NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Urinary incontinence in women

Output: Prioritised quality improvement areas for development.

Date of Quality Standards Advisory Committee meeting: 10 June 2014

Contents

1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for urinary incontinence in women. It provides the Committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the Committee in considering potential statements and measures.

1.2 Development source

The key development source(s) referenced in this briefing paper is:

Urinary incontinence: The management of urinary incontinence in women. NICE clinical guideline171 (2013)

2 Overview

2.1 Focus of quality standard

This quality standard will cover management of urinary incontinence in women 18 years and older.

2.2 Definition

Urinary incontinence (UI) is defined by the International Continence Society as 'the complaint of any involuntary leakage of urine'. UI may occur as a result of a number of abnormalities of function of the lower urinary tract or as a result of other illnesses, which tend to cause leakage in different situations.

- Stress UI is involuntary urine leakage on effort or exertion or on sneezing or coughing.
- Urgency UI is involuntary urine leakage accompanied or immediately preceded by urgency (a sudden compelling desire to urinate that is difficult to delay).
- Mixed UI is involuntary urine leakage associated with both urgency and exertion, effort, sneezing or coughing.
- Overactive bladder (OAB) is defined as urgency that occurs with or without urgency UI and usually with frequency and nocturia. OAB that occurs with incontinence is known as 'OAB wet'. OAB that occurs without incontinence is known as 'OAB dry'. These combinations of symptoms are suggestive of the

urodynamic finding of detrusor overactivity, but can be the result of other forms of urethrovesical dysfunction.

2.3 Incidence and prevalence

Urinary incontinence is an embarrassing problem to many women and thus its presence may be significantly underreported.
The Leicestershire MRC Incontinence Study, of individuals over 40 years of age, found that 33.6% of the population reported significant urinary symptoms but only 6.2% found these troublesome, and only 2.4% both bothersome and socially disabling. Of the population surveyed, 3.8% (one in nine of those with clinically significant symptoms) felt the need for help with their symptoms.[12] Women may take up to 10 years before seeking help.[3] They may be too embarrassed to seek advice, may not wish to bother their general practitioner (GP), may believe UI to be a normal consequence of the ageing process or may not appreciate that treatments are available.[4]

The Leicestershire MRC Incontinence Study found that, while 34.2% of women reported UI at times, only 3.5% experienced the symptom on a daily basis, 11.8% weekly, 7.3% monthly and 11.6% yearly.

Several studies have shown that the prevalence of any UI tends to increase up to middle age, then plateaus or falls between 50 and 70 years, with a steady increase with more advanced age. These data also show that slight to moderate UI is more common in younger women, while moderate and severe UI affects the elderly more often.[56]

2.4 Management

The management of urinary incontinence in women can be conservative, pharmacological or surgical. Conservative management refers to therapies such as

[1] Perry S, Shaw C, Assassa P, et al. An epidemiological study to establish the prevalence of urinary symptoms and felt need in the community: the Leicestershire MRC Incontinence Study. Leicestershire MRC Incontinence Study Team. Journal of Public Health Medicine 2000;22(3):427-34
[2] Dugan E, Roberts CP, Cohen SJ, et al. Why older community-dwelling adults do not discuss urinary incontinence with their primary care physicians. Journal of the American Geriatrics Society 2001;49(4):462-5
[3] Papanicolaou S, Pons M, Hampel C, et al. Medical resource utilisation and cost of care for women seeking treatment for urinary incontinence in an outpatient setting. Examples from three countries participating in the PURE study. Maturitas 2005;52 Supplement
[4] Shaw C, Tansey R, Jackson C, et al. Barriers to help seeking in people with urinary symptoms. Family Practic 2001;18(1):48-52
[5] Hannestad YS, Rortveit G, Sandvik H, et al. AA community based epidemiological survey of female urinary incontinence: the Norwegian EPICONT study. Epidemiology of Incontinence in the County of Nord-Trondelag. Journal of Clinical Epidemiology 2000;53(11):1150-7
[6] Sandvik H, Hunskaar S, Seim A, et al. Validation of a severity index in female urinary incontinence and its implementation in an epidemiological survey. Journal of Epidemiology and Community Health 1993;47(6):497-9

lifestyle interventions, physical, behavioural, drug and complementary therapies, and non-therapeutic interventions (such as products that collect or contain leakage). The preventive use of physical and behavioural therapies and of lifestyle interventions is also included. The International Continence Society defines ‘conservative treatment’ as therapies that are usually low cost, and managed principally by the person with UI with instruction/supervision from a healthcare professional. They differ from other forms of incontinence management, in that they have a low risk of adverse effects and do not prejudice other subsequent treatments.

The pharmacological treatment consists of Drugs with antimuscarinic action for the treatment of overactive bladder (OAB), desmopressing, diuretics, duloxetine and oestrogens.
When conservative treatment of overactive bladder (OAB) symptoms has failed it is usual to consider invasive or surgical therapy. The objective of all surgery for OAB symptoms should be to restore the woman’s lower urinary tract function as closely as possible to normal, with minimum short- and long-term morbidity, and for this improvement to be durable.

National Outcome Frameworks

Tables 1 shows the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

2.5 National Outcome Frameworks

Table 1 shows the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 NHS Outcomes Framework 2014–15

Domain	Overarching indicators and improvement areas
2 Enhancing quality of life for people with long-term conditions	***Overarching indicator*** 2 Health-related quality of life for people with long-term conditions (ASCOF 1 A**) ***Improvement areas*** **Ensuring people feel supported to manage their condition** 2.1 Proportion of people feeling supported to manage their condition **Improving functional ability in people with long-term conditions** 2.2 Employment of people with long-term conditions (ASCOF 1E**, PHOF 1.8*)
4 Ensuring that people have a positive experience of care	**Overarching indicators** 4a Patient experience of primary care i GP services ***Improvement areas*** **Improving people's experience of outpatient care** 4.1 Patient experience of outpatient services Improving hospitals' responsiveness to personal needs **Improving hospitals' responsiveness to personal needs**
Alignment across the health and social care system * Indicator shared with Public Health Outcomes Framework (PHOF) ** Indicator complementary with Adult Social Care Outcomes Framework (ASCOF) *** Indicator shared with Adult Social Care Outcomes Framework **** Indicator complementary with Adult Social Care Outcomes Framework and Public Health Outcomes [Delete as necessary]	

3 Summary of suggestions

3.1 Responses

In total 18 stakeholders responded to the 2-week engagement exercise 11/04/2014 – 28/04/2014.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 2 for further consideration by the Committee.

Full details on the suggestions provided are given in appendix 3 for information.

Table 2 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Assessment – full physical examination	
• Women with LUTS should be offered a full physical examination	BSU, FSRH
Assessment – initial steps	
• Women with LUTS should be offered a choice of temporary containment products	BAUS
• Women with LUTS should be asked to complete a urinary frequency and volume chart (bladder diary)	BAUS, SCM3, SCM2
Treatment - Neurostimulation	
• Sacral Nerve Stimulation	M, INS
• Percutaneous Tibial Nerve Stimulation	SCM4
Pharmacological treatment	
• Information about OAB drugs to women	SM1, FSRH
• Medication review	BAUS, AP Ltd, P
Treatment - Invasive procedures	
• Discuss with the woman the risks and benefits	BAUS
• Only surgeons who perform at least 20 procedures a year should operate on women	BAUS
Multidisciplinary team	
• Complex patients discussed at a MDT meeting	BBF, BAUS, BSU, SCM4
• Provision of choice for patients and their carers of the full range of appropriate treatments and interventions	AP Ltd
• Invasive procedures should be offered only after a MDT review	SCM3, BAUS
Pelvic floor muscle training	
• Pelvic floor muscle training should be rigorous and robust	SPM ltd, BBF, POGP, FSRH
• As prevention of urinary incontinence	SCM1
• Pelvic floor exercises should be supervised	
Self-Management	
• Lifestyle changes	SCM1, A Ltd
• Offer bladder training	
• Personalised management plan	SMC2, FSRH, BAUS BSU
• Absorbent products should not be used as treatment of UI	SCM1, P

Suggested area for improvement	Stakeholders
Safety issues • Urological complications from indwelling catheters	C
Areas not covered	
Staff competence • All staff should be trained in basic assessment and management of urinary incontinence • Lack of training results in many women not receiving comprehensive assessment	SCM2, BBF, POGP POGP, Coloclast
• Need to improve access to continence services • Commissioning integrated care	A Ltd, BBF
• Risk of catheterisation for men	NHS EPSD

SCM, Specialist Committee Member
FSRH, Faculty of Sexual and Reproductive Healthcare
POGS, Pelvic Obstetric and Gynaecological Physiotherapy
BSU, British Society of Uro-gynaecology
BAUS, British Association of Urological Surgeons
M, Medtronic
INS, International Neuromodulation Society
P, Phizer
AP ltd, Astellas Pharma Ltd
BBF, Bladder & Bowel Foundation
POGP, Pelvic Obstetric & Gynaecological Physiotherapy
SPM Ltd, Solution Project Management Ltd
C, Coloplast
A Ltd, Allergan Ltd
NHS EPSD, NHS England Patient Safety Division

4 Suggested improvement areas

4.1 Assessment – full physical examination

4.1.1 Summary of suggestions

Stakeholders highlighted the importance of carrying out a full physical examination as part of their initial assessment so that abnormalities of the abdomen and pelvis are not missed out and left untreated. Performing a vaginal examination is essential to detect abnormalities that might indicate malignancy of the pelvic organs.

They also emphasised that the probable type of urinary incontinence (UI) should be categorised as stress UI, mixed UI or overactive bladder (OAB).

4.1.2 Selected recommendations from development source

Table 3 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 3 to help inform the Committee's discussion.

Table 3 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Women with LUTS should be offered a full physical examination	**History taking and physical examination** NICE CG171 Recommendation 1.1.1 NICE CG171 Recommendation 1.1.3 NICE CG171 Recommendation 1.1.4

Women with LUTS should be offered a full physical examination

History-taking and physical examination

NICE CG174 – Recommendation 1.1.1

At the initial assessment, categorise the woman's urinary incontinence (UI) as stress UI (SUI), mixed UI, or urgency UI/overactive bladder (OAB). Start initial treatment on this basis. In mixed UI, direct treatment towards the predominant symptom. **[2006]**

NICE CG174 – Recommendation 1.1.3

During the initial assessment seek to identify relevant predisposing and precipitating factors and other diagnoses that may require referral for additional investigation and treatment. **[2006]**

NICE CG174 – Recommendation 1.1.4

Undertake routine digital assessment to confirm pelvic floor muscle contraction before the use of supervised pelvic floor muscle training for the treatment of UI. **[2006, amended 2013]**

4.1.3 Current UK practice

Although women may develop urinary incontinence following vaginal birth, there is evidence that women may wait many years before presenting to a healthcare professional with urinary incontinence. The National Audit of Continence Care[7] revealed that there are gaps in clinical care. Healthcare professionals are not consistently , providing assessment, diagnosis and follow-through according to standard practice.

[7] National Audit of Continence Care, Combined organisational and clinical report, September 2010. http://www.rcplondon.ac.uk/resources/national-audit-continence-care

4.2 Assessment – initial steps

4.2.1 Summary of suggestions

Stakeholders suggested that women should be offered a choice of temporary containment products as a temporary measure.

They also suggested the use of bladder diaries to show the pattern and timing of incontinence episodes and aid clinical assessment

4.2.2 Selected recommendations from development source

Table 4 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 4 to help inform the Committee's discussion.

Table 4 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Women with LUTS should be offered a choice of temporary containment products	**Absorbent products, urinals and toileting aids** NICE CG171 Recommendation 1.6.1
Women with LUTS should be asked to complete a urinary frequency and volume chart (bladder diary)	**Bladder diaries** NICE CG171 Recommendation 1.1.17

Absorbent products, urinals and toileting aids

NICE CG174 – Recommendation 1.6.1

Absorbent products, hand held urinals and toileting aids should not be considered as a treatment for UI. Use them only as:

- A coping strategy pending definitive treatment
- An adjunct to ongoing therapy
- Long-tern management of UI only after treatment options have been explored. **[2006]**

Bladder diaries

NICE CG174 – Recommendation 1.1.17

Use bladder diaries in the initial assessment of women with UI or OAB. Encourage women to complete a minimum of 3 days of the diary covering variations in their usual activities, such as both working and leisure days. **[2006]**

4.2.3 Current UK practice

According to the National Audit of Continence Care[8] 66% of primary care sites impose a limit on pads and containment products despite their policies stating they should be provided according to the clinical need.

[8] National Audit of Continence Care, Combined organisational and clinical report, September 2010. http://www.rcplondon.ac.uk/resources/national-audit-continence-care

Treatment – Neurostimulation

4.2.4 Summary of suggestions

Stakeholders said that percutaneous posterior Tibial Nerve Stimulation (PTNS) is frequently offered for OAB. Tariff supports PTNS while NICE supports it only in some cases.

Treatment - Neurostimulation

Stakeholders claimed that a large number of patients are not being referred on to treatments such as SNS when Botox has failed.

Stakeholders highlighted that Sacral Nerve Stimulation should be considered if incontinence episodes and quality of life are not improved despite optimised oral anti-cholinergic therapy regardless of their geographical location.

4.2.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 5 to help inform the Committee's discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Treatment - Neurostimulation	**Transcutaneous sacral nerve stimulation** NICE CG171 Recommendation 1.5.1 **Percutaneous posterior tibial nerve stimulation** NICE CG171 Recommendation 1.5.4

Treatment - Neurostimulation

NICE CG171 Recommendation 1.5.1

Do not offer transcutaneous sacral nerve stimulation to treat OAB in women [new 2013]

Treatment - Neurostimulation

NICE CG171 Recommendation 1.5.4

Do not offer percutaneous posterior tibial nerve stimulation for OAB unless:

- there has been a multidisciplinary team (MDT) review, **and**

- conservative management including OAB drug treatment has not worked adequately, **and**
- the woman does not want botulinum toxin A7 or percutaneous sacral nerve stimulation. **[new 2013]**

Explain that there is insufficient evidence to recommend the use of percutaneous posterior tibial nerve stimulation to routinely treat OAB. **[new 2013]**

4.2.3 Current UK practice

There is a duty of care to refer patients onward for SNS if patients have failed Botox or unable to catheterise. As per the Mohee study (2013)[9], almost two-thirds of patients (61%) discontinued Botox therapy at 3 years. In 2012, there were approximately 4239 patients in England who received at least 2 Botox injections (based on a Freedom of Information Request), According to this figure, at 3 years, approximately 2586 patients will discontinue Botox therapy but will still require some form of treatment. The paper states that these 2586 patients should be considered for SNS treatment, however, only 284 patients were received SNS for UI in 2012/2013 (Hospital Episode Statistics data). This indicates that there are a large number of patients who are not being referred on to other treatments such as SNS when they have failed with Botox.

[9] Mohee A, Khan A, Harris N, Eardley I, (2013) Long-term outcome of the use of intravesical botulinum toxin for the treatment of overactive bladder (OAB). BJU International, 111:106-113. DOI:1111/J.1464-410X.2012.11282.x

4.3 Pharmacological treatment

4.3.1 Summary of suggestions

Stakeholders highlighted that women should be informed about the side effects, delayed response, dosage options etc. and ensured that ineffective drugs and regimes are changed after a reasonable trial.

4.3.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 6 to help inform the Committee's discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Information about OAB drugs to women	**General Principles when using OAB drugs** NICE CG171 Recommendation 1.7.2

NICE CG171 Recommendation 1.7.2

Before OAB drug treatment starts, discuss with women:

- the likelihood of success and associated common adverse effects, **and**
- the frequency and route of administration, **and**
- that some adverse effects such as dry mouth and constipation may indicate that treatment is starting to have an effect, **and**
- that they may not see the full benefits until they have been taking the treatment for 4 weeks. **[new 2013]**

Table 8 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Medication review	**Reviewing OAB drug treatment** NICE CG171 Recommendation 1.7.11 NICE CG171 Recommendation 1.7.17

NICE CG171 Recommendation 1.7.11

Offer a face-to-face or telephone review 4 weeks after the start of each new OAB drug treatment. Ask the woman if she is satisfied with the therapy:

- If improvement is optimal, continue treatment.

- If there is no or suboptimal improvement or intolerable adverse effects change the dose, or try an alternative OAB drug (see recommendations 1.7.8–1.7.9), and review again 4 weeks later. **[new 2013]**

NICE CG171 Recommendation 1.7.17

If the woman wishes to discuss the options for further management (non-therapeutic interventions and invasive therapy) refer to the MDT and arrange urodynamic investigation to determine whether detrusor overactivity is present and responsible for her OAB symptoms:

- If detrusor overactivity is present and responsible for the OAB symptoms offer invasive therapy (see recommendations in section 1.9).
- If detrusor overactivity is present but the woman does not wish to have invasive therapy, offer advice as described in recommendation 1.6.9.
- If detrusor overactivity is not present refer back to the MDT for further discussion concerning future management. **[new 2013]**

4.3.3 Current UK practice

According to the The National Audit of Continence Care[10]gaps in organisational standards for continence care lead to gaps in clinical care. Overall, adherence to national guidance (NICE) for urinary and faecal incontinence is very variable. Healthcare professionals are not consistently:

- asking about incontinence in people who are at risk of the condition (e.g. older
- people)
- providing assessment, diagnosis and follow-through according to standard
- practice
- communicating information about causes and treatments of patients'
- incontinence
- asking patients about their own goals for treatment
- assessing the impact of incontinence on quality of life
- making care plans to achieve treatment goals and sharing these with patients and (where relevant) carers.

Persistence with long-term medication in chronic diseases is typically low and that for overactive bladder medication is lower than average. Sub-optimal persistence is a major challenge for the successful management of overactive bladder.

[10] National Audit of Continence Care, Combined organisational and clinical report, September 2010. http://www.rcplondon.ac.uk/resources/national-audit-continence-care

4.4 Invasive procedures for OAB

4.4.1 Summary of suggestions

Stakeholders highlighted that women should be given information about the risks and benefits of invasive procedures.

Stakeholders suggested that only experienced surgeons should operate on women.

4.4.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 7 to help inform the Committee's discussion.

Table 9 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Discuss with the woman the risks and benefits	**Invasive procedures for OAB** NICE CG171 Recommendation 1.9.2 NICE CG171 Recommendation 1.10.1
Only surgeons who perform at least 20 procedures a year should operate on women	**Maintaining and measuring expertise and standards of practice** NICE CG171 Recommendation 1.11.6

NICE CG171 Recommendation 1.9.2

Discuss the risks and benefits of treatment with botulinum toxin A7 with women before seeking informed consent, covering:

- the likelihood of being symptom free or having a large reduction in symptoms
- the risk of clean intermittent catheterisation and the potential for it to be needed for variable lengths of time after the effect of the injections has worn off
- the absence of evidence on duration of effect between treatments and the long-term efficacy and risks
- the risk of adverse effects, including an increased risk of urinary tract infection. **[new 2013]**

NICE CG171 Recommendation 1.10.1

When offering a surgical procedure discuss with the woman the risks and benefits of the different treatment options for SUI using the information in Information to facilitate discussion of risks and benefits of treatments for women with stress urinary incontinence. **[new 2013]**

NICE CG171 Recommendation 1.11.6

Only surgeons who carry out a sufficient case load to maintain their skills should undertake surgery for UI or OAB in women. An annual workload of at least 20 cases of each primary procedure for stress UI is recommended. Surgeons undertaking fewer than 5 cases of any procedure annually should do so only with the support of their clinical governance committee; otherwise referral pathways should be in place within clinical networks. **[2006]**

4.4.3 Current UK practice

According to the The National Audit of Continence Care[11] gaps in organisational standards for continence care lead to gaps in clinical care. Overall, adherence to national guidance (NICE) for urinary and faecal incontinence is very variable. Healthcare professionals are not consistently:

- asking about incontinence in people who are at risk of the condition (e.g. older
- people)
- providing assessment, diagnosis and follow-through according to standard
- practice
- communicating information about causes and treatments of patients'
- incontinence
- asking patients about their *own* goals for treatment
- assessing the impact of incontinence on quality of life
- making care plans to achieve treatment goals and sharing these with patients and (where relevant) carers.

Despite the availability of proven, cost-effective interventions that help to control symptoms and improve quality of life, many people experiencing LUTS are not able to access appropriate treatment within primary care

[11] National Audit of Continence Care, Combined organisational and clinical report, September 2010. http://www.rcplondon.ac.uk/resources/national-audit-continence-care

4.5 Multidisciplinary team

4.5.1 Summary of suggestions

Stakeholders suggested that the whole team approach ensures that consideration has been given to all available treatments rather than concentration on surgical techniques and give choice to women.

Stakeholders suggested that invasive procedures should be offered only after multidisciplinary review.

4.5.2 Selected recommendations from development source

Table 8 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 8 to help inform the Committee's discussion.

Table 10 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Complex patients discussed at a MDT meeting	**Multidisciplinary team** No recommendation
Provision of a choice for patients and their carers of the full range of appropriate treatments and interventions	**Multidisciplinary team** NICE CG171 Recommendation 1.8.6
Invasive procedures should be offered only after MDT review	**Multidisciplinary team** NICE CG171 Recommendation 1.8.2

NICE CG171 Recommendation 1.8.6

All MDTs should work within an established regional clinical network to ensure all women are offered the appropriate treatment options and high quality care. **[new 2013]**

NICE CG171 Recommendation 1.8.2

Offer invasive therapy for OAB and/or SUI symptoms only after an MDT review. **[new 2013]**

4.5.3 Current UK practice

According to the National Audit of Continence Care [12] the percentage of operating surgeons as part of a multidisciplinary team is 83% in acute care and 56% in primary care.

The same audit found lack of structured training in hospitals, and mental health trusts.

[12] National Audit of Continence Care, Combined organisational and clinical report, September 2010. http://www.rcplondon.ac.uk/resources/national-audit-continence-care

4.6 Pelvic floor muscle training

4.6.1 Summary of suggestions

Stakeholders suggested that the pelvic floor muscle training should be much more rigorous than current NHS practice. According to a clinical trial, the Arnold Kegel's exercises have demonstrated an 80% cure of cases within two weeks.

Stakeholders suggested the use of pelvic floor exercises as a preventative measure for pregnant women and they should be supervised to prevent women from doing them incorrectly.

Stakeholders highlighted that many patients are given written information regarding pelvic floor exercises rather than seeing someone who can supervise this.

4.6.2 Selected recommendations from development source

Table 9 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 9 to help inform the Committee's discussion.

Table 11 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Pelvic floor muscle training should be rigorous and robust (300 squeezes a day)	**Pelvic floor muscle training** NICE CG171 Recommendation 1.3.2
Pelvic floor muscle training as prevention of urinary incontinence	**Pelvic floor muscle training** No recommendation
Pelvic floor exercises should be supervised	**Pelvic floor muscle training** NICE CG171 Recommendation 1.3.1

NICE CG171 Recommendation 1.3.2

Pelvic floor muscle training programmes should comprise at least 8 contractions performed 3 times a day. **[2006]**

NICE CG171 Recommendation 1.3.1

Offer a trial of supervised pelvic floor muscle training of at least 3 months duration as first-line treatment to women with stress or mixed UI. **[2006]**

4.6.3 Current UK practice

Pelvic floor muscle training programmes should comprise at least 8 contractions performed 3 times per day. (Arnold Kegel’s principles)

4.7 Self-management

4.7.1 Summary of suggestions

Stakeholders highlighted the importance of lifestyle changes, such as reducing caffeine, exploring fluid intake and reducing BMI, in improving patient symptoms

Stakeholders also highlighted that absorbent products should not be used as treatment of urinary incontinence.

They suggested the use of bladder diaries to aid assessment

4.7.2 Selected recommendations from development source

Table 10 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 10 to help inform the Committee's discussion.

Table 12 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Lifestyle changes can improve patient's symptoms without the need for further treatments	**Lifestyle interventions** NICE CG171 Recommendation 1.2.1 NICE CG171 Recommendation 1.2.2 NICE CG171 Recommendation 1.2.3
Offer bladder training	**Behavioural therapies** NICE CG171 Recommendation 1.4.1
Personalised management plan	No recommendation
Absorbent products should not be used as treatment of UI	**Alternative conservative management options** NICE CG171 Recommendation 1.6.1

NICE CG171 Recommendation 1.2.1

Recommend a trial of caffeine reduction to women with OAB. **[2006]**

NICE CG171 Recommendation 1.2.2

Consider Advising modification of high or low fluid intake in women with UI or OAB. **[2006]**

NICE CG171 Recommendation 1.2.3

Advise women with UI or OAB who have a BMI greater than 30 to lose weight. **[2006]**

NICE CG171 Recommendation 1.4.1

Offer bladder training lasting for a minimum of 6 weeks as first-line treatment to women with urgency of mixed UI. **[2006]**

NICE CG171 Recommendation 1.6.1

Absorbent products, hand held urinals and toileting aids should not be considered as a treatment for UI. Use them only as:

- A coping strategy pending definitive treatment
- An adjunct to ongoing therapy
- Long-term management of UI only after treatment options have been explored. **[2006]**

4.7.3 Current UK practice

The NHS Mandate includes an objective that by 2015, “everyone with long-term conditions… will be offered a personalised care plan that reflects their preferences and agreed decisions”. According to the National Audit of Continence Care[13] gaps in organisational standards for continence care lead to gaps in clinical care. Overall, adherence to national guidance (NICE) for urinary and faecal incontinence is very variable. Healthcare professionals are not consistently:

- asking about incontinence in people who are at risk of the condition (e.g. older
- people)
- providing assessment, diagnosis and follow-through according to standard
- practice
- communicating information about causes and treatments of patients'
- incontinence
- asking patients about their *own* goals for treatment
- assessing the impact of incontinence on quality of life
- making care plans to achieve treatment goals and sharing these with patients and (where relevant) carers.

Despite the availability of proven, cost-effective interventions that help to control symptoms and improve quality of life, many people experiencing LUTS are not able to access appropriate treatment within primary care

[13] National Audit of Continence Care, Combined organisational and clinical report, September 2010. http://www.rcplondon.ac.uk/resources/national-audit-continence-care

4.8 Patient safety

4.8.1 Summary of suggestions

Stakeholders highlighted that indwelling catheters are known to increase the risk of experiencing more than one urological complication by more than 53 %, which is reduced dramatically by switching to intermittent catheters.

Table 11 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 11 to help inform the Committee's discussion.

Table 14 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Urological complications from indwelling catheters	**Indwelling urethral catheters** NICE CG171 Recommendation 1.6.4

NICE CG171 Recommendation 1.6.4

Give careful consideration to the impact of long-term indwelling urethral catheterisation. Discuss the practicalities, benefits and risks with the patient or, if appropriate, her carer. Indications for the use of long-term indwelling urethral catheters for women with UI include:

- chronic urinary retention in women who are unable to manage intermittent self-catheterisation
- skin wounds, pressure ulcers or irritations that are being contaminated by urine
- distress or disruption caused by bed and clothing changes
- where a woman expresses a preference for this form of management. **[2006]**

Appendix 1: Key priorities for implementation (CG171)

Recommendations that are key priorities for implementation in the source guideline and that have been referred to in the main body of this report are highlighted in grey.

Assessment and investigation

History-taking and physical examination

At the initial assessment, categorise the woman's urinary incontinence (UI) as stress UI (SUI), mixed UI, or urgency UI/overactive bladder (OAB). Start initial treatment on this basis. In mixed UI, direct treatment towards the predominant symptom. **[2006]**

[recommendation 1.1.1]

Assessment of pelvic floor muscles

Undertake routine digital assessment to confirm pelvic floor muscle contraction before the use of supervised pelvic floor muscle training for the treatment of UI.

[2006, amended 2013]

[recommendation 1.1.4]

Bladder diaries

Use bladder diaries in the initial assessment of women with UI or OAB. Encourage women to complete a minimum of 3 days of the diary covering variations in their usual activities, such as both working and leisure days. **[2006]**

[recommendation 1.1.17]

Behavioural therapies

Percutaneous posterior tibial nerve stimulation

Do not offer percutaneous posterior tibial nerve stimulation for OAB unless:

- there has been a multidisciplinary team (MDT) review, **and**
- conservative management including OAB drug treatment has not worked adequately, **and**

the woman does not want botulinum toxin A7 or percutaneous sacral nerve stimulation. **[new 2013]**

[recommendation 1.5.4]

Absorbent products, urinals and toileting aids

Absorbent products, hand held urinals and toileting aids should not be considered as a treatment for UI. Use them only as:

- A coping strategy pending definitive treatment
- An adjunct to ongoing therapy
- Long-tern management of UI only after treatment options have been explored. **[2006]**

[recommendation 1.6.1]

General principles when using OAB drugs

Before OAB drug treatment starts, discuss with women:

- the likelihood of success and associated common adverse effects, **and**
- the frequency and route of administration, **and**
- that some adverse effects such as dry mouth and constipation may indicate that treatment is starting to have an effect, **and**
- that they may not see the full benefits until they have been taking the treatment for 4 weeks. **[new 2013]**

[recommendation 1.7.2]

Choosing OAB drugs

Offer one of the following choices first to women with OAB or mixed UI:

- Oxybutynin (immediate release), **or**
- Tolterodine (immediate release), **or**
- Darifenacin (once daily preparation). **[new 2013]**

[recommendation 1.7.7]

If the first treatment for OAB or mixed UI is not effective or well tolerated, offer another drug with the lowest acquisition cost. **[new 2013]**

[recommendation 1.7.8]

The multidisciplinary team (MDT)

Offer invasive therapy for OAB and/or SUI symptoms only after an MDT review. **[new 2013]**

[recommendation 1.8.2]

Surgical approaches for SUI

When offering a surgical procedure discuss with the woman the risks and benefits of the different treatment options for SUI using the information in information to facilitate discussion of risks and benefits of treatments for women with stress urinary incontinence. **[new 2013]**

[recommendation 1.10.1]

Appendix 2: Glossary

Antimuscarinic drugs	Class of pharmacological agents acting on neuromuscular junctions in the autonomic nervous system, used for overactive bladder syndrome.
Bias	Influences on a study that can lead to invalid conclusions about a treatment or intervention. Bias in research can make a treatment look better or worse than it really is. Bias can even make it look as if the treatment works when it actually does not. Bias can occur by chance or as a result of systematic errors in the design and execution of a study. Bias can occur at various stages in the research process, for example in the collection, analysis, interpretation, publication or review of research data. For examples, see selection bias, performance bias, information bias, confounder or confounding factor, publication bias.
Bladder diary	A diary that records voiding times and voided volumes, leakage episodes, pad usage and other information such as fluid intake, degree of urgency, and degree of incontinence.
Bladder training	Bladder training (also described as bladder retraining, bladder drill, bladder re-education, bladder discipline) actively involves the individual in attempting to increase the interval between the desire to void and the actual void.
Co-morbidity	Co-existence of a disease or diseases in the people being studied in addition to the health problem that is the subject of the study.
Conservative management	Treatment or management strategies that do not involve surgery.

Detrusor overactivity (DO)	An urodynamic observation characterised by involuntary detrusor contractions during the filling phase of cystometry that may be spontaneous or provoked.
Haematuria	The presence of blood in the urine. Macroscopic haematuria is visible to the naked eye, while microscopic haematuria is only visible with the aid of a microscope.
Incidence	The probability of developing the disease or condition under study during a defined time period, usually 1 year.
Mixed urinary incontinence (MUI)	Involuntary leakage associated with urgency and also with exertion, effort, sneezing or coughing.
Nocturia	The complaint of having to wake at night one or more times to void. See also frequency.
Neurostimulation	Neurostimulation is a therapeutic activation of part of the nervous system using microelectrodes
Overactive bladder (OAB) syndrome	Urgency, with or without urge urinary incontinence, usually with frequency and nocturia. OAB wet is where (urge) incontinence is present and OAB dry is where incontinence is absent.
Pelvic floor muscle training (PFMT)	Repetitive selective voluntary contraction and relaxation of specific pelvic floor muscles.
Pelvic organ prolapse (POP)	Descent of one or more of the anterior vaginal wall, the posterior vaginal wall and the apex, or the vault of the vagina towards or through the vaginal introitus.

Prevalence	The probability of experiencing a symptom or having a condition or disease within a defined population at a defined time point.
Stress urinary incontinence (SUI)	The complaint of involuntary leakage on effort or exertion or on sneezing or coughing.
Urinary incontinence (UI)	The complaint of any involuntary urinary leakage.
Urethrovesical	Pertaining to the urethra and bladder

Appendix 3: Suggestions from stakeholder engagement exercise

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
001	SCM 1	Initial clinical assessment	It is very important that patients get fully assessed at the initial contact to ensure a correct pathway of care and to rule out red flags	We need to ensure early diagnosis of cancer and rule out sinister pathology (eg by urinalysis to exclude haematuria and bimanual examination to exclude pelvic mass) Some patients get referred routinely for continence problems without this still which is not appropriate	None
002	SCM 1	Promotion of self management	We need to promote self management in all long term conditions as patients often get better outcomes	Reducing caffeine, exploring fluid intake and reducing BMI can improve patient's symptoms without the need for further treatments which potentially have side effects.	None
003	SCM 1	Absorbent products should not be used as a treatment for urinary incontinence	Anecdotally, I see a lot of patients who are referred to community nurses for a continence assessment and end up given pads instead of having a full continence assessment. This is particularly in the frail elderly group of patients	Continence can play a major role in whether someone can continue an independent life. Often it can be a trigger for hospital admission if a patient is incontinence. It can also lead to complications such as pressure ulcers in care homes. We have a growing number of frail elderly patients and need to consider how they can access the most appropriate care	None
004	SCM 1	OAB drugs – shared decision making	Women being prescribed OAB drugs need to be fully informed about the drugs including time the	Patients need to make informed decisions about their treatments. This will improve their outcomes and compliance with	None

			drug takes to work and potential side effects	treatments, reducing the need for more invasive interventionIdeally a decision making grid for treatments for UI should be produced	
005	SCM 1	Supervised pelvic floor exercises	Many patients are given written information regarding pelvic floor exercises rather than seeing someone who can supervise this	Often this leads to patients having more invasive interventions as they have not done PFE properly (and sometimes being doing them incorrectly)	None
006	SCM 2	Key area for quality improvement 1. Early diagnosis and treatment of women with urinary incontinence	Although women may develop urinary incontinence following pregnancy and delivery, there is evidence that women may wait many years before presenting to a healthcare professional with urinary incontinence. Early diagnosis and treatment may prevent the condition worsening therefore having a greater impact on quality of life and the need for more invasive treatments	Women are often reluctant to seek treatment and are often told this is “normal” following childbirth. Social isolation, impacts on returning to work	NICE CG171 2013
007	SCM 2	Key area for quality improvement 2. The provision of a basic assessment; history, basic examination, provisional diagnosis and the know how to proceed should be known to all staff dealing with incontinent individuals. Structured training and mentorship in care for people with continence	Many patients do not receive a comprehensive assessment and the healthcare professional has not always had appropriate training in the assessment of incontinence. Tasks inappropriately delegated (referral to district nurses for pads rather than looking at treatment options). Most CCG’s have no idea on their current spend on pads and it is often far greater than treatment, yet there is pressure on pharmacy	Many women who do seek help are not fully assessed and diagnosed therefore do not receive the help they need. There are huge savings to be made if patients are treated rather than merely contained	Royal College of Physicians audit on Continence Care. UKCS minimum standards document(due to be launched in Sept. Draft available on request)

		should be made available to all healthcare professionals working with people who may experience problems.	costs which is myopic at best		
008	SCM 2	Key area for quality improvement 3. A suitable pathway should be in place for patients presenting with urinary incontinence and a range of healthcare professionals should be involved in the care pathway as part of a multidisciplinary team	Patients are often lost to follow up as a suitable range of healthcare professional is not involved in their care.	If basic initial treatment is not successful the should be measures in place for the woman to progress for onward treatment by a specialist	NICE CG171 2013
009	SCM 2	Key area for quality improvement 4. Following initial diagnosis including interpretation of a 3 day bladder diary all women should be given a conservative management plan	A 3 day bladder diary helps to aid diagnosis and treatment	Many healthcare professionals at the initial point of contact have received no training in the interpretation of bladder diaries orbasic advice and treatment	NICE CG 171 2013. Royal College of Physicians Audit on Continence Care
010	SCM 2	Key area for quality improvement 5 . All women with stress or mixed urinary incontinence should be offered 3 months pelvic floor muscle training as part of a package of conservative treatment	Pelvic floor muscle training has been shown to be effective in the treatment of stress and mixed urinary incontinence, this is part of the overall conservative treatment which should be offered for 3 months before considering more invasive treatments	Healthcare professionals need to be appropriately trained in teaching individual pelvic floor exercise programmes and this should include a digital vaginal assessment of the pelvic floor muscles	NICE CG 171 2013

011	SCM 2	Additional developmental areas of emergent practice	Use of technology	Advances like the Lifetec electronic bladder diary system mean that bladder diaries can be analysed for GP's and other HCP's and the results returned with basic advice. ePAQ quality of life assessment on line	Matthew Parsons MD thesis University of London www.epaq.co.uk
012	SCM 3	Surgical approaches for SUI	There is evidence of an increase in adverse events reports in comparison to numbers received in previous years. Women should be made fully aware of the pros and cons of the treatments.	The numbers of adverse events reports must decrease	MRHA paper 2011 MRHA press release published Nov 2012. Letter from Sir Bruce Keogh 21 Nov 2012
013	SCM 3	Key area for quality improvement 2 Clinical assessment should be comprehensive and include history taking, physical examination, assessment of pelvic floor muscles and the keeping of bladder diaries.	The reason for and the type of incontinence must be established in order that the appropriate treatment can be identified. The keeping of bladder diaries helps to establish the scale of the problem and the priority for treatment.	Women should receive treatment appropriate for their particular condition. There should be consistency of approach and delivery of service across the country.	Nice clinical guideline recommendation 2013
014	SCM 3	Key area for quality improvement 3. Offer invasive therapy for OAB and/or SUI only after an MDT review	The whole team approach ensures that consideration has been given to all available treatments (such as physiotherapy) rather than concentration on surgical techniques	Team decisions can help to ensure equity of service to patients and appropriateness of care.	NHS Leadership Academy "Working within teams"
015	SCM 3	Key area for quality improvement 4. If a woman chooses not to have further treatment	This ensures that women stay in control of their condition and do not have to "go back to the beginning " if they decide they	Patient choice is of great importance . It may be possible to save money if women do not have to repeat tests previously undertaken	NICE clinical guideline 1.6.9

		explain that if she changes her mind at a later date she can book a review appointment to discuss past tests and interventions and reconsider her treatment options	want to take their treatment further.		
016	SCM 4	Key area for quality improvement 1	Availability of pelvic floor assessment and indivualised treatment by a physiotherapist in primary care	PF physio is frequently only foun in secondary care; there are still a number of CCGs where only a leaflet is given without assessment	See underpinning data in NICE
017	SCM 4	Key area for quality improvement 2	PTNS frequently offered for OAB	Tarriff supports PTNS but NICE doesnt	Assess in CCG areas
018	SCM 4	Key area for quality improvement 3	Use of oxybutinin in frail elderly	Prev guidance was implemented without checking re frailty and falls risk	See NICE guidance for evidence
019	SCM 4	Key area for quality improvement 4	MDT available to discuss all major surgery and access to colorectal and urology input	Frequently not been funded despite commissioning targets	See NICE
020	SCM 4	Key area for quality improvement 5	Use of BSUG or BAUS database	Frequently not supported by Trusts despite guidance and plan to publish data this year	
021	SCM 4	Additional development areas of emergent practice	SNS and laparoscopic prolapse surgery		
022	NHS England Patient Safety Division	Ensuring the QS development group is mindful of potential for safety risk related to catheterisation	If the QS contains any content related to catheterisation, it is important to be aware that stocks of short-length catheters intended for females require special storage and labelling arrangements to avoid their	The National Patient Safety Agency issued a Rapid Response Report 'Female urinary catheters causing trauma to adult males' in 2009 to alert the NHS to the risk	http://www.nrls.npsa.nhs.uk/alerts/?entryid45=59897

			inadvertent use in males (where they can cause serious harm)		
023	International Neuromodulation Society	Sacral nerve stimulation for urge incontinence associated with overactive bladder	SNS should be considered if incontinence episodes and quality of life are not improved despite optimised oral anti-cholinergic therapy	SNS when provided by an interdisciplinary team in carefully selected patients has proven efficacy in refractory cases. There is great variation of access in UK. There is insufficient resource for this therapy. There is variation in practice.	
024	Solution Project Management Ltd	Key area for quality improvement 1. The quality of advice, guidance and treatment in primary care must be dramatically improved.	Urinary Stress Incontinence is a significant problem for many women but the subject matter is surrounded by taboo and ignorance. Its under-reporting is acknowledged by NICE. Much improved outcomes could be achieved, at much lower cost to the NHS, if appropriate and effective physical treatments were positively offered in the first instance.	This is a key area for improvement because dealing with the situation appropriately in the first instance would deliver much better outcomes at much lower cost. This alone would improve awareness of the fact that positive outcomes were possible and encourage a more enlightened perception amongst the profession and the population at large.	“Urinary incontinence is an embarrassing problem to many women and thus its presence may be significantly underreported.” “Where the most inclusive definitions have been used (‘ever’, ‘any’, ‘at least once in the last 12 months’), prevalence estimates in the general population range from 5% to 69% in women 15 years and older, with most studies in the range 25–45%.”
025	Solution Project Management Ltd	Key area for quality improvement 2. GP practices should, at the very least, follow NICE Guidelines	NICE CG 40 and CG171 recommend SUPERVISED Pelvic Floor Muscle Training PFMT as the first line treatment. Over 47% believed it to be adequate to just hand out an instruction leaflet.	In the absence of the adoption of Key Areas 3 and 4, adherence to the NICE Guidelines at least offers some hope to the patient. There is published evidence that, without supervision, a third of women are unable to engage their pelvic floor muscle effectively.	Pelvic floor muscle training . 29 Offer a trial of supervised pelvic floor muscle training of at least 3 months’ duration as first-line treatment to women with stress or mixed UI. [2006] CG171
026	Solution Project Management	Key area for quality improvement 3. Pelvic	The PFMT approach that is promulgated in leaflets and by	In the largest clinical trial of its kind Arnold Kegel demonstrated objective cure for USI	30 Pelvic floor muscle training programmes

	Ltd	Floor Muscle Training PFMT should be rigorous and robust and follow a method based on clinical evidence.	current practice has no basis in hard clinical evidence and represents an arbitrary and low level of 'exercise' that completely fails the patient. Extensive research of the literature fails to reveal any basis for the level and duration of the 'exercise' recommended.	in over 80% of cases WITHIN TWO WEEKS. Women following the current NHS guidance are unlikely to see any improvement in any reasonable timeframe and thus compliance is low or non-existent.	should comprise at least 8 contractions performed 3 times per day. [2006] CG171. To understand why this is completely inadequate visit www.thekegellegacy.com The principles of Kegel's exercises play no part in the PFMT offered by the NHS with the result that improvement is neither seen nor expected within three months. Kegel's principles require positive confirmation that the correct muscles are engaged, the use of resistive force to ensure effective exercise, a rigorous regime comprising around 300 squeezes per day and a positive feedback mechanism to demonstrate to the patient that improvement is being achieved – thus building compliance.
027	Solution Project Management Ltd	Key area for quality improvement 4 The quality of treatment, compliance with treatment and patient	Women are being denied effective treatment and suffering unnecessarily for many years. The £7bn market for continence pads is evidence of the scale of	By offering all women the opportunity to use the PelvicToner™ the problems associated with weak and stretched pelvic floor muscles in post-natal and post-menopause situations the majority of cases of USI could	The PelvicToner™ progressive resistance vaginal exerciser has been on the Drug Tariff since January 2011. It is

		outcomes could all be significantly improved, at lower cost, if the NHS adopted the tools readily available in its armoury. There is a clinically proven progressive resistance pelvic toning device on the Drug Tariff that offers a rapid and effective treatment for the majority of women and a tenth of the cost of the nearest alternative. The extent to which this device is offered is derisory.	the problem that is not being addressed.	be prevented, managed or cured, thus enabling scarce physiotherapy resources to be focussed on more needy cases.	clinically proven to be as effective as a three month course of supervised PFMT. (Clinical trial Bristol Urological Institute 2009. BJUI Jan 2010)
028	Bladder & Bowel Foundation	Key area for quality improvement 1 Self referral to continence services. Providing an awareness of available services and easier access to appropriate services in the community.	A number of women contact the Bladder & Bowel Foundation helpline unaware that there are continence services in their local area. More needs to be done to help women identify these services and also to help them access them in a timely manner.	Living with urinary incontinence is self-limiting and has a severe impact on dignity and quality of life. The APPG Continence report in 2012 identified improved access to services as a key area for improvement. The concept of self referral has been echoed by RCN, CSP and other professional bodies. Sadly as the APPG survey in 2013 highlighted that access to continence services is getting progressively worse in many areas.	http://rcnpublishing.com/doi/abs/10.7748/ns2013.10.28.9.19.s25?journalCode=ns http://www.appgcontinence.org.uk/pdfs/CommissioningGuideWEB.pdf http://www.appgcontinence.org.uk/pdfs/Continence%20Care%20Services%20England%20Report%202013.pdf

029	Bladder & Bowel Foundation	Key area for quality improvement 2 All women should have access to a cohesive, collaborative continence service. We would question the age limitation suggested for the standard – The B&BF helpline regularly takes calls from women with postpartum incontinence who are under the age of 18.	Recent changes to commissioning have resulted in continence services becoming fragmented and / or dissolved resulting in confusion and anxiety amongst service users. At a recent patient participation workshop wokmen with incontinence stated that they wanted to be heard and supported by an expert clinician who would guide them through their treatment pathway, referring on as required.	The competitive market that is evolving within healthcare as a result of the new commissioning rules is creating additional barriers between clinicians / teams / departments working in continence services. This has resulted in patients feeling dissulusioned and unsure. Good practice exists within continence care but these pockets are often working in isolation creating a post code lottery in terms of accessible care. Continence services that are patient focused should work seamlessly when operated by a multi-disciplinary team integrating across all levels of primary and secondary care.	http://www.appgcontinence.org.uk/pdfs/CommissioningGuideWEB.pdf http://www.appgcontinence.org.uk/pdfs/Continence%20Care%20Services%20England%20Report%202013.pdf
030	Bladder & Bowel Foundation	Key area for quality improvement 3 Complex patients should be discussed at MDT meeting	It is not unusual for patients with urinary continence to spend many months on a clinician's caseload without making any progress. Patients that have plateaued or have complex needs should be discussed at an MDT so that the best treatment plan can be agreed	Continence services need to be patient centred. To achieve this we need cohesive continence services that have the right compliment of experienced clinicians following the same clinical pathways (NICE guidance) and avoiding duplication by reviewing referrals to ensure that **the right patient sees the right clinician in the right place at the right time**.	http://www.appgcontinence.org.uk/pdfs/Continence%20Care%20Services%20England%20Report%202013.pdf http://www.appgcontinence.org.uk/pdfs/CommissioningGuideWEB.pdf http://www.nursingtimes.net/Journals/2013/07/05/c/g/s/100713-Reversing-deterioration-in-continence-services.pdf

031	Bladder & Bowel Foundation	Key area for quality improvement 4 Proactive prevention needs to be adopted alongside improved access to gold standard assessment and treatment	There is a wealth of evidence supporting the use of pelvic floor exercises as a preventative measure.	A number of women with incontinence present for treatment many years after the onset of their symptoms. More needs to be done to educate young women about the signs and symptoms of incontinence so that they know that it is important to seek help at the onset of symptoms. It is also essential to educate women on the benefits of conservative management.	http://www.appgcontinence.org.uk/pdfs/Continence%20Care%20Services%20England%20Report%202013.pdf http://www.appgcontinence.org.uk/pdfs/CommissioningGuideWEB.pdf NICE CG 171 2013
032	Bladder & Bowel Foundation	Key area for quality improvement 5 Additional resource needs to be identified to train staff in the management of Urinary incontinence	Recent changes to NHS structure and commissioning has resulted in a number of specialist clinicians taking early retirement / leaving the NHS. This coupled with budgetary constraints has reduced training budgets and consequently the level of clinical expertise is at risk.	Management of Urinary Incontinence requires specialist expertise – without this the outcomes are generally poor. Both in terms of job satisfaction for the clinician and patient satisfaction. Continence management can if done well have a huge positive impact upon reducing containment budgets, staff satisfaction and staff retention as well as significantly improving service user experience and outcomes. The value of engaging carers and Health Care assistants in the improvement of continence management should not be underestimated. Improved training at this level will also have a positive impact upon inventory management and rapid diagnosis enabling cost savings and redistribution of clinical skill.	http://www.appgcontinence.org.uk/pdfs/CommissioningGuideWEB.pdf http://www.appgcontinence.org.uk/pdfs/Continence%20Care%20Services%20England%20Report%202013.pdf
033	Bladder &	Additional developmental	There isn't a one cure fix all	Patients that are assessed well by an expert	http://www.appgcontinence.

	Bowel Foundation	areas of emergent practice Women want and need a choice of treatment options	solution for urinary continence management. More must be done to support innovation and expertise in this clinical area.	clinician and given appropriate timely, treatment whether, conservative, medical, containment or surgery are more likely to achieve a significant decrease in symptoms. Conversely poor management is costly as often containment is seen as the only option	org.uk/pdfs/Continence%20Care%20Services%20England%20Report%202013.pdf
034	Pelvic Obstetric and Gynaecological Physiotherapy	Key area for quality improvement 1 Early diagnosis and treatment of women with urinary incontinence	Although women may develop urinary incontinence following vaginal birth, there is evidence that women may wait many years before presenting to a healthcare professional with urinary incontinence. Early diagnosis and treatment may prevent the condition worsening therefore having a greater impact on quality of life and the need for more invasive treatments	Women are often reluctant to seek treatment and are often told this is “normal” following childbirth. More needs to be done to raise awareness amongst key healthcare professionals and women so that they feel empowered to seek help earlier. Services need to be accessible and provide quality treatments in line with NICE guidance.	NICE CG171 2013
035	Pelvic Obstetric and Gynaecological Physiotherapy	Sometimes clinicians have been misinformed that PFMT may cause a difficult birth		While mid pregnancy vaginal resting pressure is associated with prolonged second stage of labor, neither vaginal resting pressure nor pelvic floor muscle strength or endurance are associated with operative delivery or perineal tears. Strong pelvic floor muscles are not disadvantageous for vaginal delivery	Too tight to give birth? Assessment of pelvic floor muscle function in 277 nulliparous pregnant women. Kari Bø, International Urogynecology Journal (Impact Factor: 2.17). 06/2013; DOI:10.1007/s00192-013-2133-8
036	Pelvic Obstetric and Gynaecological Physiotherapy	Pelvic floor muscle training should be offered to women in their first pregnancy from 10	One third of pregnant women will develop urinary incontinence postpartum Pelvic floor muscle training in	Pelvic floor muscle training in pregnancy reduces the likelihood of postnatal urinary incontinence All women should be offered an opportunity	NICE CG 62 2008 Ante natal Care. Routine care for healthy pregnant women

		weeks as a strategy to prevent urinary incontinence .	pregnancy reduces the likelihood of postnatal urinary incontinence.	to be taught pelvic floor exercises antenatally particularly if they are symptomatic	
037	Pelvic Obstetric and Gynaecological Physiotherapy	Postpartum women with persistent urinary incontinence three months postpartum who received PFMT were around 40% less likely to report urinary incontinence 12 months postpartum than women who received no PFMT or just the usual postnatal care.		Supervised pelvic floor muscle training of at least 3 months' duration should be offered as first-line treatment to women with stress or mixed incontinence Ideally all women should be offered an opportunity to see a specialist physiotherapist postnatally so that continence issues can be identified and treated appropriately. If nothing else all women should be told about the importance of PF exercises and informed who to contact should problems with incontinence arise at a later date. Daily pelvic floor muscle training continued for 3 months is a safe and effective treatment for stress and mixed UI. An individualised pelvic floor muscle training programme is effective in reducing symptoms of prolapse	NICE CG37 2006 Routine post natal care of women and their babies Boyle Cochrane review 2012 Cochrane Review: 2012 Pelvic floor muscle training for prevention and treatment of urinary and faecal incontinence in antenatal and postnatal women
038	Pelvic Obstetric and Gynaecological Physiotherapy	Key area for quality improvement 2 The provision of a basic assessment; history, basic examination, provisional diagnosis and the know how to proceed should be known to all staff dealing with incontinent individuals. Structured training and	Many patients do not receive a comprehensive assessment and the healthcare professional has not always had appropriate training in the assessment of incontinence	Many women who do seek help are not fully assessed and diagnosed therefore do not receive the help they need A poor experience with an underskilled clinician may result in the women losing faith in the service and achieving a poor outcome. It is imperative that the women that finally come forward and admit they have a problem are treated by the right person, in the right place at the right time.	Royal College of Physicians audit on Continence Care

		mentorship in care for people with continence should be made available to all healthcare professionals working with people who may experience problems. Consider pelvic floor muscle training for people with: lower urinary tract dysfunction due to multiple sclerosis or stroke or other neurological conditions where the potential to voluntarily contract the pelvic floor is preserved. Select patients for this training after specialist pelvic floor assessment and consider combining treatment with biofeedback and/or electrical stimulation of the pelvic floor		ICS say that 40% SUI have POP - so management of POP should be an area for understanding in the management of SUI - and therefore PFMT and other conservative measures should be broadened to include that knowledge? Clinicians treating SUI in women need to be aware of associated POP and undergo relevant training so that treatment regimes are robust and clinically effective Patients with neurological disease are often not provided with intensive PFMT to be effective	
039	Pelvic Obstetric and Gynaecological Physiotherapy	Key area for quality improvement 3 A suitable pathway should be in place for patients presenting with urinary incontinence and a range of healthcare	Patients are often lost to follow up as a suitable range of healthcare professional is not involved in their care.	If basic initial treatment is not successful the should be measures in place for the woman to progress for onward treatment by a specialist	NICE CG171 2013

		professionals should be involved in the care pathway as part of a multidisciplinary team			
040	Pelvic Obstetric and Gynaecological Physiotherapy	Key area for quality improvement 4 Following initial diagnosis including interpretation of a 3 day bladder diary all women should be given a conservative management plan	A 3 day bladder diary helps to aid diagnosis and treatment	Many healthcare professionals at the initial point of contact have received no training in the interpretation of bladder diaries ro basic advice and treatment	NICE CG 171 2013 Royal College of Physicians Audit on Continence Care
041	Pelvic Obstetric and Gynaecological Physiotherapy	Key area for quality improvement 5 All women with stress or mixed urinary incontinence should be offered 3 months pelvic floor muscle training as part of a package of conservative treatment	Pelvic floor muscle training has been shown to be effective in the treatment of stress and mixed urinary incontinence, this is part of the overall conservative treatment which should be offered for 3 months before considering more invasive treatments	Healthcare professionals need to be appropriately trained in teaching individual pelvic floor exercise programmes and this should include a digital vaginal assessment of the pelvic floor muscles	NICE CG 171 2013
042	Faculty of Sexual and Reproductive Healthcare	Key area for quality improvement 1 At presentation - categorisation of type of incontinence – stress v OAB v mixed	Management pathways are crucially dependent on getting this right		
043	Faculty of Sexual and Reproductive Healthcare	Key area for quality improvement 2 Appropriate use of antibiotics if infection is suspected	Overuse of antibiotics when not indicated may delay definitive diagnosis, encourage emergence of resistant strains and has the potential for drug interactions and allergies		

044	Faculty of Sexual and Reproductive Healthcare	Key area for quality improvement 3 Use of bladder diaries and lifestyle changes	Simple, low cost, involves patient in self care, informative, bio feedback		
045	Faculty of Sexual and Reproductive Healthcare	Key area for quality improvement 4 Pelvic floor exercise training during first pregnancy	Simple primary prevention		
046	Faculty of Sexual and Reproductive Healthcare	Key area for quality improvement 5 Counselling re OAB pharmacological treatments	Understanding side effects, delayed response, dosage options etc aids compliance and ensures ineffective drugs and regimes are changed after a reasonable trial		
047	British Society of Uro-gynaecology	Key area for quality improvement 1 Initial Assessment	Women with lower urinary tract symptoms (LUTS) should be offered a full physical examination, including a vaginal examination, as part of their initial assessment. The probable type of urinary incontinence (UI) should be categorised as stress UI (SUI), mixed UI, or urgency UI/overactive bladder (OAB) based on the initial clinical assessment. First line treatment can be started on this basis. In mixed UI, direct treatment towards the predominant symptom.	It is important to carry out a full physical examination so that abnormalities of the abdomen and pelvis are not missed and left untreated. Performing a vaginal examination is essential to detect abnormalities that might indicate malignancy of the pelvic organs. Digital assessment to confirm pelvic floor muscle contraction should be undertaken before the use of supervised pelvic floor muscle training for the treatment of UI. This provides a baseline from which to compare the effects of this treatment.	NICE CG 171 – Key priorities for implementation
048	British Society of Uro-	Key area for quality improvement 2	50% of women will improve with supervise pelvic floor exercises	Ensuring that all women have tried conservative treatments in the community	

	gynaecology	Lifestyle advise and conservative treatments are considered prior to referral to secondary care	avoiding the risks of a surgical intervention.	prior to referral would ensure more appropriate use of resources.	
049	British Society of Uro-gynaecology	Key area for quality improvement 3 Only surgeons who perform at least 20 procedures a year operate on women	NICE guideline has since 2006 recommended that experience of tape insertion is concentrated into the hands of fewer surgeons who perform more procedures	Individual surgeons are reluctant to give up a practice that they have been doing for many years. Drives to reduce waiting lists and focus on targets detract from quality measures	
050	British Society of Uro-gynaecology	Key area for quality improvement 4 There are facilities within the organisation for multidisciplinary team working	MDT discussion for women complex problems is an integral part of management	Need for MDT in these patients needs to be recognised	NICE guidance 2013
051	British Society of Uro-gynaecology	Additional developmental areas of emergent practice Bladder care in pregnancy and postpartum.	Vaginal delivery is independently associated with significant long-term increase in stress urinary incontinence and symptoms of overactive bladder. In addition, undiagnosed and mismanagement of postpartum urinary retention can lead to bladder damage with long-term consequences such as urinary incontinence. Early diagnosis and intervention is associated with complete resolution in early postpartum.	NICE guideline for the management of urinary incontinence in women involves all women over18 years, there are no guidance or postpartum bladder care pathway. Thus, there are no standard preventive measures and managements for postpartum urinary retention and incontinence.	The studies that investigating methods of preventing of postpartum stress urinary incontinence showed that pelvic floor exercises carried out antenatally, and not postnatally under the supervision of a physiotherapist, but not midwives can reduce reported postpartum stress urinary incontinence. Altman D, Ekstrom A, Gustafsson C, et al Obstet Gynecol 2006; 108:873 – 878

					Reilly ET, Freeman RM, Waterfield MR, et al. Br J Obstet Gynaecol 2002; 109:68–76.
052	Medtronic	Key area for quality improvement 1 Patient Equity of Access to Sacral Nerve Stimulation for Urinary Incontinence	Sacral Nerve Stimulation for Urinary Incontinence is recommended within NICE guidance (CG171). NICE recommends sacral nerve stimulation for the treatment of OAB due to detrusor overactivity in women who have not responded to conservative management including drugs, who either: - Are unable to perform clean intermittent catheterisation, or, - Who have not responded to botulinum toxin A treatment As per the NICE recommended pathway, all patients who meet the criteria should be offered Sacral Nerve Stimulation as a treatment option for Urinary Incontinence regardless of geographic location.	Urinary Incontinence is a debilitating disorder affecting 12-14% of the population (2-4). Although rarely life-threatening, these disorders can have a considerable negative impact on patients' quality of life, restricting their ability to work and function socially. The management of these disorders poses a significant health care burden as the disorders are rarely cured and severity increases progressively with age. There is a duty of care to refer patients onward for SNS if patients have failed Botox or unable to catheterise. As per the Mohee study (2013), almost two-thirds of patients (61%) discontinued Botox therapy at 3 years. In 2012, there were approximately 4239 patients in England who received at least 2 Botox injections (based on a Freedom of Information Request), According to this figure, at 3 years, approximately 2586 patients will discontinue Botox therapy but will still require some form of treatment. These 2586 patients should be considered for SNS treatment, however, we know that only 284 patients were received	1. NICE Clinical Guidance on Urinary Incontinence in Women (CG 171) 2. Ouslander J. Management of overactive bladder. N Engl J Med. 2004 Feb 19;350(8):786-99 3. Wein A, Raymond R. Overactive Bladder: A better understanding of pathophysiology, diagnosis, and management. Journal. J Urol. 2006 Mar;175(3pt2):S5-S10 4. Abrams P, Cardozo L et al. The standardisation of terminology in lower urinary tract function: report from the standardisation sub-committee of the International Continence Society. Urology. 2003 Jan;61(1):37-49. Review

				SNS for UI in 2012/2013 (Hospital Episode Statistics data). This indicates that there are a large number of patients who are not being referred on to other treatments such as SNS when they have failed with Botox.	5. Mohee Study: BJU Int. 2013 Jan;111(1):106-13. doi: 10.1111/j.1464-410X.2012.11282.x. Epub 2012 Jun 6.
053	Medtronic	Key area for quality Key area for quality improvement 2 Improve Patient Pathway- Create an Integrated Pathway of Care	There is a lack of an integrated pathway of care for the treatment of SNS for UI. There are so many health care professionals involved in the treatment of incontinence; a patient will sit under a GP, a continence clinic, a gynaecologist, Urogynaecologist or Urologist. There is currently no mechanism for these HCPs to communicate and the standard of care received will vary between HCPs. Every community continence clinic should know where the local specialist is based in secondary care and a MDT should be mandatory between urologist and urogynae. In addition, a National leaflet that would outline the various treatment options for patients with Urinary Incontinence would provide them with the information of the wide spectrum of treatments as per the NICE Guidance.	A more integrated pathway of care between each step would improve a patient access to treatment and therefore quality of care. The current management of OAB involves several levels of treatment - behavioural, pharmacological, and surgical - used either in isolation or as combination therapies. Conservative and pharmacological approaches constitute first-line treatment. A proportion of patients fail first line treatment with persistence in their symptoms. These patients are left with few options which may require more invasive and irreversible surgical approaches. Without adequate information on SNS patients may not be able to make an informed consent choice and may opt for potentially irreversible surgery or indeed no treatment as they would believe that there are no more options. A National leaflet of treatment options would provide patients with information on various treatment options they can discuss with a HCP.	NICE Clinical Guidance on Urinary Incontinence in Women (CG 171)
054	British	Key area for quality	INITIAL ASSESSMENT	It is important to carry out a full physical	NICE CG 171 – Key

	Association of Urological Surgeons	improvement 1	Women with lower urinary tract symptoms (LUTS) should be offered a full physical examination, including a vaginal examination, as part of their initial assessment. The probable type of urinary incontinence (UI) should be categorised as stress UI (SUI), mixed UI, or urgency UI/overactive bladder (OAB) based on the initial clinical assessment. First line treatment can be started on this basis. In mixed UI, direct treatment towards the predominant symptom.	examination so that abnormalities of the abdomen and pelvis are not missed and left untreated. Performing a vaginal examination is essential to detect abnormalities that might indicate malignancy of the pelvic organs. Digital assessment to confirm pelvic floor muscle contraction should be undertaken before the use of supervised pelvic floor muscle training for the treatment of UI. This provides a baseline from which to compare the effects of this treatment.	priorities for implementation
055	British Association of Urological Surgeons	Key area for quality improvement 2	BLADDER DIARIES Women with lower urinary tract symptoms (LUTS) and incontinence are asked to complete a urinary frequency and volume chart, as part of their initial assessment. This should include the pattern and timing of incontinent episodes. Encourage women to complete a minimum of 3 days of the diary covering variations in their usual activities, such as both working and leisure days Development of treatment plan and agree this with the patient based on initial assessment and basic investigations including	Urinary frequency and volume charts add important information to the medical history.They can also help the healthcare professional to make an accurate diagnosis and to distinguish nocturnal polyuria (greater than a third of daily urine output during the night) from detrusor overactivity (normal urine production but increased urinary frequency with urgency and small volumes of urine passed each time). To demonstrate knowledge of impact of lifestyle modifications eg. Fluid intake, bowel management, caffeine reduction, weight reduction, smoking cessation Initiate bladder training and/or pelvic floor muscle training programme and allow 6-12 weeks for optimal treatment.	Nice CG171 Female Incontinence - key priority for implementation Quality Standard 45 for Males with LUTS CHS41 CC01 CC08 CC11 CC12

			explanation of bladder diary findings to patient and giving advice based on findings		
056	British Association of Urological Surgeons	Key area for quality improvement 3	CONTAINMENT PRODUCTS Women with urinary incontinence should be offered a choice of temporary containment products, as part of their initial assessment.	Absorbent products and toileting aids should not be considered as a treatment for urinary incontinence. Use them only as a coping strategy pending definitive treatment or as an adjunct to ongoing therapy. They can only be considered as a long-term management option in female urinary incontinence after other treatment options have been thoroughly explored.	Nice CG171 Female Incontinence - key priority for implementation
057	British Association of Urological Surgeons	Key area for quality improvement 4	MEDICATION AND REVIEW Before OAB drug treatment starts, discuss the likelihood of success and associated common adverse effects with women. The frequency and route of administration should be made clear and that some adverse effects such as dry mouth and constipation may indicate that treatment is starting to have an effect. The medication may not show its maximum benefit until the patient has been taking the treatment for 4 weeks. Women with urinary incontinence who are prescribed drug treatments to manage symptoms should therefore receive a timely medication review. Offer one of the following choices first to women with OAB or mixed	It is important that women with urinary incontinence who are taking drug treatments for their symptoms have a medication review initiated promptly after their treatment has been prescribed. The review will inform decisions about their continued use, taking into account the effect of these drugs on symptoms and quality of life, as well as any adverse effects.	Nice CG171 Female Incontinence - key priority for implementation

			urinary incontinence oxybutynin (immediate release), or tolterodine (immediate release), or darifenacin (once daily preparation). If the first treatment for OAB or mixed UI is not effective or well-tolerated, offer another drug with the lowest acquisition cost.		
058	British Association of Urological Surgeons	Key area for quality improvement 5	SURGERY FOR URINARY INCONTINENCE Offer invasive therapy for OAB and/or SUI symptoms only after an MDT review. When offering a surgical procedure discuss with the woman the risks and benefits of the different treatment options for SUI using the NICE CG 171 (Information to facilitate discussion of risks and benefits of treatments for women with stress urinary incontinence). Only surgeons who perform at least 20 procedures a year operate on women	This quality statement aims to ensure the appropriate offer of surgery to women with urinary incontinence. It will ensure patients are fully informed regarding the likelihood of benefit from surgery and the risks involved. Individual surgeons are reluctant to give up a practice that they have been doing for many years. Drives to reduce waiting lists and focus on targets detract from quality measures	Nice CG171 Female Incontinence – key priority for implementation. NICE guideline has since 2006 recommended that experience of tape insertion is concentrated into the hands of fewer surgeons who perform more procedures
059	British Association of Urological Surgeons	Funding for Support for MDT Meeting at TRUST/Network level	MDT recommended in NICE guideline	MDT(multidisciplinary meetings cannot run effectively without adequate funding to provide clerical support for coordinating meetings and supporting database entry	Nice CG171 Female Incontinence – key priority for implementation
060	Astellas Pharma Ltd	Key area for quality improvement 1: Initial assessments and investigations of	NICE CG171 recommends that all patients presenting with symptoms of urinary incontinence (UI) or overactive bladder (OAB)	Bladder problems can have a significant impact on quality of life, with the potential to negatively affect an individual's work productivity, their sleep and their mental	Royal College of Physicians, National Audit of Continence Care, Combined organisational

		symptoms in accordance with NICE guidance of people who present with symptoms of UI and OAB by appropriately trained staff, securing prompt diagnosis	should undergo an initial assessment and investigation2. This should include where appropriate3,4: • A physical examination guided by symptoms and any other medical conditions; urine and blood tests full review of medical history and current medication to identify any predisposing factors • Completion of a urinary frequency chart (a bladder diary), a symptom score questionnaire and a quality of life assessment to inform diagnosis of the underlying condition • Provision of information about symptoms and advice on lifestyle changes such as modifying fluid intake, reducing caffeine consumption and weight loss	wellbeing5,6. More fundamentally, achieving good bladder control is a basic human need and is critical to maintaining both dignity and independence. Dignity and respect sit at the heart of the NHS statutory duty to secure continuous improvements in the quality of services7 and fulfil patient rights under the NHS Constitution8, so early assessment of UI and OAB symptoms can have a crucial role to play in delivering priorities that sit at the heart of quality patient care. However, evidence suggests that “healthcare professionals are not consistently providing assessment, diagnosis and follow-through according to standard practice”9. It is therefore essential that the quality standard seeks to drive improvements in the assessment and investigation of UI and OAB symptoms, since failure to secure a prompt diagnosis and provide appropriate support can lead to poorer outcomes for patients and contribute towards additional costs to the NHS.	and clinical report, September 2010. http://www.rcplondon.ac.uk/sites/default/files/full-organisational-
061	Astellas Pharma Ltd	for quality improvement 2 Developing personalised management plans for people with OAB and UI covering diagnosis, self-care, clinical management and a named professional to contact for further information or support	The NHS Mandate includes an objective that by 2015, “everyone with long-term conditions… will be offered a personalised care plan that reflects their preferences and agreed decisions”10. CG171 supports the principle that a treatment plan should be developed, taking into account the patient’s individual needs and preferences such as child-bearing wishes11.	The National Audit of Continence Care, published by the Royal College of Physicians in 2010, found that “healthcare professionals are not consistently: Communicating information about causes and treatments of patients' incontinence Asking patients about their own goals for treatment Developing care plans to achieve treatment goals and sharing these with patients and (where relevant) carers”12 As a result, the RCP recommended that “healthcare professionals should discuss	Royal College of Physicians, National Audit of Continence Care, Combined organisational and clinical report, September 2010. http://www.rcplondon.ac.uk/sites/default/files/full-organisational-and-clinical-report-nacc-2010.pdf

				causes treatment options with patients (and carers where relevant) in such a way that patients own goals for treatment are identified and recorded”13. It also recommended that “healthcare professionals should ensure that there is a shared treatment plan that is regularly reviewed to achieve treatment and care goals”14. Poorly managed symptoms can increase the amount of time people spend in hospital settings if avoidable complications arise, such as infections15. It can also compromise safety due to an increased risk of pressure ulcers and falls16. Improvements in the quality of care and effective management of symptoms can therefore help to reduce these negative effects and support improved quality of life.	
062	Astellas Pharma Ltd	area for quality improvement 3 Timely provision of clinically appropriate interventions, management protocols and treatments, with review within one month or in a timeframe recommended by NICE guidance	Timely provision and review of treatment enables patients and professionals to evaluate relevant outcomes including symptom control, side effects and quality of life. This may promote medicines optimisation. The review can be used to identify whether an alternative treatment could offer additional benefits – such as improved efficacy or tolerability – so that an individual’s treatment and management plan can be adapted accordingly.	CG171 recommends that containment products should be used as a “coping strategy pending definitive treatment”17 and the Royal College of Physicians recommends in the NACC that “healthcare professionals should ensure that there is a shared treatment plan that is regularly reviewed to achieve treatment and care goals”18. The quality standard can help deliver this recommendation and ensure that patients are being routinely reviewed to understand if treatment is satisfactory and treatment goals are being met.	Royal College of Physicians, National Audit of Continence Care, Combined organisational and clinical report, September 2010. http://www.rcplondon.ac.uk/sites/default/files/full-organisational-and-clinical-report-nacc-2010.pdf
063	Astellas Pharma Ltd	Key area for quality improvement 4 Provision	There are a number of NICE clinical guidelines outlining best	Despite the availability of proven, cost-effective interventions that help to control	

		of a choice for patients and their carers of the full range of appropriate treatments and interventions that are of proven efficacy and safety, in accordance with NICE guidance	practice and a range of interventions that are used to manage UI and OAB depending on the nature and severity of conditions and the underlying causes (CG171 and TA290) which can help to reduce symptoms and improve quality of life.	symptoms and improve quality of life, many people experiencing LUTS are not able to access appropriate treatment within primary care19. It is important that the quality standard makes clear that healthcare professionals should work with women with OAB and UI to offer the full range of treatment options that are available to them, so that an informed choice can be taken based on needs and preferences.	
064	NHS England Quality Framework team	Thank you for the opportunity to comment on the engagement exercise for the above Quality Standard. I wish to confirm that NHS England has no substantive comments to make regarding this consultation.			
065	Coloplast	Indwelling catheters and UTIs	Indwelling catheters are known to increase the risk of experiencing more than one urological complication by more than 53 %, which is reduced dramatically by switching to intermittent catheters. Because of the risk of increased number of UTIs as well as other associated complications, the EAU guideline recommend use of indwelling catheters only in exceptional circumstances.	Because urinary tract infections are one of the most prominent complications associated with catheters in hospitals – decreasing quality of life for the patients and increasing costs to society	Please see the following list of published evidence sources on urinary incontinence, urinary tract dysfunction and the bladder management. J. Pannek (chair), M. Stöhrer (vice-chair), B. Blok, D. Castro-Diaz, G. Del Popolo, G. Kramer, P. Radziszewski,A. Reitz, J-J. Wyndaele. Guidelines on Neurogenic Lower Urinary Tract Dysfunction. Uroweb 2013. Madersbacher H, Wyndaele JJ, Igawa Y, et

					al. Conservative management in neuropatic urinary incontinence. In: Incontinence, 2nd edn. Abrams P, Khoury S, Wein A, eds. Plymouth: Health Publication, 2002; pp. 697-754. Weld et al: Effect of bladder management on urological complications in spinal cord injured patients. J Urol 2000:163;768-772
066	Coloplast	Training and Education	Education and training is key – nurses should have undertaken the appropriate training to increase patient compliance with the relevant procedure. The recent EAUN-guideline on catheterisation e.g. states that lack of knowledge among patient/caregivers can result in non-adherence to prescribed intermittent catheterisation and that health care professionals' communication skills and attitudes are instrumental in promoting confidence in carrying out the procedure and can promote long-term compliance.	Because proper education and training is a prerequisite for learning the right technique and for long-term compliance.	Vahr S, Cobussen-Boekhorst H, Eikenboom J, Geng V, Holroyd S, Lester M, Pearce I, Vandewinkel C. Catheterisation. Urethral intermittent in adults: dilatation, urethral intermittent in adults. Arnhem (The Netherlands): European Association of Urology Nurses (EAUN); 2013 Mar. 96 p.
067	Coloplast	Additional developmental areas of emergent	Phthalates are commonly used in medical devices as softeners in	Because phthalates pose a risk to human health.	Please see details of a scientific report

		practice: Monitoring and decreasing phthalates in medical devices	PVC plastics in amounts of 20-30% weight. There are concerns, however, that phthalates may in some cases pose adverse risks to human health and the environment, both individually and through cumulative exposure from their presence in multiple everyday use products. Because of these risks to human health the use of phthalates should be limited in urinary incontinence products, including intermittent catheters and urinary drainage bags. This especially applies to products designed for people who are particularly sensitive to their effects; e.g. children and pregnant or breast-feeding women.		documenting exposure to toxic phthalates from medical devices in the form of blood bags. Raul Carlson, eco2win AB; Life Cycle Assessment, LCA, of PVC Blood Bag; 2012-13 2012-03.
068	Allergan Ltd	Key area for quality improvement 1 Diagnosis of OAB patients and a clear clinical pathway	The effect of urinary incontinence on health-related quality of life is severe and comparable to other chronic diseases (see Shultz & Kopec 2003), however, the condition is under-diagnosed and under-treated despite the high prevalence.	There is an opportunity with the quality standard to address identification and diagnosis of people with urinary incontinence. The quality standard should build on the CG171 clinical guideline to establish a clear clinical pathway that takes the patient from identification to correct diagnosis, to "conservative" treatment in primary care to referral and the option of more invasive treatments for patients who are	Please see the All Party Parliamentary Group For Continence Care Report; "Cost-effective Commissioning For Continence Care": http://www.appgcontinence.org.uk/pdfs/CommissioningGuideWEB.pdf

				inadequately managed on first line oral therapies. However, the real focus needs to be on establishing services and metrics for the implementation of such a pathway. This may include: providing good quality patient education and support to ensure their awareness of treatment options. Education of GPs should also be part of this.	and Schultz SE and Kopec JA. Health Reports 2003;14(4):Catalogue 82-003
069	Allergan Ltd	Key area for quality improvement 2	Current evidence suggests that of the patients who are diagnosed, many are inadequately treated and lost to a never ending cycle of ineffective treatment. Clear referral routes should be in place between primary and secondary care for patients who are struggling to gain control of their symptoms.	Emerging evidence suggests that patients who have received several antimuscarinics place a greater burden on healthcare systems than those who received only one anticholinergic therapy. Multi-disciplinary teams should foster good communications with referring partners so that patients who are referred are at the appropriate stage for secondary care treatment. Cost savings that can result from effective urinary incontinence management, as well as benefit patients and outcomes. This is a point that needs a much higher priority, especially with commissioners.	Please see the All Party Parliamentary Group For Continence Care Report; "Cost-effective Commissioning For Continence Care": http://www.appgcontinence.org.uk/pdfs/CommissioningGuideWEB.pdf The survey report acknowledges the benefits of better continence care including reducing admissions to permanent care settings (nursing homes, secondary care, homes for disabled children and adults), costly emergency admissions to secondary care with urinary tract infections and pressure ulcers. Please see http://www.appgcontinenc

					e.org.uk/pdfs/Continence%20Care%20Services%20England%20Report%202013.pdf See also HES data on: Burden on secondary care of overactive bladder patients who are inadequately managed with anticholinergics in England (Hamid R et al 2014)
070	Allergan Ltd	Key area for quality improvement 3 Integrated care	Part of our experience is that urinary incontinence only has a low priority among commissioners. Stressing the need for commissioners to commission for integrated urinary incontinence care is the right way into it.	Integrated care is critical to the effective treatment of urinary incontinence. For this purpose part of it could and should be addressed with commissioners rather than clinical practitioners. NICE quality standards tend to address clinical practice only, but, in fact, if the overall aim is to improve patient care and outcomes, then commissioning is just as important to achieve this. Care should be encouraged to be administered close to home for patients and treatments that can be administered in the outpatient setting should be e.g. BOTOX® treatments.	Please see: The All Party Parliamentary Group For Continence Care Report; "Cost-effective Commissioning For Continence Care": http://www.appgcontinence.org.uk/pdfs/CommissioningGuideWEB.pdf
071	Pfizer	Reduced pad (Absorbent products) usage where alternative management strategies are available	"CG171 (1) recommends that absorbent products, hand held urinals and toileting aids should not be considered as a treatment for UI. Use them only as: • a coping strategy pending	"The Continence Care Survey (3) has reported that • The majority of respondents report that the level of pad supply is determined by local policy	"CG171 The management of urinary incontinence in women. http://www.nice.org.uk/nicemedia/live/14271/65143/65143.pdf Accessed

			definitive treatment • an adjunct to ongoing therapy • long-term management of UI only after treatment options have been explored. Providing continence products (e.g. alternatives to absorbent pads) will preserve the dignity of women and better enable a normal lifestyle (2) "	• Products are supplied to a level determined by budget rather than based on clinical need • Overall NHS costs have increased from £77m in 2006/7 to £121m in 2010/11. Given the expected increase in UI due to an aging population, and required cost savings in the NHS, pad usage and cost needs to be appropriately managed in line with patient's clinical need "	23.04.2014 (2) Cost-effective Commissioning For Continence Care . All Party Parliamentary Group For Continence Care Report. http://www.appgcontinence.org.uk/pdfs/CommissioningGuideWEB.pdf Accessed 23.04.2014 (3) Continence Care Services England, survey report, September 2013 http://www.appgcontinence.org.uk/pdfs/CommissioningGuideWEB.pdf Accessed 23.04.2014 Accessed 24.04.2014
072	Pfizer	Improve the proportion of patient who are reviewed in line with CG171	"Persistence with long-term medication in chronic diseases is typically low and that for overactive bladder medication is lower than average. Sub-optimal persistence is a major challenge	"Wagg et al report that at 3 months, the proportions of OAB patients still on their original treatment were solifenacin 58%, darifenacin 52%, tolterodine ER 47%, propiverine 47%, tolterodine IR 46%, oxybutynin ER 44%, trospium 42%,	"(1) Wagg et al 2012 B J U international 110 1 7 6 7 – 1 7 7 4 (2) The British Journal of Clinical Pharmacy. October 2009 Vol. 1.

			for the successful management of overactive bladder (1) Regular medication review is important for improving non-adherence, particularly for patients with long-term conditions and associated polypharmacy (2) "	oxybutynin IR 40%, flavoxate 28%. At 12 months, the proportions of patients still on their original treatment were: solifenacin 35%, tolterodine ER 28%, propiverine 27%, oxybutynin ER 26%,trospium 26%, tolterodine IR 24%, oxybutynin IR 22%, darifenacin 17%,flavoxate 14%. "	http://www.clinicalpharmacy.org.uk/volume1_2/October/guidance.pdf accessed 23.04.2014 "
073	Pfizer	Improved availability and access to continence services	"The Cost-effective Commissioning For Continence Care report (1) states that Commissioning integrated continence services is a dynamic way forward to achieve quality improvement while reducing wasteful and inefficient use of NHS resources. Benefits of an integrated continence service include • Early identification and treatment of symptoms • Improved access to specialist assessment, investigation and treatment • Agreed referral pathways to specialists • Reduced hospital admissions and re-admissions • Reduced risk of avoidable pressure ulcers • Reduction in falls	"Whilst the majority of sites have access to continence services, truly integrated services are few (2) The Continence Care Survey reported "a deterioration in the level of provision of continence services since 2007. There is a danger that some of these services will become simply a 'pad service' and the skills to deliver complex treatment and management options will be lost. If these trends continue with an ageing population, more older people will present for assessment to fewer, less experienced continence specialists with fewer resources" (3) The national audit of continence care for older people reported that while incontinence is a common problem for older people just over half of hospital sites and care homes, and only a third of mental health sites, offer structured training in	"(1) Cost-effective Commissioning For Continence Care . All Party Parliamentary Group For Continence Care Report. http://www.appgcontinence.org.uk/pdfs/CommissioningGuideWEB.pdf Accessed 23.04.2014 (2) The national audit of continence care for older people (2006) http://www.rcplondon.ac.uk/sites/default/files/2006-naccop-generic-report.pdf Accessed 23.04.2014 (3) Continence Care Services England, survey

			• Reduced rates of catheter associated infections • Reduced rates of urinary tract infection • Cost-savings associated with therapeutic interventions rather than containment • An improved quality of life, social function and dignity for the patient • Protection of those most vulnerable in society • Cost-effective provision of optimal product for management / containment where required "	continence care. They also note that documentation of continence assessment and management for older people is wholly inadequate. The report states that all staff should be trained in basic assessment and management of this troublesome condition. Training should be accessible to all and should be made a mandatory component of basic training for staff (2). "	report, September 2013 http://www.appgcontinence.org.uk/pdfs/CommissioningGuideWEB.pdf Accessed 23.04.2014 Accessed 24.04.2014