NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Urinary tract infections in adults

Date of Quality Standards Advisory Committee post-consultation meeting:
13 January 2015

2 Introduction

The draft quality standard for urinary incontinence in women was made available on the NICE website for a 4-week public consultation period between 11 November and 9 December 2014. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 15 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the Quality Standards Advisory Committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the Committee as part of the final meeting where the Committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the Committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the Committee should read this summary alongside the full set of consultation comments, which are provided in appendices 1 and 2.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

3. For each quality statement what do you think could be done to support improvement and help overcome barriers?

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- Several stakeholders suggested including anticholinergic medications in the introduction and removing diuretics as a listed pharmacological treatment.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

Adults aged 65 years and over have a full clinical assessment before being diagnosed with a urinary tract infection.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- Some stakeholders felt this statement was contrary to the guideline, stating there are no recommendations indicating that bimanual assessment is mandatory or appropriate for all women.

Measurement

Stakeholders made the following comments:

- Stakeholders stated that bimanual VE assessment in general practice could be read-coded and thus auditable.

Implementation

Stakeholders made the following comments:

- A stakeholder felt commissioners should ensure training available in bimanual examinations (See UKCS minimum standards document).

5.2 Draft statement 2

Adults with catheters are not diagnosed with a urinary tract infection by dipstick testing.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- A stakeholder welcomed the emphasis within the draft quality statement that containment products should only be offered as a “temporary coping strategy”.

Measurement

Stakeholders made the following comments:

- A stakeholder commented that whilst it is possible to collect the data for the proposed quality measure, some continence products will be self-purchased and compromise their management plan. As well as recording prescriptions for containment products as a quality measure, recording whether patients are accessing these independently would be an additional measure.

Implementation

Stakeholders made the following comments:

- To enable commissioners to evaluate whether this standard is being achieved locally, a stakeholder suggested separating the process measures to measure offer of temporary products and use when long term treatment is unsuccessful.

5.3 Draft statement 3

Adults with a urinary tract infection not responding to initial antibiotic treatment have a urine culture.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- Some stakeholders did not feel these treatments were being performed and the statement was not a key area for improvement.

Measurement

Stakeholders made the following comments in relation to consultation question 2:

- A stakeholder commented that it should be possible to collect the data.

Implementation

Stakeholders made the following comments in relation to consultation question 3:

- A stakeholder commented that access to percutaneous SNS could be improved if percutaneous SNS for refractory OAB in women was recognised within this guidance and also by an NHS England Commissioning Policy.

5.4 Draft statement 4

Non-pregnant women and adults with catheters who have asymptomatic bacteriuria are not offered antibiotics.

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- Several stakeholders agreed with the statement as the implications of invasive treatment/surgery are significant.

Measurement

Stakeholders made the following comments in relation to consultation question 2:

- A stakeholder felt this statement is impractical. That confirming review by a CNS or physio prior to SUI surgery and that 2 or 3 anticholinergics have been tried prior to BOTOX (or there be a CI to antichol) may be better. They advised the infrastructure is there and these can be built into the databases (e.g. BSUG) so felt this should be the standard rather than going through an MDT.

Implementation

Stakeholders made the following comments in relation to consultation question 3:

- Several stakeholders commented that the implication of this in terms of workload for MDT's is huge with a significant potential cost to the NHS.

5.5 Draft statement 5

Adults with catheters are not offered antibiotic prophylaxis to prevent symptomatic urinary tract infections.

Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

- A stakeholder queried where this would be done and what would happen if a patient could not contract as these patients will still need to be referred on.

Implementation

Stakeholders made the following comments in relation to consultation question 3:

- A stakeholder felt that local data collection to assess adherence to this standard will be time consuming to collect and with no evidence of benefit.

5.6 Draft statement 6

Men who have an upper urinary tract infection are referred for urological investigation.

Consultation comments

Stakeholders made the following comments in relation to draft statement 6:

- A stakeholder queried whether patients with urgency predominant may need lifestyle and/or pharmacotherapy first.

Measurement

Stakeholders made the following comments:

- A stakeholder felt it should be possible to collect the data.

Implementation

Stakeholders made the following comments:

- A stakeholder commented that three months pelvic floor exercises will be difficult to cost and they felt it would help to identify the number of sessions within the three month period.

5.7 Draft statement 7

A placeholder statement is an area of care that has been prioritised by the Quality Standards Advisory Committee but for which no source guidance is currently available. A placeholder statement indicates the need for evidence-based guidance to be developed in this area.

Consultation comments

Stakeholders made the following comments in relation to draft statement 7:

- A stakeholder queried whether a review was suggested at 4 weeks for an anticholinergic?
- .

Implementation

Stakeholders made the following comments:

- A stakeholder felt a six weeks bladder drill will be difficult to cost, it would help to identify the number of sessions within the 6 week period for patients to be seen.

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- A stakeholder advised it would be appropriate to check the position of the colorectal community regarding abdominal mesh used for vault support before this guidance is issued.

Appendix 1: Quality standard consultation comments table

No	Stakeholder	Statement	Comment on	Comments
1	DOH ARHAI		Question 1	Does this draft quality standard accurately reflect the key areas for quality improvement? - yes
1	DOH ARHAI		Question 2	If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures? – **Yes though would probably need to be prospective so responsibility of admitting clinicians**
1	DOH ARHAI		Question 3	For each quality statement what do you think could be done to support improvement and help overcome barriers? – Education for GP study days and GP periodicals as well as practice nurses
1	DOH ARHAI	1		For draft quality statement 1: Is there any evidence that this is not already being carried out in general practice? – Standard of care likely to be variable but already part of good practice
1	DOH ARHAI	2		For draft quality statement 2: Is there evidence to suggest dipstick testing is commonly used to diagnose urinary tract infections in adults with catheters? – Not aware of common usage of urinalysis with indwelling catheter
1	DOH ARHAI	6		For draft quality statement 6: Is there any evidence that men with upper urinary tract infections are not being referred for urological investigations? – This should be standard practice
1	DOH ARHAI	7		For draft placeholder statement 7: Do you know of any evidence-based guidance that could be used to develop this placeholder statement? If so, please provide details. If not, would new evidence-based guidance relating to recurrent urinary tract infections have the potential to improve practice? If so, please provide details. – **Prof CC Butler at Oxford has published many papers recently in this area**
1	DOH ARHAI		Section 1 Introduction or quality statement 1	Comment about quality statement 1. Over 65 bacteriuria is common without symptoms or benefit in treating so clinical presentation should take precedence over urinalysis

No	Stakeholder	Statement	Comment on	Comments
			(measure)	Comment about quality statement 1: Statement is a little vague - which elements of the following does a "full clinical assessment" include? (i) history (which could be done on the phone); (ii) examination (for which the patient clearly has to be seen); (iii) dipstick urinalysis and/or urine culture.
1	DOH ARHAI	3		As sensitivity is only tested after failure of treatment the actual prevalence of resistance is not known and rate of failure depends heavily on the practice antibiotic policy
1	DOH ARHAI	5		Important as the prevalence of multiresistant Gram negative is rising in urology patients especially
1	DOH ARHAI	6		Any man with bacteriuria should be investigated not just upper UTI if under 65 years
2	Royal College of Obstetricians and Gynaecologists	1		I am not aware of any evidence that this is not already being carried out in general practice – if it is then this does not represent a key area for quality improvement.
2	Royal College of Obstetricians and Gynaecologists	2		I am not aware that dipstick testing is commonly used to diagnose urinary tract infections in adults with catheters – certainly in the hospital setting the diagnosis is made by sending a catheter specimen of urine for culture. I do not think that this represents a key area for quality improvement. Catheters could be urinary, venous, epidural etc. Hence despite pertaining to UTI, as this is common in the age group with other co-morbidities, suggest being more explicit and actually stating ‘adults with urinary catheters’
2	Royal College of Obstetricians and Gynaecologists	3		This does reflect a key area for quality improvement. I think it should be possible to collect the required data. A greater awareness of the relevant SIGN guidelines would support improvement and help overcome barriers
2	Royal College of Obstetricians and Gynaecologists	4		This does reflect a key area for quality improvement. I think it should be possible to collect the required data. An additional quality statement saying that ‘Pregnant women who have asymptomatic bacteruria should be offered antibiotics’ would be welcomed. This is based on a grade A recommendation in the relevant SIGN guideline (88)
2	Royal College of Obstetricians and	5		This does reflect a key area for quality improvement. I think it should be possible to collect the required data

No	Stakeholder	Statement	Comment on	Comments
	Gynaecologists			
2	Royal College of Obstetricians and Gynaecologists			Adults with 'Urinary catheters'
2	Royal College of Obstetricians and Gynaecologists	6		Our College is focussed on women's health and this quality statement is not directly relevant to our practice. However, it does seem to me to be a key area for quality improvement. I would imagine that it should be possible to collect the data – though I wonder how all cases of upper urinary tract infection in primary care will be identified ('local data collection' doesn't really reassure me that all cases will be captured) I do not know if all men with upper urinary tract infections are currently being referred for urological investigations.
2	Royal College of Obstetricians and Gynaecologists	7		I have had a look at SIGN guideline 88 and there are a number of sections in that that addresses the prevention and management of recurrent urinary tract infections.
2	Royal College of Obstetricians and Gynaecologists		Q1	Regarding key areas for quality improvement – this is dealt with for each statement above.
2	Royal College of Obstetricians and Gynaecologists		Q2	Yes I think this would be possible to collect the data for the proposed quality measures but I am sceptical that local data collection particularly in General Practice would not be robust.
2	Royal College of Obstetricians and Gynaecologists		Q3	For quality statements 1-5 I think guidelines and protocols in the Nursing Home setting and in primary care would drive quality improvements. Similarly guidelines in Adult Medicine would improve management of the catheterised patient and the adult man with upper UTI symptoms. Dissemination of the desired quality standards with focus on primary care. Hospital practice to be made aware of changes, in particular in relation to the proposed standards on adults with catheters.
2	Royal College of Obstetricians and Gynaecologists		Q4	As mentioned above, I am not aware of any evidence that this is not already being carried out in general practice. Anecdotally it might not always be carried out in general practice due to the practice of telephone consultations.

No	Stakeholder	Statement	Comment on	Comments
2	Royal College of Obstetricians and Gynaecologists		Q5	As mentioned above, I am not aware that dipstick testing is commonly used to diagnose urinary tract infections in adults with catheters – certainly in the hospital setting the diagnosis is made by sending a catheter specimen of urine for culture.
2	Royal College of Obstetricians and Gynaecologists		Q6	I do not know if all men with upper urinary tract infections are currently being referred for urological investigations
2	Royal College of Obstetricians and Gynaecologists		Q7	I have had a look at SIGN guideline 88 and there are a number of sections in that that addresses the prevention and management of recurrent urinary tract infections.
3	Royal College of Pathologists		Section 1 Introduction or quality statement 1-6 (measure)	I am in agreement with the statements 1-6 but am not sure how easily it would be able to collect the data. The following review available on the internet looks at quality indicators for Adults with urinary tract infections. It may prove helpful. SWAB: Stichting Werkgroep Antibiotica Beleid Netherlands 2012 Optimalisation of the antibiotic policy in the Netherlands: SWAB guidelines for antimicrobial therapy of complicated urinary tract infections. This review covers a broad remit including treatment, prophylaxis for catheterised patients and management of recurrent UTI's.
3	Royal College of Pathologists		Question 5 for draft quality statement 2	We have local evidence that samples are being sent to the laboratory on adults [catheterised or not catheterised,] whose urine is dipstick positive and either there are no clinical symptoms or no information is provided. Other laboratories may have already collected data on this subject which should be easy to audit. I have personally been asked for advice on patients who have been given antibiotics in this situation. Many samples are also taken incorrectly and may give a false result. The Prodigy study being carried out by Cardiff and Southampton may provide more information. The following paper; Voided Midstream Urine Culture and Acute Cystitis in Premenopausal Women Thomas M. Hooton et al, NEJM 369 1883-1891 may be useful. They reported that cultures of voided midstream urine in healthy premenopausal women with acute uncomplicated cystitis accurately showed evidence of bladder *E. coli but not of enterococci* or group B streptococci, which are often isolated with *E. coli but appear to* rarely cause cystitis by themselves. In/out catheter samples were taken to avoid contamination.
3	Royal College of Pathologists		Q7	I suggest refer to the following papers to develop guidance: Recurrent UTI: women with 2 or more infections in 6 months or 3 or more in one year Gupta K, Trautner B W. BMJ 2013 346 who suggest sending a culture in recurrence and relapse [recurrence

No	Stakeholder	Statement	Comment on	Comments
				within 2 weeks] and treat as for cystitis/simple UTI. This paper recommends avoidance of a diaphragm and spermicides. It discusses the role of post coital and stand by antibiotics including adverse effects. Other preventative methods are also discussed BIA/PHE: Management of infection guidance for Primary care. This guideline in the section on management of UTI's refers to role of cranberry products, and notes that the potential benefit of cranberry in terms of product type (solid *v liquid),*dosing, and optimal patient population therefore remains to be elucidated and also refers to the use of nightly, standby or post coital antibiotics with concern re adverse effects. SWAB: Stichting Werkgroep Antibiotica Beleid Netherlands 2012 Refer to comments above. It considers optimal prevention methods for adults with recurrent UTI's.
4	British Geriatric Society	1		Statement 1 Adults aged 65 years and over have a full clinical assessment before being diagnosed with a urinary tract infection. **Agree but** Full clinical assessment should include: [1] delirium assessment as older people with clinical UTI may present with this symptom (and not dysuria) [2] screening for urinary incontinence and if present proceed to management and treatment plan **Support:** Geriatricians can support GPs/district nurses in the assessment of delirium and in comprehensive geriatric assessment and care in frailer patients
4	British Geriatric Society	2		Statement 2 Adults with catheters are not diagnosed with a urinary tract infection by dipstick testing. **Agree but** Quality standard should include definition of catheter-associated UTI (i.e. bacterial count (104) plus symptoms) and also that UTI within 2 days of cathteristation should be treated as a CAUTI
4	British Geriatric Society	3		Statement 3 Adults with a urinary tract infection not responding to initial antibiotic treatment have a urine culture **Do not agree for Adults aged 65 years and over** – this group should have a urine culture at the time of diagnosis and antibitotic treatment and this will also be part of the full clinical assessment as per Statement 1
4	British Geriatric Society	4		Statement 4 Non-pregnant women and adults with catheters who have asymptomatic bacteriuria are not offered antibiotics. **Agree but** Adults aged 65+ should be assessed for delirium (in addition to urinary symptoms and fever) and as per Statement 1 should have a full clinical assessment

No	Stakeholder	Statement	Comment on	Comments
4	British Geriatric Society	5		Statement 5 Adults with catheters are not offered antibiotic prophylaxis to prevent symptomatic urinary tract infections. **Agree**
4	British Geriatric Society			Statement 6 Men who have upper urinary tract infection are referred for urological investigation. **Agree**
4	British Geriatric Society		Q1	**Question 1** Does this draft quality standard accurately reflect the key areas for quality improvement? **Yes**
4	British Geriatric Society		Q2	**Question 2** If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures? **Yes**
4	British Geriatric Society		Q3	**Question 3** For each quality statement what do you think could be done to support improvement and help overcome barriers? **See above**
4	British Geriatric Society		Q7	**Question 7** For draft placeholder statement 7: Do you know of any evidence-based guidance that could be used to develop this placeholder statement? If so, please provide details. If not, would new evidence-based guidance relating to recurrent urinary tract infections have the potential to improve practice? If so, please provide details. **Various data would support that older people with confirmed UTI should be assessed for the following in order to reduce the risk of recurrent UTI – bur agree that guidance relating to this is very important** **[1] In dwelling catheter – as per APPG document a significant % of cathters are inappropriate so in the setting of CAUTI every effort should be made to remove the cahthter (intermittent cathterisation is less likely to cause infection, or patient can be treated medically or surgically for retention)** **[2] Urinary retention – postvoid residual volume should be measured and reasons for retention dienteified and treated** **[3] Atrophic vaginitis – should be identified and if present treated with PV oedtrogen** **[4] Constipation should be identified and treated** **[5] Perineal hygiene should be evaluated and facilitated if poor**
5	MRSA Action UK		General	MRSA Action UK welcomes this quality statement, and believe this information should be widely publicised to healthcare workers, patients and the public, as the growing incidence of antimicrobial resistance needs concerted effort to reduce infection, not just for individual patients but for wider societal benefit. Simple guidance on hydration and diet as outlined in section 4.1.1 is particularly

No	Stakeholder	Statement	Comment on	Comments
				needed in our view.
5	MRSA Action UK		4.1.1	Public awareness and healthcare workers Stakeholders highlighted the importance of improved public awareness of the prevention of UTIs e.g. Better hydration, diet, avoiding constipation to reduce incidence of UTI. We support this, and this should also be emphasised in both primary and secondary care, as hydration is often an area that is missed when staff are busy in our experience.Not unrelated to this healthcare professionals in primary and secondary should be aware of patients needs for intermittent self-catheterisation and be mindful of any likelihood of infection risk and how to treat it (this was mentioned by a stakeholder on page 29).
6	Digital Assessment Service – NHS Choices		General	The Digital Assessment Service welcome the guidance and have no comments on its content.
7	Department of Health		General	**I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.**
8	British Society of Urogenital Radiology (BSUR) / The Royal College of Radiologists (RCR)	6		Patients referred for urological investigations should first have simple investigations such as urinary tract ultrasound with post micturition residual volume measurement and flow rate BEFORE more invasive tests such as urodynamics. The RCR and BSUR note that this recommendation is included in the Scottish Intercollegiate Guidelines Network (2012) Management of suspected bacterial urinary tract infection in adults (recommendation 5.3e). Ultrasound and flow rate will pick up the outflow obstruction and is much quicker, more cost-effective and less invasive than CMG or VCMG. Although CMG/VCMG are useful pre-operatively (to see how the bladder is functioning prior to relieving outflow obstruction), this should not be first and only investigation.
9	Faculty of Sexual & Reproductive Healthcare	1		The proportion of adults attending the SRH service with UTI's is generally quite low but may be a secondary diagnosis in patients attending for other reasons
9	Faculty of Sexual & Reproductive Healthcare	2 & 4		Again , although patients attend SRH clinic with catheters, it's not a primary reason for presentation
9	Faculty of Sexual & Reproductive	7		Guidance relating to recurrent UTI's would be useful

No	Stakeholder	Statement	Comment on	Comments
	Healthcare			
9	Faculty of Sexual & Reproductive Healthcare		General	In general management of UTI's is not a common reason for presentation to an SRH service
10	Urology Trade Association		General	The draft quality standard, as currently written, does not distinguish between indwelling catheterisation and intermittent self-catheterisation. These methods of catheterisation may be used for different reasons and offer different outcomes, with the incidence rate for UTIs tending to be lower in people who carry out intermittent self-catheterisation in comparison to those with indwelling catheters. This quality standard should be amended to distinguish between the two, given the importance of patients being able to make an informed choice. The following research articles indicate a lower incidence rate of UTIs amongst those using intermittent self-catheterisation: Pilloni S, Krhut J, Mair D, et al. Intermittent catheterisation in older people: a valuable alternative to an indwelling catheter? Age Ageing 2005;34:57–60. Shaw C, Logan K, Webber I, et al. Effect of clean intermittent self-catheterisation on quality of life: a qualitative study. J Adv Nurs 2008;61:641–50.
10	Urology Trade Association	5		Whilst the UTA understands NICE's intention to restrict the use antibiotic prophylaxis to prevent urinary tract infections, we believe that rather than being restricted outright, they should only be used after all other options have been exhausted and not as first line treatment. The UTA would also like to note that NICE have approved the use of antibiotic prophylaxis to prevent urinary tract infections in previous clinical guidelines. For example, the clinical guideline 139: Infection: Prevention and control of healthcare-associated infections in primary and community care, which was reviewed in September 2014 with a recommendation of no update, said that: When changing catheters in patients with a long-term indwelling urinary catheter: • do not offer antibiotic prophylaxis routinely • consider antibiotic prophylaxis for patients who: o have a history of symptomatic urinary tract infection after catheter change or o experience trauma during catheterisation. [new 2012]

No	Stakeholder	Statement	Comment on	Comments
				Furthermore, NICE clinical guideline 148: Urinary incontinence in neurological disease reiterates this, adding that: "1.8.2 Consider antibiotic prophylaxis for people who have a recent history of frequent or severe urinary tract infections." The UTA believes that the inclusion of this quality statement, as it is, is inconsistent with other advice provided by NICE. This could result in confusion amongst clinicians, which could impact on patient outcomes.
10	Urology Trade Association	5		As an alternative to antibiotic prophylaxis, users of indwelling catheters should be offered a review to determine whether indwelling catheterisation is still appropriate for them or whether they should be offered intermittent self-catheterisation as an alternative. As stated previously, there is an evidence base which suggests that incidence rates of UTIs is lower in users of intermittent self-catheterisation than with indwelling catheterisation.
11	Urology User Group Coalition		General	The draft quality standard does not distinguish between indwelling catheterisation, whether urethral or suprapubic, and intermittent self-catheterisation. Patients have different needs and preferences, and whilst some feel comfortable using certain types of catheters (or certain catheterisation methods) others do not. Users of catheters require education and advice on alternative catheters and catheterisation methods. Failure to provide advice and access to catheters (or modes of catheterisation) appropriate to a person's individual needs may result in their health being compromised. Although people using all forms of urinary catheterisation run the risk of UTIs, the incidence rate tends to be lower in people who carry out intermittent self-catheterisation in comparison to those with indwelling catheters. A failure to provide users of catheters with an adequate understanding of the different methods available to help them choose the best method for them can ultimately result in an increase in conditions such as UTIs.

No	Stakeholder	Statement	Comment on	Comments
				By ensuring that users have an adequate understanding of intermittent self-catheterisation, and by ensuring that users are offered it as a treatment option at as early as possible, incidences of morbidity and hospital admissions can be reduced, whilst also improving the quality of life of users. The following research articles found that intermittent self-catheterisation resulted in lower incidence rates of UTIs: Pilloni S, Krhut J, Mair D, et al. Intermittent catheterisation in older people: a valuable alternative to an indwelling catheter? Age Ageing 2005;34:57–60. Shaw C, Logan K, Webber I, et al. Effect of clean intermittent self-catheterisation on quality of life: a qualitative study. J Adv Nurs 2008;61:641–50. NICE Clinical Guideline 139 (prevention and control of healthcare-associated infections in primary and community care) highlights that people requiring catheters should be educated on use, and be assessed on the type of catheter used. http://www.nice.org.uk/guidance/cg139/resources/guidance-infection-pdf
11	Urology User Group Coalition	5		Quality statement 5 contradicts both NICE clinical guideline 148: Urinary incontinence in neurological disease, and NICE clinical guideline 139: Infection: Prevention and control of healthcare-associated infections in primary and community care. Whereas statement 5 says that adults with catheters should not be offered antibiotic prophylaxis to prevent symptomatic urinary tract infections, CG 148 (repeated in CG 139) states that: “1.8.2 Consider antibiotic prophylaxis for people who have a recent history of frequent or severe urinary tract infections. and “1.8.5 When changing catheters in patients with a long-term indwelling urinary catheter: • do not offer antibiotic prophylaxis routinely • consider antibiotic prophylaxis for patients who: o have a history of symptomatic urinary tract infection after catheter change or

No	Stakeholder	Statement	Comment on	Comments
				○ experience trauma during catheterisation." Whilst prophylactic antibiotics are not first line management, many people with neurological conditions and recurrent or frequent UTIs who use catheters find that long term low dose prophylactic antibiotics reduce or prevent UTIs, which results in a decrease in the number of hospital admissions and an improvement in their quality of life. Both CG 148 and CG 1139 recognise that whilst prophylactic antibiotics should not be used until other options have been ruled out, they do play a role in reducing morbidity, hospital admissions, and improvement quality of life – especially for those with complex bladder and other neurological disorders who may also need to use catheters. Users of urology products have told the Urology User Group Coalition that they experienced multiple infections prior to using prophylactic antibiotics, which had reduced following long term use of these antibiotics. We believe that this quality statement should be amended to reflect that prophylactic antibiotics should occasionally be offered, but not as a first line treatment.
11	Urology User Group Coalition	5		This quality statement also does not distinguish between those who need long term catheterisation to manage bladder emptying, and those with neurological conditions whose symptoms may or may not be typical of urinary tract infections. Some neurological conditions can result in the presentation of symptoms that may or may not be an infection. Evidence of bacterial infection must be provided before antibiotics are given, but this does not necessarily mean that antibiotics should not be given at all. Often those with long term neurological conditions are experts in their own care, recognise when they have a UTI and should have access to antibiotic prescriptions.
12	British Association of Urological Surgeons	1		This quality standard should apply to all patients and not be specific to those over 65 yrs. It is true that this patient group comprises a large proportion of those being treated for UTI and logical that these patients are targeted nevertheless clinical assessment should be mandatory for all prior to antibiotic prescription. Full clinical assessment of patients over 65yrs is sometimes difficult or not possible due to co-morbidities such as dementia or other chronic illness. This is especially true for "recording of symptoms". Furthermore the other listed components of the clinical assessment; "physical examination"

No	Stakeholder	Statement	Comment on	Comments
				and “assessment of vital signs” are often normal despite the presence of a UTI. Additional laboratory tests e.g. WCC or CRP may be useful in this patient group if clinical assessment is difficult or unreliable. The data required appears feasible to collect.
12	British Association of Urological Surgeons	2		This is entirely correct; the dipstick testing of catheter specimens of urine will almost invariably yield positive results and therefore is not a reliable indicator of UTI. Again the need for clinical assessment is important. Another important point is that as well as urine dipsticks, urine cultures from catheter specimens of urine are very often positive and patients should not be treated on the basis of urine culture results alone. As per QS 3 urine culture should be reserved for non-responders to initial treatment. The data required appears feasible to collect.
12	British Association of Urological Surgeons	3		Implies urine culture should be sent only if patient does not respond to initial antibiotics but this may lead to a delay in some patients receiving an appropriate antibiotic in a timely manner and also additional visits to the GP/nurse time. Would have though it makes more sense to have a urine culture sent when UTI suspected so sensitivities known from the outset ‘if patient does not respond to initial antibiotics’
12	British Association of Urological Surgeons	6		This should perhaps go further and detail recommended investigations based on evidence from the literature. An assessment of the upper tracts and bladder emptying via an ultrasound scan of the urinary tract and a flexible cystoscopy would be considered a minimum.
12	British Association of Urological Surgeons	7		This is perhaps the one of the most important areas of future research into UTI. The mainstay of treatment for recurrent UTIs in the UK is prophylactic antibiotics and this is supported by evidence of efficacy from a Cochrane review. There are however attendant risks with the use of prophylactic antibiotics especially antimicrobial resistance. Due to the lack of comparative studies with alternative methods of prevention such as probiotics, intravesical treatments or urinary antiseptics this area should be made a research priority. Perhaps the NIHR should consider commissioning such a study. A quality standard on treatment for recurrent UTI would be difficult to formulate due to the wide variation in guidelines from organisations such as SIGN, EAU and AUA but there are a couple of relevant meta-analyses from the Cochrane group.
12	British Association of Urological Surgeons		General	Can’t see any comments regarding referring/liaison with local microbiology departments (eg GP in Bradford may want to use different first line antibiotics to a GP in Cornwall for treating a UTI).

No	Stakeholder	Statement	Comment on	Comments
13	Forte Medical Ltd	3		Should an adult with a urinary tract infection not respond to initial antibiotic treatment then it is of vital importance that the urine sent for culture is a quality midstream sample to reduce the possibility of the lab reporting heavy mixed growth from first void urine. If lab results are inconclusive then a repeat test would be necessary further delaying the prescribing of the appropriate course of antibiotics to treat the symptoms.
14	C.R. Bard		Why is this quality standard needed	Specific reference to CAUTIs needed in quality standard. CAUTIs are one of the most common hospital associated infections with considerable staff time and other costs are expended to treat and reduce the rate of CAUTIs. The financial burden of CAUTIs on the NHS is estimated at £99 million per annum (epic3 p.S32). The average cost of treating each CAUTI is £1,968 (epic3 p.S32)
14	C.R. Bard		Why is this quality standard needed	Reference to variation between NHS Trusts needed in quality standard. Recent information that we have received (FOI) and safety thermometer data show that the CAUTI rate varies dramatically by Trust. It ranged from some Trusts reporting 0 in 2012/13 to others many hundreds.
14	C.R. Bard		Why is this quality standard needed	'Unnecessary tests and antibiotic treatment'. Procedures and equipment such as (1) closed drainage system and maintenance of the connection between the catheter and the drainage system (epic3 p.S32) and (2) use of antimicrobial (silver alloy) catheters are supported by academic evidence but with no mention in quality standard.
14	C.R. Bard		Why is this quality standard needed	'Unnecessary tests and antibiotic treatment'. More focus needs to be made on the decision to use a catheter. Catheter use is not essential and is overused. For assessment of residual urine use of ultrasound bladder scanners in preference to catheterisation on the grounds of acceptability and lower incidence of adverse events is recommended. NICE clinical guideline 171 - Sep 2013
14	C.R. Bard	7		The quality standard should consider the evidence produced by a suitable continence management system as a way of (1) reducing UTIs and CAUTIs (2) Improving patient care and choice (3) saving money by reducing waste.
15	Scottish Antimicrobial Prescribing Group		Question 1 (standard omissions)	Does there also need to be something about changing catheter before/ when starting antibiotics if been in more than 7 days as a standard as we have come across inconsistency in practice in relation to this, which may lead to recurrent infection (referenced in the formally HPA 2011 Diagnosis of UTI – Quick Reference Guide for primary care. I feel that there is a standard missing on what would be expected for the management of non-pregnant adult females <65 years (as they will be the majority of cases).

No	Stakeholder	Statement	Comment on	Comments
				In my experience of looking at UTI audits within care homes and general practices, these quality standards do reflect the key areas for quality improvement, however I feel that a standard relating to the decision to prescribe for UTI in older people who do not have a catheter should be added as feel this is an omission. There is a recognised overuse of antibiotics in suspected UTI and an increase in multi-resistant UTI infections thus a quality statement bridging the gap between the assessment and diagnosis (Statement 1) and avoidance of antibiotics in the asymptomatic (Statement 4) needs to be addressed. Something along the lines of Antibiotic therapy should only be considered for female patients diagnosed with uncomplicated lower UTI (non-pregnant and non-catheterised) in the presence of two or more signs or symptoms and where the benefits of treatment are expected to outweigh the risks.
15	Scottish Antimicrobial Prescribing Group		Question 2	Yes it would be possible to collect the data. In Primary Care the accuracy of the data will depend on the degree of documentation in the notes as to how accurately this can be gathered retrospectively, and may be more difficult for care home patients where nursing staff have undertaken some assessment and this is not in the GP notes
15	Scottish Antimicrobial Prescribing Group		Question 3	In particular I think there needs to be more education with carers (both paid and unpaid) – both in the care home setting and also home carers. We have had anecdotal feedback e.g. of poor understanding of catheter management, which may have an impact on UTI. I also think we need to support GPs to manage this in an evidence based way – through education, and review of Practice processes/ management protocols. For example is there a standard screening checklist that could be used to standardise management? Tools such as education (didactic or academic detailing), clinical audit and feedback could be used to support quality improvement. We are currently piloting a multi-faceted intervention to improve diagnosis and prescribing for older patients with suspected UTI in care homes, this might indicate whether didactic education combined with audit and feedback could support improvements in this area.
15	Scottish Antimicrobial Prescribing Group		Question 4	I am aware that some GP Practices have practice protocols that do not take age into account – but dipstick everyone presenting to the reception with symptoms suggestive of UTI, and ask them to complete a questionnaire for review by GP. Most of these patients will not be seen by GP. No work has been done to date to quantify how widespread this is, but this is just observational feedback from Practices within one health centre.

No	Stakeholder	Statement	Comment on	Comments
				In our health board area, there still appear to be a significant number of patients treated for UTI following telephone consultations rather than face-to-face full clinical assessments despite this being a recommendation in our primary care Management of Infection Guidance. See comments below.
15	Scottish Antimicrobial Prescribing Group		Question 5	See comments against quality statement 2 below
15	Scottish Antimicrobial Prescribing Group		Question 6	Unable to comment
15	Scottish Antimicrobial Prescribing Group		Question 7	See comments against quality statement 7 below
15	Scottish Antimicrobial Prescribing Group	1	General	During a recent audit of UTI management in care home residents in NHSGGC we noted that a significant proportion of patients do not have a full clinical assessment done by the GP before being diagnosed with a UTI. In the first cycle of our audit in 5 care homes of 65 treated UTI episodes, at least 48% were consulted by telephone and on the second audit cycle following education sessions at least 35% of 54 treated UTI episodes were telephone consultations. It was not clear to what extent, if any, clinical assessment and vital signs were assessed by nursing staff. For the same episodes, dip testing was performed in at least 40% of episodes in the first cycle (4 patients under 65 years (2 were dipped)) and 38% in the second cycle (all 65years plus).
15	Scottish Antimicrobial Prescribing Group	2	Statement wording	During the same audit, of 7 patients with catheter associated UTI, 1 patient had a dip test performed in the first cycle and 1 of 2 in the second audit cycle, thus agree this is an area for quality improvement. Statement 2 'Adults with catheters are not diagnosed with a urinary tract infection by dipstick testing' – could this not be written as per statement 1, for consistency – to promote what should happen (in terms of clinical assessment), rather than what shouldn't. This may also make it easier to measure.
15	Scottish Antimicrobial Prescribing Group	3	Statement wording	In our care home audit, 13 of 30 second-line antibiotic episodes did not have an MSSU documented thus this is also an area for quality improvement. Statement 3 'Adults with a urinary tract infection not responding to initial antibiotic treatment have a urine culture' – should this only apply to non-pregnant adult females, because other groups (males and pregnant) should have had a culture taken at the outset.
15	Scottish Antimicrobial	4	Statement wording	Statement 4 – 'Non-pregnant women, and adults with catheters who have asymptomatic bacteria are not offered antibiotics' - I have not really come across many asymptomatic non-pregnant females

No	Stakeholder	Statement	Comment on	Comments
	Prescribing Group			presenting (as they tend to present because they are symptomatic), and would have thought the focus in terms of avoiding treatment for asymptomatic should remain on older adults and catheterised patients as in statement 1 and 2. In Scotland we have more recently being looking at whether even some **symptomatic** non-pregnant women with mild lower UTI could be self-managed e.g. with NSAIDs rather than antibiotics.
15	Scottish Antimicrobial Prescribing Group	7	General	http://www.scottishmedicines.org.uk/files/sapg/Management_of_recurrent_lower_UTI_in_non-pregnant_women.pdf Clear guidance would help encourage improvement in use of antibiotics for management of recurrent lower UTI as this has been lacking

Stakeholders who submitted comments at consultation

- DOH ARHAI
- Royal College of Obstetricians and Gynaecologists
- Royal College of Pathologists
- British Geriatric Society
- MRSA Action UK
- Digital Assessment Service – NHS Choices
- Department of Health
- British Society of Urogenital Radiology (BSUR) / The Royal College of Radiologists (RCR)
- Faculty of Sexual & Reproductive Healthcare

- Urology Trade Association
- Urology User Group Coalition
- British Association of Urological Surgeons
- Forte Medical Ltd
- C.R. Bard
- Scottish Antimicrobial Prescribing Group