



# About the Unplanned Admissions Consensus Committee

The Unplanned Admissions Consensus Committee is a collaborative body set up to assess how continence care can be more efficient and how patients can receive better treatment and improved outcomes.

In summer 2015 the Committee, a group of continence leads and healthcare professionals, first came together at a roundtable in the Houses of Parliament to discuss issues around continence care and share best practice. The Committee felt that more could be done to promote best practice across the country and, hopefully, reduce unwarranted variation in service provision. The Committee then sent a country-wide 'call for evidence' to continence leads asking for input. Following this information scoping

exercise, a Best Practice Guide on reducing unplanned admissions as a result of urinary incontinence was produced in 2015. This updated Guide, which includes a number of updated case studies from services demonstrating best practice, was launched in November 2016.

Since the initial launch in 2015, the Committee has been working to promote the recommendations within the Guide and has been pleased with the positive response and uptake the Guide's recommendations have received.

Further information on the Unplanned Admissions Consensus Committee and its work can be found at: www.unplannedadmissionscommittee.com

# Acknowledgements

# With special thanks to:

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# **FOREWORD**

The health service is reaching a tipping point in its ability to provide quality patient care, with demand for services continuing to spiral. As more and more patients visit accident and emergency (A&E) units, the ability of the NHS to manage 'demand' stretches even further.

With increased A&E attendances, emergency admissions and delayed discharges back into the community, the ability of Trusts to meet performance and financial targets becomes an even greater challenge. i-i Preventable emergency admissions have risen by 40% in the last decade. In 2014/15 there were 22.4 million attendances at England's A&E departments, an increase of 2.7% compared with 2013/14 - the largest increase in four years. Of this, 550 more people were admitted to hospital via A&E every day in 2014 than in 2013.i+i Furthermore, in 2012-13 alone there were 5.3 million emergency admissions to hospitals, representing around 67% of hospital bed days in England and costing the NHS approximately £12.5 billion." This figure has increased.

Reducing these avoidable admissions to hospital has been a long-term ambition for politicians and senior NHS officials but significant progress has yet to be realised. The NHS will not be able to cope with a continuing increase in demand unless it is successful in treating more people in the community.

One area where admissions have increased is around urinary tract infections (UTIs) and blocked urinary catheters. UTIs are the second-largest single group of healthcare-associated infections in the UK, accounting for 19.7% of all hospital acquired infections. The NHS spent £434 million in 2013/14 on treating 184,000 patients in unplanned admissions associated with a UTI and 39% of patients with blocked catheters ended up being admitted to hospital. These conditions cause pain, avoidable prolonged stay in hospital and, in some cases, even death. As well as a cost issue, this is also a quality of life issue for so many patients and their families.

I have been proud to serve as the Chair of the Unplanned Admissions Consensus Committee over the last year. In this time, I have worked with the Committee to develop and promote this Best Practice Guide, which aims to provide practical steps that can be taken to improve continence services across the country.

The vision of the Committee is clear; to be part of the solution in ensuring that the NHS can not only cope with rising demand as a result of unplanned admissions, but also to help reverse this trend.

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i-i The State of health care and adult social care in England 2015/16, Care Quality Commission, October 2016

i http://bmjopen.bmj.com/content/3/1/e002007.long

i+i House of Commons Library, Briefing Paper Number 6964, 17th July 2015. Accident and Emergency Statistics. Found online at: https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=7&cad=rja&uact=8&ved=0ahUKEwj9mcfyxObPAhVnCcAKHbLMDE0QFghRMA Y&url=http%3A%2F%2Fresearchbriefings.files.parliament.uk%2Fdocuments%2FSN06964%2FSN06964.pdf&usg=AFQjCNHl76ZzwqRu6eFO\_hoGa3M

ii Emergency admissions to hospital: managing the demand, National Audit Office, October 2013: http://www.nao.org.uk/wp-content/uploads/2013/10/10288-001-Emergency-admissions.pdf

iii Department of Health. Saving lives high impact intervention No 6. Urinary catheter care bundle. 2007. Available at: http://tinyurl.com/37qgzbp

iv Admissions of failure: The truth about unplanned NHS admissions in England, The Medical Technology Group, November 2015.



We feel passionately about promoting best practice as a method of reducing regional variation in patient experience and patient outcomes.

This Guide aims to provide a constructive platform for decision makers across government, the NHS and political parties to ensure these goals become a reality. I hope that this updated Guide will continue to inspire service leads to implement best practice and would like to thank all those who have contributed to the development and promotion of this Guide.



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Continence Service Manager at Wokingham Community Hospital Chair of the Unplanned Admissions Consensus Committee



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# SUMMARY OF BEST PRACTICE RECOMMENDATIONS

GPs should be comfortable at asking questions to patients presenting with 1 symptoms of incontinence. The Quality Outcomes Framework (QOF) should include a financial 2 incentive to diagnose incontinence issues in patients and instigate a patient management plan. A national awareness campaign on incontinence should be initiated overall 3 and there needs to be better signposting of information for patients. Bladder ultrasound scanning can be used to help a healthcare professional 4 make an informed decision about the clinical management of patients presenting with urinary bladder complications. Intermittent catheterisation (IC) should be the method of choice to drain 5 retained urine wherever feasible. 6 Hospital Trusts should invest in appropriate staff training in catheterisation. **Every Trust should have one named person responsible for continence.** 7 This continence lead should be responsible for education and training. All Trusts should promote the use of catheter passports. A template 8 passport should be developed and used by all Trusts. GPs should receive training on the different continence products 9 available and/or refer to community continence teams where the specialist knowledge is based. Patient management systems should be used to improve prescribing, 10 patient care and quality of life whilst reducing cost. NHS England should prioritise the development of commissioning guidance on bladder (and bowel) incontinence to improve the quality 11 of local commissioning. There needs to be a focus on avoiding unnecessary hospitalisation and recommending a named continence commissioner/prescribing lead in each CCG.

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# 1. UNDERSTANDING THE PROBLEM: INCONTINENCE AND UNPLANNED ADMISSIONS

- 1.1 Incontinence can affect anyone - of any age. It is a common and distressing problem, which can have a serious impact on the quality of life for patients, their families The Bladder and Bowel and carers. Foundation estimates that there are approximately 9 million people (other studies suggest between 3 and 6 million) in the UK experiencing some form of incontinence.v Stress incontinence, or leakage of urine from the bladder on exertion, for example when coughing or sneezing, is the most common form with nearly one third of women thought to suffer the condition with varying degrees.
- 1.2 Incontinence is a taboo area and embarrassment prevents many patients accessing NHS services that could help. Too many patients remain undiagnosed, and many healthcare professionals believe that GPs need greater awareness of how common the condition is and what might be done to help patients talk to a healthcare professional about the condition.
- 1.3 Incontinence is associated with a number of comorbidities such as arthritis, asthma,

- chronic anxiety, depression, diabetes, heart disease, neurological conditions, sleep disorders and dementia.<sup>vi</sup>
- Incontinence is a significant factor in 1.4 admissions to hospitals and care homes. Data from NHS England (2012-2013) shows that UTI was one of the most frequent reasons for emergency hospital admissions, with on average 67 admissions per 100,000 population, per quarter.vii Moreover, around 43-56% of all UTIs are associated with the use of a urinary catheterviii and 15-25% of hospital inpatientsix and 10% of residents in care homes are using a long-term catheterx. This increases considerably the likelihood of the patient developing a catheter associated urinary tract infection (CAUTI). Furthermore urine contamination (bacteriuria) occurs at the rate of 3 to 10% per day with 100% of patients developing asymptomatic bacterial contamination after 30 days of catheterisation.xi 24% of patients affected by asymptomatic bacteriuria will go onto symptoms of a CAUTI.xii In extreme cases these CAUTIs

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v Available at: https://www.bladderandbowelfoundation.org/bladder/bladder-conditions-and-symptoms/stress-urinary-incontinence/

vi Coyne KS et al, 'Risk factors and comorbid conditions associated with lower urinary tract symptoms: EpiLUTS', BJU International, 2009, 103(Suppl 3):24-32. Available online via: http://www.ncbi.nlm.nih.gov/pubmed/19302499

vii NHS England. Emergency admissions for ambulatory care sensitive conditions — characteristics and trends at national level. March 2014. Available at: http://www.england.nhs.uk/wp-content/uploads/2014/03/red-acsc-em-admissions-2.pdf

viii Available at: content/uploads/2015/04/10-amr-lon-reducing-hcai.pdf

ix Available here: http://www.cdc.gov/HAI/ca\_uti/uti.html

x Available here: http://www.pharmaceutical-journal.com/publications/20068794.cpdarticle

xi Guideline for prevention of catheter-associated Urinary Tract Infections 2009, Healthcare Infection Control Practices Advisory Committee, 2009

xii Loveday HP, Wilson JA, Pratt RJ et al. Epic 3: National evidence based guidelines for preventing healthcare associated infections in NHS hospitals in England. Journal of Hospital Infection 2014;86(1):S1–70.



- can lead to life threatening conditions and even death.
- 1.5 Catheterisation is a procedure leading to the insertion of a hollow tube into the bladder to help people who cannot control or have difficulties emptying their bladder, get on with their lives.
- 1.6 Another common complication of long-term catheter use is encrustation by mineral salts, leading to catheter blockage. bacteria contaminating the bladder and catheter surface cause the urine to become alkaline. Crystals form on the catheter surface and obstruct the flow of urine. The bladder keeps filling with urine and steadily swells. It can become over-distended and sometimes painful. In some cases urine will start leaking out from the bladder to the outside through the "natural" tube (urethra). Other times the urine cannot bypass the catheter blockage causing significant pain. Sometimes it can lead to serious kidney and bloodstream infections, pyelonephritis and sepsis. About half of all long-term catheter users experience catheter encrustation and a blockage at some point.xiii Having a blockage can be frightening and, according to healthcare professionals, many patients said that the first one they had was particularly so because they did not know what was wrong.
- 1.7 The Medical Technology Group (MTG) has found that the NHS spent in 2013/14 £434 million on treating 184,000 emergency admissions caused by a urinary tract

- infection. This is a per patient cost of £2,361. The same research also showed that Clinical Commissioning Groups (CCGs) spends an average of £84,609 per year on patients who have been admitted to hospital for a blocked catheter.\* This equates to 39% of all cases being treated in a hospital setting unnecessarily **costing the NHS over £17 million a year** (this is if they do not subsequently present with a CAUTI). This is a procedure that should be performed safely, cheaply, and routinely in the community with no unnecessary cost to the acute sector.\*
- 1.8 These emergency admission costs do not take into account costs associated with continence services in the community funded by CCGs. This involves prescribing costs and the use of products such as catheters and pads. NHS funding and resourcing for continence nurses and healthcare professionals is variable, as is training and practice. There are interventions in primary care and community care that could prevent costly emergency admissions to hospital and save money in primary care.
- 1.9 The reasons why so many unnecessary admissions from continence-related issues are occurring resulting in poor experiences and outcomes for patients as well as unnecessary costs and uses of NHS resources are complex. This includes a lack of awareness of continence issues among GPs, healthcare professionals and patients themselves.

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xiii Kohler-Ockmore and Feneley, 1996; Getliffe, 1994

xiv Admissions of failure: The truth about unplanned NHS admissions in England, The Medical Technology Group, November 2015, pg 4

xv Admissions of failure: The truth about unplanned NHS admissions in England, The Medical Technology Group, November 2015, pg 4

xvi Admissions of failure: The truth about unplanned NHS admissions in England, The Medical Technology Group, November 2015



# 2. AWARENESS OF CONTINENCE ISSUES AND DIAGNOSIS

A number of factors impact on the overall levels of awareness of continence issues and diagnosis, including patient experience and embarrassment, GP awareness levels and the lack of related public health campaigns.

# **Patient Experience**

"Living with a urinary continence problem involves a seemingly endless search for answers. Parts of life may be lost as adjustments are made in response to symptoms. It takes time, thought, and courage to keep sorting out and searching for ways to best manage the condition."

- Bladder and Bowel Foundation
- 2.1 One of the inhibitors to dealing with urinary incontinence is the reluctance to admit to having continence problems. Misunderstanding of symptoms, embarrassment and shame due to a perceived loss of control or dignity, means that many people delay seeking help for manageable conditions, or assume that

support is not available. Having said that, from 2006-2007 data revealed that approximately 1.3 million people sought help for continence problems. Data from 2010-2011 show this has escalated to 2.3 million people<sup>xvii</sup>, suggesting that this historic reluctance may be changing, or this data is the result of an ageing population.<sup>xviii</sup>

- 2.2 The Bladder and Bowel Foundation together with the Cystic and Overactive Bladder Foundation produced a report in July 2015, based on a qualitative workshop, where patients with bladder problems reported that they:
  - Did not feel listened to or taken seriously when they first sought help from their doctor
  - Were not treated with dignity or respect
  - Lacked confidence that clinicians understood their symptoms or knew how to treat their condition
  - Were not offered adequate information about their condition or their treatment options
  - Did not feel involved in decisions about their treatment and care
  - Did not have access to high quality interventions that are recommended by the National Institute for Health and Care Excellence (NICE)

xvii Eustice S et al (2013) Reversing deterioration in continence services. Nursing Times; 109: 27, 18-19
xviii National Schedule of Reference Costs 2010/11: NHS Trusts and PCTs Combined Community and Outreach Nursing Services: Specialist Nursing,
November 2011

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"Bladder and bowel problems lack the same 'status' as more recognised chronic conditions, even though the effect of moderate continence problems on quality of life is similar to that of conditions such as diabetes, high blood pressure or cancer."

- The Bladder and Bowel Foundation and Cystic and Overactive Bladder Foundation report - July 15
- 2.3 Of the 33 cases where oral evidence was heard, 22 raised significant concerns relating to continence, bladder and bowel care.

# **GP Awareness**

- 2.4 Many of the respondents to the call for evidence stated that GPs have a crucial role in helping patients feel comfortable talking about continence issues. GPs should not be worried about asking questions of their patients should they fit a certain patient profile. A poor understanding of continence issues within general practice can leave patients in the community feeling isolated and unsure of who to turn to for advice. There may be a perception that this issue is purely a nursing issue, rather than an issue for doctors also.
- 2.5 The Quality and Outcomes Framework (QOF) is a voluntary process for all GP surgeries in England and is an annual reward and incentive programme detailing GP practice achievement results.xix A QOF entry for continence would mean there would be a financial incentive to diagnose

incontinence issues in patients and instigate a patient management plan. Dealing with incontinence costs the NHS at least £80 million per year so addressing this issue will be hugely beneficial for the overall NHS budget.\*\*

# **Public Health Campaigns**

- 2.6 The All Party Parliamentary Group on Continence has done an excellent job in moving continence up the agenda within Westminster and NHS England. The Bladder and Bowel Foundation has reached patients and healthcare professionals through publicity campaigns in public toilets, through the media, and by providing fact sheets for hospitals and GP surgeries. Wider publicity campaigns have proven to be very effective in educating the public, as highlighted by the acclaimed F.A.S.T campaign on stroke.
- 2.7 Keeping adequately hydrated by drinking plenty of water is thought to help maintain bladder health. It is also not uncommon for UTIs to affect the elderly, as many are put off drinking water to avoid frequent toilet visits. Some of the contributors spoke about the challenges of combating CAUTIs in care and residential homes. One of the Consensus Committee spoke about the success of hydration packs issued to residential homes and how they hoped that these packs would reduce the number of patients presenting with CAUTIs whilst also reducing the incidence of other conditions such as constipation.
- 2.8 There have been national campaigns relating to MRSA and clostridium difficile. Public Health England are now looking at

xix Available at http://www.hscic.gov.uk/qof

xx Available at: https://www.supplychain.nhs.uk/news/press-releases/2010/improving-supply-of-continence-products/

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the benefits of a new public awareness campaign on the signs and symptoms of sepsis, aimed at those most at risk. These life threatening infections can often be caused by CAUTIs. In terms of prevalence and cost, the problems of CAUTIs are much bigger. The Department of Health should ask Public Health England to look into the benefits of a national awareness campaign on the importance of hydration and encouraging patients to seek help from their GP and other healthcare professionals in order to prevent UTIs and related conditions.

2.9 Bladder ultrasound scanning can be used to help a healthcare professional make an informed decision about the clinical management of patients presenting with urinary bladder complications. It can be used to measure pre and post-void residual urine, thus determining bladder volume and potential incomplete bladder emptying; this helps in the prevention of incontinence issues.<sup>xxi</sup> It can also help clinicians with planning trials without a catheter (TWOCs).

# **RECOMMENDATIONS:**

- ► GPs should be comfortable asking questions to patients presenting with symptoms of incontinence.
- ► The Quality Outcomes Framework (QOF) should include a financial incentive to diagnose incontinence issues in patients and instigate a patient management plan.
- ► A national awareness campaign on incontinence should be initiated overall and there needs to be better signposting of information for patients.
- ▶ Bladder ultrasound scanning can be used to help a healthcare professional make an informed decision about removing a catheter and the clinical management of patients presenting with urinary bladder complications.

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# 3. TRAINING, SELF-MANAGEMENT AND NHS TRUSTS

- 3.1 Incontinence can be treated or managed through a number of ways which include lifestyle changes, exercises and pharmacological management. However, most of the issues that relate to unplanned hospital admissions include the use of products such as a catheter, a thin tube that is inserted into your bladder to drain urine.
- 3.2 There are two main types of catheterisation; indwelling and intermittent. An indwelling urinary catheter is a hollow tube that is inserted and anchored to the bladder and left in place for periods of time of between a few days to several weeks or months. Intermittent urinary catheters are semi-rigid tubes that are inserted between once to 8 times a day to drain the bladder, and removed immediately after the bladder has been emptied. Patients can be taught how to insert the catheter themselves; this is known as clean intermittent selfcatheterisation (CISC). Sometimes a carer or relative helps with inserting the catheter and this is called intermittent catheterisation.
- 3.3 While an indwelling catheter avoids the inconvenience of removing and inserting catheters throughout the day, their use does mean a higher risk of UTIs, blockages and leaks than intermittent catheters.xxiii Encrustation of the catheter is a common

- occurrence causing recurrent blockage in 40-50% of long-term catheterised patients.\*\*\* It is estimated that 4% of community patients have an indwelling catheter fitted.\*\*\*
- 3.4 In the past, district and specialist nurses were trained to care for catheterised patients after a problem had presented itself - rather than to prevent the problem actually occurring in the first place. If the blockage happened at night, the patient's only option was to be treated at the local A&E Over the last ten years, department. emphasis has focused on pro-activity and recognising potential problems. Planned catheter changes or use of catheter maintenance solutions based on individual patient patterns and the use of intermittent catheters is now the normal standard that nurses should adhere to. ISC has become more common and should be the method of choice for draining retained urine.

# Training Patients - clean intermittent selfcatheterisation (CISC)

3.5 It is estimated that 25% of hospital patients have an indwelling urinary catheter fitted, of which 5% develop a urinary tract infection (UTI).xxv

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- 3.6 The consensus committee heard that, from a hospital Trust perspective, there is a lack of awareness of the benefits of intermittent catheterisation and the importance of training patients how to self-catheterise. This is crucial as many first catheterisations take place in a hospital setting either in A&E or on the ward.
- 3.7 The number of continence healthcare professionals working within NHS Trusts varies across the country and this will have a direct impact on the number of nurses trained in teaching patients how to self-catheterise. As patients leave hospital still needing to be catheterised, ensuring that they are fitted with the most appropriate product and are in a position to self-manage their condition is one of the biggest factors in avoiding readmission and costly visits to A&E with blocked catheters and CAUTIs.
- 3.8 A Freedom of Information (FOI) request was sent to every NHS Trust in the country asking how many specialist urology nurses/continence nurses are employed within each Trust. The 109 responses revealed that in 2010/11 there was an average of 3.59 specialist urology nurses/continence nurses per NHS Trust. Despite the Francis Report and calls for greater investment in continence services in recent years, by 2014/15 this had only increased to 3.84 nurses per Trust.
- 3.9 The same FOI revealed that out of the 109 Trusts surveyed, 57 had a named continence lead just 52% of Trusts. The consensus committee felt that having one named person in each Trust responsible for continence would ensure that a lead individual would be present to implement effective training and good practice for this important area.
- 3.10 The call for evidence demonstrated that

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many continence advisors felt that to see a significant reduction in unplanned hospital admissions associated with blocked catheters, all health and social care workers involved in the direct care of such patients should have knowledge of how catheters work, what causes blockages and simple things they may be able to do to allow the catheter to drain again. The FOI revealed that each Trust spent an average of 535 hours of staff time on catheter and continence training in the last financial year.

# **Catheter Passports**

3.11 The consensus committee and many of the responses from the call for evidence stated that it is essential that patient care is planned on an individual basis to obtain an accurate catheter history and in order to develop a device plan for the patient.

"All patients discharged from hospital with a catheter should be given information packs on how to care for their catheter, with useful contact numbers of healthcare professionals in the community so they know who to turn to if they have a problem."

- Call for evidence - Newham CCG

3.12 Many NHS Hospital Trusts across the country have issued a 'passport' to all patients with a long term urinary catheter. Patients and their carers are thus encouraged to use the passport as an information source on where to go for help and what to do should there be issues with the catheter. The easy-to-use initiative involves the patient with their care from start

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to finish and encourages noting any issues that need to be addressed. Healthcare professionals should add to the passport detailing any ongoing health issues as well as current or previous infections, thus ensuring total transparency and consistency of care.

- 3.13 The passport is modelled on other types of patients who take ownership of their condition and much like pregnant women (who are encouraged to keep a record of their pregnancy with them) the passport is kept with patients at all times. The urinary catheter passport has been so successful in improving patient and staff awareness in many Trusts, that it should be an initiative rolled out across all other NHS Trusts across the country.
- 3.14 There is no one set catheter passport in use throughout the UK. It is crucial that they are easy to fill out and maintain, and allow easy

- access to important information about a patient's condition and how they are managing it. There needs to be a model for Trusts to use when developing a catheter passport to ensure they record the appropriate information.
- 3.15 The FOI, sent to all NHS Trusts, generated 116 responses. Of this, 41 Trusts responded by saying that they used catheter passports. 75 stated that they do not use catheter passports. The importance of having the right information contained within the catheter passport is revealed by the fact that just 7 of the Trusts that use catheter passports include a urine colour chart, which is designed to demonstrate the importance of hydration. Having a standard template for this would ensure that Trusts do not miss capturing important information.

# CASE STUDY: Health Innovation Network (HIN) in South London: No Catheter NO CAUTI

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- No Catheter No CAUTI is an exciting programme which seeks to reduce the number of catheter related infections, acquired in both hospitals and community healthcare settings, across South London.
- Patients who do not have a catheter in place by very definition cannot acquire a catheter associated urinary tract infection (CAUTI). No Catheter No CAUTI promotes alternatives to catheterisation (such as self-catheterisation), empowers nurses to remove catheters, and encourages rapid review when infection does occur.
- Ambitious in its reach, this project has been rolled out across; Guy's and St Thomas'

- Hospitals NHS Foundation Trust, King's College Hospitals NHS Foundation Trust, Kingston Hospital NHS Trust, Croydon Health Service NHS Trust, and St George's University Hospitals NHS Foundation Trust, together with Lambeth and Southwark community services.
- Around 113,000 inpatients are catheterised every year, with 8,600 urinary tract infections (UTIs) recorded annually across the acute trusts above. The number of catheters in the community and subsequent related infections are much harder to identify.
- In addition to the primary aim of improving patient outcomes, No Catheter No CAUTI

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seeks to reduce the financial burden of related infections. Unplanned admissions and additional bed days resulting from UTIs have an annual cost of £14.6m million to the acute Trusts in South London. If CAUTIs were reduced by 50% that would represent a £7 million saving.

- The programme seeks to spark a social movement around catheter care, for which engagement from a wide range of stakeholders has been crucial.
- No Catheter No CAUTI seeks to educate both patients and staff on catheter care management and infection avoidance. Central to achieving this aim has been involving patients, carers and service users in the co-design of information materials, which the project team has done in conjunction with Age UK. The resulting patient information

- materials produced addresses common concerns, challenge misconceptions, and seek to reduce stigma around the topic of catheterisation.
- The project team has worked closely with a range of clinical staff to imbed the intervention in every day practice. Each acute trust was also asked to identify an executive sponsor who could report progress at board level.
- No Catheter No CAUTI is a two year project led by the Health Innovation Network's Patient Safety Collaborative (PSC). This is one of a number of programmes that the PSC are promoting to increase patient safety across the locality. The Health Innovation Network is the Academic Health Science Network for South London.

### **RECOMMENDATIONS:**

- Intermittent catheterisation (IC) should be the method of choice to drain retained urine wherever appropriate.
- ► Hospital Trusts should invest in appropriate staff training on catheterisation.
- ► Every Trust should have one named person responsible for continence.

  This continence lead should be responsible for education and training.
- ► All Trusts should promote the use of catheter passports. A template passport should be developed and used by all Trusts.



# 4. SAVINGS AND BETTER PATIENT OUTCOMES IN PRESCRIBING, PRIMARY AND COMMUNITY CARE

# **Prescribing Costs**

4.1 The annual spend on continence devices prescribed in the community in 2014 is estimated to be around £155,000,000 (England data only).xxvi This does not include the costs then associated with unplanned hospital admission for a blocked catheter or the development of a CAUTI. A considerable amount of this spend is in primary care and in the community.

"Some GPs openly acknowledged that their knowledge of the range of products was limited and that often the decision to prescribe aids was not clinically led."

- Call for evidence Berkshire Healthcare Foundation Trust
- 4.2 In community settings, catheters are prescribed by GPs. Many of the members of the consensus committee, and representations made within the call for evidence, highlighted that, in their experience, patients were not always able to access advice and support regarding continence aids and appliances, and that there was a great deal of unnecessary

- expense. One of the issues related to the lack of GP awareness of continence issues is the lack of knowledge of the differences between products.
- 4.3 GP judgement should be based entirely on clinical need in order to reduce risk to the patient. Moreover, it is thought that routinely prescribing the same products without analysis of individual clinical needs results in waste and unnecessary additional costs including the risk of costly unplanned admissions and complications. The cost of unplanned hospital admissions should be assessed alongside prescribing costs to demonstrate the value of changes in practice in one part of the system.
- 4.4 A system of centralising management of patients within the community who require prescription continence care products under the Drug Tariff can be beneficial. Patient management systems are computer-based software packages that provide centralised patient management for continence and stoma services in order to deliver the best patient care, whilst closely controlling budget. These systems can be used within the community to monitor and manage prescriptions for continence and stoma products. The system acts as a database and helps healthcare professionals review and optimise continence and stoma product



usage within the community. This was considered an effective way of delivering the improved outcomes and savings as it instigated a system of improved prescribing.

4.6 The call for evidence revealed that in some parts of the country a nurse led service has been established for the prescribing of continence appliances in parallel with investment and funding for community based continence nurses.

# **Continence Nurses and Advisors**

4.5 Much like with NHS Trusts, if continence services are to be given the priority that is required by CCGs, it is important that CCGs have in place the appropriate number of nurses trained in catheterisation and a named continence lead. NHS England should prioritise the development of commissioning guidance on bladder (and bowel) incontinence to improve the quality of local commissioning with a focus on avoiding unnecessary hospitalisation and recommending a named continence commissioner/prescribing lead in each CCG.

"Once the continence caseload was brought together and managed by healthcare professionals that understood the caseload and the products patients were using, improvements in patient care were quickly realised."

- Stockport NHS Foundation Trust

# RECOMMENDATIONS:

- ► GPs should receive training on the different continence products available and/or refer to community continence teams where the specialist knowledge is based.
- Patient management systems should be used to improve prescribing, patient care and quality of life whilst reducing cost.
- NHS England should prioritise the development of commissioning guidance on bladder (and bowel) incontinence to improve the quality of local commissioning. There needs to be a focus on avoiding unnecessary hospitalisation and recommending a named continence commissioner/prescribing lead in each CCG.



# CASE STUDY: Better healthcare together – CSH Surrey

# **Problem**

In March 2015 the Community Assessment Unit within CSH Surrey was closed, which led to patients being transferred to the care of the continence service. Non housebound patients had no documentation or record of their catheter care.

### **Aim**

The aim of the programme was to bridge the gap of non-housebound patients that attend catheter clinics to have their own documentation and record of their catheter care. A service was to reduce the number of unplanned visits, and increase the number of planned visits.

# **Programme**

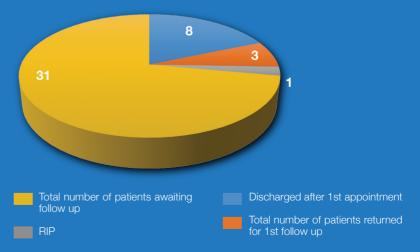
The continence service introduced catheter passports in March 2016. Each patient with an identified continence problem is issued with a passport.

Catheter passports were issued to each and every patient that attends a catheter clinic for catheter care. Patients are empowered to bring with them a record of care to each catheter clinic appointment, A&E attendance, hospital admission and to take on holiday.

# Results

- 70% of patients returned to first follow up appointment and brought the passport, however combined follow up appointments this improved to 74%.
- Patients are very enthusiastic about having their own record of care. They feel empowered and more in control of their own care, particularly those who go on holiday.
- Being able to record a patient's catheter history has allowed identification of potential problems and avoidance of unnecessary attendance to the emergency department.
- The passport supports continuity of care between community and hospital settings.
- The advice and support contained within the booklet has proved to be a useful guide for patients and practitioners, including GPs.
- The patient acts as a Patient Record and captures the relevant information needed for catheter change.
- Reducing attendances to the hospital Emergency Department.

# Patient outcome after initial contact & passport given





# CASE STUDY: Nottingham University Hospitals

### **Problem**

- Inconsistent practice in inserting urinary catheters across all staff.
- Inconsistent use of products when inserting urinary catheters.
- Initiative to decrease catheter associated urinary tract infections (CAUTIs).

Implementing an all-in-one catheterisation pack to standardise the products used across the trust and improve practice whilst driving down the rate of infection.

# **Programme**

- The continence team lead for the Trust undertook a 4 week fellowship in America to assess the impact of education on this topic and the introduction of a catheter insertion pack.
- The BARD® Tray was the chosen product to be used across the Trust. The tray had many benefits, primarily that the products required to catheterise a patient were all contained within it. This made the process timelier for staff and eliminated the issues of staff forgetting certain pieces of equipment.
- Having all the products in one tray together means that staff would not forget to take equipment with them therefore no longer having to break off from the procedure to collect those items. This decreases the risk of contamination, preventing CAUTIs, and also makes the process more dignified for the patient.
- The catheter and urine drainage bag are preconnected with a removable seal. Having this seal in place means that the drainage bag can stay in place for up to 14 days. This significantly reduces the risk of the catheter and drainage bag becoming accidentally disconnected, therefore reducing the risk of infection.

### Results and outcomes in 2016

After product recognition training and staff engagement of over 600 members of staff, the BARD® catheterisation tray has been fully adopted at Nottingham University Hospitals and is a good example of a positive change in culture and practice for staff. Clinical members of staff continue to speak highly of the tray and are reaping the benefits of having everything they need all in one tray together. In 2015 NUH benefited from a 45% reduction in Catheter **Associated Urinary Tract Infections** (CAUTIS) with the rate catheterisation remaining the same. If the CAUTI rates for 2016 continue to fall as they are, there will be an overall 70% reduction since the implementation of the tray.

The cost avoidance in treating CAUTIs in 2015 was approximately £95,000 and with the further estimated reductions in 2016 we have approximated a £130,000 overall cost saving. There is an added cost saving of approximately £40,000 on a like for like product basis. The overall estimated cost saving for **Nottingham University Hospitals by** the end of 2016 will be £170,000.

This project is a great example of how collaborative working with clinicians, procurement and industry can influence and change practice for the benefit of the patient.



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# CASE STUDY: NHS Rotherham

# **Problem**

- Costs were increasing faster than PCT (now overall CCG) prescribing inflation.
- The PCT (now CCG) had no idea about how many patients were using continence equipment or how many had a review during the last 12 months, and therefore could not assure compliance with Good Practice in Continence Services DH 2000 or NICE guidance (CG40).
- NHS Rotherham had no community continence service and no mechanism for funding this development.
- NHS Rotherham had intelligence on how patient's lives were affected by inadequate continence equipment/advice.

# Aim

The NHS Rotherham Medicine Management team identified 5 areas of prescribing where the GPs acknowledged that they made little intervention and only prescribed what was requested. The aim was to redesign the service by transferring the prescribing and budgetary management of these products to the health professional best equipped to manage the service.

# **Programme**

- The expenditure on continence equipment was transferred to the continence advisor and the continence service was set up with a PPD practice code.
- A band 6 community continence nurse and a band 3 project administrator were appointed.
- A technician from the Medicines Management Team visited all practices and collected the patient information from the GP systems. This was transferred to the new continence service. Two months later all prescription details for continence equipment were removed from GP systems.
- Patients now call the continence service to order their prescription. If the patient reports problems or the clinical template indicates problems they are referred to the continence nurse before the prescription is issued. Patients can also request a prescription by e-mail.
- Prescriptions are then forwarded to the patient, a community pharmacy nominated by the patient, or an appliance contractor nominated by the patient.
- All patients receive an annual review and a considerable amount of unmet need was initially discovered.

# **Results**

- In the four years since the project started continence prescribing costs in England increased by 25.95% whereas in Rotherham costs decreased by - 4.52%.
- Rotherham's expenditure in 2013/14 = £588,760.
- If Rotherham's costs had increased in line with national growth expenditure in 2013/14 would have been £829,715 resulting in a potential saving of £240,955 a cost reduction 29%.



# CASE STUDY: Berkshire Healthcare NHS Foundation Trust

# **Problem**

- Inappropriate issuing of supplies to patients on FP10 and therefore unnecessary expenditure and
- service coming into being.
- GP's openly acknowledged that their knowledge of the range of products was limited and that often the decision to prescribe aids were NOT clinically led.
- Patients were being admitted to hospital with UTIs linked to catheterisation or incomplete bladder emptying and these issues were not being identified and prevented.

### Aim

- Ensure long term catheters are managed outs, and therefore enhance the quality of patients' care by ensuring all care is
- for other healthcare professionals. The long term catheters, have greater access

# **Programme**

- service continence products.
- All patients who require continence aids on explained to the patient.
- administrator for the service, and if appropriate this will trigger a Specialist Continence Nurse



# Savings

- Within the first 6 months £70,953.06 was saved
- £106.11 in September 2014. In August 2016 the cost per patient order is even lower, at £101.58.
- This system identified 26 examples of patients risk of infection.
- products were uncovered, including a female
- 500 ISC catheters were returned; even if used 6 times per day this equates to a 3 month supply,

# **Improvements to Patient Care**

were 111 responses (50%)

- 96% rated the service as good /excellent
- 95% rated the clinical support they were given as good/ excellent

"As you can imagine we were very uneasy when we heard there was to be a new continence service and could imagine all sorts of problems. We have been very happy with the way your service works and have not had any problems at all! The people we speak to are polite and knowledgeable and delivery is accurate and prompt. We would like to pat you on the back for your wonderful work."

- Patient testimonial



# CASE STUDY: Royal Liverpool and Broadgreen University Hospitals

### **Problem**

Looking at historical data we were patients admitted with urinary University Hospital. In April 2013 it highlighted

- 703 patients admitted (213 with
- Of the 703 patients, 538 were Liverpool patients and 164 were from other PCTs.

# Aim

- Improve links between primary

# **Programme**

- It was established that district nursing teams were unhappy to change urinary catheters in the community without detailed
- Working with the Community Continence Teams and Infection Prevention and Control we have developed a catheter passport which is now being used across the Merseyside region.
- placement, catheter management, patient information on selfcare and useful contact details for support and advice. It also resistance profiles of concern.
- results are awaited.
- precautions may also need to be taken into account. The patient benefit.
- Quarterly meetings are established which include management of UTI's and reduction of unplanned admissions.
- A catheter care MDT meeting was created, including the Liverpool Community Continence Team, a Consultant Urologist

# **Results**

The latest results are currently being collated and will be published initiative has been a success.





# CASE STUDY: Betsi Cadwalder University Health Board

# Catheter Trays

# **Problem**

- The Cardiff and Vale University Health Board (C&V UHB) has responsibility approximate population 500,000; this includes nine (including University Hospitals) and a large number of District Nurses.
- Catheterisation within patients' homes comprised a distinct proportion of the normal duties of District Nurses.
- Within the C&V UHB the incidence equipment shortages leading to the inability to catheterise at the patients' home was estimated between one incident per week to one per month.

# **Aim**

With the aim of minimising clinical incidents and improving clinical practice, the C&V UHB carried out a trial of a Foley catheter tray to be carried by District Nurses as emergency boot stock.

# **Programme**

- This involved a collaborative approach to community catheter care led by the Director of Continence Services, the Head and Senior Nurse for District Nursing and the Urology Department.
- The group looked at what equipment was required to undertake catheterisation in line with all national guidelines and local policies and the BARD® met all specifications.
- A business plan was formulated to supply all District Nurses with a boot stock of this tray.
- Funding was agreed for 200 trays which were purchased of standard size 12Ch and 500mls medium tube drainage bag. A further 16 all silicone trays of the same specification were also purchased for patients with a latex allergy.
- All staff were trained on tray contents prior to distribution.

# Results

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- Reduction in catheterisation time of approx 10 15 mins per catheterisation, allowing professionals to be released for other aspects of care.
- Staff and patients found the trays very convenient, with all equipment in one place.
- It has a positive impact on the patient's perception of the nurse, with increased professionalism.
- Reduction in professional stress levels as equipment is all in one place so staff do not have to run about to look for items.
- Reduced clinical risk (as all equipment available) and embarrassment for patients as less time exposed.



# CASE STUDY: Betsi Cadwalder University Health Board Referral and Patient Management

# **Problem**

- Too many patients were presenting at Emergency Departments (ED) with urinary including blocked catheters. In 2015 there were 697 such cases across North Wales.
- Of these cases some patients were known to District Nurses but they still presented at ED during 'office hours' or patients were not known to District Nurses and therefore they would have no alternative but to present at ED.
- There are resource implications for Welsh Ambulance Service Trust (WAST) as some patients are being conveyed to ED via ambulances which may limit resources in the event of lifethreatening circumstances.

### Aim

- Reduce the number of patients attending ED with catheter related problems.
- Ensure patients with catheter related problems are managed proactively in the community, and in a timely manner in the event of a crisis.
- Ensure catheterised patients who require hospital intervention are fast tracked to the appropriate department as opposed to attending ED.
- Ensure all patients discharged from hospital with a urinary catheter are referred to District Nurses.
- Ensure all catheterised patients are discharged from hospital with sufficient products to reduce infection risks until on-going supplies are prescribed and dispensed.
- Ensure District Nurses are provided with the required information on discharge to safely manage catheterised patients in the community.
- Improve patient experience and outcomes by ensuring every patient is given an information leaflet detailing how to care for their catheter and are issued with emergency contact details.

# **Programme**

- A process has been developed to ensure that all patients discharged from hospital with a urinary catheter are referred to District Nurses via Single Point of Access (SPoA) for ongoing management and support and to ensure WAST are aware of who to contact in the event of a catheter related problem to avoid despatching an emergency ambulance and possible ED attendance.
- A monthly audit is conducted of existing catheter documentation to improve compliance.

Continued >>





# **Programme Continued**

- An electronic register of all catheterised patients is being developed which will be accessible to various HCP's (hospital and community) including WAST staff. The register will contain information regarding reason for catheterisation and who should change the catheter. The register will also include an 'alert system' which will notify District Nurses if a patient attends ED or GPOOH with a catheter related problem.
- Myth busting sessions have been undertaken to dispel many catheter misconceptions such as 'we cannot do first catheterisations or first catheter changes' and 'male nurses cannot catheterise female patients'.
- Catheterisation training needs of staff have been considered with additional training planned.
- A 'home from hospital prescription request' has been developed and piloted to improve the process of obtaining on-going catheter related supplies in a timely manner, this also promotes formulary compliance.
- To improve the care of the catheterised patient and streamline documentation, a urinary catheter 'passport' is being developed.

# **Results**

- Initial feedback indicates the initiative is succeeding with the latest attendance figures currently being collated and will be published when available.
- As a direct result of the initiative, a 'Trial Without Catheter at Home Service' is being introduced which will improve the patient's journey and increase capacity within the Urology Diagnostic Unit for more complex care.

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# FOI RESPONSES

120 Trusts responded to the Freedom of Information Request.

1. How many specialist urology/continence nurses were there within your Trust in each of the last five financial years? Averages below:

2010/2011	2011/12	2012/13	2013/14	2014/15
3.58912281	3.716783	3.785862	3.789483	3.844522

2. How many hours of staff training were allocated in the last financial year, under the remit of continence care, to catheterisation?

Average: 535

4. Do you have a named continence lead within your Trust?

Yes: 57 (48%), NO: 52 (43%), Did not answer: 11 (9%)

5. Are catheter passports used at all within your Trust?

Yes: 41 (34%), No: 75 (63%), Did not answer: 4 (3%)

7. If a catheter passport is used within your Trust does it contain a urine colour chart?

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Yes: 7 (6%), No: 41 (34%), Did not respond: 72 (60%)

8. Do you have a urine colour chart on every toilet door within each hospital?

Yes: 5 (4%), No: 110 (92%), Did not respond: 5 (4%)



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# CONCLUSION

The NHS is at a crucial point in its existence. High demand and an ever tightening budget mean it is now more important than ever that services are both efficient and successful in achieving high quality patient care. The Care Quality Commission's October 2016 report on the state of adult health and social care described this as the "tipping point" for the delivery of care across the UK.

This Best Practice Guide provides several key recommendations that, when implemented by CCGs and continence services, will help to drive a regionally consistent high quality of continence care and in the process will drive tangible savings. The aim is to be part of the solution in reducing demand on NHS and social care services.

As the case studies within this Guide demonstrate, there are parts of the country where

innovative solutions and earlier interventions are being implemented, reducing costs and improving lives. These solutions are crucial to reversing current trends of increased A&E attendances, emergency admissions and delayed discharges.

The Guide hopes to provide CCGs and healthcare professionals with examples of how the NHS can deliver value through service reform by the adoption of best practice and we hope that there will be a wide uptake of these recommendations.

The Committee will continue to promote these recommendations, and will provide support to those who are leading transformation and change within their CCG or Trust. To receive further information, or to discuss how you can support the Committee's work, please contact the Committee's secretariat at: sara@pbpoliticalconsulting.com.



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