# Management practices for urinary incontinence in women in the primary care setting: health care professionals' perspective


## Abstract

Urinary incontinence (UI) is a debilitating condition affecting up to 40 % of women. NICE guidelines and the NHS long term plan recommend access to multi-disciplinary teams for management of pelvic floor disorders, and a clear management strategy. Our aim was to provide a snapshot of current knowledge and provision in primary care where women with UI may routinely present

We conducted semi-structured interviews using a pre-prepared interview guide, with GPs, practice nurses and physiotherapists in primary care. The transcripts were analysed using the framework method of analysis in order to identify key themes regarding management of UI. Findings suggested that it is unusual for women to present with UI as the primary condition but rather that this often mentioned as a side issue. The health care professionals interviewed were not aware of any clearly defined local strategies for onward management. It was further suggested that only younger women would benefit from pelvic floor rehabilitation and there was an overarching belief that physiotherapy was only relevant for this younger group. Older women were referred for continence advice with the expectation that this would result in pharmaceutical treatment and/or pads for protection rather than rehabilitation.

The recent Independent Medicines and Medical Devices Safety review highlights the need for all women presenting with UI to be offered conservative treatment initially. Our findings suggest that an important factor in providing this will be ensuring robust local management strategies exist and improved education of those in primary care regarding appropriate protocols.

*Keywords*: primary care, urinary incontinence, pelvic floor muscle training, physiotherapy

## Background

Urinary incontinence (UI) is defined as involuntary loss of urine and is a common problem reported to affect as many as 40% of adult women (Cooper et al., 2015). The term can include stress UI (SUI) associated with impact or increased abdominal/pelvic pressure, urgency UI (UUI), associated with increased urgency or desire to void and a combination of the two, mixed UI (MUI) (Haylen et al., 2010). It is both embarrassing and debilitating, impacting all aspects of life: employment due to absence from the workplace (Fultz et al., 2005), personal relationships (Nilsson et al., 2009) and participation in sport and exercise (Menezes, 2015, Nygaard et al., 2005). Traditionally UI has been associated with childbirth, obesity and the ageing process (Danforth et al., 2006), but the levels of UI in young, nulliparous athletes are high, ranging from 23 – 41 % (Alves et al., 2017, Bo et al., 2011, Carls, 2007, Jacome et al., 2011). Indeed, UI in athletic women has been reported to be almost double that in a matched group of sedentary women (Carvalhais et al., 2017).

Despite the high prevalence of UI, fewer than half of those affected will present to healthcare professionals for help (Cooper et al., 2015). This is potentially an even bigger issue in young athletes where 90% of those who reported symptoms via questionnaires had never mentioned the issue to either a coach or member of the medical team (Carls, 2007). It has been suggested that low levels of help seeking behaviour may be due to a number of factors: lack of awareness regarding the condition and potential treatments, embarrassment, fear that the symptoms are too trivial to mention and a belief that it is a normal consequence of having children or ageing (Tinetti et al., 2018, Shaw et al., 2001). The education of both women and health care professionals regarding pelvic floor disorders and potential treatments has been recommended to encourage more women to seek help (Chen et al., 2019, Shaw et al., 2007).

There is robust evidence to support pelvic floor muscle training (PFMT) for UI (Cacciari et al., 2017). A minimum of three months of supervised PMFT is recommended as the first line treatment for SUI by the National Institute for Healthcare and Excellence (NICE) (NICE, 2019). In reality management strategies for pelvic floor disorders can vary widely between professional disciplines, and it has been suggested that prioritising key areas may provide a more consistent strategy: improved access to specialist services, improved collaboration between professions, increased education and research around pelvic floor dysfunction, improved public and professional awareness of pelvic health and increased funding (Davis et al., 2010). This is also reflected in the NHS long term plan, under provision for maternity and neonatal services, where it is proposed that collaboration between primary and secondary care should be improved and that women should have access to multidisciplinary pelvic health clinics throughout England (NHS, 2019). Moreover, this plan also reflects the NICE guidelines for first line management of UI to include a three-month trial of supervised PFMT months underlining:

> "Physiotherapy is by far the most cost effective intervention for treating mild to moderate incontinence and prolapse." (NHS, 2019).

It is therefore important to explore if current services for the management of UI in the primary care setting reflect these recommendations. Thus, the aim of this study was to provide a snapshot of current knowledge and management practice for women with UI in primary care. Primary care providers were chosen as this is where women with UI are likely to present, in the first instance.

The specific objectives were:

1. To identify the current knowledge of health care professionals regarding the management of UI in women

2. To identify treatment strategies and referral pathways offered to women with UI
3. To particularly explore any variation in the management of athletic women with UI compared to that for all women

## Method

Ethical approval for the study was given by the Faculty of Medicine and Health Sciences Research Ethics Committee, University of Nottingham (Reference: 280-1904).

### *Participants*

We planned to recruit six to eight local health care professionals (HCP) from within the Derbyshire and Nottinghamshire areas for interview. The number of participants was intended to provide a snapshot of the key issues but was also dictated partly by available time and resources. Use of 'information power' as opposed to 'saturation' has been proposed by Malterud et al. (Malterud et al., 2016). That is, where the aim is narrow, and the sample specificity is dense then the quality of the dialogue will be strong, so smaller sample sizes may be justified. Further, the established theory of this subject from previous investigations supports a smaller sample size when investigating whether the previous theory is still current. The HCP selected were comprised of GPs, nurses and physiotherapists, as these professionals are likely to be the first point of contact for many women with UI in the community. The aim was to recruit similar numbers of participants from each professional group.

Participants were recruited by email and word of mouth from Primary Care centres and physiotherapy clinics within Derbyshire and Nottinghamshire. All participants provided, informed, written consent before any data was collected.

### *Interviews*

Individual, face-to-face interviews were conducted at an appropriate time and place for the interviewee, e.g. during brief, break times at their place of work. All interviews were semi-

structured and followed a topic guide designed for the study, after consideration of the available literature and clinical, anecdotal reports from patients regarding their experiences, (Appendix 1). The guide covered six broad topic areas; types of patient that most commonly present to these HCPs, management strategies for urinary incontinence, understanding of policy and guidelines for management of UI (both locally and nationally), management of UI specifically in athletic women, access to pelvic health physiotherapy and any locally recommended referral strategies for the management of UI that the HCP could follow. The interviews were piloted with two researchers from within the wider rehabilitation research team. Both researchers are experienced qualitative researchers within the field of rehabilitation and in this case, acted as study participants in order to pilot the interview schedule. They commented on the style and format of the questions and the guide was modified accordingly. This data was not used in the study findings.

All interviews were conducted by a specialist pelvic health physiotherapist researcher with some understanding of the local services available. Interviews were digitally recorded and stored in a secure password protected file on a dedicated web server at the University of Nottingham. Personal identifiers were removed, and the anonymised files were sent electronically to an approved transcribing service. Transcripts were checked by the researcher who had conducted the interviews and were then uploaded into a qualitative software package for line by line coding.

### *Analysis*

Data was analysed thematically using the framework method (Gale et al., 2013). The initial coding structure was developed by three researchers (GC, CC and JA) but was refined continuously as the interviews were conducted. A qualitative data package (NVivo 12, QSR International) was used to systematically code each transcript. Matrices were developed within NVIVO to develop a working analytical framework, and data chunks were transferred

onto the matrix. Potential themes and subthemes were identified and reviewed by these researchers.

## Findings

Seven participants were recruited and comprised two GPs, three practice nurses and two physiotherapists. All but one physiotherapist worked solely within the primary care setting. This physiotherapist was the lead physiotherapist for an elite group of athletes ranging from youth to professional. Her responsibility for these athletes was to oversee their medical care and ensure that they were directed to the correct pathway for treatment of each presenting condition. This involved private health care in the case of the professional athletes and NHS provision for those not yet at that level. One further physiotherapist agreed to be interviewed but was not then available within the study period.

For each interview, the researcher attended the participant's place of work and recorded the interview in a private office at a time that was made available between patient contacts. Interviews ranged from 16 minutes to 33 minutes, with an average duration of 21 minutes. This short duration reflects the difficulty in engaging busy professionals within the primary care setting.

### *Themes*

Five main themes with sub themes were identified from the data:

1. Reasons why women present with urinary incontinence
2. Beliefs regarding management of urinary incontinence in the community
3. Conservative management of UI in primary care
    a) Supervised pelvic floor muscle training
    b) Education for HCP regarding pelvic floor assessment and exercises
4. Management of athletic women with urinary incontinence

5. Pelvic health physiotherapy as a specialism
    a) The role of pelvic health physiotherapy
    b) Pelvic health physiotherapy v continence advice

1. **Reasons why women present with urinary incontinence**

The HCPs reported that women usually mentioned that they suffered with UI as an aside, having attended the clinic for another reason. As one might expect, the primary presenting condition was largely dependent on the profession of the HCP, for example women presented to nurses when attending for cervical screening or for pessary advice and fitting:

> "It's probably like, a few times women have talked to me when they've come in for their smear, so it's like stress incontinence, which women do think is normal. And I would then inform them that actually it isn't normal although a lot of us suffer from it and there are things that they can do." (Nurse C)

Similarly, if they presented to GPs with symptoms of pelvic organ prolapse, they may also comment that UI is an issue:

> "…..sometimes it's complicated in that they're talking about a prolapse and incontinence at the same time." (GP A)

At a physiotherapy consultation it was more likely that women might refer to urinary symptoms during a musculoskeletal assessment when routine screening questions for cauda equina syndrome were asked:

> "if they've come in with back pain, because of the special questions, then I think that's probably when it happens most often…… So, once I've asked about bowel or bladder, they then may say, 'ooh I've got a few issues since I had the children'. So yes, they would, they sometimes inadvertently mention it." (Physio B)

All of the HCPs interviewed reported that, although they had experience of women reporting urinary symptoms, this was not a condition that women would regularly present with as their primary complaint.

Although all of the HCP were aware of the high prevalence of UI in women, none were aware of any specific screening policies for UI within their own practices. One physiotherapist, who managed the healthcare for elite sports women, youth to adult, noted that only one of the athletes under her care had reported UI. She suggested that it may be useful to screen for potential pelvic floor issues in the future as part of the annual athlete health checks. However, she also raised concerns that this may lead to anxiety for the athlete if UI was suggested to be a significant problem:

> "……anxiety is quite prevalent too[ in elite athletes], and the last thing you want to do with people that are maybe prone to be slightly anxious is make them paranoid about something that potentially they're managing ok so that's the other flip side of it I suppose." (Physio A)

2. **Beliefs regarding management of urinary incontinence in the community**

None of the HCPs spontaneously referred directly to NICE guidelines or indeed any local or practice policy when questioned regarding their routine management of UI. When prompted regarding national guidelines, and specifically - the recommendation to offer a trial of supervised pelvic floor muscle training of at least three months duration - most were not aware of this specific guidance. It was noted by one interviewee that, as a practitioner dealing with multiple issues, it can be hard to be aware of every guideline, particularly when this is not your specific area of expertise:

> "to highlight the guidelines and really so you know the correct pathway and the NICE guidelines, it's really difficult in a world where you're treating lots of different

conditions to be able to keep on top of all those different groups of patients." (Physio B)

It was suggested by some that not all women would be appropriate for PFMT and that this would only be of benefit for younger women.

"……personally I don't think that referring them for pelvic floor exercises in a 70 or 80-year-old lady is the right thing to do. We'd talk about a ring pessary or something like that, so yeah it's the age and that context." (GP A)

It was further suggested that younger women with no other morbidities, such as low oestrogen levels, would be the most appropriate patients for pelvic floor muscle training:

"The younger, fitter cohort of patients, where it's probably not oestrogen level dependent, where some significant pelvic floor improvement may well give a significant improvement in symptoms." (GP B)

None of the interviewees were aware of any structured local strategies regarding the onward management of UI. They were aware of the nurse lead continence advice service and that pelvic health physiotherapy could be an option but were not aware of how to access the latter. In general, their management plan was based on their own professional area of expertise. Some described educational talks and conversations with pelvic health physiotherapists as informing and shaping their practice and referred to this when considering PFMT as a treatment option:

"We did have a physiotherapist come in once who specialises in these sorts of areas, so we had a talk. And she gave some cards out. So, I guess I have some understanding of what might be the first line in terms of if you think someone has got pelvic floor issues that the first line isn't referral for surgery; it might be to see a physiotherapist." (GP A)

Those who were aware of NICE recommendations believed that, because they were not aware of any specific local recommended protocol, it was sometimes difficult for them to follow the national guidelines. He further suggested that having a multi-disciplinary team which could be accessed easily for all treatment; from physiotherapy rehabilitation, or medical management through to surgery, if required, would be the optimum way of organising the service:

> "……so yes we can refer people into the urogynae clinics, but there isn't that urogynae-physio pathway accessibly easily……..it seems to be, yes OK at this point I've got to go, I think it can be managed in the community, let's get you seen by incontinence nurses, or no I've got to get you seen by a urogynaecologist. And there isn't that initial pathway. And I hate to use the one-stop shop approach, but a pathway which goes this is the way in, they'll be seen by an expert. We can arrange pelvic floor exercises, we can do bladder training, we can then go yes that's worked, no it hasn't, let's get you onto Bulkamid or whatever. There isn't that one path entry which would be really useful, that'd be good." (GP B)

The same GP went on to describe that, in the absence of a clearly defined structure for appropriate referral locally he often chose to manage the majority of cases himself without referring onward to specialist care. It was again also believed that PFMT was only appropriate for the management of UI in younger women and in most patients the most appropriate route would be a trial of anticholinergics or hormone replacement therapy.

The nurses interviewed felt they were in a position where women were more likely to mention urinary symptoms, often while attending for other intimate procedures, such as pessary fitting or cervical screening:

> "I think they just feel a bit more comfortable with the nurse rather than the doctor as well and obviously coz we're seeing them regularly we see them every sort of 3 to 6 months they sort of get a bit of relationship with you so they probably feel a bit more comfortable telling you things." (Nurse A)

However, none of the nurses had the autonomy to refer women directly for specialist treatment and instead had to refer the patient back to the GP for management. This then involved making another appointment and perhaps a further examination for the woman to negotiate when attempting to seek help for a sensitive issue. When asked specifically about local policy or guidelines as to how these women might be managed the nurses felt they had no specific pathway to manage the issues.

> "No if I'm honest…… I see them here; they mention it as an issue, and I give them the encouragement to go and get it looked into." (Nurse B)

The concern was raised that, having made the effort to come forward, the patient could then be lost within the system:

> "……. the chances are they [the doctors] don't follow it up and I don't check that they follow it up. So, I have the discussion with them and make out that actually it isn't normal and we shouldn't be suffering like this as women and that you can do something about it..... I wouldn't arrange any follow-up so and I wouldn't remember potentially." (Nurse C)

The physiotherapists were aware that physiotherapy could be beneficial in the treatment of UI, but they were unsure where a specialist pelvic health service might be accessed locally.

The consensus from the GPs and nurses was that they believed they needed more information regarding local services for the conservative management of UI. While they were aware of

the nurse led continence advice service, they were not aware of any specialist physiotherapy that could be accessed via the NHS.

Those HCPs who had taken part in practice information sessions from specialist physiotherapists regarding pelvic health physiotherapy were more aware of the extent to which a conservative approach in dealing with UI could be effective. GPs reported managing UI with the treatments easily available to them such as anti-muscarinics or topical oestrogen where appropriate and remarked that pelvic floor muscle exercises might be a treatment option for some. They would, however, only refer to a specialist for PFMT if they believed that the women were unsure of how to do these exercises:

> "No, I think if they need pelvic floor exercises and they give the impression that they're not actually confident to do that themselves then I would refer them." (GP A)

In summary, although most of the HCP knew that women with UI could potentially be referred for continence advice or for pelvic health physiotherapy, they were not always sure where they might be able to access specialist services and physiotherapy specifically. None had any awareness of formal pathways for management of UI either within their own practices or indeed in the local area.

3. **Conservative management of UI in primary care**

a) <u>'Supervised' Pelvic Floor Muscle Training (PFMT)</u>

Given that NICE guidelines recommend at least three months of supervised PFMT, the interviewees were asked what they understood by the term 'supervised'. This was in order to ascertain whether they believed this was something that required specialist referral, or whether they felt that managing PFMT was within their own scope of practice. All believed that this would involve teaching the exercises and monitoring progress rather than just providing information and/or a leaflet. The majority did not feel that they had the knowledge

or expertise to be able to assess or train women to perform their pelvic floor exercises adequately. There was concern that by prescribing a woman a program of exercises they could potentially be causing harm:

> "it's alright sort of handing out a leaflet, but you might not be doing the exercises correctly and things. I don't know if that might cause more harm than good if you, I mean it certainly wouldn't work would it I mean if you're doing the wrong exercises?" (Nurse A)

One GP felt that, although he was comfortable to suggest PFMT, he was not confident to be able to assess the muscle function:

> "no, I don't feel that confident. So probably I would look for prolapse. I will talk to them about whether coughing or straining will give rise to incontinence. And if they're not sure, I'll ask them if they're OK to try that and just see if that results in. But in terms of an assessment of the pelvic floor, I'm not entirely sure what that means." (GP A)

nor did he feel qualified to advise women how to contract the muscles:

> "OK, I have a concept of pelvic floor exercises, but being a male, I don't really understand what it means. I don't have a, it's a little bit like what would it be like to give birth? I don't know. Painful, distressing! So, you know, trying to explain to someone how to do pelvic floor exercises as a man just doesn't seem a sensible thing to do. So, I will ask about it: are you doing pelvic floor exercises? And ask them what they mean by that, but that's probably as far as it will go." (GP A)

Although the physiotherapists were more comfortable with basic advice regarding muscle recruitment and rehabilitation, they were unsure as to when patients might require more specialist input:

> "I think because it's such a specialised area I think the tendency might be to just back away completely from it. And there may be a lot more that we could do, but it's knowing how, knowing how far you should go with those patients and how far, you know, and when it's appropriate, no you need to be seen by a specialist physio." (Physio B)

b) Education for HCP regarding pelvic floor assessment and exercises

The majority of those interviewed expressed an interest in learning more about PFM assessment and training and suggested that it would be appropriate to be able to advise patients, even if only to start their treatment prior to specialist referral. They felt that their current lack of confidence regarding their knowledge would prevent them from doing so. Opinions regarding what form this education should take varied between the professions. One GP expressed a need to have more patient centred information that he could pass on:

> "But maybe to have some information about how you do it or access to YouTube videos or whatever explaining it, that would be quite useful." (GP A)

The nurses, however, all expressed an interest in learning how to assess the muscles and teach the patients how to contract them. Nurses felt in a prime position to be able to do this with the correct training as often women who mention having UI do so during an intimate examination. It was therefore felt that any potential barrier had already been overcome:

> "I'd be interested in, yeah definitely. Because very often it's quite a personal thing coming for a smear and you're chatting about things down there anyway…..to assess the pelvic floor, yeah, yeah I'd like to know how to do that." (Nurse B)

> "So, I think it is important that we raise awareness and I would like more training or education in it really " (Nurse C)

The physiotherapists were more confident as to where they might access reliable information:

> "I'm always quite careful in terms of the information I give them, so I'd go to the special interest group [POGP] and get that because I know that that's going to be the latest kind of, because thinking changes of anything doesn't it?" (Physio B)

Overall, the consensus was that it was appropriate to refer to a pelvic health specialist but that this was not easy to do and so more training or access to reliable information would be helpful. GPs suggested that this could be in the form of self-help videos via YouTube or, in the case of the nurses, access to courses to learn more about basic pelvic floor muscle assessment, to ensure that patients could safely embark on an exercise program.

4. **Management of athletic women with urinary incontinence**

Interviewees were asked if they knew there was a higher prevalence of UI in athletic women than in their sedentary counterparts, as this was a particular focus within this study. There was a mixed reaction to this with some expressing surprise:

> "you'd think the opposite. I mean they're fit they're healthy, they're younger em… you just think the opposite don't you." (Nurse A)

Others, however, suggested that when one takes into account the extra stress that running and other impact activities might have on the PFM then increased prevalence of UI may be related to that:

> "Does it surprise? I suppose the answer is no, because inevitably it's leading to raised abdominal pressure; hence someone who, not doing any exercise can just about cope, the moment they try and do something they will have that issue." (GP B)

When asked if the HCPs felt that athletic women should alter their sporting activity in order to manage their UI, all felt strongly that these women should be encouraged to continue with

their sport despite the symptoms. It was believed that taking part in sport itself had multiple health benefits that would outweigh the risk of harm to the PFM:

> "my view on exercise is that if I don't know if it's doing any harm then I would normally say carry on exercising, and we'll try and find out how to manage your issue." (GP A)

Where an elite athlete was experiencing UI, it was considered that continuing training was particularly important due to the detrimental effects of pausing training on performance and mental wellbeing:

> "Absolutely, yes absolutely, I would be very much encouraging them to continue with it and not to stop it. But I think based on those quite serious systems that could be catastrophic to their training and to their sport, then I'd be much more proactive in terms of, you know, we need to be much more responsive to it and get something done." (Physio A)

This was also reflected by those treating recreational athletes.

> "they'd rather put up with the symptoms than miss out on a couple of weeks training basically." (Physio B)

In order to ensure that the woman's urinary symptoms did not preclude them from their athletic activities it was strongly suggested that treatment should be more proactive in this group than it might be for sedentary women:

> "I think in an athlete I would tend to be more, aggressive is the word, more proactive in getting them help." (GP A)

5. **Pelvic health physiotherapy as a specialism**

Participants were asked what knowledge they had regarding pelvic health as a physiotherapy speciality and which patients they would choose to refer to physiotherapy as opposed to continence advice.

a) The Role of Pelvic Health Physiotherapy

Although one interviewee said that prior to the interview, she had not been aware of pelvic health physiotherapy at all, the majority had come across the speciality or had worked with them professionally. The consensus was that as physiotherapists traditionally are involved in muscle rehabilitation, trunk strengthening and control, it would be expected that they would work in this field.

> " ….I would say to do with the pelvic floor, core strengthening, so yeah I can see where it would have a part." (Nurse B)

It was noted, however, that there may be small numbers of physiotherapists working in this area:

> "I think it is quite a niche area I think, as far as I'm aware." (Nurse A)

Comments suggested that physiotherapy would be more relevant for younger and athletic women with UI than for sedentary patients.

> "I guess if it was a sports-related thing I would probably more likely to get to a physio than I would do if it was a non-sport related one." (GP A)

b) Pelvic Health Physiotherapy v Continence Advice

All HCPs interviewed were aware of nurse lead continence advice clinics and believed this was a different type of service to pelvic health physiotherapy. When deciding where to refer women, the age of the patient was a significant factor in the decision. The suggestion was that continence advice was generally for those where rehabilitation was inappropriate, and where

referral was for pharmaceutical management or even for protective pads alone. It should be noted that, for most interviewees, 50 years of age plus was referred to as being an older woman (who was therefore less likely to need proactive treatment):

> "Well, just from my experience with the continence nurse, different information. So sometimes it can be hormonal treatment which she can initiate, and then also [incontinence] products to use…….and then [physio] Working on those core muscles." (Nurse B)

> "Yeah for older people and it would be, we would refer to a continence nurse for that reason because then they can get pads on the NHS can't they? But that would be older people rather than younger women…….so if it's a younger female I would say physio probably……..helping to improve pelvic floor to reduce risk of incontinence; whereas the incontinence nurse I'd say is when you're just accepting that you're incontinent and we need to manage it." (Nurse C)

Thus, re-iterating other suggestions that PFMT was only relevant for younger women.

## Discussion

Although urinary incontinence is a common condition, it was rare for women to present specifically for this condition alone. Instead, it was usual for women to mention their UI as an aside when attending for another condition. This reflects findings in previous studies where patients may perceive the condition to be too trivial to report (Shaw et al., 2001). It has been suggested that reluctance to seek help may be due to embarrassment or because it is not perceived to be a medical issue and women will not seek help for issues they perceive as normal (Tinetti et al., 2018). Although there have been recommendations that annual screening for UI should be performed (O'Reilly et al., 2018), this was not reported to be usual practice by any of the HCPs interviewed.

NICE guidelines regarding the conservative management of UI, recommend supervised PFMT for a minimum of three months prior to embarking on other treatment strategies (NICE, 2019). Within the group of HCPs interviewed, most were not aware of the specifics of these guidelines, and those that were, were unsure of where they might access pelvic health physiotherapy within the locality. None reported any knowledge of local protocols for the management of UI, yet all wanted more information both regarding local services and in-house management strategies. Interestingly this region currently does have the facility both for GP referral and self-referral to pelvic health physiotherapy services, although the interviewees did not seem to be aware of this. It is not known why this might be, but again suggests that better education and/or advertising is required. Future investigations should investigate which primary care centres actually use these existing sites and why they became aware of the existence of such facilities, when clearly others are not? Furthermore, it would be important to explore the experiences of women with urinary incontinence and investigate whether they have attempted to seek treatment and what their experiences of this might have been.

All the HCPs agreed that 'supervised pelvic floor muscle training' should mean specialist assessment, prescription of exercises and monitoring of the program, as opposed to providing generic leaflets or advice sheets. Other authors have documented a lack of confidence in GPs regarding both their ability to teach pelvic floor exercises and the likelihood of those exercises leading to successful treatment (Grealish and O'Dowd, 1998). Similarly, none of the interviewees here felt confident to either assess or to monitor a program of PFMT. All the nurses interviewed, however, expressed an interest in acquiring further knowledge as and believed that, as they were already performing intimate examinations, they would be in a prime position to initiate a PFMT program, even if this was just to start treatment prior to specialist referral. Others have argued previously that practice

nurses should be involved in the provision of PFMT (Child et al., 2013, Shaw et al., 2007, Waterfield, 2011). There may, however, be barriers to such a scheme in the wider context due to time available in the primary care setting, as has been found when exploring similar provision of PFMT via midwifery led care (Salmon et al., 2020).

There was a mixed reaction regarding the high prevalence rates of UI in athletic women; some felt this was to be expected given the high impact nature of some athletic activities, while others were surprised that they should suffer with a condition that they associated more often with age and poor health. All agreed that it was a priority for athletic women to continue with their sport as the benefits of exercise would outweigh any risks to their pelvic floors. They further believed that athletic women should be a higher priority to get help in order that they could continue with exercise. It was further suggested that younger athletic women were more likely to benefit from PFMT programs and that physiotherapists would be better placed to provide this.

When questioned regarding their understanding of pelvic health physiotherapy, most were aware of this as a speciality but did not know where this service might be available locally. They were all aware, however, of the local nurse led continence advice service and knew how to refer to this. It was surprising that the general belief was that this service would only treat pharmaceutically, provide protective pads and teach management strategies rather than offering PFMT as the first line treatment. In reality, this is not the case. It was further suggested that only older women should be referred to the continence advice service as they were unlikely to improve and should therefore learn to manage the condition. This highlights two misconceptions; firstly, that PFMT is only suitable for younger women and that physiotherapy is the only route to provide this service and secondly, that the continence advisors only manage UI with medication or with protection, such as pads. This raises the

potential question, are ‘younger’ women being referred directly to secondary care for surgery or bulking injections without being offered PFMT at all?

The recent review chaired by Baroness Cumberledge which included an investigation into the use of mesh implants for the treatment of SUI and pelvic organ prolapse, has underlined that women must be offered conservative treatment for UI prior to being referred for surgery (Cumberledge, 2020). This only serves to emphasise the importance that recommendations for supervised PFMT for first line management of UI are offered to all women. This was recommended in the first instance by NICE in 2006 (NICE, 2006) and confirmed in the revisions in 2013 and 2019 (NICE, 2013, NICE, 2019). Further, it has been recommended in the NHS long term plan that women should have

> “access to multidisciplinary pelvic health clinics and pathways across England via referral” (NHS, 2019).

Despite these recommendations our findings confirm previous research that the strategy for implementing the management of UI in the primary care setting appears to be fragmented and variable (Davis et al., 2010).

Improving conservative management for UI requires clear guidelines and planning but also the capacity for that policy to be applied within primary care. Improving the care of women with UI would require consultation between the relevant professional bodies to establish the most practical ways in which to implement the guidelines and NHS policy. Physiotherapy as a profession should be integral to this strategic planning. The recent collaboration between the CSP, and in particular the POGP, and the Royal College of Midwives to improve access to women’s health specialists in the perinatal period should act as a template for future consultations. There is a need to establish clear pathways that enable women to be referred for specialist conservative management. Furthermore, establishing

expert multidisciplinary teams of specialist physiotherapists, continence advisors, and urogynaecologists to facilitate the referral and appropriate management of UI by primary care practitioners is vital. Although this suggestion has previously been referred to in the NHS long term plan, it is specific to women in the child rearing year (NHS, 2019). Women of all ages should be able to access such a service.

### Limitations of the study

The potential limitation of this research is that it was restricted to a small locality and to a small group. Nevertheless, it provided a snapshot of current practice in primary care of the management of UI and moreover confirmed previous research findings.

One researcher who had a good knowledge of local services, such as pelvic health physiotherapy and the nurse lead continence advice service conducted all the interviews. Although a potential limitation, it could, however, also be argued that this was a strength. A good working knowledge of existing referral pathways could ensure asking the right questions to reveal if the interviewee was aware of such services and available methods to access them.

It may have been interesting to include other professions, such as midwives or health visitors within the sample, in order to gain insight into any variability in management strategies, particularly around the perinatal period. However, this has been done in a very recent comprehensive qualitative investigation regarding the challenges and opportunities faced by midwives, other health care professionals and indeed the women themselves in the antenatal period. This showed that there is lack of confidence to teach PFMT and to manage UI within the antenatal care pathway. It also underlined that guidelines and policy both at local and national level were inconsistent (Terry et al., 2020).

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## Author contributions

KGC and AD conceived the protocol and were involved in all parts of the analysis and writing of the final manuscript.

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## Ethics approval and consent to participate

The study has been reviewed and approved by the University of Nottingham, Faculty of Medicine and Health Sciences Research Ethics Committee (Ethics reference number 280 – 1904). All participants provided written, informed consent prior to any data collection.

## Consent for publication

All participants provided written informed consent for the use of anonymised direct quotations from the interviews to be used in written reports prior to taking part.

## Conflict of interest

The authors declare that they have no competing interests. KGC is the current clinical editor of the POGP journal and in order to maintain the full anonymity for both parts of the double

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