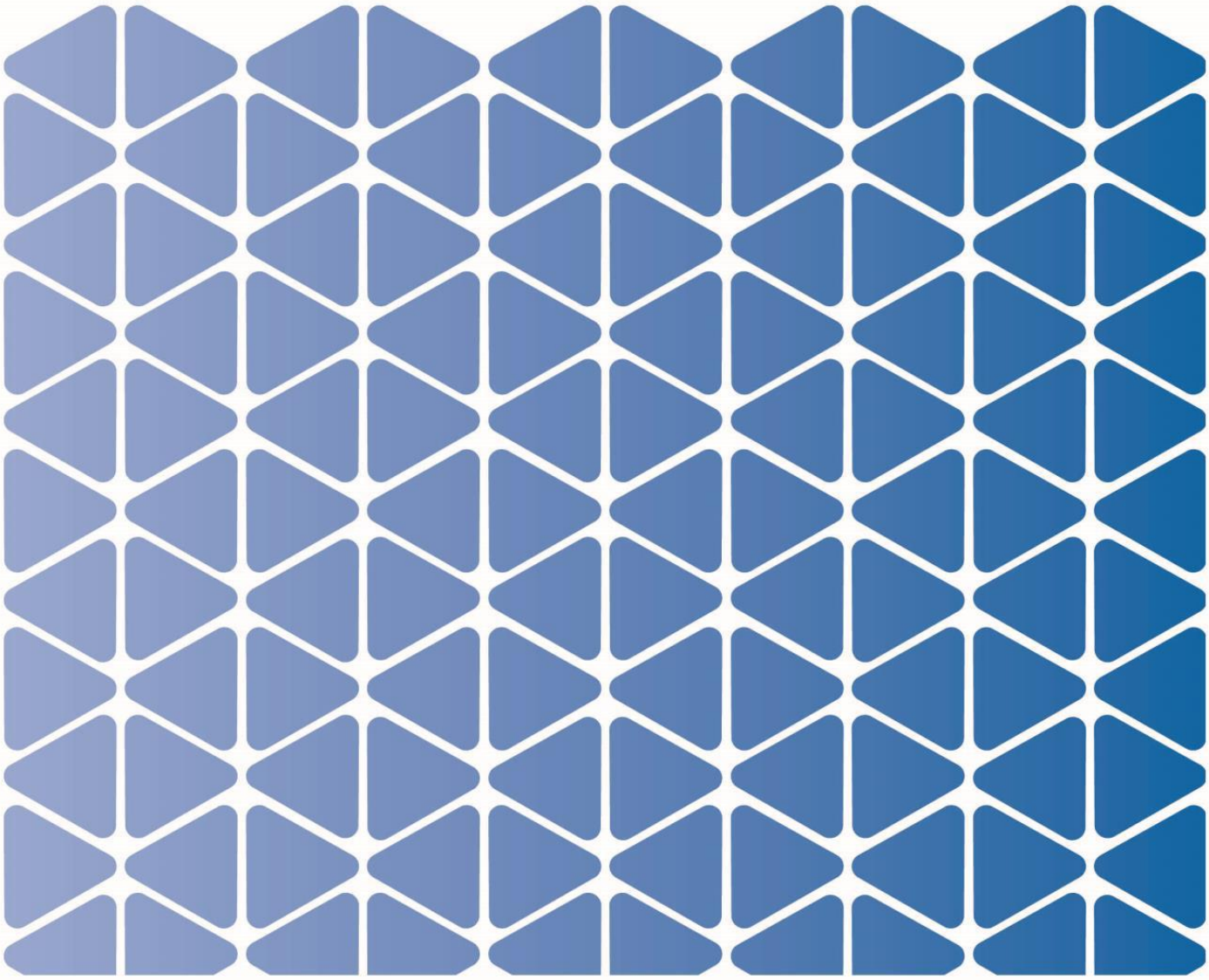
PATIENT INFORMATION

Your journey through the Perimenopause and Menopause



The Menopause Team

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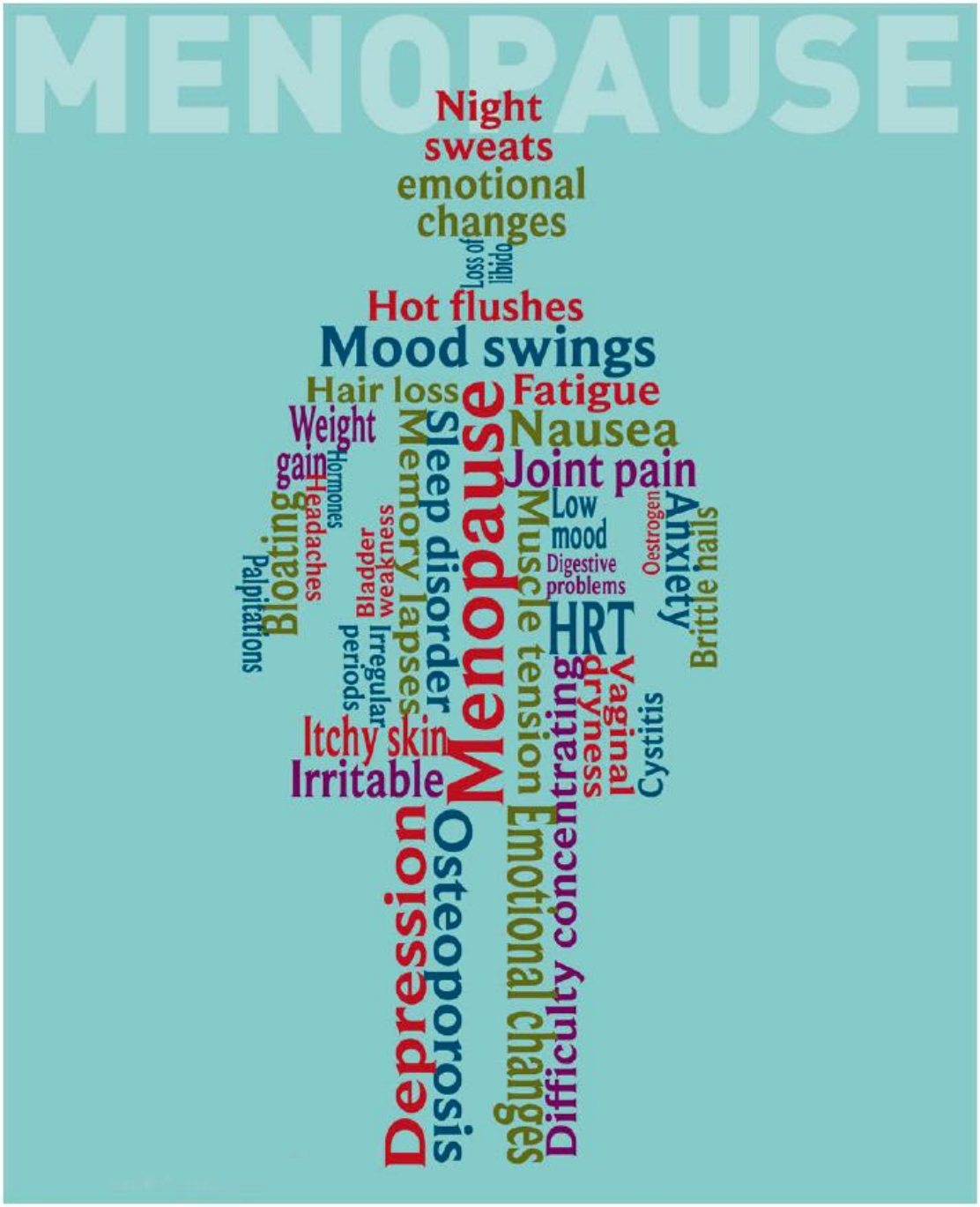


Meno: menstrual cycle
Pause: stop

What is the Menopause and Peri-menopause

The menopause is when a woman stops having periods as she reaches the end of her natural reproductive life. It is caused by ovarian failure; when the ovary runs out of eggs. Ovarian function is regulated by follicle stimulating hormones (FSH) and luteinising hormone (LH) produced by the brain (pituitary gland). With age our ovaries gradually become less responsive to these hormones, resulting in a lower production of oestrogen. This decrease in oestrogen means the lining of the womb is not stimulated, so periods become irregular and stop. Low oestrogen associated with the menopause can cause a wide variety of symptoms, as oestrogen receptors are present throughout the body.

Menopausal symptoms can effect home, social, work and sex life. 8 out of 10 women experience some symptoms, typically lasting about 4 years after the last period, but in 10% women these can last up to 12 years. 42% of women still experience symptoms when they are 60-65 years, hence there is no upper age limit for commencing treatment.

Stages of the Menopause

- ***Perimenopause***: the time leading up to the menopause and continues until 12 months after the final period, associated with irregular periods as the ovaries are not always releasing an egg (ovulation).

- ***Menopause***: when a woman stops menstruating (having periods) and reaches the end of her natural reproductive life. It is defined as occurring when a woman has not had a period for 12 months (if taking no hormonal contraception) or based on symptoms if previous hysterectomy (no uterus/womb). The symptoms are related to the change in hormones; when the ovaries stop producing eggs and secreting hormones (oestrogen, progesterone and testosterone).
    - Average age of natural menopause is 51 years.

- ***Post-menopause***: the time after the menopause has occurred, starting when a woman has not had a period for 12 consecutive months.

- ***Premature Ovarian Insufficiency (POI)***: when menopause occurs before the age of 40 years. It affects 1 in 100 women. This can be natural or as the result of medical or surgical treatment.

- ***Early menopause:*** when menopause occurs between the age of 40-45 years.

Diagnosis:

- Menopause: >12 months since last period, with or without symptoms (no FSH blood test is necessary if >45 years of age)
- Perimenopause: If symptoms and >45 years no blood tests (FSH) are necessary for diagnosis
    - Only use FSH for diagnosis if <45 years (DO NOT use if on COCP or high-dose progesterone)
- Previous hysterectomy: diagnosis based on symptoms
- POI: <40years, no or infrequent periods, with or without symptoms: 2x raised FSH (taken 4-6 weeks apart)

The Symptoms of the Menopause and perimenopause

– these can occur in multiple sites in the body.

- Change in menstrual cycle
- Vasomotor symptoms: hot flushes and night sweats
    - These are caused by constriction and dilatation of blood vessels in the skin, that can cause a sudden increase in blood flow to allow heal loss. These symptoms can have a major impact on quality of life. They occur in 75% of peri and postmenopausal women and can last for more than 10 years.
- Musculoskeletal symptoms: joint and muscle pains
- Effects on mood (psychological): low mood and anxiety, memory and concentration loss, brain fog
    - Mild depressive symptoms that impair quality of life but are usually intermittent and often associated with hormonal fluctuations in the perimenopause
- Urogenital symptoms: vaginal dryness, vaginal irritation, incontinence, urinary tract infections
    - Due to the thinning and shrinking of the tissues of the vulva, vagina, urethra and bladder caused by oestrogen deficiency, resulting in multiple symptoms.
- Sexual difficulties: low libido
- Many other symptoms can also be associated

Long-term health implications of the menopause

- ***Bones***:
    - Increased risk of fragile bones (osteoporosis) and fractures due to the higher bone turnover and bone loss. Osteoporosis affects 1 in 2 postmenopausal women not on HRT, and 1 in 3 of these will suffer a fragility fracture.

- ***Heart***:
    - Women are 5x more likely to have heart disease after the menopause. Oestrogen has a role to reduce inflammation and dilates blood vessels, which may improve cardiovascular health. Heart attacks can be harder to diagnose in women and have a worse prognosis.
    - 10x more women die of heart disease than breast cancer in USA every year

- ***Diabetes***
    - The incidence of type 2 diabetes may be increased in the peri/post-menopause due to the metabolic changes that happen in response to decreased oestrogen levels.

- ***Obesity***
    - Our physical activity generally decreases with age, leading to an increased risk of diabetes. Due to the reduction in oestrogen levels, there is a change to fat distribution; being stored more across the midline, leading to a ‘pear’ body shape. This results in an increased risk of metabolic syndrome, T2 diabetes and heart disease
    - Obesity (BMI >30) has overtaken smoking as the commonest cause of all cancers

- ***Cognitive decline and early dementia***
    - Oestrogen is important for cell function and other processes in the brain

- ***Depression***
    - Low oestrogen levels have been associated with a 2-3 times increased risk of clinical depression

Greene Climacteric Scale

The Greene Scale provides a brief measure of menopause symptoms. It can be used to assess changes in different symptoms, before and after menopause treatment. Three main areas are measured:
1. Psychological (items 1-11). 2. Physical (items 12-18). 3. Vasomotor (items 19, 20).

Please indicate the extent to which you are bothered at the moment by any of these symptoms by placing a tick in the appropriate box:

SYMPTOMS	Not at all 0	A little 1	Quite a bit 2	Extremely 3	
1. Heart beating quickly or strongly					
2. Feeling tense or nervous					
3. Difficulty in sleeping					
4. Excitable					
5. Attacks of anxiety, panic					
6. Difficulty in concentrating					
7. Feeling tired or lacking in energy					
8. Loss of interest in most things					
9. Feeling unhappy or depressed					
10. Crying spells					
11. Irritability					
12. Feeling dizzy or faint					
13. Pressure or tightness in head					
14. Parts of body feel numb					
15. Headaches					
16. Muscle and joint pains					
17. Loss of feeling in hands or feet					
18. Breathing difficulties					
19. Hot flushes					
20. Sweating at night					
21. Loss of interest in sex					
Score					Total

Greene, J, *A factor analytic study of climacteric symptoms* **Journal of Psychosomatic Research** (1976), 20, 425—430.

You may find it useful to keep a record of your symptoms. This can also be used as a gage to assess how your symptoms have changed over time, especially if you have been started on some treatment to help them.

Management options

Lifestyle changes and interventions that can help general health and wellbeing

- Alcohol – can make symptoms including hot flushes worse and increases the risk of breast cancer
    - NHS recommends 'low-risk' drinking as <14 units/week spread over at least 3 days (a standard glass of wine is 2.1 units)
- Smoking – increases the risk of cancer and can make all symptoms generally worse
- Weight – Obesity is the leading cause of all cancers
    - Normal BMI 19-25, overweight 25-30, Obese >30
- Diet – Mediterranean diet, with a calorie intake of <2000/day combined with exercise
    - Lose weight - Better Health - NHS (www.nhs.uk)
    - 12 tips to help you lose weight - NHS (www.nhs.uk)
- Exercise – moderate intensity exercise helps symptoms, including vasomotor symptoms
    - NHS recommends we do 30mins of sweat inducing/moderate exercise 5x a week to maintain our weight, and more if we are trying to lose weight
    - This should include weight bearing/strengthening activities at least 2x a week
    - Physical activity guidelines for adults aged 19 to 64 - NHS (www.nhs.uk)

Treatment options:

1. **Non-Hormonal Alternatives**
    - Clonidine – only alternative treatment licenced for vasomotor symptoms, normally a blood pressure medication, so must stop gradually to prevent rebound high blood pressure.
    - SSRIs: selective serotonin reuptake inhibitors –
        - Citalopram, Sertraline – decrease hot flushes
        - Fluoxetine, sertraline – can affect libido
        - Paroxetine & fluoxetine: NOT for use in women with breast cancer on Tamoxifen
        - Side effects of SSRIs and SNRIs: dry mouth, nausea, constipation, appetite, libido problems
    - SNRIs: Serotonin and norepinephrine reuptake inhibitors –helps hot flushes, fatigue, mood
        - Venlafaxine – safest option if on Tamoxifen, less effect on libido, can improve migraines
    - Gabapentin / Pregabalin – some improvement in hot flushes, sleep, pain, headaches
        - Side effects: sleepiness, dizziness, weight gain, dry mouth

    NICE: Do not offer as first-line treatment for vasomotor symptoms alone
    No evidence of benefit on mood in patient not diagnosed with depression
    No benefit for long-term future health, may help some symptoms, but all come with their own side effects

2. **Non-pharmaceutical** (see useful contacts in references)
    - ***Cognitive behavioural therapy (CBT)***: Good evidence it can alleviate many menopausal symptoms including: low mood and anxiety, hot flushes and night sweats, as well as insomnia. CBT combines relaxation techniques, sleep hygiene and learning to take positive health attitude to menopausal changes. It can be accessed via your GP, counsellors, psychological wellbeing practitioners (PWPs), specialist nurses, or self-help books or aps.
        - *CBT factsheet: WHC website, by Professor Myra Hunter, Kings College London*
    - Acupuncture: women often report reduction of hot flushes and night sweats

3. **<u>Complementary therapies and unregulated preparations</u>** – these are not recommended as efficacy and safety of unregulated therapies are unknown. They can also interact with other medicines including tamoxifen, anticoagulants and anticonvulsants. There is minimal evidence they may relieve some symptoms. If taking herbal preparations, ensure they are approved with the THR logo (traditional herbal medicines).
   - Evening Primrose: not recommended by NICE
   - Isoflavones/Phyto estrogens and soya products (plant substitutes in diet including red clover): evidence is variable, but shows little benefit. NOT recommended in patients with breast cancer.
   - Black cohosh: (hot flushes), interacts with other medications and can cause liver damage
   - St John's wart: (vasomotor symptoms) purity and constituents unknown, can interact with other drugs. DO NOT use if on Tamoxifen, as makes it ineffective
   - Ginseng and Chinese herbal medicines: no evidence improves symptoms

See – Complementary and alternative therapies WHC Factsheet

4. **<u>Hormone Replacement Therapy (HRT):</u>**
   HRT should be prescribed on an individual basis after discussing the risks and benefits
   It is not a contraceptive – so another form of contraception also needs to be taken

   - **Oestrogen**: This is the primary hormone to replace as menopausal symptoms are due to low oestrogen levels
     - Can be given separately as a patch, gel or spray (transdermally; through the skin) or orally
     - Or as a combined patch with progesterone
     - Oral oestrogen is generally avoided due to the increased risk of blood clots, especially in women with a BMI of over 30

   - **Progesterone**: this needs replacing if you have a uterus (womb) to protect the lining from becoming thickened and abnormal, which can in some cases progress to endometrial cancer. You do not need it if you have had a hysterectomy. You may be given it short term if your hysterectomy was for endometriosis.
     - Oral: Utrogestan – useful for sleep problems due to sedative side effect, so taken at night. It is not associated with increased risk of blood clots.
     - Mirena coil: helps control irregular bleeding with a 20-80% amenorrhoea rate (no periods). It remains in for 5 years and can also work as contraception.
     - Combined oestrogen and progesterone patch (with or without a monthly withdrawal bleed)

   - **Testosterone**: Not needed in the majority or women. But supplementation can be necessary for some women with low sexual desire if HRT alone is not effective and low levels are confirmed on blood tests. *Testosterone levels actually decline from 20 - 40years, and have stabilised by the menopause*
     - Gel – Tostran 2% or Testogel (off-licence but good safety data)
     - See separate information leaflet as use in women is off-label

   - **Topical vaginal oestrogen**: for urogenital symptoms.
     - Is safely given alongside systemic HRT; to work locally on the vagina and vulva.
     - Can be given to some patients where HRT is contraindicated (ie history of breast cancer).
     - Is safe to use when breastfeeding (as is other HRT).
     - Can be continued long-term, as symptoms often return when treatment is stopped.
     - Adverse effects are very rare; unscheduled bleeding should be reported to your GP.
       - Do not need to routinely monitor endometrial thickness
     - Also consider: vaginal moisturisers (Replens) and lubricants (SYLK).
     - DO NOT USE if on an aromatase inhibitor as part of breast cancer treatment

Benefits of HRT:

- HRT treats the symptoms caused by low oestrogen levels - no other treatment is as effective
- Cardiovascular disease (CVD): HRT is not associated with increased CVD or risk of dying if initiated before the age of 60 years
    - Presence of risk factors is not a contraindication provided they are optimally managed
    - There does not seem to be an increase in cardiovascular events or mortality if started less than 10 years after the menopause
- Type 2 Diabetes: no increased risk of developing diabetes, some evidence of reduction.
- Osteoporosis (OP) and fragility fractures – Oestrogen maintains bone mineral density, reducing the risk of fractures. This benefit may continue longer for women who continue it
    - There is increased bone loss during the peri/menopause, leading to increased risk of osteoporosis. 1 in 2 women (not on HRT) will develop OP and 1 in 3 will have a fragility fracture
    - Fracture risk is reduced while taking HRT, but benefit decreases once stopped
    - HRT is licenced for osteoporosis prevention
- Dementia: some studies show a potential decrease incidence of developing early onset Alzheimer's
- Muscle mass and strength: some evidence that HRT may improve, but this is generally maintained through activity and exercise
- Colon Cancer: may be reduced especially by oral HRT
- Breast cancer: no increased risk with oestrogen only HRT, potentially some reduction
- Decrease in all-cause mortality if taken long-term

Risks of HRT:

- Blood clots (venous thromboembolism/VTE): increased with oral HRT (verses baseline population risk).
    - There is no increased risk from baseline with transdermal preparations (TD) at standard doses
    - Consider referring menopausal women at a high risk of VTE (family history or hereditary thrombophilia) to a haematologist for assessment before starting HRT
    - VTE risk increases in all women with age and BMI
    - Give TD in women with an increased risk of VTE ie BMI >30
    - Risk is highest in the first year

- Stroke: small increased risk with oral (not transdermal) HRT started in older women >60 years, more so in the first year after initiation. No statistically significant increase if start < 60years

- Breast cancer: The baseline risk of breast cancer for women varies according to other underlying risk factors.
    - Oestrogen only HRT is associated with little or no change in the risk of breast cancer
    - Combined oestrogen and progesterone HRT may be associated with an increased risk of breast cancer. Any increased risk is related to the duration of treatment and reduces after stopping HRT. **However,** there is no increased risk of mortality from breast cancer.
    - The risk of breast cancer is likely higher with obesity/smoking/alcohol consumption compared with HRT use. Breast cancer risk doubles with BMI over 30.

- Ovarian cancer: there may be a slight increased risk, but this is very small; only 1 extra case per 1000 HRT users

- Endometrial cancer: if oestrogen only HRT is given to women with a uterus. This is reduced by the addition of progesterone. Continuous progesterone is better long-term protection that cyclical.

Contra-indications to HRT:

HRT is generally not recommended for women with a history of:

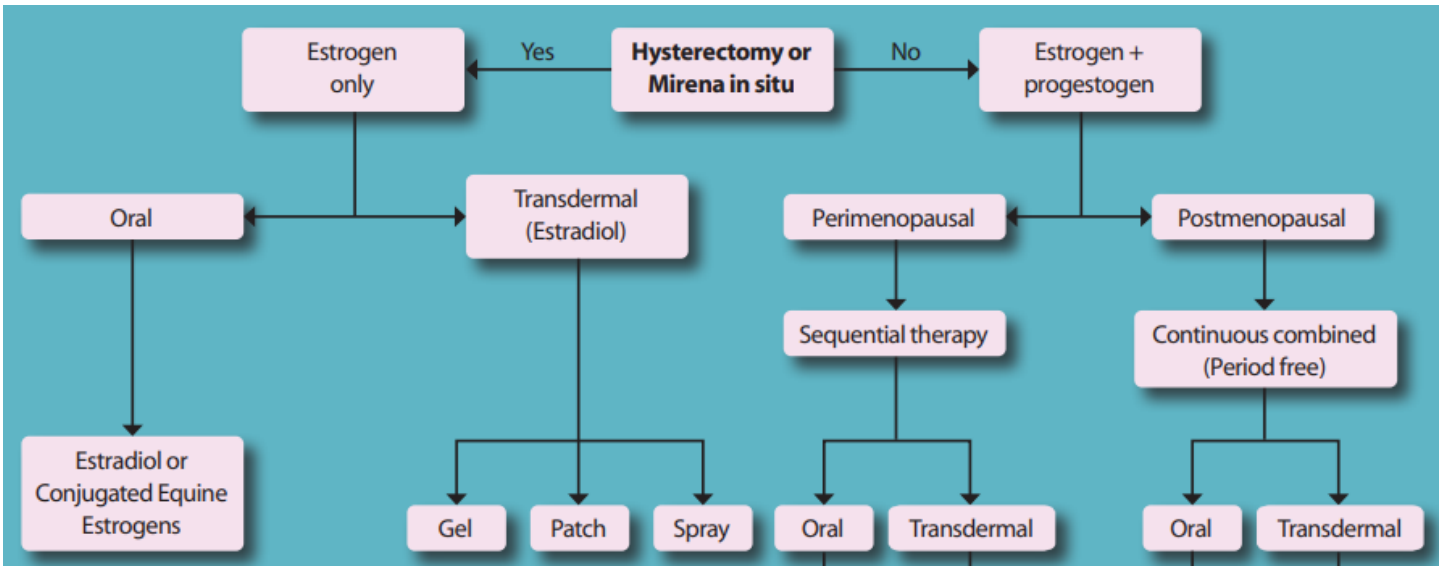
- Stroke, VTE, severe liver disease, breast cancer or endometrial cancer
- Risks are increased if started >60 years. But this does not mean those >60 years should have to stop it

HRT Regimen:

- **Sequential or cyclical HRT** - continuous daily oestrogen, and progesterone for only 12-14 days of the month. This is used for peri-menopausal women, who still have some ongoing ovarian function. In the 2 week break without progesterone, you should have a withdrawal bleed.

- **Continuous Combined HRT**: provides a constant dose of oestrogen and progesterone throughout the cycle. This is a bleed free regimen used for postmenopausal women who have stopped their periods.

By the age of 54 years, 80% of women will have stopped their periods, so if originally commenced on sequential, can be changed to continuous combined regimen.



BMS HRT - Guide

Follow-up

You should be reviewed 3-4 months after you have been started on HRT (or an alternative), to check your symptoms are controlled and you do not have any side effects. Once you are on a stable dose, you should then be seen annually by your GP or the menopause clinic.

Each appointment provides the opportunity to discuss the importance of keeping up to date with National Health Screening (cervical and breast).

GPs should refer to the specialist Menopause clinic if they have previously commenced you on HRT and you have poor symptom control. Or if you have high risk co-morbidities, contraindications to HRT, or they are uncertain regarding the most suitable treatment option, and they would like you to have a specialist review before commencing HRT.

When stopping HRT; this can be done gradually or immediately. If stopped gradually this can limit the return of symptoms in the short term, but there is no difference in the rate of recurrence of symptoms in the long term.

Common side Effects:

Oestrogen: fluid retention, breast tenderness, bloating, nausea/dyspepsia, headaches
- Reduce dose, change route, change type, are the side effects due to progesterone?

Progesterone: fluid retention, breast tenderness, headaches, mood swings, PMT-like symptoms
- Change type, reduce dose (not often possible), change route, alter duration

Post-Menopausal Bleeding

Unscheduled bleeding is a common side effect in the first 3 months of starting on HRT, but should be reported. If it occurs after 3m you must immediately inform your GP so that it can be investigated
- It is recommended to stop all HRT for 6 weeks to ensure the bleeding stops to establish cause
- If bleeding stops HRT can then be restarted at an altered regime (increased progesterone and reduced oestrogen)

Iatrogenic Menopause

Menopause as a result of medical or surgical treatment ie:

- Medical or surgical treatment for cancer or other gynaecological conditions (endometriosis)
- This may include surgical removal of the ovaries
- You will be provided with information regarding fertility and menopause in advance
- Subtotal hysterectomy (retention of your cervix) or endometriosis: you may be given progesterone for a short period prior to then being changed to oestrogen only HRT

POI: Premature Ovarian Insufficiency

Diagnosis: <40yrs with menopausal symptoms, no or infrequent periods and 2x raised FSH blood tests taken 4-6 weeks apart. 25% have no menopausal symptoms

Causes:
- Unexplained or Idiopathic (70-90%)
  - Family history present in 20-30% of cases
- Autoimmune processes (30%)
- Chromosomal and genetic defects (10-20%)
- Iatrogenic (surgery- Bilateral salpingo-oophorectomy BSO)/chemotherapy/radiation)
- Infections (POI reported after various infections mumps, HIV, herpes zoster, cytomegalovirus, tuberculosis, malaria, varicella, and shigella).

Management: offer HRT (unless contraindicated) or COCP (combined oral contraceptive pill) until at least the age of 51 years

- HRT: more beneficial effect on blood pressure (vs COCP), it is not a contraceptive so can be taken if trying to conceive (5-10% of women with POI can spontaneously ovulate, so need to take contraception if pregnancy is unwanted)
  - Use sequentially if trying to conceive (continuous oestrogen, with progesterone for 12-14days)
  - Use continuous combined if not trying to conceive, as well as contraception
- Any side effects should settle after 3 months, can then increase oestrogen dose as necessary
- The baseline risk of breast cancer and CVD increases with age but is very low in women aged under 40 years
- Both HRT and COCP provide good bone protection
- COCP: is a contraceptive and free on prescription

Monitoring:

- DEXA scan may be indicated at diagnosis: Adcal and oestrogen help improve bone mineralisation if signs of osteopenia. Consider repeating at 5 years
- Measure oestrogen: aim for >200, but base on symptomatic control
- May need much higher than average doses

See POI patient information leaflet for more details

Contraceptive advice:

- HRT is not a contraceptive
- You can take HRT and the COCP or POP (the progesterone in the COCP/POP is not licenced as uterine protection)
- You can stop contraception when:
    - Periods stop and you are >50 years → use contraception for 1 more year
    - Periods stop and you are <50 years → use contraception for 2 more years
    - If no periods (because using progesterone contraception)– if >50 years and FSH >30 → continue for 1 more year

Faculty of sexual & Reproductive Health on contraception for women aged over 40 years

Breast cancer

- HRT should be stopped if breast cancer is diagnosed and the possibility of early menopause discussed
- HRT should not be offered routinely to women with a history of breast cancer
    - It can be used in exceptional circumstances where risks and benefits have been discussed
- The majority of women can use topical oestrogen cream or pessaries
    - DO NOT USE topical oestrogen cream if on aromatase inhibitor
- HRT can be given to those with BRCA1 or 2 after risk reducing surgery (removal of both ovaries)
- NICE recommends: Clonidine, Venlafaxine and Gabapentin
- NICE states: SSRIs, SNRIs, and Pregablin,- provide no benefit for menopausal symptoms
- If on Tamoxifen - DO NOT use SSRI's paroxetine/fluoxetine
- If on Aromatase inhibitors (Letrazole) – DO NOT use topical oestrogen
- Do not offer soy (isoflavone), red clover, black cohosh, vitamin E or magnetic devices

New Developments:

A recent trial of neurokinin 3 receptor agonist (fezolinetant), a non-hormonal agent, has shown benefit for symptom control and safety. It is at present only available in the research setting

Understanding the risks of breast cancer

Women's Health Concern

A comparison of lifestyle risk factors versus Hormone Replacement Therapy (HRT) treatment.

Difference in breast cancer incidence per 1,000 women aged 50-59.
Approximate number of women developing breast cancer over the next five years.

NICE Guideline, Menopause: Diagnosis and management November 2015

23 cases of breast cancer diagnosed in the UK general population

An additional four cases in women on combined hormone replacement therapy (HRT)

Four fewer cases in women on oestrogen only Hormone Replacement Therapy (HRT)

An additional four cases in women on combined hormonal contraceptives (the pill)

An additional five cases in women who drink 2 or more units of alcohol per day

Three additional cases in women who are current smokers

An additional 24 cases in women who are overweight or obese (BMI equal or greater than 30)

Seven fewer cases in women who take at least2½ hours moderate exercise per week

Women's Health Concern

www.womens-health-concern.org
Reg Charity No: 279651
Company Reg No: 1432023

Women's Health Concern is the patient arm of the BMS.
We provide an independent service to advise, reassure and educate women of all ages about their health, wellbeing and lifestyle concerns.

Go to **www.womens-health-concern.org**

BMS British Menopause Society

www.thebms.org.uk
Reg Charity No: 1015144
Company Reg No: 02759439

March 2017

Menopause in the workplace

Some women can have difficulties dealing with their symptoms at work, due to embarrassment or fear they may be stigmatised. The most commonly reported difficulties are poor concentration, tiredness, poor memory, feeling low/depressed and lowered confidence.

Employers have a duty of care to ensure the health, safety and welling being of their staff. HR departments are encouraged to offer awareness and support. Some employers have a menopause champion or named person in HR. Discuss with them your symptoms and what coping strategies can be put in place to help you; additional support, flexible working, desk fans, work station closer to the window or toilets.

References and further reading:

NICE Guideline on the Menopause: diagnosis and management.

www.nhs.uk/live-well

BMS – British Menopause Society – www.thebms.org.uk

CBT factsheet: WHC website, by Professor Myra Hunter, Kings College London

www.womens-health-concern.org/help-and-advice/factsheets/

www.menopausematters.co.uk

www.managmymenopause.co.uk

03-WHC-FACTSHEET-Complementary-And-Alternative-Therapies-NOV2022-B.pdf (womens-health-concern.org) **Useful Contacts recommended by BMS:**
British Acupuncture Council www.acupuncture.org.uk
British Reflexology Association www.britreflex.co.uk
Complementary Medical Association www.the-cma.org.uk
International Federation of Professional Aromatherapists www.ifparoma.org
National Institute of Medical Herbalists www.nimh.org.uk
Society of Homeopaths www.homeopathy-soh.org

On the Worcester Hospital website:

bit.ly/WRHMenopause

Understanding the risks of Breast cancer WHC

Testosterone - patient information leaflet

Premature Ovarian Insufficiency (POI) - Patient information leaflet

Surgical Menopause – Patient information leaflet – coming soon

Patient Experience
We know that being admitted to hospital can be a difficult and unsettling time for you. If you have any questions or concerns, please do speak with a member of staff on the ward or in the relevant department who will do their best to answer your questions and reassure you.

Feedback
Feedback is really important and useful to us – it can tell us where we are working well and where improvements can be made. There are lots of ways you can share your experience with us including completing our Friends and Family Test – cards are available and can be posted on all wards, departments and clinics at our hospitals. We value your comments and feedback and thank you for taking the time to share this with us.

Patient Advice and Liaison Service (PALS)
If you have any concerns or questions about your care, we advise you to talk with the midwife in charge or the department manager in the first instance as they are best placed to answer any questions or resolve concerns quickly. If the relevant member of staff is unable to help resolve your concern, you can contact the PALS Team. We offer informal help, advice or support about any aspect of hospital services & experiences.

Our PALS team will liaise with the various departments in our hospitals on your behalf, if you feel unable to do so, to resolve your problems and where appropriate refer to outside help.

If you are still unhappy you can contact the Complaints Department, who can investigate your concerns. You can make a complaint orally, electronically or in writing and we can advise and guide you through the complaints procedure.

How to contact PALS:

Telephone Patient Services: 0300 123 1732 or via email at: wah-tr.PALS@nhs.net

Opening times:
The PALS telephone lines are open Monday to Friday from 8.30am to 4.00pm. Please be aware that you may need to leave a voicemail message, but we aim to return your call within one working day.

If you are unable to understand this leaflet, please communicate with a member of staff.