Department of Health and Social Care: Women's Health Strategy
Chartered Society of Physiotherapy
Consultation response

To: Rt Hon Matt Hancock MP
Department of Health and Social Care
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London, SW1H 0EU

The CSP is the professional body for the UK's 60,000 registered physiotherapists, physiotherapy students and support workers.

This submission has been developed by the CSP with particularly contributions from the Pelvic, Obstetric and Gynaecological Physiotherapy professional network affiliated to the CSP.

Summary of CSP recommendations

Place women at the centre of health and social care

- Implement personalisation and shared decision-making for all NHS services so that women's voices are heard
- Ensure data collection in primary care and national audits of rehabilitation provision include socio-demographic data, and data on all those with rehab needs not accessing services, so that inequity facing women patients can be understood and addressed

Improve women's access to care

- MSK First Contact Physiotherapists in primary care to be available to all women
- Improve and expand community based rehabilitation to address unmet needs amongst women
- Increase numbers of specialist pelvic health physiotherapists and provide funding to allow training to upskill more physiotherapy staff, in line with the commitment in the Long Term Plan (3.17).
- Promote specialist physiotherapy provision through NHS, PHE and other healthcare platforms to encourage early, equitable and easy access to the right pelvic healthcare over a women's lifetime.

Prevent ill-health amongst women

- Invest in falls prevention services to reduce deaths, disability and dependency amongst older women
- Prevent MSK problems through access to occupation health physiotherapy for women at work
- Reduce stress amongst working women through flexible working rights and addressing workforce shortages in the NHS
- Tackle inadequate PPE measures, which disproportionately impact on the health of women working in health and care
- Introduce new legislation to tackle workplace pregnancy and maternity discrimination.

1. Placing women at the centre of their health and social care

Listening to women, personalising care

1.1 The CSP strongly supports Personalised Care and a shared decision-making approach, and believes it is critical to making services fit for purpose to meet modern population needs, including addressing health inequities experienced by women.

1.2 Women wait longer to be diagnosed for many conditions, including cancer. They are more likely to have heart disease misdiagnosed. Women are also more likely to wrongly have their physical symptoms ascribed to mental health issues,and at the same time are more likely to experience depression and anxiety as a result of a physical long term condition.(1) The problems of delayed and incorrect diagnosis and treatment disproportionately experienced by women, contributes to health inequity.(2)

1.2 This inequity is compounded for women from Black, Asian and minority ethnic backgrounds and from the LGBTQIA+ community. People from Black, Asian and minority ethnic backgrounds are more likely than the white British population to report poor treatment when visiting their GP surgery and experience insufficient support from local services.(3) LGBTQIA+ people are more likely to be dissatisfied with health services compared to heterosexual people and experience discriminatory behavior.(4) Trans people specifically report a negative experience seeking to access health care and report that their specific needs were ignored or not taken into account.(5)

1.3 The NHS Long Term Plan proposes a Comprehensive Model of Personalised Care. This should also include a shared decision-making approach. This has the potential to lead to a significant reduction in referrals to secondary care as well informed patients tend to opt for conservative management over surgical intervention where possible. It involves clinicians developing plans in partnership with women, led by patient insight and meaningful goals based on ‘what matters to me’.

Understanding women’s health needs

1.4 Women of all ethnicities are less likely than men to be invited to, or participate in medical trials and research.(6) This can contribute to poor understanding about prevalence of conditions among women, presenting symptoms and effective treatment. Research funding should be allocated in ways which ensure women’s health needs, experiences and outcomes are properly evaluated.

1.5 We know from existing data (see below) that there is inequity in the rehabilitation offered to women and in take up of services when it is offered. Better data is critical to understanding the extent of this. Improvements to national audits of rehab provision and routine data collection across primary care, community and social care, and linking up these data sets, is urgently needed.

2. Improving Women’s access to healthcare

Pelvic health

2.1 While delayed or incorrect diagnosis and treatment are an issue for women with a range of long term conditions, the situation is particularly problematic in pelvic health among women. This illustrates many of the solutions to the systemic issues that need to be addressed in addressing health inequities more broadly.

2.2 A third of women suffer from a pelvic floor disorder after childbirth, including urinary incontinence and pelvic organ prolapse. Other risk factors include ageing, menopause and gynecological surgery. Urinary incontinence is known to reduce women's participation in sport and exercise and to impact on their quality of life [7-9] Continence issues may precipitate secondary health conditions, such as urinary tract infections and skin ulceration.

2.4 Contact with a physiotherapist offers both recommended first line treatment for urinary incontinence and health promotion and prevention strategies, and has been proven to be both clinically and cost effective.[10,11] Pelvic floor training has been proven to be more effective than alternative treatments. An economic evaluation of Duloxetine, a UI drug, for the treatment of women with stress urinary incontinence showed that pelvic floor training was cheaper and more clinically and cost effective.[12]

2.5 Nearly half of women affected by urinary incontinence fail to present to their primary health care provider.[13] Many believe that their symptoms are 'normal' or too trivial to bother professionals with.[14] Those that do present often do not receive the care that they require as care is fragmented and variable.[12] Women of all ages need to be provided with information on pelvic health issues to empower them to seek the correct care. This should include their understanding of the pelvic floor muscles, prevention of continence issues, management of prolapse and the effects of birth trauma on pelvic health and general wellbeing. Women need clinical support to understand and adhere to a management programme that may take time to be effective and may require repeat interventions.

2.6 Endometriosis is the second most common gynecological condition in the UK which affects women of all ages and costs the UK economy £8.2bn a year in treatment, loss of work and healthcare costs.[15] Evidence from the APPG on Women's Health report found that 40% of those surveyed needed 10 GP appointments or more before being referred to a specialist, 10% of women took 15 years or more to get a diagnosis from when they first went to a healthcare professional with symptoms and 25% of women received the wrong diagnosis.[16] The quality of life for women with a history of endometriosis and those with chronic pelvic pain of other origin is affected most by the pain levels experienced. A biopsychosocial approach including physiotherapy incorporating myofascial treatment is recommended.[17]

2.7 Since the early 2000's, many women with pelvic floor disorders were offered transvaginal mesh implants. The use of mesh is not currently permitted due to evidence that the complications have caused significant harm to some women and in the UK 1 in 15 women have later had to have their implant surgically removed.[2] This situation has led to many women not presenting for treatment for fear of an operation but also for many women seeking a surgical alternative with the use of pessaries and physiotherapy management.

2.8 There is therefore an urgent need to train primary care teams to recognise pelvic health issues for women of all ages so that correct diagnosis happens at a much earlier stage, and so that clinicians understand the treatment options, adhere to NICE and other guidelines and can communicate these to women so that they can take action and make informed choices about treatment.

2.9 The setting up of Perinatal Pelvic Health Services with an increase in specialist physiotherapists is a welcome step, along with additional training for maternity staff to improve prevention, identification and treatment of pelvic floor dysfunction in the

perinatal period. This expansion of provision is an important step in building longer term pelvic health provision for women of all ages including the elderly, and there is an urgent requirement to increase availability of specialist physiotherapy services across community primary and secondary care platforms.

2.10 Maternity apps and the digital red book should contain clear information and questions about pelvic health so that women have the confidence to know that their symptoms require further investigation. Women should be asked specifically if they have pelvic floor symptoms such as bladder or bowel incontinence, pelvic pain or sexual dysfunction to encourage treatment provision and uptake.

Long term conditions and rehabilitation

2.11 40% of people have at least one long term condition. Rates for having multiple long-term conditions are higher amongst women than men, and even higher among older women and women from certain ethnic groups.[18] Many long-term conditions can be managed effectively with rehabilitation and supported self-management in the community. Currently rehabilitation services are mainly organised in silos by diagnosis. The CSP is part of a growing consensus that rehabilitation in the NHS needs to be far more integrated and based on needs and symptom from a comprehensive assessment of individuals rehabilitation needs, which may arise from multiple conditions.

2.12 In Primary Care Teams, First Contact Physiotherapists (FCPs) are taking this approach as the first point of contact for people presenting to primary care with musculoskeletal health issues. One area where FCPs have a critical role to play is in the diagnosis and management of chronic musculoskeletal conditions. Women are almost three times more likely than men to be affected by rheumatoid arthritis.[19] Osteoporosis is the most common form of arthritis and affects three times as many women as men, and is linked to higher risk of falls and fractures. The pre-osteoporosis stage, osteopenia, can act as an early warning, and enable women to reverse bone density loss through bone strengthening exercises and in some cases treatment. All women need to be able to access an FCP via their GP surgery through the roll out of FCPs as part of the primary care team.

2.13 Across many conditions take up of rehab is limited, with women being particularly affected. For example, before the pandemic, only 50% of patients who are eligible for cardiac rehabilitation took it up, in spite of proven effectiveness. Women are less likely to attend cardiac rehab than men across all ethnicities, and the uptake is even lower among women from deprived areas.[20]

2.14 The NHS England Long Term Plan includes ambitious targets on referrals and uptake of rehabilitation in the community for respiratory, cardiac and stroke which would be life transforming as well as reducing demand on the most costly parts of health and social care systems. But as yet there is no target for expansion of the rehabilitation workforce in the Community Sector necessary to achieve these goals.

2.15 Covid has pushed levels of unmet rehabilitation needs to a crisis point, impacting most on women. 70% of patients admitted to hospital with Covid-19 had not yet recovered by March 2021, with women most affected.[21] Women under 50 were 7 times more likely to be more breathless, twice as likely to report worse fatigue and more likely to have a new disability, than men of the same age, seven months after hospital treatment. Middle-aged women appeared to be worst affected by long-term health problems, including Long Covid.[22] Furthermore, women are more likely to be

affected by Long Covid than men.[23] In March 2021 932,000 people were affected by Long Covid, and 80% are expected to have rehabilitation needs.[25]

2.16 Millions of women with long term conditions and frailty have deconditioned and deteriorated as a result of lockdown and disruption to services and are impacted by the severe backlog in elective procedures which depend on quality rehabilitation.

2.17 As well as expanding access to community rehabilitation for people with long term conditions, including those recovering from Covid, there needs to be a change in what is offered to make it more accessible, particularly addressing the barriers experienced by women.

2.18 Recent patient insight research carried out for the CSP suggests that people would find rehabilitation more accessible if more of it took place outside of medical settings.[25] For some women, the option of more local or remote rehabilitation, as part of a blended offer of remote and in person services, could help address practical barriers to accessing services such as the lower access to a car amongst women.[26] With more women managing multiple long term physical conditions, as well as anxiety and depression, developing a more integrated rehab offer in the community, with a greater emphasis on psychological support would also benefit women's health.

2.19 To encompass the needs of women in different circumstances rehabilitation services need to be flexible in their approach. Including carers in sessions can enable take up and would health benefits for carers, the majority of whom are women. Studies into cardiovascular rehabilitation programmes have suggested that higher take-up among South Asian women could be achieved through providing same sex groups and using same ethnicity advocates.[27]

3. Preventing ill-health amongst women

Falls prevention

3.1 Older women are particularly at risk of falls related injuries which can lead to death, disability or dependency. The cost of falls to the NHS of falls is estimated to be more than £2.3 billion per year. Multifactorial falls risk assessment reduces falls by 24% and should be offered to all older people who have fallen or are at risk of falls.[28] Yet falls prevention services are not available in all parts of England. This should be addressed.

Musculoskeletal health

3.2 Musculoskeletal(MSK) disorders accounted for 8.9 million lost working days in 2019/20, second only to stress related conditions.[40] Some MSK conditions are more prevent amongst women. Access to good occupational health physiotherapy services and professional ergonomic advice, tailored to the needs of working women, should therefore be a key part of preventing women's ill heath.

Workplace stress and mental health

3.3 70% of the physiotherapy workforce are women, as are 77% of all NHS workers. Physiotherapists and physiotherapy support workers work across all sectors with two thirds employed directly by the NHS and many more providing NHS services for independent providers.

Stress related ill-health amongst working women

3.4 Stress is a major cause of ill-health amongst working women. Female health workers were more likely to suffer than male healthcare workers from high anxiety. This is even higher among black, Asian and minority ethnic women, with ethnic minority health workers were 50% more likely to experience post-traumatic stress disorder than non-ethnic minority colleagues.[29]

3.5 Addressing the causes of stress is therefore essential to improving women's' health. A major cause of stress for women who work is lack of flexibility to enable caring and other responsibilities outside work which fall disproportionally to women. NHS England and NHS Improvement estimate that there are currently 250,000 carers working in the NHS with many aged between 45 – 64. The CSP has therefore welcomed NHS England's introduction of a working carer's passport to improve identification, recognition and support for carers within the workplace.[30] The CSP believe that to meet the needs of women in the workplace, flexible working needs to be; accessible to everyone, voluntary and enable a genuine balance between home and work life.

3.6 The 2020 NHS survey found that only 59% of NHS physiotherapy staff in England reported being satisfied with opportunities for flexible working patterns.[29] A 2016 survey of CSP stewards found nearly 1 in 5 said that they were aware of members leaving their NHS job because they could not negotiate the flexible working arrangements they needed.[31]

3.7 Pressures of workload can also cause stress among CSP members, most of whom are women working in the healthcare system. Only 36% of respondents to the 2020 NHS Survey reported that their employer took positive actions to support staff health and wellbeing. A recent inquiry by Health and Social Care Select committee stated that *'burnout is a widespread reality in today's NHS and has negative consequences for the mental health of individual staff, impacting on their colleagues and the patients and service users they care for'.* [32]

3.8 To relieve stress on the predominantly female NHS physiotherapy workforce we urgently need to take advantage of the growth in physiotherapy graduate numbers by offering all guaranteeing physiotherapy students an NHS job. Make temporary positions created to respond to the pandemic permanent and increasing the number of support workers.

3.9 A further element affecting the stress amongst women is the experiences of women from marginalised backgrounds at work and in wider society. The 2020 NHS survey found that that discrimination remains an issue in the NHS and is experienced by 13.1 per cent of workers for a variety of reasons including gender and ethnic background. Ethnic background remains the most common reason cited for discrimination and was mentioned by 48.2 per cent of staff. Action on mental wellbeing needs to address discrimination in the workplace, including those experienced by Black, Asian and minority ethnic women.

3.10 The CSP supports the announcement by NHS England and NHS Improvement to invest an extra £15 million in mental health support for NHS staff and initiatives. We are pleased to have informed the NHS England Health and Wellbeing framework which is expected to be released June. In this framework we are keen to see more content included on employers responsibilities to tackle the organisational causes of work related stress. A good practice example that we propose employers consider

rolling out in the workplace is the Health and Safety Executive toolkit for NHS on dealing with stress.[33]

Women's health and safety at work

3.11 A concentration of women in frontline physiotherapy roles contributes to gender inequalities in rates of workplace accidents and ill health.

3.12 The CSP has together with 20 healthcare organisations are urging changes to some Covid PPE measures relating to aerosol generated procedures.[34] There is now direct empirical evidence that the virus is readily transmitted in health care settings beyond formally-classified aerosol generating procedures.

3.13 During the pandemic some pregnant women physios have not received appropriate risk assessments and work adjustments. This is echoed in new evidence that shows one in four pregnant women have been discriminated against since the start of the Covid crisis, with employers routinely breaking health and safety law.[35] This situation is even worse for pregnant women from Black, Asian and minority ethnic backgrounds, disabled women and migrant women in the workplace.[36] This is why the CSP has joined a call for legislation to help tackle workplace pregnancy and maternity discrimination.[37]

3.14 1 in 3 women has experienced, or is going through the menopause at any one time, and for many this has an effect on their working life. Disabled women and those with pre-existing health conditions have reported that the menopause can aggravate their existing impairments and health conditions or even trigger new ones.[38] Managers and employers need to give these the same consideration that they do to other health conditions to avoid discriminating against women. New legislation for older workers could lead to workplaces developing and consistently applying policies that offer better support to staff experiencing the menopause. The CSP would also recommend that the NHS Wales Menopause Policy[39] is viewed as a good practice document for employers.

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For further information on anything contained in this response or any aspect of the Chartered Society of Physiotherapy's work, please contact:

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