Management of urinary incontinence in women

Provided by: Royal Cornwall Hospitals NHS Trust

Publication type: Proposed quality and productivity example

Sharing good practice: What are 'Proposed Quality and Productivity' case studies?

The NICE Quality and Productivity collection provides users with practical case studies that address the quality and productivity challenge in health and social care. All examples submitted are evaluated by NICE. This evaluation is based on the degree to which the initiative meets the criteria of savings, quality, evidence and implementability.

Proposed quality and productivity examples are predominantly local case studies that meet most of the criteria but are yet to be fully implemented. This may be because they are at an early stage of implementation and further evidence is forthcoming. These proposed examples may still be of interest. Additional information will be requested within a year from the date of publication. A summary of findings is provided below along with comments and recommendations about how this case study may be developed.

Overview
Regular teaching sessions in primary care using NICE guidance on the management of urinary incontinence in women and regular multidisciplinary team reviews improve clinical outcomes. Compliance with NICE guidance results in reduced referral to secondary care. The multidisciplinary team review process was started on a voluntary basis by the team at the Royal Cornwall Hospitals NHS Trust. The trust directorate has acknowledged its importance and it is hoped that it will be accepted as a regular session. The initiative affects many areas within the NHS, including primary care, community care and hospital care.

NICE comment
The initiative aims to improve the quality of care, patient safety and the experience of patients and their carers. Sustainability is not yet proven. The initiative has only been implemented in Cornwall.

After introducing the 'Easy step guide' for referrals to the continence service, a re-audit found 99% compliance with NICE guidance on urinary incontinence. This audit is now a mandatory yearly rolling audit in Cornwall.

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Details of initiative

Purpose	The key aim of the project was to ensure women were receiving appropriate assessment and management for urinary incontinence before a decision to refer to secondary care. Secondary aims were to evaluate the implementation of NICE's guidance on the management of urinary incontinence in women and to assess the review conducted by the multidisciplinary team based on NICE's guidance.
Description (including scope)	Urinary incontinence is a common symptom that can affect women of all ages, with a wide range of severity and nature. Offering patients adequate and thorough assessment of their symptoms, helps avoid 10–14 referrals per month and unnecessary medical tests or surgical interventions. Whilst rarely life-threatening, incontinence may seriously influence the physical, psychological and social wellbeing of affected women. The impact on the families and carers of women with urinary incontinence may be profound, and the resource implications for the health service considerable. Urinary incontinence is distressing and socially disruptive. It may be the cause of personal health and hygiene problems. It may restrict employment and educational or leisure opportunities, and lead to embarrassment and exclusion. Results of an audit informed the initiative, which looks to address compliance with NICE guidance at referral for secondary care. This led to more regular teaching sessions for primary care staff, the development of an easy step guide for use in primary care and the establishment of regular audits.
Topic	Right care, productive care.
Other information	Prior to the initiative it was observed that: • Care for women with urinary incontinence (UI) was irregular and inconsistent • Every 4-6 months, compliance to referral criteria for conservative measures (pelvic floor physiotherapy, bladder retraining and life style modification) needed re-emphasis • There were no multidisciplinary team reviews for women with overactive bladder (OAB) or stress urinary incontinence (SUI) symptoms before they were offered surgery or other invasive treatment. Established urogynaecology units are mainly tertiary centres and have a multidisciplinary team process in place.

Savings anticipated

Amount of savings anticipated	Annual saving of £40,000 for a population of 550,000 or £7,327 per 100,000 population. The savings take into account the costs required to achieve them.
Type of saving	Care costing is difficult to assess in incontinence cases. Nevertheless, a mixture of real cash savings and improved productivity is likely. This was from reduced referrals to secondary care and avoiding unnecessary medical (urodynamic testing) and/or surgical interventions (6 stress incontinence surgeries in 3 months).
Any costs required to achieve the savings	The additional costs for the urogynaecology nurse and additional time for multidisciplinary teams and staff providing the teaching sessions every 6 months.
Programme budget	Problems of the genitourinary system.
Supporting evidence	The initiative helped avoid 10–14 unnecessary referrals per month. These patients were referred back for appropriate conservative management and subsequently only 3 out of the 14 women were referred for treatment. There was an estimated cost saving of £4,810–£6,734 per month (£131 for consultation and £350 for urodynamics totalling £481 per patient). Multidisciplinary team outcomes showed that 6 patients were prevented from having incontinence surgery after a multidisciplinary team review. Before this initiative, patients were referred without first having appropriate conservative management. Patients were not delayed in primary care if secondary care interventions were required.

Quality outcomes anticipated

Impact on quality of care or population health	The results of the audit showed that once regular teaching was started, patients received appropriate conservative management and fewer unnecessary urodynamic tests before referral to secondary care. This had an impact on patient outcome through less invasive testing.
Impact on patients, people who use services and/or population safety	The multidisciplinary team review process improves patient safety by offering patients adequate and thorough assessment of their symptoms, avoiding unnecessary medical or surgical interventions. Urodynamic investigations sometimes lead to urinary tract infections and may be unnecessary. No serious conditions have been missed or diagnosed late as a result of patients not being referred to secondary care services.

Impact on patients, people who use services, carers, public and/or population experience	The multidisciplinary team review process improves patient and carer experience by avoiding unnecessary referrals and avoiding medical or surgical interventions. Urodynamic interventions would be avoided sparing patients the embarrassment of the procedure. The initiative has led to 10–14 referrals per month being avoided. An audit of multidisciplinary team outcomes showed that 6 patients avoided incontinence surgery after a multidisciplinary team review. This contributed to cost savings and appropriate management.
Supporting evidence	In many hospitals, screening of referrals in urogynaecology already occurs in GP referral centres, which helps ensure that appropriate referrals take place in line with the Map of Medicine. If an inappropriate referral occurs, the GP is immediately informed, referred to the Map of Medicine and conservative measures for urinary incontinence suggested. This formed the basis of the audit. Although the Map of Medicine was comprehensive, it was found to be too complex to follow easily, and this is why primary care organisations requested an 'Easy step guide' referral pathway. Results from the initial audit showed that: • The average age of patients was 55 years (16-102) • Their average parity was 2 (0-6) • Average BMI was 26 (22-54) • 40% (20) of women did not see a physiotherapist prior to secondary care referral to consider surgical options for SUI • 68% (34) of women had urodynamics without seeing a physiotherapist • 96% (48) of women were on incorrect fluids and taking caffeine (4 mugs -6 pots/day) • No women with stress incontinence were booked for surgery after MDT discussion as no MDT existed at that time • 24% of referrals were rejected. This added to waiting times (8-12 weeks), and inconvenience both to patients and doctors. The audit results were presented in a governance meeting, disseminated to staff and published in a newsletter.

Evidence of effectiveness

Evidence base for case study	Underpinned by NICE guidance CG171 (2013) and NICE quality standard 77 (2015).
Evidence to date of	Example is from the Royal Cornwall Hospitals NHS Trust and has

deliverables from implementation	not been tested in other teams or organisations.
Supporting evidence	Key learning points • Make it easy: If the referrers find it difficult to follow a complex pathway, it is unlikely to work. Therefore, it is important to make it easy for all involved including patients. See the 'Easy step guide' at the end of this case study. • Human factor: People may go back to old habits or routines. Regular education and teaching improves outcomes, and has been proven in the submitter's NICE compliance audit. • Make a start: Regular multidisciplinary team reviews were performed on a voluntary basis. The hospital directorate has acknowledged their importance and they will hopefully be accepted as a regular session. The multidisciplinary team review process improves patient safety by offering patients adequate and thorough assessment of their symptoms, avoiding unnecessary or complicated medical and surgical interventions.

Details of implementation

Implementation details	The continence service consists of a community-based team (consultant continence nurse specialist, 2 specialist nurses and 2 physiotherapists) who work closely with a team of 7 gynaecologists with an interest in urogynaecology that is led by the lead subspecialist urogynaecologist at the Royal Cornwall Hospitals NHS Trust. After starting the subspecialist urogynaecology clinics, it was clear that regular education and teaching was needed to ensure ongoing compliance with NICE's guidance on urinary incontinence. An audit of 50 case notes was carried out to assess compliance with NICE's guidance on urinary incontinence at referral to secondary care. Women who had not received conservative management were sent back to primary care for conservative measures, which added to the waiting time, caused inconvenience to patients, took up consultant time in Gynaecology outpatients department and ultimately led to added cost. The audit also showed that compliance with referral for conservative measures (pelvic floor physiotherapy, bladder retraining and life style modification) needed re-emphasis every 4–6 months. It was also noted that there were no multidisciplinary team reviews for women with overactive bladder or stress urinary incontinence symptoms before they were offered surgery or other invasive treatment. The submitter met with GPs and the referral management system

	(RMS) team to emphasise the importance of following the referral pathway for urinary incontinence in women, as in NICE's guidance. Feedback was received from primary care that they would prefer a simpler, easy step guide to assess women with symptoms of urinary incontinence. The community continence team and gynaecologists at the Royal Cornwall Hospitals NHS Trust worked together and developed an easy step referral pathway for women with symptoms of urinary incontinence. This has ensured a more streamlined and easy-to-follow guidance pathway. Overall, this has improved patient satisfaction and has improved appropriate referrals to the secondary care service, saving costs. Some women who received conservative management did not require referral to secondary care, so avoiding unnecessary medical or surgical interventions. After introducing the 'Easy step guide' for referrals to the continence service, a re-audit of 50 case notes showed 99% compliance with NICE's guidance on urinary incontinence. This audit is now a mandatory annual rolling audit in the directorate of Women's and Children Division at the Royal Cornwall Hospitals NHS Trust. The need for multidisciplinary team review for women with overactive bladder or stress urinary incontinence symptoms before they were offered surgery or other invasive treatment was identified. A team consisting of a subspecialist urogynaecologist, gynaecologists, consultant care of the elderly physicians, a consultant continence nurse, physiotherapists and a urogynaecology nurse specialist now meet regularly. This is a voluntary initiative for most of the team. However, with the proven improvement in patient outcome measures, it is hoped that the multidisciplinary team review will become a regular part of the job plan of the team members.
Time taken to implement	The initiative can be implemented in the medium term: between 3 and 12 months.
Ease of implementation	If referrers find it difficult to follow a complex pathway, it is unlikely the initiative will work. This initiative should be implemented as simply as possible. This makes things easier for staff as well as patients. The 'Easy step guide' is included in the Appendix.
Level of support and commitment	The multidisciplinary team review process was started on a voluntary basis by the team at Royal Cornwall Hospitals NHS Trust. The Directorate of Women's and Children Division at the hospital has acknowledged its importance and it is hoped that it will be accepted as a regular session.
Barriers to implementation	Pressures to refer the patients prematurely, often bypassing

	guidance. Waiting time to see a consultant was longer (by 8–12 weeks) if incorrectly referred, causing patient inconvenience and pressure on the service. 12 referrals were rejected during the audit period, which was disappointing for the patient and doctor. The barriers were overcome by: • Auditing referrals based on NICE's guidance • Developing an 'Easy step guide' to the referral pathway for urinary incontinence in women. • Regular re-education and review of the subject through regular teaching sessions every 6 months for GPs. • Assessing compliance with NICE's guidance on urinary incontinence through a rolling audit every year, with results disseminated to staff. • Appointing an urogynaecology nurse specialist who contributes to ongoing education and teaching. • Identifying the need for a multidisciplinary team review process. The need for this was emphasised to the Trust and to the directorate of Women's and Children Division with special reference to compliance with NICE's guidance. The Directorate ensures effective, safe and high quality service provision of Obstetrics and Gynaecology.
Risks	If referrers find it difficult to follow a complex pathway, it is unlikely to work. Therefore, it is important to make the process easy to follow, which will benefit clinicians as well as patients.
Supporting evidence	The Royal Cornwall Hospitals urodynamic multidisciplinary team and pelvic floor multidisciplinary team includes continence nurse, physiotherapist, urogynaecology nurse specialist, bowel nurse specialist, urogynaecologist, colorectal consultant, radiologist and geriatrician representation. In the Royal Cornwall Hospitals NHS Trust, urologists have their own multidisciplinary team. However, there is regular liaison across the team regarding cases. Urodynamics may be an unnecessary invasive test and can lead to urinary tract infections, as well as patient embarrassment during the test. Dedicated pelvic floor muscle exercises may improve patients' symptoms and so they may not need urodynamics. Patients are caused inconvenience if they attend for an appointment that could have been avoided, and the physical and emotional stress of a consultation and examination, especially when is not required or may be repeated after conservative treatment.

Further evidence

Dependencies	The results of the regular review of training showed: • the need for regular teaching on management of urinary incontinence, especially conservative management • the need to make referral criteria easy to follow: the submitter has now developed and implemented an 'Easy step guide' for urinary incontinence in women • a lack of multidisciplinary team review process, and emphasised its importance and need to the directorate in line with NICE's recommendations.

Contacts and resources

Contacts and resources	If you require any further information please email: qualityandproductivity@nice.org.uk and we will forward your enquiry and contact details to the provider of this case study. Please quote reference 15/0004 in your email. National Institute for Health and Care Excellence (2015) Urinary incontinence in women. NICE quality standard 77 National Institute for Health and Clinical Excellence (2013) Urinary incontinence: the management of urinary incontinence in women. NICE guideline CG171

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Appendix A: 'Easy Step' Guide:

Pathway for female urinary incontinence

At the first visit:
Take a thorough history of the urinary incontinence (UI).
Give 3 day bladder diary, instruction sheet and symptom profile.
Provide a universal pot for urinalysis at next contact.

Useful tips:

Check for:
- UTI
- Medication effect
- Constipation
- Atrophic vaginitis
- Obesity
- fluid intake
- Chronic cough

Note: If voiding dysfunction (hesitancy; straining; feeling of incomplete emptying; urgency; frequency; nocturia) or recurrent UTI's – **arrange local bladder scan**

Simple treatments to try:

Stress Urinary Incontinence (SUI):

- **Pelvic floor muscle exercises** (**PFME):** refer to local physiotherapist for supervised pelvic floor muscle training and review in 3 months following physio report.

Overactive bladder (OAB):

- **Lifestyle modifications -** caffeine reduction, modification of fluid intake, body mass index greater than 30 should be advised to lose weight.
- **Bladder training** – 6 weeks and review.
- **Trial of** - anticholingeric (oxybutynin IR*) or antimuscarininc (tolterodine IR or darifenacin OD) first line for women with OAB or mixed UI (at least 2 types) and review.

*Not to frail older women

Things not to do
Don't offer absorbent products/pads as treatment for UI.

Don't refer for urodynamic investigations unless:

- treatment (described above) has been tried and failed
- diagnosis is in doubt
- the patient wants surgery

Don't refer to secondary care until conservative measures have been tried

When to refer on
If any **Red Flags** – refer direct and urgent to appropriate consultant in secondary care for:

- Micro (50yrs+) & macro haematuria; refer to haematuria pathway

- Recurrent UTI with haematuria (40yrs+); refer to haematuria pathway
- Suspected mass arising from urogenital organs

In women with UI, further indications for **consideration for referral** to an appropriate specialist service include:

- persisting bladder or urethral pain
- clinically benign pelvic masses
- associated faecal incontinence
- suspected neurological disease
- symptoms of voiding difficulty
- suspected urogenital fistulae
- previous continence surgery
- previous pelvic cancer surgery
- previous pelvic radiation therapy

Refer to General Gynaecology clinic

- ❖ Persistent bothersome stress urinary incontinence after conservative management
- ❖ Mixed urinary incontinence after conservative management

Refer to Uro-Gynae Subspecialist for Urinaryincontinence (after initial assessment): for MDT review

- ❖ Urgency / overactive symptoms not effectively treated by bladder retraining, fluid advice and after trying 2 different first line medications
- ❖ Persistent bothersome stress urinary incontinence after a surgical procedure (TVT/TOT/Colposuspension)
- ❖ Complex symptoms as proven by urodynamics (Voiding dysfunction along with stress incontinence/detrusor over-activity)

  Stress incontinence in patients unsuitable for midurethral tape (TVT/TOT) e.g. family not complete, raised BMI.