Classification: Official

Publication reference: PRN00147

Service specification: Perinatal Pelvic Health Services

16 October 2023, Version 1

1. Scope

1.1 Introduction

This service specification covers the provision of Perinatal Pelvic Health Services (PPHS). The definitions and standards set out below should be used as a guide to establish a system-wide service that is available to all women within the Local Maternity and Neonatal System (LMNS) footprint antenatally and for at least 12 months postnatally. The service should be coproduced with the multi-disciplinary team and local service users and tailored to local needs, expertise, and opportunities.

This document should be read in conjunction with the national Implementation Guidance for PPHS (to be published imminently in October), which for each section of this specification sets out:

- relevant national guidance, standards, and evidence;
- the support and resources available for implementation; and
- examples of good practice from established services.

1.2 Service description

PPHS lead local delivery of the national NHS Long Term Plan ambition to improve the prevention, identification, and referral to NICE-recommended treatment for pelvic health problems during pregnancy and at least one year following birth, with the aim of reducing the number of women living with pelvic health problems postnatally and in later life. PPHS will expand the core service offer beyond existing NICE and RCOG Green-top Guidelines on care for obstetric anal sphincter injuries (OASI). The services will ensure that all pregnant

women receive advice and support to prevent pelvic health problems, and that those with problems are offered all conservative treatment options before surgery is considered, in line with NICE Guidance.[1]

1.3 Background

There is no systematic national data on perinatal pelvic health problems in England. Research estimates that about one in three women experience urinary incontinence three months after pregnancy,[2] around one in seven anal incontinence six months after birth,[3] and one in 12 women report symptoms of pelvic organ prolapse.[4] However, pelvic health problems are commonly under-reported due to embarrassment, shame, or a belief that problems are 'normal' before or following childbirth[5] and cannot be treated. The impact of pelvic health problems and their ramifications for women's lives can be devastating. Pelvic health problems can affect women's ability to work, their sexual and social relationships, and evidence has linked poor pelvic health with poor mental health.[6]

The NHS Long Term Plan set out a commitment to "improve access to postnatal physiotherapy to support women who need it to recover from birth" and to "ensure that women have access to multidisciplinary pelvic health clinics and pathways across England".

NICE Guidance recommends that all women using maternity services should be given information on pelvic floor dysfunction, how to prevent it, the symptoms, and how to access local treatment; and that for women with urinary incontinence and pelvic organ prolapse, non-surgical interventions including physiotherapy should be offered before surgical interventions are discussed.[7] This was echoed in the 2020 Independent Medicines and Medical Devices Safety Review, which recommended that "Conservative measures must be offered to women before surgery. We have heard that specialist pelvic floor physiotherapy cannot match the current demand. The service commissioner should identify gaps in the workforce… A co-ordinated strategy can then be developed to remedy the gap."[8]

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[1] Overview | Urinary incontinence and pelvic organ prolapse in women: management | Guidance | NICE
[2] Thom DH, Rortveit G. Prevalence of postpartum urinary incontinence: a systematic review. *Acta Obstetricia et Gynecologica Scandinavica* 2010; 89(12): 1511-22.
[3] Johannessen HH, Mørkved S, Stordahl A, Wibe A, Falk RS. Evolution and risk factors of anal incontinence during the first 6 years after first delivery: a prospective cohort study. BJOG. 2020 Nov;127(12):1499-1506. doi: 10.1111/1471-0528.16322. Epub 2020 Jun 8. PMID: 32418309.
[4] NICE Guideline – [NG123] Urinary incontinence and pelvic organ prolapse in women: management
[5] Ross, S. Baird, B. Women's experience of gynaecological and urogynaecological services in primary and secondary care. *The King's Fund* 2019
[6] Woolhouse, H, et al (2014). Physical health after childbirth and maternal depression in the first 12 months post partum: results of an Australian nulliparous pregnancy cohort study. Midwifery, 30(3), 378-384.
Giallo, R., Pilkington, P., McDonald, E., Gartland, D., Woolhouse, H., & Brown, S. (2017). Physical, sexual and social health factors associated with the trajectories of maternal depressive symptoms from pregnancy to 4 years postpartum. Social psychiatry and psychiatric epidemiology, 52(7), 815-828.
[7] NICE NG123 (Urinary incontinence and pelvic organ prolapse in women: management)
[8] the Independent Medicines and Medical Devices safety Review (immdsreview.org.uk)

2. Care pathway and clinical dependencies

2.1 Care pathway

PPHS are responsible for working with maternity and other perinatal services to improve the prevention, identification, and access to NICE-recommended[9] treatment for pelvic health problems antenatally and at least 12 months postnatally. PPHS should be established System-wide with shared protocols and standards so that all women within each LMNS footprint can expect to receive the same standards of care. PPHS will work with local service users and Maternity and Neonatal Voices Partnerships (MNVPs) to coproduce the care pathway.

PPHS have three overarching functions, beneath which are a range of key actions (see **Appendix A: Overview of Perinatal Pelvic Health Service ambitions**):

- To embed evidence-based practice in antenatal, intrapartum and postnatal care to prevent and mitigate pelvic health problems resulting from pregnancy and childbirth.
- To improve the rate of identification of pelvic health problems antenatally and postnatally.
- To ensure timely access to NICE-recommended conservative treatment for common pelvic health problems antenatally and at least 12 months postnatally in inpatient and outpatient settings.

PPHS will provide services relating to pelvic health problems around pregnancy and birth, typical presentations include but are not limited to:

- Urinary incontinence
- Emptying disorders of the bladder
- Anal incontinence
- Emptying disorders of the bowel
- Pelvic organ prolapse
- Perineal tears
- Perineal wound infection
- Sexual dysfunction related to birth
- Rectus abdominis diastasis
- Pelvic girdle pain (PGP)

It is for local Systems to determine which presentations should be led by the PPHS. In any case, the PPHS is intended to build on – and not replace – existing pathways and capacity. Where pathways and capacity are in place to provide treatment for any of the presentations

[9] Overview | Pelvic floor dysfunction: prevention and non-surgical management | Guidance | NICE

above – for example, MSK pathways to support PGP or Cauda Equina Syndrome – these should continue, with the PPHS playing a co-ordinating/referring role.

Some women experience healthcare inequalities in maternity and wider health services, and this includes but is not limited to women from an ethnic minority background, women living in the most deprived areas, women with multiple long-term health conditions, women from other groups that share protected characteristics as defined by the Equality Act 2010, and those experiencing social exclusion. PPHS should therefore consider and monitor access, experience, and outcomes for these groups and ensure alignment with LMNS Equity and Equality Action Plans.

2.1.1 Embed evidence-based practice in perinatal care to prevent and mitigate pelvic health problems resulting from pregnancy and childbirth

a) Routine education about pelvic health problems antenatally and postnatally

PPHS will ensure that all women using maternity services in the LMNS footprint receive routine information at every contact antenatally and postnatally about perinatal pelvic health; problems that could arise; and how to prevent them.

The PPHS will work with relevant healthcare professionals – including but not limited to staff in maternity services, primary care and health visiting – to make sure that information about pelvic health problems is discussed with women at all routine perinatal appointments. As set out in NICE Guidance,[10] this should include a discussion about the symptoms of pelvic health problems; risk factors; prevention, including pelvic floor exercises (PFE); when to get help; where to go for help; and potential management options.

Verbal discussions should be accompanied with further information resources. PPHS should also seek to integrate information on pelvic health into local maternity apps and/or information portals where in use, which can enable information to be staggered at relevant points in the perinatal pathway. Two types of patient information resources should be provided in the perinatal period:

(1) **Clinical information**, which should include: the symptoms of pelvic health problems; visual aids to help identify potential causes of symptoms; when to get help; and an outline of risk factors, prevention (including PFE) and management options (including non-surgical management and lifestyle changes) in line with NICE Guidance.[11] Information should be provided for the antenatal, intrapartum,

[10] Overview | Pelvic floor dysfunction: prevention and non-surgical management | Guidance | NICE
[11] Overview | Pelvic floor dysfunction: prevention and non-surgical management | Guidance | NICE

and postnatal periods, which, in addition to the information previously stated, should include:

(a) **Antenatal and intrapartum information** should include physical activity in pregnancy, birth choices and preparing for birth (including perineal tears and what can be done to reduce the risk of tears).

(b) **Postnatal information** should include advice on post-birth recovery (including timeframes and what is considered 'common'), wound care, perineal tears, bladder care, constipation, when to resume PFE and how to embed as a lifelong habit, returning to physical activity, and mental health.

NHS England is commissioning the development of a clinical patient information standard for perinatal pelvic health, which will set out standards and materials for the provision of printed and electronic information throughout the perinatal period. This will be available by the end of 2023/24. Until this standardised information is available services should use existing resources.

(2) **Local service information**, which should be coproduced with local service users and include: how to access help locally (including self-referral), what sort of help might be provided, a link to a self-assessment tool, and signposting to other relevant services and resources, including mental health support and services for women who are not in the perinatal period.

Information resources should be coproduced with the multi-disciplinary team and service users to ensure they are relevant and accessible for local populations. Resources should be available in a range of formats, including printed leaflets and digital information, and include visual aids such as illustrations and videos.

Information resources should be culturally competent and accessible, in line with the *Accessible Information Standard*. Women's information needs should be assessed at the booking appointment and information should then be provided in a format that they are best able to access. Resources should be translated into key languages, with consideration for the language needs of the local population.

It is recommended that PPHS additionally hold group information sessions on perinatal pelvic health problems, either in-person or online. These could be stand alone or as part of other antenatal classes. Consider also carrying out community outreach, particularly for communities most likely to experience healthcare inequalities, for example by working with relevant community groups and involving members of the community as champions or peer supporters.

b) A baseline self-assessment of pelvic health as early as possible in pregnancy and postnatally

The PPHS will work with maternity services to ensure that all women are offered a self-assessment of their pelvic health as early as possible in pregnancy - by 18 weeks. The PPHS will engage with primary care to encourage offer and signposting of the assessment at the postnatal GP check, so that women with identified problems can be referred for specialist support as appropriate. The assessment could be repeated later in antenatal and postnatal care to identify issues that arise and quantify any deterioration in pelvic floor function. The tool should link to the Single Point of Access to facilitate referral to treatment where needed.

NHS England have commissioned the development of a Perinatal Pelvic Health Self-Assessment Tool which will be available in the summer of 2024. Where services have already established a self-assessment tool, this should continue to be used until the national tool is available. All other services should plan for adoption of the NHS England tool (or an equivalent clinically-validated tool) from summer 2024.

c) Information and advice to begin Pelvic Floor Exercises (PFE) antenatally, and support to continue throughout perinatal care

PPHS will work with maternity services to ensure that women are given taught and supported to do PFE as early as possible in pregnancy and throughout routine antenatal care. Women should be encouraged to do PFE regularly and advised that it helps prevent symptoms of pelvic floor dysfunction in pregnancy, postnatally and in later life.[12] PPHS will also work with maternity, primary care and health visiting services to make sure that during routine postnatal care women are again shown how to do PFE, when to resume PFE and encouraged to do so.[13]

The PPHS will ensure a range of resources are provided to women on how to do PFE, which could include leaflets, websites, and mobile apps. Additional support should be available for women who need more time to learn how to perform PFE correctly.

PPHS should consider holding group classes or one-to-one appointments that provide information and support with PFE, either online or in-person. These could be standalone or as part of other antenatal classes. PPHS may also consider using a risk assessment tool (see section 2.1.1.d) to identify women at greater risk of pelvic health problems and offer them a more structured programme of PFE.

[12] NG210
[13] NG210

PPHS should further consider how adherence to PFE might be assessed to support any service-level evaluation of outcomes.

d) Additional support for those identified as at higher risk of issues

PPHS should provide targeted specialist preventative support and interventions for women identified as being at greater risk of pelvic health problems.[14] This should include adopting shared standards and protocols for identifying pregnant women considered at greater risk. PPHS should consider providing additional preventative support for these women, which could include one-to-one appointments or group classes (in-person or online).

e) Adopt practice to mitigate the risks of obstetric injury during birth, and provide quality wound care

PPHS will work to support maternity services to review and improve obstetric and midwifery practice to minimise the risk of obstetric injury during birth (including perineal tears, bruising and birth trauma) and provide quality wound care in line with NICE Guidance.[15]

In particular, PPHS will work with maternity services to implement the Royal College of Obstetricians and Gynaecologists OASI Care Bundle to reduce rates of OASI.[16]

2.1.2 Improve the rate of identification of pelvic health problems antenatally and postnatally

a) Provision of training and information for relevant staff groups

PPHS will engage with relevant staff groups to embed training on perinatal pelvic health in line with the indicative standards set out in the Core Capabilities Framework for Perinatal Pelvic Healthcare (due for publication in Q3 23/24). In addition to maternity staff, PPHS should engage with key primary care staff, health visitors and any other relevant groups across the LMNS that see women perinatally. This will include conducting outreach, education, and training events as required, led by specialist physiotherapists or specialist midwives.

The PPHS will raise awareness amongst relevant staff groups of available patient information (see section 2.1.1.a), assessment tools (see section 2.1.1.b) and the single point of access (see section 2.1.3.b).

[14] Overview | Pelvic floor dysfunction: prevention and non-surgical management | Guidance | NICE
[15] Overview | Intrapartum care for healthy women and babies | Guidance | NICE
[16] Impact of a quality improvement project to reduce the rate of obstetric anal sphincter injury: a multicentre study with a stepped-wedge design - Gurol-Urganci - 2021 - BJOG: An International Journal of Obstetrics & Gynaecology - Wiley Online Library

b) Follow-up for women who have experienced risk factors for pelvic health problems during birth

The PPHS will agree shared pathways and protocols for follow-up in inpatient and outpatient settings for women who have experienced risk factors for pelvic health problems during birth, including but not limited to: assisted vaginal birth (forceps or vacuum), a vaginal birth when the baby is lying face up (occipito-posterior), and injury to the anal sphincter (perineal trauma and tears).

2.1.3 Ensure timely access to NICE-recommended treatment in inpatient and outpatient settings for common perinatal pelvic health problems

a) Specialist physiotherapy treatment for pelvic health problems in line with NICE Guidance

The PPHS will ensure that women with symptoms of pelvic health problems have access to appropriately timed pelvic health physiotherapy assessment and personalised treatment – including specialist physiotherapy - in line with NICE Guidance and NHS waiting time standards, as set out in the Constitution handbook[17]. PPHS should develop shared standards for which women will require 'urgent care' and what constitutes 'appropriately timed' care.

The service should be available to all women antenatally and for at least 12 months postnatally. The PPHS will ensure that for these women, conservative management is always considered - and where appropriate, offered - before surgical interventions are discussed.

The PPHS is intended to supplement – and not replace – existing pathways and capacity. Where pathways and capacity are already in place for any 'in scope' conditions – for example, pathways to support PGP, Cauda Equina Syndrome or rectus abdominis diastasis– these should continue, with the PPHS playing a co-ordinating/referring role.

It is important that services are accessible, particularly for those most likely to face health inequalities and for women with symptoms that affect their ability to access care. This may mean offering consultations in-person, by video, over the phone or in community settings.

Evidence has linked poor pelvic health with poor mental health[18]. PPHS will further ensure there is appropriate screening for symptomatic women, signposting and agreed referral pathways to relevant mental health services.

[17] https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england/the-handbook-to-the-nhs-constitution-for-england
[18] Ibid 6

b) A single point of access for perinatal pelvic health services

The PPHS will operate a single point of access (SPoA) across the LMNS footprint, to streamline the referral process and ensure that both conservative support and treatment and – where required – referral for surgical management is available in a co-ordinated, timely manner.

Where one single point of access is not feasible across the LMNS footprint (for example, due to a lack of digital interoperability), *standardised* points of access can be established across the footprint. In this case, every point of access must work to shared standard operating procedures (SOPs), with individual monitoring/review to ensure equal service provision and standards across the System. The number of standardised points of access should be kept to a minimum to reduce complexity and decision making for signposting professionals and women. Obstacles to establishing a SPoA should be raised in the appropriate issues log and kept under review, with a view to future resolution.

SOPs should be developed locally and include standards for triaging referrals, definitions for urgent and routine cases and timeframes within which each should be seen. There should also be clear protocols for seamless facilitation to surgical or other specialist management if necessary, with communication and links to consultants within gynaecology, urogynaecology and colorectal services. SOPs will need to include an agreed procedure for managing inappropriate referrals and red flags.

Triage of referrals should always be undertaken by an appropriately trained physiotherapist or suitably trained counterpart. Dedicated administrative capacity must also be specified to support operation of the single point of access and appointment scheduling. This capacity can either come from existing establishment in maternity or therapies services or be funded by the PPHS.

PPHS need to consider how information on care is stored and passed between services, how outcomes and improvements are audited and measured, and how feedback is passed back across services as appropriate.

PPHS should have the capability to track and audit referrals into the SPoA. Data collected should include information on the type of referral (clinician or self), type of pelvic health problem at referral, parity, age, language, whether the woman has any disabilities, and their ethnicity and postcode. Data on the latter measure of ethnicity and postcode should be used to assess whether PPHS are being accessed at an equitable rate by those most likely to experience health inequalities. Services should also routinely monitor and review referral to treatment times.

PPHS will need to consider accessibility requirements for the single point of access, including translations and paper-based forms or digital support for those who need it. Wherever possible, the single point of access should also support service user choice on where to receive assessment and treatment.

c) Reduce referral to treatment times by streamlining referral processes

The single point of access should accept self-referrals alongside clinical referrals to reduce waiting times and minimise administrative barriers to treatment. The ability to self-refer should be made available to women antenatally and for at least 12 months postnatally.

A clinically validated assessment tool (as specified in 2.1.1.b) can be linked to the self-referral process to ensure self-referrals are appropriate and to facilitate triage.

d) Leadership in the local planning, provision, and improvement of perinatal pelvic health care

The PPHS will lead and collaborate in the planning, provision, and improvement of perinatal pelvic health care across providers, specialities, and community services in the local Integrated Care System (ICS).

PPHS leads will need to provide professional leadership and co-ordination to ensure that clinicians and other professionals across the perinatal pathway know how to identify, refer and help manage problems as appropriate; and foster good communication between professionals to ensure that women receive high-quality, evidence based, easy to access, seamless and integrated support.

PPHS will work with all relevant services to ensure that all women receive the same level of information and support across all possible pathways, including women who have had a stillbirth, women with babies in neonatal services, women who have had their baby removed at birth, women in mother and baby units, and women in the criminal justice system.

Quality improvement and change management strategies should be implemented by the service team to support the improvement of care.

2.2 Co-dependencies with other services

Maternity and physiotherapy

PPHS should be jointly led by maternity and physiotherapy services, and will need to ensure integration and collaboration with both services.

PPHS should be provided antenatally and for a minimum of 12 months postnatally and ICSs should consider pathways and capacity to support women who fall outside this access criteria. PPHS will also need to collaborate with existing pelvic health, continence and musculoskeletal services to ensure integration of care for women with OASI, PGP and other related perinatal physical health issues.

PPHS will work with midwives and midwifery support workers to improve their ability and confidence to provide advice and support on perinatal pelvic health antenatally and postnatally, and to improve intrapartum practice. PPHS will work with obstetricians to improve intrapartum practice to reduce the risk of obstetric injury during birth and provide quality wound care, including implementing the OASI care bundle.

Gynaecology, urogynaecology and colorectal

Pathways for consultant led OASI care, and MDTs for complex pelvic health and gynaecological care should be in place already, in line with NICE Guidance[19] and RCOG Greentop Guidelines[20]. PPHS will build on these existing services, broadening the service offer beyond OASI and other complex care.

NICE Guidance sets out that non-surgical treatment should always be offered before surgical options are considered for pelvic health problems. PPHS must be collaborative support services to the maternity frontline and the community. There is a need for quick facilitation to surgical management, if necessary, with communication and links to consultants within gynaecology, urogynaecology and colorectal. Teams should work together to support women to make informed decisions about their care and to develop a personalised care plan, using shared decision making that involves the woman, healthcare professionals with expertise in rehabilitation and recovery, and those with expertise in interventions.

There should be representation from the medical team on the PPHS multi-disciplinary team and the doctor responsible should be consulted and support integration of complex conditions back to the hospital and surgery list where required.

Primary care, health visiting, and family and Women's Health hubs

PPHS should engage with all services that see women in the perinatal period. In particular, PPHS should engage with Primary Care so that women receive appropriate support and advice at the postnatal GP check and other postnatal appointments. PPHS should also work with Health Visitors to improve the advice and support they provide postnatally in relation to

[19] Overview | Urinary incontinence and pelvic organ prolapse in women: management | Guidance | NICE
[20] Third- and Fourth-degree Perineal Tears, Management (Green-top Guideline No. 29) | RCOG

pelvic health. Further, PPHS should consider opportunities to work with Family and Women's Health Hubs, including the potential to be co-located in the community.

Mental health services

Pelvic health problems are linked with poor mental health postnatally[21] and it can be distressing for women to discuss issues related to pelvic health. PPHS should therefore establish links with mental health services, particularly maternal mental health services, perinatal mental health services and psychosexual counselling services, to ensure effective signposting and referral between pelvic and mental health care and vice versa.

Service User Representation

The service should be coproduced with a diverse range of service users – representative of the local population – to ensure that it meets the needs of and is accessible to all women, including those most likely to experience health inequalities. When planning service user engagement, LMNS should consult the NHS England statutory guidance on *Working in partnership with people and communities*.

Services will engage with local service users on a regular basis, to ensure they are involved in the local planning and improvement care, in line with local patient and public involvement policies. PPHS should consider having a Service User Voice Representative with lived experience of perinatal pelvic health problems on the project team and this role should be flexible and appropriately remunerated to facilitate accessibility and equity. PPHS should also look to work with and update the MNVP on the progress of the PPHS. Services should further consider the variety of opportunities available for engaging service users, such as by working with community groups, children's centres, and places of worship, as well as utilising social media.

Voluntary, Community and Social Enterprise (VCSE) Groups.

A wealth of voluntary, community and social enterprise (VCSE) groups and other organisations offer support across the country to women on pelvic health, though this varies from area to area. PPHS should therefore engage with VCSE groups from an early stage, as a means to gain service user input, raise local awareness of the PPHS service offer, but also where appropriate to signpost for additional community support.

[21]Woolhouse, H, et al (2014). Physical health after childbirth and maternal depression in the first 12 months post partum: results of an Australian nulliparous pregnancy cohort study. Midwifery, 30(3), 378-384.
Giallo, R., Pilkington, P., McDonald, E., Gartland, D., Woolhouse, H., & Brown, S. (2017). Physical, sexual and social health factors associated with the trajectories of maternal depressive symptoms from pregnancy to 4 years postpartum. Social psychiatry and psychiatric epidemiology, 52(7), 815-828.

2.3 Staffing

The PPHS will ensure that there is defined dedicated clinical establishment within the multi-disciplinary team to carry out these key functions. This will be based on analysis of local needs; however, at a minimum, dedicated specialist capacity for the PPHS should include:

- **A lead Specialist Pelvic Health Physiotherapist (recommended Band 8a or above)** to oversee and provide clinical leadership and service management, as well as to provide the most specialist care (ideally they would be an Advanced Clinical Practitioner). This role should also support training, education, and development for other staff in the PPHS team.
- **Pelvic Health Physiotherapists** to provide day to day specialist pelvic health care, outreach to other services and triage referrals as appropriate. For succession planning and sustainability of the service, there should be dedicated time in the PPHS for physiotherapists in a range of bands, including ongoing placements in local junior physiotherapist rotations, and offering student physiotherapy placements wherever possible.
- **A Specialist Midwife or Midwife with a special interest in pelvic health (recommend Band 7 or in line with local requirements)** to work with staff in maternity services to improve pelvic health care.
- **Administrative support** to support with the administrative needs of PPHS, including but not limited to: administration relating to the single point of access, pathway coordination, being a point of care for patients to navigate the system, support for classes, providing standard information, following-up to ensure attendance at appointments, and collecting data.

Recommended bandings have been indicated for some posts, based on early roll out experience. However, it will be for local systems to determine what additional staffing is best required to deliver the objectives set out in section 2.1 and the local vision and plan to improve care. Clinical establishment – including grade and whole time equivalency - should be clearly defined within the PPHS' commissioning documents, and should be reviewed at agreed intervals against rates of referral into the single point of access and assessments of Referral to Treatment Times for both urgent and routine presentations, so as to ensure appropriate capacity.

Processes and ongoing funding should be put in place to ensure that all staff groups have access to training, development, regular peer support and review, in service training, appraisal, job planning, and mandatory training, including with colleagues nationally, as appropriate.

The PPHS should have an operational resilience plan to maintain service delivery through periods of planned and unplanned absence. As part of this, the PPHS should address current and future staffing needs through succession planning against critical posts and ensure that development opportunities are in place for those with the potential to fill these posts.

The PPHS should give due consideration to ensuring representation of local communities within the clinical team.

2.4 Service governance and leadership

The PPHS should be jointly led by maternity and physiotherapy services, with joint oversight including regular review of service KPIs, risks and issues, in both Women's and Children's/Maternity and Therapies' governance. Within this:

- Women's and Children's should take a lead on operational issues, to ensure that services and staffing levels are meeting the needs of the local population. This means that day-to-day escalation of any PPHS staffing should be agreed with maternity leads. They should also lead on professional matters relating to midwives or midwifery support roles.
- Therapies should take a lead on professional physiotherapy matters, to ensure sustainable staffing. This should involve physiotherapist recruitment, training and professional development, peer support and review (2.3.1) along with ensuring alignment with local physiotherapy rotations and trainee placements.

Operational resilience plans (as described in 2.3.1) should therefore be jointly agreed between Women's and Children's and Therapies leadership.

2.5 Clinical settings

PPHS should identify and establish treatment rooms in outpatient care settings, to provide care as close as possible to women and in the community where possible, such as in primary care premises, community hospitals or in family/community hubs.

Appropriate treatment rooms would include:

- A bed and curtained area for service users to undress
- A sink
- A computer or desk for a laptop, and a telephone
- Adequate space, ideally enough for a pram or cot and a support partner or chaperone
- Access to a toilet

2.6. Funding and commissioning

Funding for PPHS is intended to respond to gaps in existing care provision and add to existing services. Where an existing service exists that aims to meet the needs set out in 2.1, it is not expected that the PPHS would replace this provision; but that pathways should seamlessly augment existing services. PPHS funding is intended for local systems to build on – and not replace or detract from – existing funded staffing establishment.

From April 2024, an additional £11.2m sustained funding will be allocated to Integrated Care Boards (ICB) baselines, of which [FOR LOCAL COMPLETION: £X,000 PA will be allocated to X Integrated Care Board] to support the provision of PPHS. This should be used to secure sufficient additional capacity for PPHS activities, including professional leadership, training, education and outreach, and more generally to provide an optimal staffing level for best practice care as set out in 2.3. Funding can also be used to cover recurrent service-related costs such as for digital single points of access, or resources to encourage compliance with PFE. Allocations are based on Systems' respective shares of the national funding available using the ICB Core Target allocations methodology, and therefore could be subject to fluctuations in future years in accordance with that methodology. PPHS funding will be revenue spend.

3. Population covered and population needs

3.1 Population covered by this specification

This service is for all women in [nb. FOR LOCAL COMPLETION] who are pregnant and for at least 12 months after birth, including for women who have experienced a stillbirth or miscarriage.

3.2 Population needs

There were 624,828 live births in England and Wales in 2021[nb. AMEND AS APPROPRIATE FOR LOCAL COMPLETION]. and this figure remains in line with the long-term trend of decreasing births.[22] Despite this trend, there has been an increase in the proportion of women having more medically complex births.[23]

There is no national data on the prevalence of either urinary or anal incontinence or pelvic organ prolapse, and estimates based on the best available research vary significantly. However, it is estimated that a third of women experience urinary incontinence at three

[22] Births in England and Wales - Office for National Statistics (ons.gov.uk)
[23] Comptroller and Auditor General, Maternity Services in England, Session 2013-14 HC 794, National Audit Office, November 2013

months postpartum, and that this prevalence only changes slightly over the first year.[24] More than two-thirds of women with postpartum urinary incontinence will still report it 12 years later[25] A recent study found that 23% of women experienced anal incontinence in late pregnancy, 13.3% reported incontinence a year later and 13.7% at six years after childbirth.[26] In primary care in the UK 8.4% of women report symptoms of pelvic organ prolapse, and on examination prolapse is present in up to 50% of women.[27] Pelvic health problems are thought to be significantly underreported due to embarrassment or a perception that pelvic health problems are not a health concern, so the true prevalence may be higher.[28]

3.3 Evidence base

Cochrane review evidence shows that for women who were continent at the start of pregnancy, structured PFE in early pregnancy can bring about a 62% reduction in incidence of urinary incontinence in late pregnancy, and a 29% reduction at 3-6 months postpartum.[29] The review found that there is less clear available evidence around the effects of PFE as a treatment for women who were incontinent at the beginning of pregnancy..[30] Physiotherapy is also the most cost-effective intervention for preventing and treating incontinence and prolapse.[31]

According to the 2022 CQC maternity survey, less than half of women (47%) said they were 'definitely' given information about their own physical recovery after birth and almost a third (32%) said their GP did not spend enough time talking to them about their own physical health.[32]

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4. Outcomes and applicable quality standards

4.1 Quality statement – aim of service

- All women receive routine antenatal and postnatal information on pelvic health problems, can identify problems and seek treatment.
- All women report their initial baseline situation as early as possible in pregnancy - by 18 weeks - and at the postnatal GP check using a validated self-assessment tool.
- All women receive information and support on how to do PFE as early in pregnancy as possible and as part of routine antenatal and postnatal care.
- Fewer women experience perineal tears; in particular, fewer OASI (third- and fourth-degree tears).
- There are fewer emergency readmissions into acute services due to wound breakdown postnatally.
- All staff providing care and support to women (including those working in maternity and gynaecology services, primary care and health visitors) are competent and confident in the identification and, where appropriate, management or referral pathways for pelvic health problems; accessing regular training as required to maintain their skills.
- Services grow their capacity to meet demand, by increasing their establishment of Specialist Physiotherapists and other relevant staff within PPHS.
- All women, for whom it is appropriate, can be referred to specialist, personalised care in a timely manner (either via a clinician referral or via self-referral). A single point of access and clear and streamlined referral pathways are in place for all women antenatally and for at least 12 months postnatally.
- Women experience improved pelvic health at defined points antenatally and postnatally, following treatment and intervention from PPHS.
- Women are satisfied with the quality of specialist care and support when needed.
- Women across ethnicities and those living in the most deprived areas are referred to PPHS at an equitable rate.

Table 1: NHS Outcomes Framework domains

The NHS Outcomes Framework sets out the high-level national outcomes that the NHS should be aiming to improve. They focus on improving health and reducing health inequalities.

Domain 1	Preventing people from dying prematurely	
Domain 2	Enhancing quality of life for people with long-term conditions	X
Domain 3	Helping people to recover from episodes of ill-health or following injury	X
Domain 4	Ensuring people have a positive experience of care	X
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	X

4.2 Applicable obligatory national standards

- Pelvic floor dysfunction: prevention and non-surgical management [NG210], NICE guideline, 2021
- Postnatal care [NG194], NICE guideline, 2021
- Antenatal care [NG201], NICE guideline, 2021
- Urinary incontinence and pelvic organ prolapse in women: management [NG123], NICE guideline, 2019
- Intrapartum care for healthy women and babies [CG190], NICE Clinical guideline, 2017
- Faecal incontinence in adults: management [CG49], NICE Clinical guideline, 2007

4.3 Other applicable national standards

- NHS waiting time standard (NHS Constitution handbook)
- Core Capabilities Framework for Perinatal Pelvic Healthcare, Skills for Health, 2023
- POGP UK Clinical Guideline on Best Practice in the Use of Vaginal Pessaries, 2021
- Royal College of Nursing, Bladder and Bowel Care in Childbirth, 2021
- Murphy DJ, Strachan BK, Bahl R, on behalf of the Royal College of Obstetricians Gynaecologists. Assisted Vaginal Birth. BJOG 2020;127:e70–e112.
- NMC Standards of proficiency for midwives, 2019

- The Management of Third- and Fourth-degree Perineal Tears, (Green-top Guideline No. 29), Royal College of Obstetricians and Gynaecologists, 2015
- The Initial Management of Chronic Pelvic Pain (Green-top Guideline No. 41), Royal College of Obstetricians and Gynaecologists, 2012

4.4 Key performance indicators (KPIs)

All PPHS will need to monitor service performance, outcomes, and women's experiences of receiving care. There are two types of KPIs:

- **Locally collected KPIs:** should be collected locally for service monitoring and improvement.
- **Nationally collected KPIs:** where routine national data is available and will be monitored on national dashboards.

Services should ensure that where possible, data is collected and analysed according to ethnicity and indices of multiple deprivation. For measures of patient experience, it is important that the data includes appropriate representation from those groups most likely to be impacted by health inequalities.

The KPI collection process, including service user surveys, should be codesigned and the results regularly evaluated with local service users and where possible the local MNVP.

Locally collected KPIs

- **1:** Is coproduced information and education for service users in place across all linked providers?
- **2:** The proportion of service users who are confident in their knowledge of key perinatal pelvic health symptoms and where to find advice/support antenatally.
- **3:** The proportion of service users completing a baseline self-assessment by 18 weeks gestation (for use when national Self-Assessment Tool published).
- **4:** The proportion of service users completing baseline self-assessment at six to eight weeks postnatally (for use when national Self-Assessment Tool published).
- **5:** The proportion of service users who are confident to begin and maintain pelvic floor exercises.
- **6:** The proportion of service users who report being routinely asked about pelvic health in postnatal care.
- **7:** Whole time equivalency (WTE) and banding of specialist physiotherapists and midwives with time dedicated to PPHS.

- **8:** Is a Single Point of Access in place for all service users with perinatal pelvic health problems across all linked providers?
- **9:** Rate of referrals to service (clinician or self-referral).
- **10:** The proportion of service users who are satisfied with how quickly they can receive specialist care from a pelvic health physiotherapist when needed.
- **11:** Numbers waiting for Referral to Treatment (RTT) in time bands from referral to first physiotherapy appointment.
- **12:** The proportion of service users reporting improvements on patient functional rating scales (for use when national Self-Assessment Tool published).
- **13:** The proportion of service users satisfied with the quality of specialist care and support when needed.

Nationally collected KPIs

- **14:** The proportion of service users who felt that the GP definitely spent enough time talking to them about their own physical health at the six to eight week postnatal check. (CQC Maternity Survey)
- **14:** Percentage of third- and fourth-degree tears.

5. Abbreviations and acronyms explained

- ICB: Integrated Care Board
- ICS: Integrated Care System
- LMNS: Local Maternity and Neonatal Service
- MNVP: Maternity and Neonatal Voices Partnership
- NICE: National Institute for Health and Care Excellence
- OASI: Obstetric Anal Sphincter Injury
- PFE: Pelvic Floor Exercises
- PGP: Pelvic Girdle Pain
- PPHS: Perinatal Pelvic Health Service
- WTE: Whole time equivalency

Appendix A: Overview of Perinatal Pelvic Health Service ambitions

	Prevention	Identification	Treatment
Antenatal	All women receive routine education about pelvic health problems antenatally (2.1.1.a)		All women are offered physiotherapy treatment for pelvic health problems in line with NICE Guidance (2.1.3.a)
	All women are offered a baseline self-assessment of pelvic health antenatally by 18 weeks (2.1.1.b)		All women are referred for treatment via a single point of access for perinatal pelvic health services (2.1.3. b)
	All women are given advice and information to begin Pelvic Floor Exercises antenatally, and are supported to continue throughout perinatal care (2.1.1.c)		All women can access appropriately timed treatment with the option to self-refer (2.1.3. c)
	All women identified as at higher risk of issues receive additional preventative support (2.1.1.d)		
Intrapartum	All women are offered intrapartum care that reduces the risk of obstetric injury during birth and quality wound care. This should include compliance with the OASI Care Bundle (2.1.1.e)		
Postnatal (for at least one year)	All women receive routine education about pelvic health problems postnatally (2.1.1.a)	All women who have experienced risk factors for pelvic health problems during birth receive appropriate follow-up (2.1.2.b)	All women are offered physiotherapy treatment for pelvic health problems in line with NICE Guidance (2.1.3.a)
	All women are offered a self-assessment of pelvic health postnatally at 6 – 8 weeks (2.1.1.b)		All women are referred for treatment via a single point of access for perinatal pelvic health services (2.1.3. b)
	All women are given advice and information to resume Pelvic Floor Exercises postnatally (2.1.1.c)		All women can access appropriately timed treatment with the option to self-refer (2.1.3. c)