The case for low-cost, preventative pelvic health support for women

Based on findings from the Medway MUTU pilot

Context

The report, *Improving pelvic health pathways in primary and community care*, sets out the case for making low-cost, preventative pelvic health support available to women through clinically owned NHS pathways. It draws on the Medway Women's Health Hub pilot of the digital pelvic health programme MUTU, delivered through Reach Healthcare, a primary care network. It identified significant unmet need, strong demand when eligibility was widened, and important learning about how digital support must be implemented if it is to reach women effectively.

Pelvic health symptoms are common, normalised and under-treated. The pilot shows that many women are living with symptoms such as urine leakage, prolapse and diastasis recti without formal support, despite the impact on confidence, quality of life and emotional wellbeing. **The opportunity is to move from short-term pilots to a funded, equitable pathway** that combines trusted clinical communication, digital self-management and clear routes into physiotherapy or further care when needed.

The case for immediate action

The Medway pilot demonstrates that pelvic health need is present, persistent and often hidden. MUTU received 100 sign-ups against 50 funded licences, indicating latent demand within a single PCN footprint once. Baseline responses showed high levels of symptoms, including urine leakage, prolapse and diastasis recti. Only a small proportion had previously been offered NHS treatment or physiotherapy, while many had searched online or done nothing at all.

This is a health inequalities issue as well as a clinical issue. Women who can pay privately may access support, while women relying on inconsistent NHS provision may continue to live with symptoms. The local population served by Reach Healthcare has higher deprivation than the national average, making the pilot particularly relevant for systems seeking to improve prevention, shift care closer to home and address unmet women's health needs before they escalate.

Key recommendations

1. **Embed low-cost pelvic health support in routine pathways.** Commissioners should integrate proven digital and home-based pelvic health offers into clinically owned pathways, alongside community physiotherapy and women's health hub provision. This should be a recurrent preventative offer, not a short-term pilot, with clear referral, onboarding, monitoring and escalation routes.
2. **Use trusted NHS communication.** Recruitment and onboarding should come through GP practices, women's health hubs or NHS-branded channels. The pilot showed that communication from an unknown supplier reduced engagement, while trusted practice communication generated response. If practices are expected to support recruitment and follow-up, this workload needs to be funded.
3. **Define priority cohorts.** Priority groups should include digitally enabled women up to four years postpartum, women with continence symptoms, mild prolapse, diastasis recti, low confidence, or those waiting for physiotherapy. The pilot indicates need persists beyond the early postnatal period.

4. **Build data capture into routine care.** Offers, uptake and outcomes should be coded into the patient record and supported by platform analytics, rather than relying mainly on survey completion. Without routine coding, pelvic health need remains invisible to commissioners and difficult to fund.
5. **Protect equity and choice.** Digital support should be available to women who can benefit from it, with alternatives for women who cannot or do not wish to use a digital programme. Pathways should account for language, literacy, cultural barriers, digital access and confidence.
6. **Measure what matters.** Success should include uptake, symptom confidence, quality-of-life improvement, reduced isolation and women's ability to undertake normal activities without leakage or fear. Conventional short-term financial return measures may miss the value of prevention and social impact.

Implementation learning

The pathway will determine the impact. Medway showed that a simple text offer from a trusted practice can generate interest, but women also need clear joining instructions, timely reminders and proportionate follow-up. Data collection should support participation rather than act as a barrier. Supplier administration, governance and analytics are important, but clinical ownership and NHS communication are essential for confidence and uptake.

The pilot also shows that innovation in women's health is too often dependent on motivated individuals working beyond their core role. If systems want scalable prevention, they need recurrent resource, implementation support and accountable pathway ownership. Otherwise, low-cost interventions remain promising but fragile, and demand continues to outstrip funded access.

Call to action

1. **Use the report to influence commissioners and funders.** Share the learning with ICBs, public health teams, women's health hubs, primary care leaders and innovation networks. Position the report around equity, prevention, the Women's Health Strategy shifts, and the practical steps required to make low-cost support available at scale.
2. **Produce an equity-focused extract.** Develop a short funding brief that foregrounds unmet need among women who cannot pay privately, the quality-of-life impact of pelvic health symptoms, and the case for making MUTU and similar offers part of routine NHS support.
3. **Secure a conversation on sustainable funding.** Explore public health, ICB and joint prevention funding routes, including relevant Better Care Fund opportunities where appropriate. The immediate next step is to secure an introduction to the Medway public health team.
4. **Link pelvic health to wider demand and prevention work.** Connect the findings with Regular Attenders work in Surrey and other programmes examining repeated GP attendance, menopause-related symptoms and hidden women's health needs. This may strengthen the case that earlier support can improve quality of life and reduce avoidable demand.
5. **Move from pilot to pathway.** The next decision should be how to fund, evaluate and sustain a clinically owned, digitally enabled pelvic health pathway for the women most likely to benefit, rather than whether to run another small pilot.