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| **Checklist for submitting comments**   * Use this comments form and submit it as a **Word document (not a PDF)**. * Complete the disclosure about links with, or funding from, the tobacco industry. * Include **document name,** **page number and line number** of the text each comment is about. * Combine all comments from your organisation into 1 response form. **We cannot accept more than 1 response from each organisation**. * **Do** **not** paste other tables into this table – type directly into the table. * Ensure each comment stands alone; **do not** cross-refer within one comment to another comment. * **Clearly mark any confidential information or other material that you do not wish to be made public. Also, ensure you state in your email to NICE that your submission includes confidential comments.** * **Do not name or identify any person or include medical information about yourself or another person** from which you or the person could be identified as all such data will be deleted or redacted. * Spell out any abbreviations you use. * For copyright reasons, **do not include attachments** such as research articles, letters, or leaflets. We return comments forms that have attachments without reading them. You may resubmit the form without attachments, but it must be received by the deadline. * **We do not accept comments submitted after the deadline stated for close of consultation.**   You can see any guidance that we have produced on topics related to this guideline by checking [NICE Pathways](http://pathways.nice.org.uk/).  **Note:** We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate.  Comments received during our consultations are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the comments we received, and are not endorsed by NICE, its officers or advisory Committees. |

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|  | **Please read the checklist above before submitting comments.** **We cannot accept forms that are not filled in correctly.**  We would like to hear your views on the draft recommendations presented in the guideline, and any comments you may have on the rationale and impact sections in the guideline and the evidence presented in the evidence reviews documents. We would also welcome views on the Equality Impact Assessment.  In addition to your comments below on our guideline documents, we would like to hear your views on these questions. **Please include your answers to these questions with your comments in the table below.**   1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. 2. Would implementation of any of the draft recommendations have significant cost implications? 3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) 4. Development of this guideline began before the COVID-19 pandemic. We have aimed to ensure that the recommendations take into account COVID-19 where possible but please tell us if there are any particular issues relating to COVID-19 that we should consider when finalising the guideline for publication. 5. NICE is aware that there are existing NICE guidelines regarding symptoms associated with pelvic floor dysfunction such as NG123 Urinary incontinence and pelvic organ prolapse in women: management; CG49 Faecal incontinence in adults: management; and CG148 Urinary incontinence in neurological disease: assessment and management. The draft guideline on pelvic floor dysfunction cross refers to these existing NICE guidelines where necessary. However, after this consultation NICE will assess whether some or all of these guideline recommendations should be amalgamated. If you have any views on this potential amalgamation of guideline recommendations, please let us know.   See [[Developing NICE guidance: how to get involved](http://www.nice.org.uk/process/pmg22/chapter/how-you-can-get-involved)](https://www.nice.org.uk/process/pmg20/resources/developing-nice-guidelines-how-to-get-involved-2722986687/chapter/commenting-on-a-draft-guideline) for suggestions of general points to think about when commenting. |
| Organisation name (if you are responding as an individual rather than a registered stakeholder please specify). | Pelvic Partnership |
| Disclosure (please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry). | n/a |
| Name of person completing form | Jen Campbell, co-ordinator at the Pelvic Partnership |

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| **Comment number** | **Document**  [e.g. guideline, evidence review A, B, C etc., methods, EIA] | Page number  **‘General’** for comments on whole document | Line number  **‘General’** for comments on whole document | Comments  * Insert each comment in a new row. * Do not paste other tables into this table, because your comments could get lost – type directly into this table. * Include section or recommendation number in this column. |
| 1 | Guideline | General | General | The Pelvic Partnership offers support and information to women with pregnancy-related pelvic girdle pain (PGP), their families and carers. PGP affects around one in five women causing pain, immobility and associated mental health impacts.  PGP is a biomechanical joint problem that can be successfully treated with manual therapy during pregnancy and postnatally. Many women are unable to access manual therapy on the NHS and are therefore left no option but to seek treatment privately from physiotherapists, osteopaths or chiropractors – if they can afford it. Unfortunately many women have reported being unable to be treated on the NHS and afford private manual therapy, leaving them in severe pain and immobility.  Many women experience PGP alongside problems with their pelvic floor, it being either too weak or more commonly, overactive or tight. We encourage women’s health physios to consider PGP as a factor when assessing and treating pelvic floor dysfunction. Similarly, if women have had manual therapy to treat their PGP and treatment has reached a plateau, we would encourage them to have their pelvic floor assessed for pelvic floor dysfunction.  We welcome the aims and objectives of this draft guideline to raise awareness and provide clarity around pelvic floor problems. In particular, while bladder incontinence is becoming more normalised, faecal incontinence and other issues remain taboo and as such women are living with ongoing pelvic floor problems unnecessarily.  We also encourage the guideline to cover awareness raising for those aged 18+ as well as teenagers, and focus on antenatal and postnatal awareness sessions focusing on issues related to the pelvic floor and PGP.  The majority of our comments below seek to provide further clarity and ensure clear understanding. |
| 2 | Guideline | 4 | 11 | The guideline states that symptoms and disorders associated with pelvic floor dysfunction are included in this guideline. This list includes “chronic pelvic pain” but there is no clear definition about what “chronic pelvic pain” is.  We consider there should be a clear definition of what syndromes “chronic pelvic pain” is referring to, i.e endometriosis, pelvic girdle pain or pelvic floor dysfunction and pain, which are all very painful conditions but present very differently and have different links with the pelvic floor.  Given the high number of women who experience both pelvic floor problems and pelvic girdle pain, we consider pelvic girdle pain should be added to this list, or included in a clear definition of “chronic pelvic pain”.  As the term in repeated throughout the guideline, some clarification of what it encompasses would be helpful. |
| 3 | Guideline | 5 | 16-17 | Given the high number of women who experience both pelvic floor problems and pelvic girdle pain, all healthcare practitioners in this field should have an understanding of pelvic floor dysfunction and pelvic girdle pain.  Where this is not currently the case, training should be made available covering pelvic girdle pain and how it relates to pelvic floor problems in women, especially during pregnancy and postnatally. Many women tell us that they receive treatment for either PGP or PF problems, but many practitioners do not have the expertise to treat both, and so women are left with either pain or continence issues (or a combination of both unresolved). |
| 4 | Guideline | 5 | 26 | Other examples should be given, e.g. the postnatal period, menopause etc |
| 5 | Guideline | 8 | 1 | We consider pelvic girdle pain should be added as a non-modifiable risk factor related to pregnancy. |
| 6 | Guideline | 8 | 1 | It is important that women are also provided with information about pregnancy-related pelvic girdle pain, given the high number of women who experience pelvic floor problems alongside their pelvic girdle pain. |
| 7 | Guideline | 10 | 18-20 | Greater clarity is needed around what is pelvic floor muscle training and training provided to healthcare practitioners to demonstrate clearly how to do it. Many women report that they are still being given a sheet of exercises which focus on tightening the pelvic floor, and which can exacerbate pain and incontinence for women with an overactive pelvic floor, particularly associated with episiotomy or perineal tears.  Pelvic floor muscle training needs to be defined clearly and include contraction and relaxation of the pelvic floor muscles, given the risks associated with an overactive pelvic floor. |
| 8 | Guideline | 11 | 3 – 20 | Information about pelvic girdle pain should also be provided to women who are pregnant or who have recently given birth, alongside clear and accessible information about pelvic floor muscle training (including how to contract and relax the pelvic floor muscles).  Given the high number of women who experience pelvic girdle pain alongside their pelvic floor problems, another recommendation should be added here offering all women an assessment for pelvic girdle pain, and ongoing manual therapy treatment as needed, during pregnancy and after they have given birth. |
| 9 | Guideline | 11 | 26 | As explained above, need to add “and relaxation of the pelvic floor muscles”. |
| 10 | Guideline | 13 | 1 | Suggest “communicating with women” instead of “communicating with patients |
| 10 | Guideline | 14 | 11 | As explained above, need a clearer definition of “chronic pelvic pain” to include pelvic girdle pain. |
| 11 | Guideline | 14 | 13 | A clinical examination should include a hands-on internal assessment of the pelvic floor muscles by the primary healthcare practitioner or by a referral to a women’s health physiotherapist if required. This should not just focus on whether the woman can tighten her pelvic floor, but also whether there are painful areas which may need trigger point release treatment. |
| 12 | Guideline | 16 | 15-16 | Rather than “conduct routine digital assessments” need to be clearer about what this involves, i.e. a hands-on internal vaginal and possibly anal assessment of the pelvic floor muscles by the practitioner using their fingers to assess the pelvic floor muscles when contracting and relaxing.  Once again, “and relaxation” of the pelvic floor muscles needs to be added here. |
| 14 | Guideline | 16 | 23 | Who does “other care providers” refer to – is this GPs, nurses etc or does this refer to carers in a care home? |
| 15 | Guideline | 19 | 10 (and below) | It is not clear what “supervised pelvic floor training” refers to – is this individual treatment, classes or monitoring with phone calls? What should the minimum frequency of supervision be? Many women tell us they are given exercises and told to return after a few weeks to check how they are getting on, or just given a sheet of exercises to take away. Could it be made clearer what the expectation of review frequency and quality is? |

Insert extra rows as needed

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