to our conventional structure of delivering menopause care as well as menopause education and training.

In respect of educational meetings, many of these have been able to proceed by being delivered virtually. This is likely to continue over the coming months, and potentially beyond depending on social distancing requirements.

After the enforced cancellation of the BMS Annual Scientific Conference in July 2020, the British Menopause Society moved to introduce an innovative and sustainable programme of virtual educational meetings for healthcare professionals to meet current educational demands. These included one-day women's health meetings; the Women's Health Concern (WHC) symposium and the two-day theory courses for the Principles and Practice of Menopause Care (PPMC) and the Cognitive Behavioural Therapy (CBT) training course. The BMS Annual conference for July 2021 is due to be delivered as a virtual meeting.

As part of supporting the training of HCP, in 2020 the BMS developed a virtual educational programme including study days to ensure the provision of menopause education continues during the pandemic. Further, the BMS has taken the decision that all forthcoming BMS meetings and study days in 2021 will be delivered virtually to allow continuity in delivering education in the current climate.

Virtual meetings with pre-recorded lectures and live question and answer sessions as well as live webinars are likely to become part of how menopause education will be delivered in the foreseeable future and potentially beyond. Whilst this will bring its own challenges in arranging and delivering, it is also likely to open the door to a wider audience who rather than being constrained by whether a meeting is local to them or the practicalities of travelling to it, could attend a meeting virtually regardless of location. It is also likely to offer more flexibility with both organising and delivering meetings.

In addition, webinars and online educational resources (such as IMPART offered by the International Menopause Society) may offer additional educational resources that can be accessed remotely.

<https://www.imsociety.org/education/impart-registration/>

<https://www.imsociety.org/education/webinars/>

Given that many NHS services both in primary as well as secondary care have already set up processes for virtual patient consultations, the virtual structure can also be considered to conduct training remotely. This could include three-way web-based video consultations involving the trainer, the patient and the trainee. Such remote training could also allow remote assessment with the trainer observing the trainee conducting a virtual consultation in their own practice. Any such pathways should have a clear process related to patient consent and confidentiality in keeping with GMC recommendations.

<https://www.gmc-uk.org/ethical-guidance/learning-materials/remote-prescribing-high-level-principles>

In addition, such pathways may require piloting when first introduced to ensure feasibility of application. It will also subsequently require validation against current conventional face to face methods of training.

The nature of menopause consultations and as a result menopause training lends itself well to a virtual structure of delivery as a significant majority of consultations are conducted without the need for a physical examination. It, however, remains essential that access to face to face consultations remain available where a physical examination is needed (e.g. pelvic or breast examination) and access to endometrial assessment (pelvic ultrasound/endometrial biopsy/hysteroscopy) for women for ongoing unscheduled bleeding on HRT. This should also be considered when delivering menopause training to ensure trainees are able to assess and decide when there is need for a face to face assessment. Any adaptations to the structure of menopause training is likely to be in line with that applied by other national educational bodies.

To further support the training of HCP, in 2020 the BMS launched a new training programme (*Principles and Practice of Menopause Care PPMC*) to support the provision of menopause care in the UK. The programme comprises progressive theory and optional practical training components, leading to a qualification in menopause care. Further information on the programme can be accessed through the BMS website on the following links:

<https://thebms.org.uk/education/principles-practice-of-menopause-care/>

<https://thebms.org.uk/education/principles-practice-of-menopause-care/apply-for-the-ppmc-training-programme/>

Setting up remote menopause training may require additional technical and administrative support including having web cameras and microphones linked to the PCs used by the clinical service, identifying secure software for remote video consultations that maintains patient confidentiality, and having administrative support to allow the communication of the clinical and prescribing plans to patients and GPs.

The above changes to practice should enable menopause education and training to continue in the current climate, and some of the changes may continue to be part of how training is provided beyond the pandemic. Given the potentially unpredictable nature of the COVID-19 pandemic, it is important that the provision of menopause services including education and training, adapt to the current circumstances and pressures on health services to minimise patient hospital visits and face to face contact where appropriate.

In summary, the recommendations made in this document should help facilitate the ongoing delivery of menopause care during the pandemic and enable women to continue to be able to access advice on how they can optimise the management of their menopausal symptoms, address other menopause related concerns and to optimise their health during the menopause transition and beyond. Given the potentially unpredictable nature of the COVID-19 pandemic it is important that the provision of menopause services continues to adapt to the challenges facing the health services.

There is also a need to ensure in the forthcoming recovery phase of the pandemic that menopause services are not overlooked. The menopause can have a significant impact on many women, and the importance of appropriate care for such women needs to be fully recognised. There is also an ongoing need to support HCP in primary and secondary care to maintain menopause service delivery in the current climate.

This document will be kept be under review and further updated to reflect any appropriate changes.

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