W8: Implementation of pelvic floor muscle training programs in health services: challenges and strategies
Workshop Chair: Helena Frawley, Australia
03 September 2019 10:00 - 11:00

<table>
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<tr>
<td>10:00</td>
<td>10:05</td>
<td>Introduction</td>
<td>Helena Frawley</td>
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<td>10:05</td>
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<td>- Implementation: leakage of evidence-into-practice throughout the healthcare system. Barriers and enablers to implementation of PFMT</td>
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<td>- A vignette describing an everyday clinical scenario of a patient referred to PFMT for POP/UI</td>
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<td>The Behaviour Change Wheel (BCW) as it applies to PFMT intervention. Understanding the levels that impact on implementation of evidence into practice at different levels of the health service.</td>
<td>E Jean C Hay-Smith, Sarah Dean</td>
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<td>10:25</td>
<td>10:40</td>
<td>Group-based activity: Identification of barriers, and how to incorporate behaviour change techniques in delivery of interventions to facilitate uptake of new practice and services.</td>
<td>Helena Frawley, E Jean C Hay-Smith, Sarah Dean</td>
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Aims of Workshop
This workshop will address the barriers and enablers to implementation of pelvic floor muscle training (PFMT) in health services, using a vignette that reflects a typical clinical scenario. While evidence for PFMT as an effective treatment for urinary incontinence and pelvic organ prolapse is strong, and international recommendations endorse this intervention as first-line treatment, availability of the service is variable and uptake and adherence is poor. The reasons are complex and relate to several levels within the health service: the treatment itself, the patient, the clinician, the social and the organisational context. This interactive workshop will provide strategies for participants to implement in their workplace to address the barriers and enablers to effective implementation of PFMT, so that evidence can be translated into practice.

Learning Objectives
Appreciation of the complexity and challenges of implementation of PFMT into a health service, and an understanding of why it is not always successful.

Target Audience
Urogynaecology, Conservative Management. All clinical disciplines and those interested in research translation.

Advanced/Basic
Intermediate

Suggested Learning before Workshop Attendance
Introduction: Implementation: leakage of evidence-into-practice throughout the healthcare system

Implementation of evidence-into-practice into a healthcare system – with fidelity to the research – is challenging, and these challenges are faced by many evidence-based interventions. Health services delivery of evidence-based PFMT is not immune to these challenges. While PFMT is recommended as the first-line intervention for women with urinary incontinence (UI) or pelvic organ prolapse (POP) (Dumoulin 2016), actual practice does not reflect these good intentions in many jurisdictions (Lamin 2016, Ismail 2009, Chiarelli 1997). There is a known evidence-into-practice gap of up to 17 years (Morris 2011) for new interventions, and the incorporation of evidence into policy, in order to change a healthcare system, may be an even larger gap. Even when there is an intent to implement evidence, attrition or ‘leakage’ of adherence to the recommendations occurs along the pipeline of research into practice (Glasziou 2005). This attrition has been documented in many aspects of healthcare (Mickan 2011), however there are no reports of why and how this attrition occurs in the implementation of PFMT. Lack of attention to the attrition which occurs at each of the stages of change (aware, agree, adopt, adhere) is a lost opportunity for patient benefit. Findings from these other areas of healthcare will be used to inform our discussions of why and how the ‘leakage’ is occurring in the health system for PFMT, and why there may be unique aspects related to PFMT. Studies are emerging which consider the broader aspects which impact on implementation and uptake of PFMT in the childbearing year (Salmon 2017), however a complete synthesis of factors relevant to other populations affected by pelvic floor dysfunction is lacking. Indeed, recent research suggests local uptake of evidence is less informed by the traditional linear pipeline of ‘evidence–guidelines–practice’ and more by locally contextual issues such as budget, capacity and political influence (Atkins 2017).

Barriers and enablers to implementation of PFMT: This topic will explore examples of barriers and enablers in a health service that may impact on successful implementation.

A vignette describing an everyday clinical scenario of a patient referred to PFMT for POP/UI

The following vignette will be presented and strategies to maximise evidence-based practice in this scenario, and how this could be managed differently explored:

Family doctor / surgeon referred patient to physiotherapist / continence professional for POP/UI, said she could give PFMT a try. After being on a waiting list for 4 months, the patient attended an initial visit. Because of clinical load and waiting list, the therapist offered the patient a program of 4 visits. Patient cancelled 2nd visit but managed to attend 3rd visit. Patient was dissatisfied, she reported she was not improved and did not want to attend again. The therapist referred the patient back to the referring doctor. The case was labelled as patient had ‘failed’ PFMT, and the patient proceeded to surgery.

The Behaviour Change Wheel (BCW) (Michie et al 2011) as it applies to PFMT
Sarah Dean, Psychologist, UK and Jean Hay-Smith, Rehabilitation Academic, New Zealand

This topic explores the three ‘levels’ of the BCW and how they apply to implementation of PFMT. First, at the centre, the sources of behaviour which are capability, opportunity and motivation (COM-B). Second, the middle level, the implementation functions (such as enabling, persuading, training, education – see Hay-Smith et al 2015) we might use to facilitate behaviour change. Third, the outer level, the policy categories (e.g. service provision, guidelines), which we acknowledge yet rarely overtly consider as ‘clinical’ sources of influence on behaviour. Drawing on previous and current research trials of the panel each of these levels is illustrated with respect to their influence on awareness, agreement, adopting, and adhering to PFMT. Workshop participants will then apply this learning to the vignette (see below).
Group based activity: With reference to the vignette, this session will involve a practical activity to be done in groups per table. Participants will brainstorm the aspects they perceive to be barriers and enablers in a health service which impact on implementation of evidence-based recommendations, using the BCW as a framework for understanding where these barriers and facilitators lie. Each group will choose items from the policy level and brainstorm ways to support awareness, agreement, accessibility, adoption and adherence of evidence-based recommendations.

Group feedback: Each table / break-out group will feedback to the whole group, the barriers and facilitators they thought were at play in the vignette, with reference to their own particular health service. This may involve multiple perspectives, reflecting the diverse geographical, cultural and health services contexts represented by individual group members. If time allows, discussion will explore how other members of the healthcare team may support implementation of evidence-based PFMT for women with pelvic floor dysfunction at different life-stages, and how a multi-disciplinary approach may be facilitated.

References:

### W8: Implementation of pelvic floor muscle training programs in health services: challenges and strategies  
**2019, Sep 3**

- Helena Frawley, Australia
- Sarah Dean, UK
- Jean Hay-Smith, New Zealand
- Rohini Terry, UK

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- Handout for all workshops is available via the ICS app, USB stick and website.
- Please silence all mobile phones
- PDF versions of the slides (where approved) will be made available after the meeting via the ICS website so please keep taking photos and video to a minimum.

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### Affiliations to disclose:

- None

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**Funding for speaker to attend:**
- **Self-funded** ☑
- **Institution (non-industry) funded** ☑
- **Sponsored (non-industry) funded** ☑

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### PROGRAM

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ICS Workshop #8, 3 Sep 2019
Helena Frawley, PhD, FACP
• Associate Professor, Physiotherapy, Monash University
• Melbourne, Australia

What is implementation?

- Implementation: (Lomas 1993)
  - Active, planned, tailored
  - Involves identifying & assisting in overcoming the barriers to the use of the knowledge
  - It uses the message itself, plus:
    - Organisational & behavioural tools that are sensitive to constraints & opportunities of health professionals in identified settings
- Implementation research:
  - Scientific study of methods to promote the uptake of research findings for the purpose of improving the quality of care

Implementation in clinical practice

17 years for 14% of original research to be integrated into practice for patient gain (Balas & Boren 2000)

PFMT implementation (ICI 2017)

Opportunities for PFM assessment, exercise instruction and supervised training for prevention and treatment
What do we know about effective PFMT?

- **active ingredients:**
  - Confirmation of correct PFM contraction
  - Instruction in a dose-effective PFMT program
  - Supervised practice
  - Evidence into practice: with fidelity to the evidence

Current clinical practice:
- Not part of standard (AN or PN) maternity care
- May occur in private system
- Relies on individual efforts outside model of standard care

Whole of health system approach

- Change required at all levels in the system

Evidence for Level 1, Gr A

Implementation of PFMT: leakage of evidence-into-practice throughout the healthcare system

The leaky ‘pipeline’ of research to practice

29 guideline recommendations

The ‘pipeline’ of research to practice

Whole of health system approach

- **Macro**
  - Economic and political context

- **Meso**
  - Social and organisational context

- **Micro**
  - Individual clinician and patient level

Evidence for Level 1, Gr A

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Evidence-based practice in context

**Context is everything!**

- Clinical state and circumstances
- Research evidence
- Patients' preferences and actions

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**MESO: barriers? strategies?**

- Problem of scale up in public health:
  - Loss of fidelity to the research evidence
  - Under-resourced, diluted, information-focused, ineffective
  - Competing priorities

- Research efforts at implementation
  - Xing 2017
  - PF education and information program for nurses and women
  - Correct PFM contraction not confirmed; no supervision of PFMT
  - Frawley 2014:
    - Significant barriers, clinician and system levels
    - Sustainability

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**MESO: barriers? strategies?**

- Smart allocation of resources
- Linkages
- Referral pathways
- Very contextual
- Local solutions
- Modelling
- Champions
- Clear messages
MACRO: barriers? strategies?

Economic and political context
- Scale up
- Priorities, perceived value

Problems at the Top End

Results:
- Previous research has focused on women's perspectives of treatment and management of postnatal UI with limited evidence exploring views and experiences of women during the antenatal period or healthcare professionals regarding PFME during childbearing years.
- Despite evidence for the effectiveness of PFME for preventing UI, these findings suggest that PFME is not implemented effectively during pregnancy.

Jean Hay-Smith

Affiliations to disclose:
None

Funding for speaker to attend:
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The Behaviour Change Wheel
Jean Hay-Smith
The Behaviour Change Wheel

Capability – includes necessary knowledge and skills
Opportunity – factors outside person making behaviour possible or prompt it
Motivation – brain processes that energize and direct behaviour

Green: Sources of behaviour

Red: Intervention functions
Educate – ↑ knowledge, understanding
Persuade – communicate to induce positive or negative feelings or action
Training – imparting skills

Grey: Policy categories
Regulation – scope of practice
Guideline - National Institute for Health and Care Excellence
Service provision – midwifery services and their funding

Sarah Dean

Affiliations to disclose:
Sarah Dean's time is partly supported by the UK’s National Institute of Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care South West Peninsula at the Royal Devon and Exeter NHS Foundation Trust.
The views expressed are those of the presenter and not necessarily those of the NHS, the NIHR or the Department of Health.

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Changing Behaviour is difficult!
There are many!

No one model or theory provides a sufficient explanation of how behaviour can be changed for all people in all settings.

**BCT 66: Goal Setting (behaviour)**

*Description:*
Set or agree a goal defined in terms of the behaviour to be achieved.

*Example (adapted):*
Agree a daily exercise goal with the person and reach agreement about the goal.

*Source:* BCT Taxonomy (v1) Michie et al 2013

**Therapeutic Exercise**

Make sure patient is involved in all goal setting and that they understand and agree (in writing) to all short term and long term goals.

**BCT Label**

- Goal setting

Understand and agree (and in writing) to all short term and long term goals.

**BCT Label**

- Behavioural contract

**Behaviour Contract & Commitment**

Make sure patient is involved in all goal setting and that they understand and agree (in writing) to all short term and long term goals and verbalise their commitment.

Clinician: “please will you sign (initial) this sheet where I have written down the goal we have just agreed.”

Ask the person to make statements indicating strong commitment to change the behaviour:

Patient says: I will do my exercises .. x times per week...

**Workshop activity – set up**

Two groups at each table

Facilitator will give you a pack

Follow instructions in the pack

Basic idea is to ‘label’ up your case (BCTs labels & COM-B labels)

Discuss what enables PFMT and what are the barriers to PFMT
Workshop activity – debrief

How did the labelling go?
- COM-B labels?
- BCT labels?

Deciding if it was an enabler or a barrier?
Deciding what level? – organisation – health professional – patient
Working out where the problems lie, what the solutions might be

Workshop Discussion

Any comments or questions?

Please remember to do the workshop evaluation

W8:

Thank you

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2019, Sep 3

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