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SERVICE EVALUATION

Setting up a physiotherapy-led pessary self-management service: learning from a successful pilot project and building a sustainable quality service

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Abstract
This article highlights the practical elements involved in setting up a physiotherapy-led pessary self-management service, and discusses how the project has evolved over time to ensure sustainability. Physiotherapists are becoming more interested in using pessary skills when treating patients with pelvic organ prolapse (POP), and members of the profession are well placed to offer these individuals a pessary option alongside other conservative treatments. These extra skills can equip physiotherapists so that they can offer a seamless POP service.

Keywords: conservative treatment, pelvic organ prolapse, pessary, self-management.

Introduction

A pessary self-management service was set up at Cambridge University Hospitals (CUH) NHS Foundation Trust, Cambridge, UK, in March 2013. The first author (C.A.B.), a women's health physiotherapist, was recruited to run the service. Her training consisted of observing the second author, the urogynaecology consultant (R.K.), and being supervised during pessary changes. Once the first author felt competent to change pessaries independently, patients were invited to learn pessary self-management. During this training period, the physiotherapist learned how to size a patient for a pessary, and how to inspect the vagina with a disposable plastic bivalved vaginal speculum.

Traditionally, physiotherapists treat pelvic organ prolapse (POP) with conservative measures such as pelvic floor muscle training (PFMT) and lifestyle advice. However, to date, there have been only a small number of randomized clinical trials of the effectiveness of PFMT for POP. The POPPY trial (Hagen *et al.* 2014) showed that PFMT had reduced patients' POP symptoms at 12 months after treatment, and a Cochrane systematic review (Hagen & Stark 2011) demonstrated that PMFT was effective, but longer-term studies are needed. Currently, there is no National Institute for Health and Care Excellence clinical guideline for POP.

The role of physiotherapists in the management of POP is evolving. More members of the profession are becoming interested in using vaginal pessaries alongside coexisting treatments in order to provide symptomatic relief in cases of POP. Physiotherapists are well placed to learn pessary management, and may believe that they are able to offer patients a seamless service by providing them with all forms of conservative treatment for the condition. Many patients are unaware that there are other treatment options for POP apart from surgery.

The PEPPY trial (GCU & NHSGGC 2015) proposed that PFMT may be more effective in patients with a vaginal pessary. Such devices reduce the descent of the pelvic organs and allow the muscles to contract in a more effective way. Therefore, there may be scope to use vaginal pessaries in a more therapeutic manner in the future.

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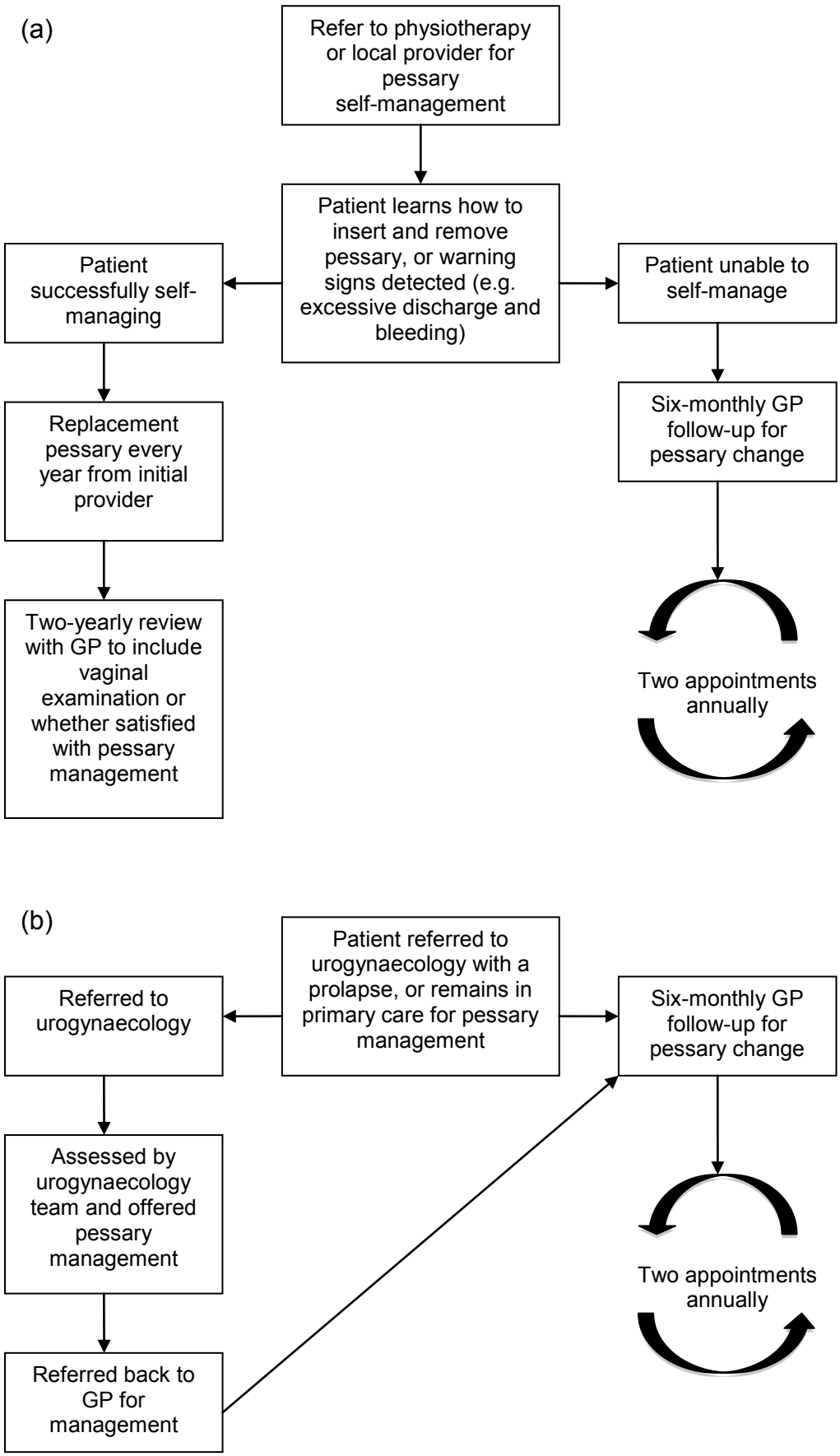

Figure 1. Comparison of pelvic organ prolapse pathways for (a) self-management and (b) doctor-led management of pessaries: (GP) general practitioner.

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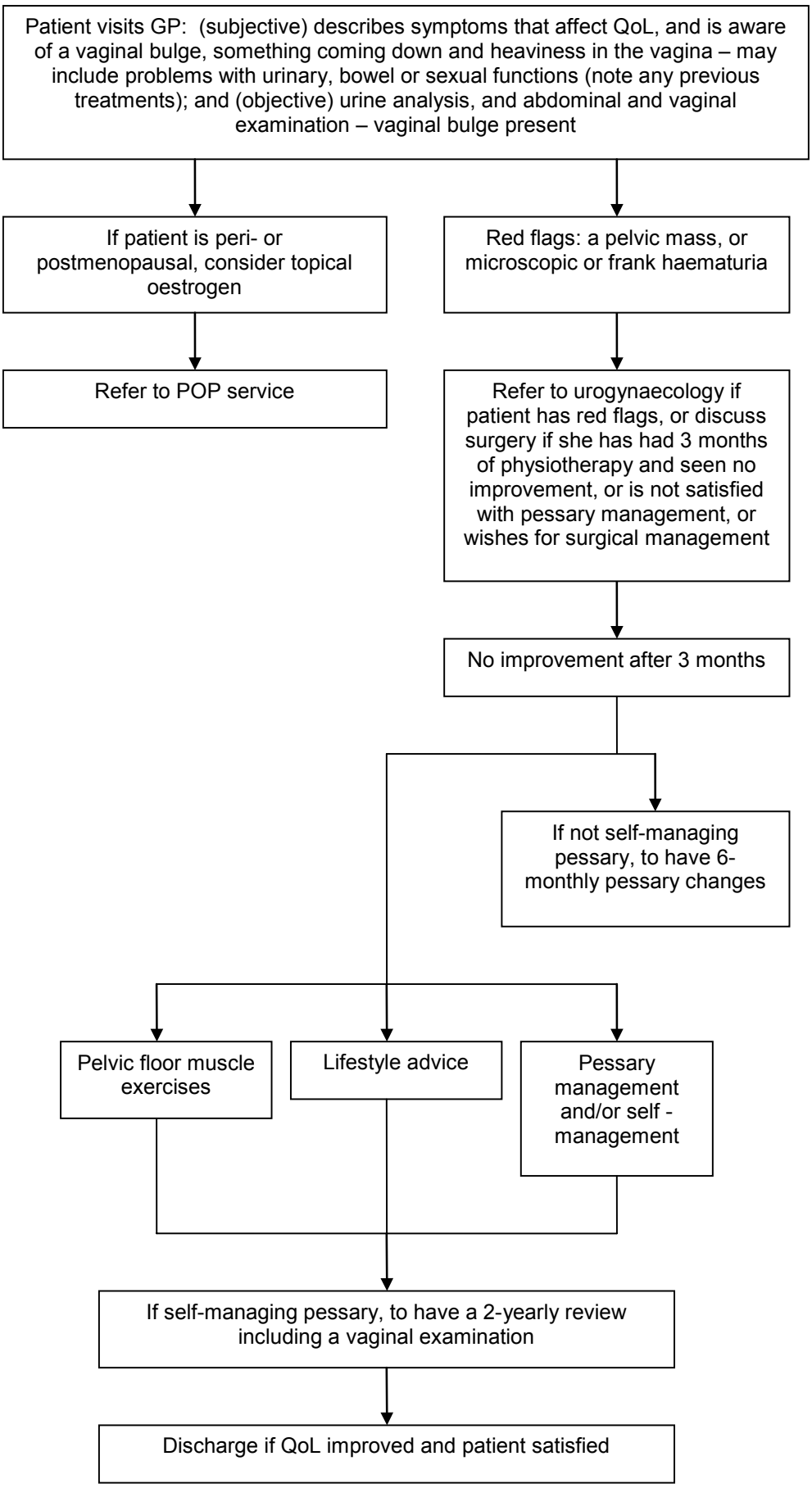

Figure 2. Pathway for the pelvic organ prolapse (POP) service: (GP) general practitioner; and (QoL) quality of life.

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The aim of the present article is to explain how the pessary self-management service was set up, and how a physiotherapist can run such a project. The original findings of the POP Home project were published in *BMJ Quality Improvement Reports* (Kearney & Brown 2014). The service has now evolved to allow for sustainability.

The new pessary self-management clinic

Funding for the service was awarded by the Health Foundation's Shine 2012 programme. This allowed a physiotherapist to be recruited for this new role. The structure of the service allows women to be referred directly to the POP Home project because it runs concurrently with the urogynaecology clinics, which allows women to be sized for a pessary and learn about self-management at the same appointment (for a comparison of self-management versus doctor-led care, see Fig. 1). This is usually performed by the physiotherapist. Patients are also referred to the service from primary care. Again, this is so that they can learn self-management, with or without a pessary fitting. Individuals can also self-refer to the service if they have a pessary *in situ*. Patients referred to the service must have had a recent vaginal examination by a doctor so as to rule out any other condition that might require further investigation or treatment.

Follow-up is carried out by the physiotherapist with either a telephone call or an e-mail 4 weeks after the initial appointment. This contact gives patients another opportunity to ask any questions, and allows the clinician to record the outcomes. Patients may occasionally report that their pessaries have slipped or fallen out, and the follow-up gives them an opportunity to book another appointment to try a larger size. Once individuals are self-managing, no other appointments are made. The contact details of the physiotherapist, an information leaflet and access to an educational video are given to the patients. If patients decide that the pessary has not improved their symptoms, wish to discuss surgery or experience difficulty with pessary management, they are referred back to their referring general practitioner (GP) or consultant.

Spreading pessary self-management

An extension of funding from the Health Foundation as part of the Spreading Improvement Programme has allowed the teaching of pessary self-management to be spread to other secondary care sites and clinical commissioning groups (CCGs) across the East of England. This has been provided using two models.

Clinical commissioning groups have been approached and offered free training for medical practices. This allows nurses or GPs to attend and learn pessary skills and self-management. The training includes teaching skills such as sizing and changing pessaries, troubleshooting, and practising inserting and removing a pessary with a gynaecology model. Following the training, clinicians can then offer their patients the option of pessary self-management. This model of training was also offered to secondary care hospitals.

The second model involves running pessary study days in Cambridgeshire. General practitioners, nurses and physiotherapists have attended the training sessions.

To date, three acute hospitals and four CCGs have hosted the training models, and 78 clinicians have attended. Work is still continuing to spread the teaching of pessary self-management until August 2015.

The future of the service

Combining the conservative treatment approach that is already used by physiotherapists and pessary management is a natural progression. The physiotherapy department at CUH is now receiving referrals for patients whose treatment consists of all forms of conservative treatment. Work is ongoing in collaboration with CCGs to establish a formal pathway for the conservative treatment of POP that includes the provision of a self-management option for pessary use as part of the community physiotherapy service (see Fig. 2).

Conclusion

Pessary self-management and pessary care are skills that physiotherapists can acquire when they are given the correct training. They are well placed to provide their patients with the conservative management package required to treat individuals with POP before they are referred for surgical options.

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