Written evidence from The Pelvic Obstetric and Gynaecological Physiotherapy (POGP) organisation. [WRH0025]

Introduction:

The Pelvic Obstetric and Gynaecological Physiotherapy (POGP) organisation is a registered charity and professional network of the Chartered Society of Physiotherapy. We have 1200 members who are all physiotherapists working in the field of pelvic health. Our areas of expertise are in the care of women during their childbearing years, the management of bladder and bowel problems especially incontinence in men and women of all ages, the management of patients following gynaecological, urological and colorectal surgery, and the management and treatment of pelvic pain.

POGP have members across the UK and internationally. The UK is increasingly devolved in healthcare and supporting members to deliver evidence-based healthcare according to current guidelines can be challenging when the policies informing practice are differently interpreted, funded and implemented.

The majority of POGP members are involved in delivering healthcare in the fields identified for this short inquiry but most specifically gynaecology and urogynaecology and with urinary incontinence and vaginal prolapse, and additionally the area of pelvic pain – associated with endometriosis and adenomyosis.

POGP welcomes the chance to contribute to this select committee to complement the work it is involved in with NHS England/ NHS Scotland / the various strands of work covering the Maternity Transformation Project / physiotherapy services in the Complex Mesh Centres / the Perinatal Pelvic Health self-assessment tool development project / as a registered stakeholder in NICE / as part of the National Bladder and Bowel Health pathway development and as providers of training in this highly specialist area of physiotherapy across the UK.

General comments:

I know that I am not alone in expressing deep frustration on behalf of POGP at the timescales applied to these potentially very important opportunities to improve healthcare and ask the right questions of Government. POGP is a highly relevant organisation to this short inquiry, but our members are working clinicians and have limited time available within work or beyond their working day to prepare information in the format and timeframe requested by inquiries and committees that is of the highest quality. A longer timeline would be of great value to allow full representation from relevant organisations.

POGP members have the expertise throughout the childbearing years and into later life for women with perinatal urinary incontinence, and ongoing pelvic floor dysfunction, subsequent to vaginal deliveries. Women presenting in their perimenopause period should

be referred to a specialist physiotherapist in the first instance according to NICE Guidelines NG123. Increasingly for women with pelvic floor dysfunction a multidisciplinary approach is required as prolapse and urinary incontinence are often accompanied by bowel symptoms.

Disparities in healthcare

It is clear from our member feedback and from clinical studies seeking to look at best practice and differing approaches to common urogynaecological conditions that there is disparity for women between what treatment they will be offered, at what stage and what the final outcome will be. Despite NICE Guidelines (NG123 and NG210, NG149, QS77, CG148, NG194, PH27, NG201) and the Baroness Cumberlege report, 'First do no harm', women may be offered very different healthcare options depending on their age, location and presenting problem. Some will be told that non-surgical management such as physiotherapy is not required because they need an operation, others will be told to lose weight, do their pelvic floor exercises and avoid strenuous activity. Worse, women may be told that they haven't got a problem.

Clinical expertise

A recent experience for POGP was being involved with NHS Digital to help produce online content to encourage people to know about and maintain healthy pelvic floors. A considerable difficulty in this project was that the language that NHS digital required did not align with that used in clinical practice and the clinical advisory team for NHS Digital were not prepared to change their position. POGP do not know who the NHS clinical advisory team are; what their expertise is and whether it was a multidisciplinary panel. POGP withdrew from this project.

In areas of highly specialised practice it is important that representation is appropriate and the correct language is utilized to ensure the message is understood by all.

Advice

Clear guidance for women trying to navigate symptoms of pelvic floor dysfunction such as prolapse and urinary incontinence is not readily available. Women may be handed a sheet about pelvic floor exercises without the clinician having conducted a vaginal examination; an obvious prolapse may be missed or a woman who does not know how to recruit her pelvic floor muscles appropriately may be left doing the exercises incorrectly . Simple information about bladder and bowel health could be easily created with guidance for women about how long to persevere independently and when to seek further help and from where. The rapid expansion of healthcare-based apps is an excellent opportunity but there needs to be oversight that the information is correct / evidence-based and widely applicable. Especially as evidence suggests that up to 40% of women do not know how to exercise their pelvic floor correctly.

GPs and Primary Care

It is suggested that women take somewhere between 7 and 10 years to seek help for conditions that are stigmatised and embarrassing including bladder and bowel incontinence and vaginal prolapse. Evidence suggests that women are still being told "well what do you expect, you've had children". Potential non-surgical treatments such as the use of a vaginal pessary device which might allow the women to stay active are dismissed as 'something only older women get'; "you're too young for one of those" are not offered by GPs. From experience, involving GPs in the research process and guideline development is extremely challenging. Beyond that, the dissemination and adoption process of the guidelines such as NICE is not mandatory so the improved care for women is often delayed well beyond the initial contact. If the advice at an early stage was appropriate and women were directed to early sources of specialist help, they may not need further referral to secondary or tertiary care due to access to early conservative intervention.

Key to this point is the training curricula for GPs. It must include obstetrics and gynaecology. This would also allow women postnatally to access care beyond the 6/ 8 week check which is not long enough for all women to have resolved their pelvic floor dysfunction and we would urge that this is conducted face to face and not as is increasingly the case, remotely.

POGP would urge that GPs are trained appropriately in gynaecology/urogynaecology/ perinatal pelvic floor conditions and that national guidelines and evidence is disseminated and implementation mandatory. This will have considerable workforce issues, highlighted in Baroness Cumberlege's report 'First do no harm' and the Perinatal Pelvic Health Service implementation programme.

Previous reports suggest an additional barrier for GPs may be difficulties in access to specialist physiotherapy services, and it may be easier for them to refer to continence services that include pad provision ([1]). Further, some GPs believe, incorrectly, that pelvic floor muscle training would not be effective for 'older' women and containment is the only option. Therefore, it may be useful to extend the First Contact Provider provision, or the clinical assessment and treatment provision for triage as has successfully been applied in musculo-skeletal services. This would require longer appointment times as the assessment process for pelvic floor symptoms requires time and sensitivity to ensure optimum results and reduce symptoms.

It is exciting to see the provision of additional funding for the provision of additional Women's Health Hubs throughout England and Wales. We believe that these valuable primary care services for women could however benefit from the addition of specialist physiotherapy services within these multi-disciplinary teams. The ethos of a one-stop shop that is provided within the heart of the community would be an ideal place for many

[1] Campbell, K.G., & Drummond, A (2021) Management practices for urinary incontinence in women in the primary care setting: healthcare professional's perspective, JPOGP, Issue 128, Spring 2021

women to discuss embarrassing symptoms that they often believe to be 'not severe enough to bother the doctor with'.

Covid

It is too early to say what the long-term sequelae of Covid will be for the areas being considered by this inquiry. It is clear that the lengthened waiting lists, the difficulty fully accessing the operating schedules and possibly the loss of skillset in the surgical teams for gynaecology and urogynaecology has impacted considerably across the UK. Specific examples are women with significant prolapse being waitlisted leaving them with vaginal prolapses which extend beyond the vagina i.e. are literally hanging out. There is inconsistency of waiting times and access across the various stages involved in the healthcare from - urogyae/gynae preoperative assessment to required investigations – such as bladder tests / scans / ultrasounds. In some cases women will 'wait' on a gynae outpatient list then be triaged to physiotherapy before seeing the gynaecologist, then 'wait' on a physiotherapy waiting list, then 'wait' again to be seen after their physiotherapy programme.

Additionally, Covid has had an impact on the general wellbeing of women with increasing obesity and harder access to exercise options including swimming sessions. Obesity is a known factor for prolapse and urinary incontinence so the women may then be more symptomatic.

Data

One of the outcomes from the Cumberlege report regarding the use of mesh in urogynaecology was to demand greater rigour in the recording of operative processes. The British Society of Urogynaecology (BSUG) audit database seeks to gather surgical data from its members. This in time will prove an excellent resource but it is not compulsory, and it is not clear what the data will be able to influence. A non-surgical intervention audit would provide national data on what management women are receiving for urinary incontinence and urogynaecology conditions. A national month of data collection would allow comparison across regions / age brackets / length of waiting times and also include the use of additional interventions such as botox for bladder overactivity, pessary use for prolapse and urethral bulking operations.

It is believed that up to 50% of women may have an anatomical prolapse where the pelvic organs slip down into the vaginal space. This may be the front, back, or the roof of the vagina supporting the bladder, rectum or uterus respectively. Data suggests that about 11-15% women present with a symptomatic prolapse. This suggests that there is a very significant gap where health education could perhaps prevent women with prolapse becoming symptomatic with early interventions. This work has to some extent begun with the implementation of the Perinatal Pelvic Health Services implementation programme. Every perinatal clinical encounter should ask whether there are any pelvic floor and

continence issues and the assurance that while these symptoms are common they are not normal.

Guidelines

As suggested above there are a number of guidelines available to get best practice in primary, secondary and tertiary care. This inquiry should ask government how healthcare implementation could improve. Where a guideline is available for a specific condition such as endometriosis, resource needs to follow to allow women to know that it exists and to enable healthcare providers to adjust their service provision to meet the standards.

One of the areas of difficulty is that many organisations develop their own guidelines and inevitably there is considerable overlap of time and resource. It is imperative that there is a centrally driven evidence-based pathway for all the major conditions. All the stakeholders could be involved, with patient representation and clinical pathways advised and then adopted. Key to this would be having a communication pathway for women so they can identify what 'gold standard' looks like. Many of these projects are funded directly or indirectly so this would be adjustment rather than new financing.

Pain

It is well recognised that pain is a condition in itself and requires a multidisciplinary approach to improve the quality of life for those with chronic or acutely painful conditions such as endometriosis or adenomyosis. Women with these conditions are known to have gone through multiple appointments in primary and/or secondary care and have had numerous tests and procedures that may not have been indicated. Understanding where to speed up the diagnostic process would help to reduce the chronicity of these conditions for women who are young and suffer considerable hardship financially socially and mentally due to the uncertainty that they have to tolerate. Specialist services should be expanded and not be limited to a few centres, especially as endometriosis effects up to 10% of the female population– they are currently hard to access and find, with long waiting lists and some with very restrictive criteria.

Conclusion

POGP would further welcome the opportunity to be involved in providing oral evidence to this select committee. Our members work across the UK and in all areas of healthcare and in urinary incontinence and vaginal prolapse, physiotherapy is the recommended first line of management by NICE.

Apart from the direct aspects of the scope of this committee, it is often suggested that optimal pelvic health and pelvic floor function could be achieved with earlier education programmes for schoolchildren, consistent access to information and support for women in

their childbearing years, encouragement to seek help in the perimenopause when pelvic floor dysfunction often presents, and much improved training and continence care (not incontinence management) in the elderly particularly those in social care and supported living.

Helping women to understand that help is available and to know what the many different professionals in this field can provide is key to healthcare in this area and helping women to help themselves.

September 2023