Support for commissioning for nocturnal enuresis (bedwetting) in children and young people

Overview and resources

This resource helps with quality improvement by providing information on key clinical, cost and service-related issues to consider during the commissioning process and signposting to other implementation support tools.

More information about NICE support for commissioning

Use the NICE pathway on Bedwetting (nocturnal enuresis) in children and young people (2013) for fast access to NICE guidance and implementation resources to support commissioning for nocturnal enuresis. The NICE pathway on Constipation may also be useful for NICE guidance and resources to support commissioning for integrated paediatric continence services.

Why the quality standard on nocturnal enuresis in children and young people is needed

Who is responsible for commissioning for nocturnal enuresis in children and young people

- Clinical commissioning groups (CCGs)
- NHS England area teams
Who should CCGs and NHS England area teams work with?

CCGs and NHS England should work collaboratively with local authorities, professionals and services working with children and young people aged 5 to 18 years, including GPs, NHS acute trusts, school nurses, community nurses and health visitors, to ensure that they have opportunities to improve their awareness of children's and young people's continence problems.

When planning services, commissioners should also address the needs, location and availability of services for children and young people with disabilities, those from deprived communities and those from black, Asian and minority ethnic groups, because the parents from these groups are less likely to access treatment for their children.

The quality statements and their commissioning and resource implications

Quality statement 1: Assessment

Children and young people who are bedwetting have a comprehensive initial assessment.

Rationale

A number of factors can cause or contribute to bedwetting in children and young people that may affect their treatment and support needs. A comprehensive initial assessment will ensure the plan for managing bedwetting meets the child's or young person's needs and helps parents or carers to cope with bedwetting.

Commissioner and provider actions

- Clinical commissioners should specify that all primary healthcare professionals who work with children and young people, and their families or carers, including GPs, health visitors, community nurses and school nurses, are able to provide a comprehensive initial assessment of bedwetting in children and young people. This should be available for children and young people with developmental or learning difficulties and physical disabilities.

- Health and social care commissioners should specify that services for initial assessment of bedwetting should not exclude younger children (aged 5–7 years) on the basis of age alone.

- Clinical commissioners should work closely with local authorities and ensure that care pathways enable social care and primary healthcare professionals to refer children and young people to an appropriate specialist service if maltreatment is suspected.
Health and social care service providers should be able to demonstrate to commissioners that local service arrangements are in line with the quality measures for quality statement 1.

**Estimated resource impact**

- The resource impact associated with this quality statement depends on the progress towards implementing Nocturnal enuresis (NICE clinical guideline 111).

- Ensuring that assessments and investigations of children and young people with bedwetting problems are carried out at primary care level (for example, by school nurses, health visitors, community nurses or at GP practices) may help achieve cost savings in the longer term, through fewer referrals to community paediatric continence services or secondary care.

- Outpatient attendances to community continence services cost around £105 (NHS reference costs 2012/13) and secondary care paediatric urology outpatient attendance is £162 (2014/15 national tariff).

- There may be a cost incurred to ensure that there are adequately trained staff competent to provide a comprehensive assessment and to cover additional staff time where needed, to clear any existing waiting lists or to reduce waiting times.

- There may be increased costs for interpretation and translation services to support communication with, for example, non-English speakers, sign-language users or people with learning disabilities. Costs will vary depending on the nature of the interpretation or translation, for example, whether it is face to face, sign or phone interpreting. The costs will also vary in different areas; so in some areas, face-to-face interpretation may cost £40 per hour and translation may cost at around £25 per 150 words.

**Quality statement 2: Initial advice**

<table>
<thead>
<tr>
<th>Children and young people have an agreed review date if they, or their parents or carers, are given advice about changing their daily routine to help with bedwetting.</th>
</tr>
</thead>
</table>

**Rationale**

It may be appropriate to offer initial advice to children and young people, and their parents or carers, about making changes to their daily routine based on the comprehensive initial assessment of bedwetting. This could include advice on fluid intake, diet, and toileting patterns, as well as approaches to lifting and waking, and reward systems. It is important to agree a date to review
progress to avoid children and young people continuing with the agreed plan indefinitely with no real improvement in their bedwetting.

**Commissioner and provider actions**

- Clinical commissioning groups (CCGs) and NHS England local area teams should estimate the number of children and young people who will need a date to review progress against the agreed treatment plan to ensure that there is capacity in the system to enable the treatment needs of children and young people, their parents or carers, to be met.

- Health and social care commissioners should specify that services for managing bedwetting should not exclude younger children (aged 5–7 years) on the basis of age alone.

- Healthcare providers should be able to demonstrate to commissioners that local service arrangements are in line with the quality measures for quality statement 2.

**Estimated resource impact**

- No cost implications are expected as this is likely to be covered as part of discussions in line with quality statement 1 on initial advice.

- Cost implications of reviews resulting from quality statement 2 are considered in quality statement 3.

**Quality statement 3: Initial treatment**

> Children and young people, and their parents or carers if appropriate, have a discussion about initial treatment if bedwetting has not improved after changing their daily routine.

**Rationale**

The choice of initial treatment should be informed by the comprehensive initial assessment, and should take into account the preference of the child or young person and, if appropriate, their parents or carers. Factors such as age, associated functional difficulties and disabilities, financial burdens and living situations may affect their preferences. Discussing the initial treatment options will ensure children and young people and their parents or carers are able to make an informed decision about which treatment will meet their specific needs.
Commissioner and provider actions

- Clinical commissioning groups (CCGs) and NHS England local area teams should ensure that providers can demonstrate that children and young people, and their parents or carers, have the opportunity to discuss treatment options, when bedwetting has not responded to changes in their daily routine.

- Healthcare providers should be able to demonstrate to commissioners that local service arrangements are in line with the quality measures for quality statement 3.

Estimated resource impact

- Depending on local current practice, there may be an increase in the number of reviews undertaken and this may have an impact on staff time.

Quality statement 4: Access to treatment

Children and young people who are bedwetting receive the treatment agreed in their initial treatment plan.

Rationale

Once a child or young person and, if appropriate, their parents or carers, has made an informed choice about using an alarm or desmopressin as the treatment for bedwetting, this should be agreed in their initial treatment plan. They should then receive the treatment in their plan. Bedwetting can put families under considerable pressure and once they have asked for help they need to receive treatment so they can resolve the problem. Any delay in their agreed treatment being available, for example as a result of local waiting lists or treatment policy, may put families under unnecessary pressure and have a negative impact on the outcomes for the child or young person.

Commissioner and provider actions

- Clinical commissioners and NHS England local area teams should ensure that the services they commission have appropriate policies and resources to enable children and young people who are bedwetting to have an initial treatment plan and to receive the treatment in their plan.

- Clinical commissioners should ensure that treatments are accessible and that there are no delays to treatment once the initial treatment plan has been agreed.
Health and social care commissioners should specify that services for the treatment of bedwetting should not exclude children and young people with comorbidities, or younger children (aged 5–7 years) on the basis of age alone.

Clinical commissioners should ensure that services provide sufficient and suitable alarms for the treatment of bedwetting and that they are made available without delay for children and young people.

Clinical commissioners should ensure that locally agreed prescribing guidelines are in place so that oral medication for the treatment of bedwetting is prescribed without delay and in accordance with quality statement 4.

Service providers should be able to demonstrate that children and young people who are bedwetting receive the treatment that is agreed in their initial treatment plan, in line with quality measures for statement 4. They should also be able to demonstrate that they are monitoring waiting times for initial treatment for bedwetting.

**Estimated resource impact**

- There may be additional costs incurred from improving access to initial treatment for bedwetting. The cost of enuresis alarms ranges from £39 to £137 depending on the type ([ERIC](http://www.eric.org.uk)). In addition to the cost of the alarm, there is a further cost for a replacement sensor (each time the alarm is loaned to a new person) and for batteries.

- The cost of desmopressin will depend on the dosage used and the treatment duration. For example, a 3-month treatment (recommendation 1.10.5 in [NICE clinical guideline 111](http://www.nice.org.uk/guidance/CG111)) with desmopressin ranges from £30 at the lower dose of 0.2 mg daily to £60 at the higher dose of 0.4 mg daily.

- In cases where combination treatment is required, the cost of a three-month combination treatment of an alarm (including sensor and batteries) and desmopressin ranges from approximately £142 at the lower dose of 0.2 mg daily and £172 at the higher dose of 0.4 mg daily.

**Quality statement 5: Access to specialist review**

Children and young people whose bedwetting has not responded to courses of initial treatment are referred for specialist review.
Rationale

If bedwetting in children and young people does not respond to courses of initial treatments, referral should be made for a specialist review so that the factors associated with a poor response (for example, overactive bladder, underlying disease, or social and/or emotional issues) can be assessed. Services that provide specialist reviews after courses of initial treatments have been tried for bedwetting may help to reduce the number of inappropriate hospital referrals, which will benefit the child or young person and may reduce costs.

Commissioner and provider actions

- Clinical commissioning groups (CCGs), NHS England area teams may commission paediatric continence services in a number of different ways. An integrated paediatric continence service that is run by a multidisciplinary team and is led by a paediatric continence nurse specialist is one example. Integrated paediatric continence services treat children and young people with bladder or bowel problems. For more information, see Paediatric continence commissioning guide (Paediatric Continence Forum, 2014).

- Health and social care commissioners should ensure that there are care pathways in place that enable children and young people with bedwetting that has not responded to courses of initial treatment to be referred for further review and assessment of factors associated with a poor response.

- In order to achieve optimal use of resources, clinical commissioners should refer to and be aware of assessments and interventions that are not recommended for managing bedwetting in NICE clinical guideline 111.

- Service providers should be able to demonstrate to commissioners that local service referral arrangements are in line with the quality measures for statement 5.

Estimated resource impact

- Clear and effective referral and care pathways will help provide effective management of bedwetting in children and young people. This might help reduce the number of children and young people with unresolved bedwetting, therefore saving the NHS resources in the longer term.

- The number of referrals to secondary care may also be reduced. A consultant-led appointment in secondary care paediatric urology costs £162 (2014/15 national tariff – outpatient attendances – Paediatric Urology).
Appropriate referrals for further review and assessments for children and young people whose bedwetting is not responding to courses of initial treatments will enable earlier identification of other associated factors and save money for the NHS by avoiding inappropriate treatments.

Disclaimer

This resource provides support for the local use of NICE quality standards. It does not constitute formal NICE guidance. Each resource should therefore be used in conjunction with the relevant NICE quality standard and current national guidance on commissioning.

Copyright

© National Institute for Health and Care Excellence 2014. All rights reserved. NICE copyright material can be downloaded for private research and study, and may be reproduced for educational and not-for-profit purposes. No reproduction by or for commercial organisations, or for commercial purposes, is allowed without the written permission of NICE.