

The top half of the cover features a light blue background. On the left, several blue and white capsules are scattered. On the right, a white diagonal line separates the capsules from a microscopic image of blue, rod-shaped bacteria. A white-bordered box in the upper right corner contains the text 'UNPLANNED ADMISSIONS CONSENSUS COMMITTEE'.

UNPLANNED  
ADMISSIONS  
CONSENSUS  
COMMITTEE

REDUCING  
UNPLANNED ADMISSIONS  
TO HOSPITAL AS A RESULT OF  
URINARY INCONTINENCE

Version 4 – 2019/20

# ABOUT THE UNPLANNED ADMISSIONS CONSENSUS COMMITTEE

UNPLANNED  
ADMISSIONS  
CONSENSUS  
COMMITTEE

The Unplanned Admissions Consensus Committee (UACC) is a collaborative body who work to promote best practice in urinary continence care across the country. We believe that every patient should receive the right care at the right time and in the right place. We wish to support and promote initiatives designed to achieve this across the UK.

In summer 2015 the Committee 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 countrywide '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, and updated again in 2016 and 2018.

Since then 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. The UACC has also developed an Online Toolkit to support healthcare practitioners and commissioners in the practical uptake of the Guide recommendations, which can be found the Committee's website: [www.unplannedadmissionscommittee.com](http://www.unplannedadmissionscommittee.com).

This year the Guide has been updated to align the UACC's work with the Government's antimicrobial resistance (AMR) strategy and the Department of Health and Social Care's agenda on infection prevention. These priority areas are reflected in the NHS Long Term Plan (the 'Plan'), which sets areas of focus for the NHS for the next ten years and beyond. The work of the UACC on reduction of catheter-associated urinary tract infections (CAUTIs) links with this AMR agenda, and the Committee aims to continue its work to promote best practice in continence care across the country.

Improvement in care for patients is central to everything the UACC does. The Committee has reviewed and updated its widely recognised Best Practice Guide to ensure it remains a hub of best practice and practical information. This fourth edition of the Guide includes a number of updated recommendations and case studies from services demonstrating best practice.

We work with NHS Improvement, the Royal College of Nursing and the Infection Prevention Society (IPS) to engage with and support clinicians, as well as the NHS. The Committee shares industry connections with Becton Dickinson (formally Bard).

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# FOREWORD



Urinary tract infections (UTIs) are one of the most common bacterial infectious diseases both outside and within hospitals.<sup>1</sup> In 2017/18 alone, the NHS spent £386.1 million on treating unplanned admissions for UTIs.<sup>2</sup> A great number of these unplanned admissions are preventable or treatable outside of the hospital setting. According to the NHS National Tariff Payment System the average cost of admission to hospital due to a UTI is £1,331. This highlights that there is a clear economic case for reducing unnecessary unplanned admissions resulting from UTIs.

In addition to this vast expenditure, it is recognised that failed treatment of the most common infections, including Urinary Tract Infections (UTIs), is a leading and increasing cause of anti-microbial resistance; the ability of micro-organisms to withstand antimicrobial treatments such as antibiotics. Data from 2016 showed that for every 100,000 persons, 73 of them acquired an e-coli bacteraemia; 47% of those infections were from UTIs. Furthermore, UTIs also account 13.7% of all community antibiotic prescriptions and account for up to 3% of all primary care consultations. This failure to provide effective treatment can also lead to more severe conditions, such as sepsis; a serious complication of an infection which can lead to multiple organ failure and death.

The consequences of failed treatment demonstrates why it is so important for all patients to receive high quality and effective treatment of UTIs. This is why the Unplanned Admissions Consensus Committee was created and continues to promote best practice to those involved in commissioning or delivering continence care.

I have been honoured to serve as the Chair of the Unplanned Admissions Consensus Committee since its inception and am proud of what we have achieved. The Committee launched its first Best Practice Guide in 2015. A second version was updated and published in 2016 and an online toolkit was developed in 2017 to host and signpost further practical support and information. The toolkit is constantly updated, so I would encourage everyone to check it regularly to see what support materials have been added. This latest guide builds on this work, seeking to further align our goals with the fight against AMR and hospital acquired infections.

The Committee has also grown its membership, to include clinical representatives, patient organisations and NHS England / Improvement. We have the expertise and the UACC is the forum through which we can help improve awareness and practice. Through the ongoing support of each and every Committee member, as well as continence leads from across the UK, I am hopeful that we can reduce the trend in the number of UTIs, CAUTIs and hospital acquired infections.

A handwritten signature in black ink, appearing to read 'Michelle Hunt', enclosed within a simple, hand-drawn oval shape.

**Michelle Hunt,**

Continence Service Manager at Wokingham Community Hospital

Chair of the Unplanned Admissions Consensus Committee

<sup>1</sup> Johansen et al, Eu. Urol. Suppl (2016); (2) Tandogdu et al, Curr Opi Inf Dis (2016) (3) ECDC (2016);  
<sup>2</sup> <https://www.theyworkforyou.com/wrans/?id=2018-11-21.194075.h&s=Virendra#g194075.q0>



# SUMMARY OF BEST PRACTICE RECOMMENDATIONS

- 1** The Government should do more to recognise the link between urinary tract infections (UTIs) and antimicrobial use. We call on the Government to support initiatives to reduce unnecessary antibiotic use as a way to address antimicrobial resistance (AMR).
- 2** A national public health campaign promoting bladder health should be initiated and there needs to be overall better signposting of information for patients.
- 3** A nationally run educational campaign promoting the correct use and management of urinary catheters, with a particular focus on community and primary care settings.
- 4** There should be training opportunities for health care practitioners to learn about best practice regarding the management of catheters, with a focus on reducing catheter-associated urinary tract infections (CAUTIs) thereby reducing infections and antimicrobial prescription.
- 5** GPs should be comfortable asking questions to patients presenting with symptoms of urinary incontinence and should instigate a patient management plan. As a part of this, they should use a standardised pathway for care to rule out of ‘red flags’.
- 6** There should be a financial incentive to diagnose incontinence issues in patients and instigate a patient management plan, such as a Quality Outcomes Framework (QOF).
- 7** Bladder ultrasound scanning should be used as the first choice to help a healthcare professional make an informed decision about the clinical management of a patient presenting with urinary bladder complications. *A business case for scanners can be downloaded from the Online Toolkit.*
- 8** Intermittent catheterisation (IC) should be the method of choice to drain retained urine wherever feasible.
- 9** All relevant healthcare environments should invest in appropriate staff training in catheterisation, which could include e-learning.
- 10** All Trusts should promote the use of catheter passports. *A template catheter passport can be downloaded from the Online Toolkit.*
- 11** NHS England/Improvement should work with collaborative bodies such as the UACC to ensure best practice is shared across the UK.
- 12** Every Trust should have one named person responsible for continence. This continence lead should be responsible for promoting education and training.
- 13** GPs should receive training on the different continence products available and/or refer to community continence teams where the specialist knowledge is based.
- 14** Patient management systems should be used to improve prescribing, patient care and quality of life whilst reducing cost.

# SECTION 1: UNDERSTANDING THE PROBLEM: CATHETERISATION, UTIs AND UNPLANNED ADMISSIONS

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 and carers. The NHS estimates that there are between 3 and 6 million people in the UK with some degree of urinary incontinence.<sup>3</sup> However this figure could actually be much higher. A survey conducted by The Urology Foundation in 2017 found that almost 1 in 3 British adults have experienced urinary incontinence. 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<sup>4</sup>.

The chances of developing urinary incontinence can be increased by a number of factors, including pregnancy and childbirth, neurological conditions, obesity, having lower urinary tract symptoms (LUTS), a family history of the condition and the ageing process.<sup>5</sup>

Incontinence is a significant factor in admissions to hospitals and care homes. NHS England reported in 2014 that urinary tract infections (UTIs) were the condition with the highest emergency admissions rates<sup>6</sup>. Of these UTIs, between 43% and 56% were associated with a urinary catheter.<sup>7</sup> With 10% of residents in care homes<sup>8</sup> and 15-25% of hospital inpatients<sup>9</sup> using a long-term catheter, the likelihood of these patients developing a catheter associated urinary tract infection (CAUTI) is increased considerably. 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.<sup>10</sup> We know that 24% of patients affected by asymptomatic bacteriuria will go on to develop symptoms of a CAUTI.<sup>11</sup> Whilst infrequent, approximately 3.6% of cases with CAUTIs can lead to life threatening

conditions, such as bacteraemia or sepsis, where mortality rates range from 10-33%.

Catheterisation is a procedure where a hollow tube is inserted into the bladder to help people who have difficulties emptying their bladder or cannot control their bladder function, get on with their lives. This can be either intermittently or indwelling and can be short term or long term.

Another common complication of long-term catheter use is encrustation by mineral salts, leading to catheter blockage. Some 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.<sup>12</sup> 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.

When the UACC first met to discuss urinary continence care in 2013, there were 5.3 million emergency admissions to hospitals, costing the NHS approximately £12.5 billion.<sup>13</sup> This figure has since risen to 5.8 million emergency admissions costing the NHS 13.9 billion in 2016/17.<sup>14</sup> The Medical Technology Group (MTG) found that in 2013/14, the NHS spent £434 million on treating 184,000 emergency admissions caused by a urinary

tract infection. This figure grew to £530.8 million in 2016/17<sup>15</sup>. The UACC expects this figure to continue growing exponentially by 2020 making this policy area important for those wishing to reduce unplanned admissions to hospitals and save the NHS money.

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.

Furthermore, according to NHS England approximately 300,000 patients a year in England are affected by a healthcare-associated infection (HCAI) as a result of care within the NHS, costing the NHS approximately £1 billion every year.<sup>16</sup> UTIs are the most common health care-associated infections (HCAI), accounting for 17.2% of all HCAIs. This means reducing HCAIs remains high on the Government's safety and quality agenda and in the general public's expectations for quality of care.<sup>17</sup> To reflect this, in 2016 the Department of Health (now Department of Health and Social Care) announced government plans to halve the number of gram-negative bloodstream infections by 2020. E. coli infections – which represent 65% of gram-negative infections – killed more than 5,500 NHS patients in 2015. E.coli is a leading cause of UTIs, further highlighting the case for reducing UTIs and improving care.

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.

- 3 'Urinary Incontinence Symptoms And Treatments' (Nhsinform.scot, 2018) <<https://www.nhsinform.scot/illnesses-and-conditions/kidneys-bladder-and-prostate/urinary-incontinence>>
- 4 Bladder Conditions and Stress Incontinence, 'Stress Urinary Incontinence - Bladder & Bowel Community' (Bladder & Bowel Community, 2018) <<https://www.bladderandbowel.org/bladder/bladder-conditions-and-symptoms/stress-urinary-incontinence/>>
- 5 'Urinary Incontinence Symptoms And Treatments' (Nhsinform.scot, 2018) <<https://www.nhsinform.scot/illnesses-and-conditions/kidneys-bladder-and-prostate/urinary-incontinence>>
- 6 'Reducing Incidence Of Urinary Tract Infections By Promoting Hydration In Care Homes' (NICE 2018) <<https://www.nice.org.uk/sharedlearning/reducing-incidence-of-urinary-tract-infections-by-promoting-hydration-in-care-homes>>
- 7 Loveday H, Wilson J, Pratt R et al (2014) epic 3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England, *Journal of Hospital Infection* 86S1 (2014) S1–S70
- 8 Available here: <http://www.pharmaceutical-journal.com/publications/20068794.cpdarticle> (2015)
- 9 Available here: [http://www.cdc.gov/HAI/ca\\_uti/uti.html](http://www.cdc.gov/HAI/ca_uti/uti.html) (2017)
- 10 Healthcare Infection Control Practices Advisory Committee, 'Guideline For Prevention Of Catheter-Associated Urinary Tract Infections 2009' (2009)
- 11 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.
- 12 Tika Ram Bhandari, Sudha Shahi and Naveen Mahaseth, 'Massive Encrustations As A Consequence Of Longterm Indwelling Urethral Catheter: A Rare Case Report' (2018) 34 *Annals of Medicine and Surgery*.
- 13 'Emergency Admissions To Hospital: Managing The Demand' (National Audit Office, 2013) <<https://www.nao.org.uk/wp-content/uploads/2013/10/10288-001-Executive-Summary.pdf>>
- 14 'Reducing Emergency Admissions' (National Audit Office, 2018) <<https://www.nao.org.uk/report/reducing-emergency-admissions/>>
- 15 <https://www.theyworkforyou.com/wrans/?id=2018-11-21.194075.h&s=urinary>
- 16 'Reducing HCAI - What the Commissioner needs to know.' (NHS England, 2015) <<https://www.england.nhs.uk/wp-content/uploads/2015/04/10-amr-lon-reducing-hcai.pdf>>
- 17 'Reducing HCAI - What the Commissioner needs to know.' (NHS England, 2015) <<https://www.england.nhs.uk/wp-content/uploads/2015/04/10-amr-lon-reducing-hcai.pdf>>

## SECTION 2: UK AMR STRATEGY AND ALIGNMENT WITH THE UACC WORK

The NHS Long Term Plan was launched in January 2019 and sets the direction of travel, highlighting areas of focus for the NHS for the next ten years and beyond.<sup>18</sup> Whilst continence is not included in the Long Term Plan, there are close links between (urinary) continence care, UTIs and antimicrobial resistance (AMR). AMR is at the top of the agenda for the Government and the NHS, and as such, the Plan makes reference to the Government's five-year action plan on AMR. Of particular relevance, the Plan commits to supporting system-wide improvement and infection prevention and control practice, which ties in with the UACC's work of sharing and improving best practice.

According to Public Health England's Annual epidemiological commentary:

- While many of the infections were community-onset it is estimated that a large proportion (up to 50% in the case of *E. coli*) have had recent healthcare interactions. Therefore, in order to reduce infection rates further, control efforts in the hospital setting must be maintained or strengthened, while increasing focus on interventions in the community and the interface between hospital and community infection control teams improved.

- UTI remained the most important primary focus of *E. coli*, *Klebsiella* spp. and *Pseudomonas aeruginosa* bacteraemia, causing 49.1%, 33.5% and 29.7% of cases respectively. In particular, a total of 43,242 cases of *E. coli* bacteraemia were reported by NHS Trusts in England, an increase of 5.2% from the previous year, and a 33.8% increase since 2012/13.
  - *E. coli* bacteraemia had the highest rate of all the bacteraemias caused by Gram-negative organisms, causing 77.7 cases per 100,000 population.
- The high rates of Gram-negative bacteraemias and diverse nature of the underlying causes of these infections compared to MRSA and CDI present a significant challenge to achieving the ambition to halve healthcare-associated Gram-negative bacteraemia by 2023/2024.

The consistent high rates of Gram-negative bacteraemia's and diverse nature of the underlying causes of these infections compared to MRSA and CDI present a significant challenge to halve healthcare-associated Gram-negative bacteraemia by 2023/24.<sup>19</sup>



The UK's five-year action plan for AMR 2019-24 supports the Government's 20-year vision for AMR.<sup>20</sup> The action plan places an emphasis on prevention and control of priority infections that drive resistance, including Gram-negatives.

Given that UTIs are the main cause for Gram-negative infections, there is a clear link between Gram-negatives and the Government's ambition to reduce these infections. This links with the UACC's work on reducing CAUTIs through sharing best practice on catheter use and management. As such, the UACC, as a hub for expertise on continence care, is well-placed to support the Government in tackling AMR in the community setting.

“At the heart of this [Long Term Plan] is the principle that prevention is better than cure...In the future, the NHS will do much more to support people to stay healthy, rather than just treat them when ill.”

Matt Hancock, Secretary of State for Health and Social Care, January 2019<sup>21</sup>

**RECOMMENDATION 1: The Government should do more to recognise the link between urinary tract infections (UTIs) and antimicrobial use. We call on the Government to support initiatives to reduce unnecessary antibiotic use as a way to address antimicrobial resistance (AMR).**

18 NHS Long Term Plan 2019. <<https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/>>

19 UK's 5-year national action plan on AMR <<https://www.gov.uk/government/publications/uk-5-year-action-plan-for-antimicrobial-resistance-2019-to-2024>>

20 *ibid.*

21 <https://www.nursingtimes.net/news/policies-and-guidance/plan-will-make-nhs-world-class-employer-claims-hancock-08-01-2019/>

# SECTION 3: 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**

One of the inhibitors to dealing with urinary incontinence is the reluctance of many people to admit to having a continence problem. A survey conducted by The Urology Foundation in 2017 found that 19% of British adults are reluctant to seek help over urinary incontinence.<sup>22</sup> 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.

In 2016, a number of charities attended a workshop facilitated by Age UK, on the impact of continence issues on patients with long-term conditions and older people. A report was published in July 2018, “My bladder and bowel own my life<sup>23</sup>”, based on the discussions held during the workshop. Findings included the fact that patient experience is one of the key continence research areas in need of more work.

The following findings regarding patient experience were included in the report:

- People with continence problems often feel embarrassed and as a result, many self-manage their condition in silence or for a long time before seeking help.
- Continence-related problems can be made worse by the lack of understanding and stigma. Many people, for example, believe that the condition is inevitable in ageing. The existing taboo should be broken through new policy campaigns and more public discussions.
- Workshop attendees agreed that evidence of patients’ experiences is not well represented in current research. Qualitative research can help explain some of the key issues faced by patients with incontinence.

Furthermore, The Urology Foundation found that 2 in 5 sufferers have experienced embarrassment, depression, marriage issues and career and debt problems due to urinary incontinence,<sup>24</sup> highlighting the real and wide reaching effects urinary incontinence can have on lives.

## Public Health Campaigns

Public awareness campaigns have proven to be successful in educating the public about a myriad of conditions and encouraging people to seek help. The acclaimed F.A.S.T campaign on strokes is one such example. In 2016, the UK Sepsis Trust launched a campaign which called nationally for the public and healthcare professionals to ask “Could it Be Sepsis?” whenever they see any of the ‘Sepsis Six’ symptoms. The charity evidences the campaign with data that showed the use of the Sepsis Six was linked to a 50% reduction in mortality, a decreased length of stay in hospital, and fewer intensive care days.

There have been national campaigns relating to MRSA, clostridium difficile and sepsis. These life threatening infections can often be caused by CAUTIs. In terms of prevalence and cost, the problems of CAUTIs are much bigger.

The UACC believe that the Department of Health and Social Care should ask Public Health England to look into the benefits of a national awareness campaign on the importance of hydration. Furthermore, they should encourage patients to seek help from their GP and other healthcare professionals in order to prevent UTIs and related conditions.

Furthermore, the fact that CAUTIs are a significant manifestation of Gram-negative blood stream

infections (GNBSIs) highlights the importance of appropriate management of catheters to reduce the recurrence of these infections and lower anti-microbial use. As such, the UACC believes there should be a nationally run educational campaign promoting the correct use and management of urinary catheters, with a particular focus on community and primary care settings.

It is the UACC’s hope that these recommendations would receive NHS England’s support, as noted in its updated Excellence in Continence Care guide, which were published in June 2018 and highlight the importance of delivering public education and developing an awareness strategy as part of delivering best practice in continence care.<sup>26</sup>

“We will not tackle taboos until we start talking about them: we must destigmatise the subject so that no one faces humiliation if they admit to a problem. We need to bring this issue out into the open once and for all, so that people no longer suffer in silence and we can reduce the long-term health implications and additional costs for the NHS.”

Madeline Moon, MP for Bridgend Lab in parliamentary debate on Incontinence, 2017<sup>25</sup>

**RECOMMENDATION 2: A national public health campaign promoting bladder health should be initiated and there needs to be better overall signposting of information for patients.**

22 <https://www.theurologyfoundation.org/news/326-tuf-launches-world-continence-week-campaign-for-2017>

23 ‘My bladder and bowel own my life’ (Age UK, Marie Curie, National Institute for Health Research, Devices for Dignity, British Society of Gastroenterology, Parkinson’s UK, James Lind Alliance, The Urology Foundation, Alzheimer’s Society, Guts UK, 2018) <https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/health--wellbeing/incontinence-report/incontinence-needs---2018-report-v9.pdf>

24 <https://www.theurologyfoundation.org/news/326-tuf-launches-world-continence-week-campaign-for-2017>

25 <http://www.appgcontinence.org.uk/pdfs/incontinence-5sept17.pdf>

26 ‘Excellence In Continence Care: Practical Guidance For Commissioners, And Leaders In Health And Social Care’ (NHS England 2018) <<https://www.england.nhs.uk/wp-content/uploads/2018/07/excellence-in-continence-care.pdf>>

# Training

“I want to ensure training is organised and funded so that everyone can reach their full potential [...] I want to make sure you have the access to the skills you need to make the most of these new opportunities.”

Matt Hancock, Secretary of State for Health and Social Care, 2018<sup>30</sup>

The UACC recognises that effective reduction of GNBSIs is multifaceted. As such, a comprehensive approach to reducing infections, including CAUTIs, requires effective training programmes to improve best practice. NHS Improvement and Public Health England recognises this in their improvement guide (2017), with the tool listing education and training as a way to reduce GNBSIs.

The Statutory/Mandatory Core Skills Training Framework (CSTF) includes a subject on infection prevention and control, requiring all healthcare staff groups involved in direct patient care or services to have had training on the topic.<sup>27</sup> This includes provisions on understanding what is meant by the team healthcare associated infections, the chain of infection, risk assessment and how this informs infection prevention and control practice.<sup>28</sup> The UACC welcomes efforts by stakeholders such as NHS England, the Royal College of Nursing (RCN) and the Infection Prevention Society (IPS) in creating easily accessible and practical tools for healthcare professionals.<sup>29</sup>

Furthermore, the NHS Long Term Plan sets out an ambition to create a fully integrated community-based health care, which would be supported “through the ongoing training and development of multidisciplinary teams in primary and community hubs”. Whilst the UACC welcomes the Government’s commitment to supporting community-based healthcare, we believe more should be done to support practitioners in primary and community settings, who often work under increased pressures. This should include education and training with a specific focus on correct management of catheter

and the impact this could have on CAUTIs reduction and thereby unnecessary antimicrobial usage. For example, practical e-learning tools such as Massive Open Online Courses (MOOCs) on continence care and catheter management present an easily accessible, low cost route for primary healthcare practitioners and community nursing teams, as well as the general public to learn more about best practice in this area.

As the hub for best practice in continence care, the UACC believes we are well-placed to supporting the Government in sharing expertise and best practice in this area.

**RECOMMENDATION 3: A nationally run educational campaign promoting the correct use and management of urinary catheters, with a particular focus on community and primary care settings.**

**RECOMMENDATION 4: There should be training opportunities for healthcare practitioners to learn about best practice regarding catheter management of, with a focus on reducing catheter-associated urinary tract infections (CAUTIs).**

27 <https://www.skillsforhealth.org.uk/services/item/146-core-skills-training-framework>

28 <https://www.skillsforhealth.org.uk/images/services/cstf/StatMand%20CSTF%20Subject%20Guide%20v1.6.pdf>

29 <https://www.ips.uk.net/professional-practice/competences/>; <https://portal.e-lfh.org.uk/>; <https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2019/february/007-313.pdf>

30 <https://www.gov.uk/government/speeches/matt-hancock-my-priorities-for-the-health-and-social-care-system>

# Case study: CQUIN UTI: Embedding Integrated Best Practice Principles – Newcastle Upon Tyne Hospitals NHS Foundation Trust

## **Problem:**

The new CQUIN UTI was announced in March 2019 and this is based on quality improvement work, the diagnosis and management of Urinary Tract Infections (UTI) in people older than 65 years. The CQUIN must meet four quality improvement standards:

- Diagnosis of lower UTI should be based on documented clinical signs or symptoms in accordance with PHE UTI Diagnosis Guidelines.
- Urine dipstick test should NOT be used to diagnose lower UTI.
- Antibiotics should be prescribed following the treatment options in NICE Lower UTI Guideline (NG109).
- Urine sample should be sent to microbiology in line with PHE/NICE guidelines.

## **Aim:**

- A project in the Newcastle Upon Tyne Hospitals NHS Foundation Trust intended to improve the diagnosis and management of UTIs in people older than 65 years. Measures were developed in line with Public Health England and NICE guidelines.

## **Programme:**

- Data is submitted quarterly to PHE through an online submission portal. This data is publicly made available on the PHE Fingertips AMR Portal approximately 9 weeks after each quarter.
- The achievement of this CQUIN is 90% of antibiotic prescriptions for lower UTI in older people meeting NICE guidance for lower UTI and PHE Diagnosis of UTI guidance, in terms of diagnosis and treatment. The minimum payment level is 60% and the maximum is 90%.

## **Results:**

New flow chart for diagnosis and management of UTI

- The flow charts have been developed in line with PHE and NICE guidelines. They are being used as educational tools and prompts in all clinical areas/departments. There are 2 flow charts:
  - Men and non-pregnant women (under 65 years old) with suspected UTI;
  - Men and women over 65 years with suspected UTI.



### Posters explaining 'To Dip or Not to Dip'

- Posters have been designed and introduced into dirty utility areas/slucies on each adult clinical area. The poster contains key messages on when 'To Dip or Not to Dip'.

### Rx Guidelines

- The Newcastle Hospitals prescribing guidelines have been reviewed and updated. These say that if empirical treatment is indicated, antibiotic prescription should follow Rx Guidelines. The guidelines are available through the Trusts Intranet.

### Order Entry Form for urine microbiology

- Correct completion of the Order Entry Form request has been disseminated through education sessions. Good clinical details enable microbiology staff to perform the correct tests and issue a meaningful report back to the clinical area/department.
- There has been an emphasis that the person filling in the request should understand why the test is being requested in the first instance.

### Education

- The education message to clinical staff has been driven through a number of senior healthcare professionals. This includes:
  - Urine dipsticks are not useful to diagnose UTI in patients over 65 years or when a urinary catheter is *in situ*.
  - Asymptomatic bacteriuria is common and does not require treatment.
  - Urine culture is not indicated unless UTI is suspected.
  - When UTI is suspected:
- Treat empirically according to the Trust's Rx Guidelines.
- Send a urine culture with thorough clinical details.
- Review culture results at 24-48 hours to guide ongoing targeted treatment.

# Case study: *Integrated product formulary* - Newcastle upon Tyne Hospitals NHS Foundation Trust

## **Problem:**

- The purpose of the evidence-based continence formulary for urinary catheters, urine drainage systems and related products is to provide clinical staff with information relating to continence products recommended for use within Newcastle upon Tyne Hospitals NHS Foundation Trust, Newcastle Gateshead CCG, Northumbria Healthcare NHS Foundation Trust, Gateshead NHS Foundation Trust, Northumberland CCG and North Tyneside CCG.
- In January 2020 the North of Tyne, Gateshead and North Cumbria Urinary Catheter Care Product Formulary 2020 was approved and signed off by the area's Prescribing Committee. The products and information in the formulary is for acute and community care.

## **Aim:**

- This project intended to bring local Continence Services, Urology, Uro-gynaecology, Procurement and Supplies departments, as well as the local CCG collaboratively together and work on a Task and Finish Project.
- This involved the reviewing of three Trusts formularies, evaluating catheter product equipment available through NHS Procurement and Supplies and FP10. A regional formulary was then developed for catheter-related products.

## **Programme:**

- The project aimed to safeguard the interest of the patient, and ensure that there is a variety of products available to manage patient need.
- It also aimed to ensure that practitioners have adequate information to support their practice when choosing continence appliances, promote rational prescribing and sustainability issues, as well as cost effective use of a product.

## **Results:**

- It has been stipulated that the formulary should be used alongside each Trusts continence standards and guidelines. The formulary brings standardisation across the region, but there is the caveat that a patient may need to defer from the formulary for a clinical need.
- This joined-up approach is beneficial in terms of reducing financial spend and ensuring a sustained percentage decrease and limit product variation. The ideal option for implementation of the formulary would be to instigate a 100% switch over of products within community. Realistically the aim will be to achieve 80% switch over of indwelling catheters and catheter products/accessories, as some patients may need a different non-formulary product.
- Within acute care the formulary is easier to implement and sustain in terms of monitoring and a 100% switch over of products can be initiated.
- This piece of inter collaborative working ensures local engagement with Continence services, Urology, Uro- gynaecology, Supplies and Procurement departments and the local CCG.
- Next stage involves implementation and introduction of systems which will monitor prescribing and ordering practices as well as controlling spend by the Trusts.

## GP Awareness

Many of those who responded to the call for evidence organised by the UACC in 2015 stated that GPs have a crucial role in helping patients feel comfortable talking about continence issues. As the first point of contact, GPs are well placed to address continence problems with patients.

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.

In a parliamentary debate in 2017, Madeline Moon MP stated that “People should have the confidence to talk about the problem to GPs and to seek an early diagnosis and intervention. People should not have to assume that it is something they have to live with. It is estimated that people manage the problem themselves for an average of five years before seeking help.”<sup>31</sup>

**RECOMMENDATION 5:** GPs should be comfortable asking questions to patients when presented with symptoms of urinary incontinence and should instigate a patient management plan. As a part of this, they should use a standardised pathway for care to rule out ‘red flags’. *A template pathway for care can be downloaded from the Online Toolkit.*

<sup>31</sup> <http://www.appgcontinence.org.uk/pdfs/incontinence-5sept17.pdf>

# Case Study: Development of GP Guidelines for Promotion of Urinary Continence in Dudley

## **Problem:**

- Inappropriate referrals to secondary care in Dudley were leading to long waiting lists and inconsistent patterns of treatment.
- The Dudley Continence Service had the capacity and expertise to effectively treat stress, mixed and urge incontinence with a range of non-pharmacological treatments before recommending drug and device usage, while monitoring and reviewing the effect of treatment.
- However, the Service needed a set of Guidelines for GP use to ensure effective management of patients when referring to secondary care.

## **Aim:**

- A Continence Project Working Group, including UACC members Dr John Firth and Gill Davey, came together to establish a set of guidelines for GPs, intended to provide holistic patient care and ensure a consistent approach to the management of urinary incontinence across primary and secondary care.

## **Programme:**

- The Continence Project Working Group met several times over the course of two years to establish the guidelines.
- The Working Group worked with the Area Medicines Management Committee, the local Prescribing Team and a local Formulary Pharmacist to ensure the Guidelines reflected best practice across the pathway.
- The Guidelines are regularly reviewed, and the wider Continence service regularly audits the outcome of its interventions to maintain high standards of patient care.

## **Result:**

- Following the implementation of the Guidelines, overall prescribing was found to be appropriate.
- Medication reviews were undertaken as highlighted by the audit and recommendations made to GPs.

### Financial Incentives to Promote Best Practice

The Quality and Outcomes Framework (QOF) is a voluntary system for all GP surgeries in England and is an annual reward and incentive programme detailing GP practice achievement results.<sup>32</sup> 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. Whilst there is limited information on the cost of managing urinary incontinence in the UK, data from the Leicestershire MRC Incontinence Study has shown that treating clinically significant urinary incontinence could cost the NHS approximately £536m<sup>33</sup>

**RECOMMENDATION 6: There should be a financial incentive to diagnose incontinence issues in patients and instigate a patient management plan, such as a Quality Outcomes Framework (QOF).**

### Timely Diagnosis

Bladder ultrasound scanning can be used to help healthcare professionals in both primary and secondary care 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>34</sup> It can also help clinicians with planning and undertaking trials without a catheter (TWOCs).

**RECOMMENDATION 7: Bladder ultrasound scanning should be used as the first choice to help a healthcare professional make an informed decision about the clinical management of a patient presenting with urinary bladder complications. A *business case for scanners* can be downloaded from the *Online Toolkit*.**

<sup>32</sup> Available at <http://www.hscic.gov.uk/qof>

<sup>33</sup> 'Urinary incontinence in women: the management of urinary incontinence in women' (NICE 2013) <<https://www.nice.org.uk/guidance/cg171/evidence/full-guideline-updated-november-2015-pdf-191581165>>

<sup>34</sup> 'Ultrasound scanning of the bladder: a guideline for best practice.' (Bard 2013) <<http://media.bardmedical.com/media/1724/ultrasound-scanning-guidelines.pdf>>



# SECTION 4: TRAINING, SELF-MANAGEMENT AND NHS TRUSTS

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 the bladder to drain urine.

There are two main types of catheterisation; indwelling and intermittent. An indwelling urinary catheter is a hollow tube that is inserted and anchored in 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 self-catheterisation (CISC). Sometimes a carer or relative helps with inserting the catheter and this is called intermittent catheterisation.

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.<sup>35</sup> Encrustation of the catheter is a common occurrence

causing recurrent blockage in approximately 50% of long-term catheterised patients.<sup>36</sup> It is estimated that 4% of community patients have an indwelling catheter fitted.<sup>37</sup>

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 department. Over the last ten years, 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.

**Recommendation 8: Intermittent catheterisation (IC) should be the method of choice to drain retained urine wherever feasible.**

35 'Urinary catheter: Types' (NHS England 2017) <<https://www.nhs.uk/conditions/urinary-catheters/types/>>

36 Tika Ram Bhandari, Sudha Shahi and Naveen Mahaseeth, 'Massive Encrustations As A Consequence Of Longterm Indwelling Urethral Catheter: A Rare Case Report' (2018) 34 Annals of Medicine and Surgery

37 Underhill L, 'A Versatile Range Of Leg Bags For Use In Community Patients' (2014) 28 JCN

# Case study: *Programme of catheterisation standardisation* - Sherwood Forest Hospitals NHS Foundation Trust

## **Problem:**

- The Trust identified through Root Cause Analysis of CAUTI related bacteraemia that there were some inconsistencies with catheterisation practices across the Trust.
- Not all the products required for catheterisation were being used in every area, and large bore catheters were being used when this was not necessary.
- This was contributing to higher infection rates.

## **Aim:**

- Performing in line with national guidance and standardising practice across the Trust.
- Reducing the number of patient infections related to CAUTIs.

## **Programme:**

- Sherwood Forest Hospitals implemented the BARD<sup>®</sup> Tray following a trial. These trays standardised the equipment for catheterisation.
- Trays were used in all adult inpatient wards, Emergency Department and Emergency Admissions Unit.

## **Result:**

- Having all the equipment available in one place reduced the risk of something being forgotten, and enabled the identification of any training gaps in staff knowledge with regard to catheterisation.
- CAUTI rate was reduced from 13.3% in July 2016, before the trays were introduced, to 2.1% in June 2017 – a reduction of over 80%. The last audit of CAUTI rates from March 2018 indicated the rate was 2.0%.
- With the reduction in CAUTI rate, the introduction of the trays saved approximately £33,000 over a year.

# Case study: *All-in-one catheterisation pack* – 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).

## **Aim:**

- 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 pre-connected 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.

## **Result:**

- 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 of catheterisation remaining the same.
- The cost avoidance in treating CAUTIs in 2015 was approximately £95,000 and it was estimated that in 2016 NUH achieved a £130,000 overall cost saving.
- The overall estimated cost saving for Nottingham University Hospitals by the end of 2016 was £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.

### **Training Patients - clean intermittent self-catheterisation (CISC)**

The catheterisation rate among hospitalised patients is estimated to be of 17-26%<sup>38</sup>, of which 5% develop a urinary tract infection (UTI)<sup>39</sup>.

The Committee have found that there is often 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.

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.

In 2015, the UACC submitted a Freedom of Information (FOI) request to every NHS Trust requesting the number of specialist urology nurses/continence nurses employed within each Trust. The responses revealed that in 2010/11 there was an average of 3.59 specialist urology nurses/continence nurses per NHS Trust which grew to 3.84 per Trust

in 2014/15. The Committee sent out an updated FOI in 2018, and were delighted to discover that by 2017/18 this number had increased to 4.64 urology/continence nurses per Trust. The Committee are pleased with this direction of travel, but feels continued growth is needed to keep up with the growing number of patients.

From its discussions across the UK, the UACC has found continence advisors feel 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 effectively.

Sufficient time needs to be spent on staff training for catheter and continence care every year to promote best practice. This could include e-learning as well as more traditional training formats, and be adapted to the workforces needs.

**RECOMMENDATION 9: All relevant healthcare environments should invest in appropriate staff training in catheterisation, which could include e-learning.**

<sup>38</sup> David Clifford Shackley and others, 'Variation In The Prevalence Of Urinary Catheters: A Profile Of National Health Service Patients In England' (2017) 7 BMJ Open.

<sup>39</sup> Saint S and others, 'The Efficacy Of Silver Alloy-Coated Urinary Catheters In Preventing Urinary Tract Infection: A Meta-Analysis' (1999) 162 The Journal of Urology

# Case study: *UTI Prevention and Management in Primary and Community Care study day - Cardiff and Vale*

## University Health Board

### Problem:

- From April 2017 *E.coli bacteraemia* was added to the Welsh Government's expected healthcare associated infections (HCAI) reductions. A rate of less than or equal to 67 per 100,000 population was the target for all major healthcare organisations in Wales.
- Welsh Health Boards encourage action to prevent these infections. However, these actions are not always devolved by education and information onto Community, Residential or Nursing Home care settings. According to Public Health Wales<sup>40</sup>, UTIs remain at a similar prevalence in 2017 as compared with 2011, which shows that interventions to reduce such infections haven't been effective.
- It was agreed by both the All Wales Continence Forum and the Infection Prevention Society that there was a significant amount of education required to bring primary and community care up to date with HCAI development.

### Aim:

- An educational study day was planned with support from Becton Dickson (formally Bard) for South and Mid Wales to improve the levels of education.

### Programme:

- The study day was identified as 'UTI Prevention and Management in Primary and Community Care'.
- The agenda was multidisciplinary and offered a unique opportunity to understand the issues and solutions for both preventing and managing UTIs in at-risk patients in both the primary and community care settings.

- Topics on the agenda included preventing UTI's to prevent Blood Stream Infections – Standards for Best Practice Intervention; Aseptic Non Touch Technique (ANTT); Catheter Maintenance Solutions and diagnosing and sampling for UTI's in primary and community settings among others.
- Speakers included representation from Welsh Government and Office of the Chief Nursing Officer for Wales; Public Health (Wales); Infection Prevention; Antimicrobial Pharmacist; 1,000 Lives Improvement and Continence Services.
- Attendance was estimated to be approximately 60 delegates

### Result:

- Response and interest for the study day was so overwhelming that an alternative venue had to be sorted to accommodate the increase in numbers and over 108 delegates attended.
- Feedback from the study day was extremely positive and has initiated requests from other areas of Wales and Welsh Government to put on further educational study days with regards to Prevention of UTI's.
- The impact of the information the delegates gained will be best identified in the next collation of *E.coli* rates for UTI's to see if any reduction and monitoring the use of antibiotics via pharmacy.
- More training days should be organised to train NHS staff about bladder health, and to ensure that they are capable of better signposting of information for patients.

<sup>40</sup> 'National Point Prevalence Survey of Healthcare Associated Infection, Device Usage and Antimicrobial Prescribing 2017' (Public Health Wales 2018) <<https://www.wales.nhs.uk/sitesplus/documents/888/Wales%202017%20PPS%20Report%20Final%28b%29.pdf>>



# Case study: *A Year of Harm Free Care* – Newcastle Specialist Continence Service

## **Problem:**

- More awareness and understanding is needed when it comes to assessing the need for a urinary catheter, removing them when clinically no longer required and promoting alternative management systems.
- This proved to be challenging for the Newcastle Specialist Continence Service in the past, as four key specialist areas worked in isolation and made their own recommendations, which could result in conflicting messages being sent to clinical staff.

## **Aim:**

- Over a number of years an active catheter care group, including nursing and medical representation, has taken forward catheter related issues, urinary tract infections and catheter associated infection related projects.
- The projects have included the development of guidelines and competencies for urinary and supra pubic catheterisation, intermittent catheterisation, removal of a urinary catheter and bladder scanning. A product formulary has been developed for acute and community care, patient information leaflets, catheter passport, care plans which include the HOUDINI framework, and care pathways.
- In order to promote this work ensuring a succinct process, a working group was established who have embedded *A Year of Harm Free Care*.

## **Programme:**

- The *A Year of Harm Free Care* initiative was a rolling 12-month strategy based on the collaboration of four key specialist teams: Infection Prevention and Control (IPC), Falls Prevention, Continence and Tissue Viability.
- This approach was to prevent multiple documents and awareness campaigns occurring at the same time which can lead to information overload to clinical staff when important elements of key messages can be missed, and potentially resulting in increased harms.
- Throughout the year there were themed months, each focusing on one of the key messages from the four specialties.

## **Result:**

- A variety of communication strategies were employed to raise awareness of the initiative and bespoke monthly delivery of key messages and education. These included a monthly screensaver, slots at the Patients Safety Briefings and nursing forums, intranet adverts, promotional stands, and articles in newsletters.
- Staff did report that the initiatives improved their knowledge and it changed their practice. The most common suggestion was to increase and improve the strategies for communicating the initiative across all disciplines within the organisation.

## Catheter Passports

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.

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 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, ensuring total transparency and consistency of care.

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 should be kept with patients at all times. The urinary catheter passport has been successful in improving patient and staff awareness in many Trusts and so it should be rolled out across all NHS Trusts across the country.

Although NHS Improvement has recently developed a catheter passport,<sup>41</sup> there is no one set catheter passport in use throughout the UK. The UACC has supported efforts for standardisation by developing a template which can be adapted based on local population needs. This can be downloaded from the Committee's website. 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.

The FOI sent to all NHS Trusts in 2015 found that, of the 116 responses, only 41 Trusts used catheter passports. In 2018 the UACC repeated the FOI and found that, of the 111 Trusts who responded, an impressive 105 Trusts have now adopted the passports. This is due to the hard work of continence advisors, like those on the UACC, who recognise the value of these passports for patient care.

**RECOMMENDATION 10: All Trusts should promote the use of catheter passports. A template catheter passport can be downloaded from the Online Toolkit.**

**RECOMMENDATION 11: NHS England/Improvement should work with collaborative bodies such as the UACC to ensure best practice is shared across the UK.**

<sup>41</sup> <https://improvement.nhs.uk/resources/urinary-catheter-tools/>

## Case study: *Introduction of a catheter passport across the Black Country* – The Dudley Group NHS Foundation Trust

### **Problem:**

- Despite many NHS Trusts across England utilising catheter passports, many of the Trusts in Black Country failed to do so.

### **Aim:**

- In 2018, a sub-group from the Quality and safety committee was established to look at rates of UTIs in the Black Country. The first action identified was to produce a passport for the Dudley residents who have catheters. This would establish a more accurate way of monitoring of who had catheters and reviewing rates of UTIs.
- Utilising the UACC template passport, lead clinicians worked together to develop a catheter passport that could be adapted across the Black Country.
- Patients were also involved in the production of the catheter passport, and many of their requests were incorporated into the final document.

### **Results:**

- Following the recommendations in the 2015 Best Practice Guide, a catheter passport was introduced by the Dudley Group Foundation NHS Trust, Dudley CCG, Dudley and Walsall Mental Health Trust and Black Country Partnership Trust.
- Implementation of this passport has been ongoing in 2018. Once the catheter passport is fully implemented, the full impact will be monitored. Dates have been set for 2019 to look at costs of antibiotic use, catheter costs and how many patients have catheters and passports.
- Feedback forms have been given to patients using the passports, and responders have said that they feel more valued, and that the passport is a very useful tool.

### Continence Nurses and Advisors

In 2015, the UACC submitted a FOI to every Trust in England to ask whether they have appointed a named continence lead. Of the 109 Trusts surveyed in 2015, only 57 had a named continence lead, which was just over half. In the 2018 FOI, the Committee found that, of the 147 Trusts which responded, 90 now have a named lead for continence care.

This increased number demonstrates the positive uptake of best practice across England. However, more still needs to be done to ensure the remaining Trusts recognise the value in appointing a lead. Having one named person in each Trust responsible for continence ensures that a lead individual would be present to implement effective training and good practice.

Furthermore, the National Audit of Continence Care found that many services were not providing services in line with NICE guidance and that the quality of care is worse among older patients over the age of 65 in whom the condition is most prevalent.<sup>42</sup> Of women suffering from 'moderate' or 'severe' urinary incontinence, less than one third were found to be receiving health or social services for their condition.

It is clear that, 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 healthcare professionals trained in catheterisation, including nurses 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. This guidance should build on NHS England's *Excellence in Continence Care* guidelines published in 2018. The commissioning guidelines should include a recommendation for a named continence commissioner/prescribing lead in each CCG.

“We absolutely need to develop the workforce of health professionals so that they are more informed and educated about continence issues across the board and are able to support and care for individuals in a safe, effective and dignified manner.”

Steve Brine, former Parliamentary Under-Secretary of State for Health and Social Care, 2017<sup>43</sup>

**Recommendation 12: Every Trust should have one named person responsible for continence. This continence lead should be responsible for promoting education and training.**

42 National Audit of Continence Care (2012) <<https://www.rcplondon.ac.uk/projects/outputs/national-audit-continence-care-nacc>>

43 <http://www.appgcontinence.org.uk/pdfs/incontinence-5sept17.pdf>

# Case study: *Continence Service Manager at the Berkshire Healthcare Foundation Trust*

## **Problem:**

- The Berkshire NHS Foundation Trust provides healthcare services for approximately 800,000 people throughout the county<sup>44</sup>.
- Excellent coordination is needed when delivering continence care services in order to ensure patients receive the best possible care, and to reduce levels of continence overprescribing, and ensure budgetary expenditure remains in line with service targets.

## **Project:**

- Michelle Hunt was appointed Continence Service Manager at the Berkshire Healthcare Foundation Trust in 2012. She now acts as the key point of contact and is responsible for the continence services, as well as supervising the work of a group of nurses and physiotherapists.

## **Results:**

- Having a clear lead has facilitated communications, and has helped develop a clear internal structure.
- The Continence Service Manager now represents the trust in a number of external organisations, including the UACC, where she's the Chair. This helps her learn about innovations in continence care, which she, as a lead, can implement in her trust. She also has the opportunity of sharing best practice and acting as a spokesperson for her trust's continence care service.
- Michelle has helped develop and implement key projects in her trust, including the introduction of a continence management system. Which led to a reduction in product budget of £70000 within the first 6 months of the trial<sup>45</sup>.
- Patients have said that 'the service couldn't be bettered'<sup>46</sup>
- According to a CQC's report<sup>47</sup>, staff in the Trust 'said they received support from peers and their managers through team meetings, one to one meetings and annual appraisals, where learning needs were identified.'

<sup>44</sup> Hunt M, 'Lessons From Introducing A Continence Management System' (2018) 24 British Journal of Healthcare Management

<sup>45</sup> Hunt M, 'Lessons From Introducing A Continence Management System' (2018) 24 British Journal of Healthcare Management

<sup>46</sup> 'Continence Advice Service' (Berkshire Healthcare NHS Foundation Trust 2018) <<https://www.berkshirehealthcare.nhs.uk/our-services/adult-healthcare/continence-advice-service/>>

<sup>47</sup> 'Berkshire Healthcare NHS Foundation Trust, Community health services for adults: Quality Report' (Care Quality Commission 2016) <[https://www.cqc.org.uk/sites/default/files/new\\_reports/AAA8344.pdf](https://www.cqc.org.uk/sites/default/files/new_reports/AAA8344.pdf)>

# SECTION 5: SAVINGS AND BETTER PATIENT OUTCOMES IN PRESCRIBING, PRIMARY AND COMMUNITY CARE

## Prescribing Costs

The annual spend on incontinence appliances prescribed in the community in 2018 is estimated to be around £57.3 million (England data only).<sup>48</sup> Data also showed that the NHS spent an estimate of £144 million in catheters in 2018. Furthermore, recent figures showed that CAUTI cost the NHS up to £99m per annum, or £1,968 per episode in additional bed days and treatment.<sup>49</sup> 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.

In community settings, catheters are prescribed by GPs. Many of the members of the Consensus Committee have said 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.

In a parliamentary debate in 2017, Rosie Cooper MP argued *“It is really important to note that people who rely on... looking after themselves are not getting the best service, and doctors and nurses are sadly not receiving training in this most important area... We should not just pad them up. People can be helped with exercise, for example, and there are many interventions that could help instead of them being told simply, “Go and buy a pad.”*<sup>50</sup> This raises an important point around the need for appropriate training for GPs on various aids that can support their patients.

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 the individual clinical needs results in 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.

**RECOMMENDATION 13: GPs should receive training on the different continence products available and/or refer to community continence teams where the specialist knowledge is based.**

48 Prescription Cost Analysis (PCA) data for England, 2018 <<https://digital.nhs.uk/data-and-information/publications/statistical/prescription-cost-analysis/2018#summary>>

49 <https://www.england.nhs.uk/wp-content/uploads/2018/07/excellence-in-continance-care.pdf>

50 <http://www.appgcontinence.org.uk/pdfs/incontinence-5sept17.pdf>



# Case study: *GP training and guidance* – The Dudley Group NHS Foundation Trust

## **Problem:**

- After a catheter passport was introduced in the Black Country there was a need to ensure that the NHS staff utilising the tool knew what to do with the document. A lack of knowledge on the catheter passport could confuse patients and deem it useless.

## **Aim:**

- The sub-group from the Quality and Safety Committee that focused on UTIs and introduced the catheter passport wanted to ensure that GPs –as well as other healthcare specialists– knew what to do when a patient came with a passport.
- The aim was to give them more knowledge on appliances, correct codes and the accessories that are needed to ensure that the system is efficient.

## **Programme:**

- The catheter passport (both the physical version and the e-copy) was launched in July 2018 to GPs.
- A Public Health Infection Prevention Specialist and the Continence Service Manager at the Dudley Group NHS Foundation Trust gave GPs an insight into how the catheter passport would operate, and gave them guidance on how to take specimens correctly.

- A Renal Consultant gave a talk on Acute Kidney Injury and how medication impacts heavily on this condition. A Renal Pharmacist gave facts and figures on costs of this to the Dudley economy.
- This session was complimented by a GP questionnaire organised by a member of the UACC, which has helped get a better understanding of GP knowledge on incontinence, UTIs and urology issues.

## **Result:**

- GPs welcomed the fact that a document had all the necessary information for them to access.
- Similar initiatives have been carried out with other healthcare specialists. A presentation was given to pharmacists in July 2018 to guide them about catheters and accessories patients may require. The next step will be to speak with district nurses to ensure that they can fill the document out and can ask questions.

### **Patient Management Systems**

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 is an effective way of delivering improved outcomes and savings as it instigates a system of improved prescribing.

**RECOMMENDATION 14: Patient management systems should be used to improve prescribing, patient care and quality of life whilst reducing cost.**

# Case study: *Continence prescription service* - Berkshire Health-care NHS Foundation Trust

## **Problem:**

- Inappropriate issuing of supplies to patients on FP10 and therefore unnecessary expenditure and poor quality care.
- Patients were not fully supported in the use of continence aids and appliances on FP10 before the service came into being.
- GPs 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 appropriate use of products, reduce the complications of using products, such as UTIs, which can cause hospital admissions.
- Ensure long term catheters are managed effectively to prevent emergency call outs, and therefore enhance the quality of patients' care by ensuring all care is planned.
- Ensure the service had a supportive role for other healthcare professionals. The district nursing service who currently manage patients in their own home with long term catheters, have greater access to specialist support and advice for those patients whose catheters or sheath systems are problematic.

## **Programme:**

- The service implemented a patient management system to optimise the use of continence products.
- All patients who require continence aids on FP10 are now fully assessed to ensure that they are prescribed the most appropriate product. The use of the products are fully explained to the patient.

- Patients are reviewed at every monthly reorder. Initially triage questions are asked by the administrator for the service, and if appropriate this will trigger a Specialist Continence Nurse assessment. This ensures that the patient receives the best possible care and most appropriate product. This also ensures that as the patients' needs change, their care is reviewed.

## **Result:**

- Within the first 6 months £70,953.06 was saved on the purchase of continence products through appropriate stock levels.
- The cost per patient order per month was £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 using catheter maintenance solutions with no rationale for usage, which created unnecessary risk of infection.
- Numerous examples of patients overstocking products were uncovered, including a female patient with enough catheters to last for 2 years.
- 500 ISC catheters were returned; even if used 6 times per day this equates to a 3 month supply, which cannot be reused to other patients and equates to over £750 of wasted resources.
- An audit of service users was undertaken, there 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: *Referral and Patient Management* - Betsi Cadwalder University Health Board

## **Problem:**

- Too many patients were presenting at Emergency Departments (ED) with urinary catheter related problems, including blocked catheters.
- Of those presenting, some patients were known to District Nurses but they were still presented at ED during 'office hours.' Furthermore, some 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 as some patients were being conveyed to ED via ambulances which may limit resources in the event of life-threatening 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 was 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 the ambulance service 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 was introduced of existing catheter documentation to improve compliance.
- An electronic register of all catheterised patients was developed which is accessible to various HCP's (hospital and community) including ambulance staff. The register contains 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 with a catheter related problem.
- A catheter passport was developed and implemented to improve the care of patients and streamline documentation.

## **Result:**

- Feedback shows the initiative is succeeding.
- As a direct result of the initiative, a 'Trial Without Catheter at Home Service' was introduced which has improved the patient's journey and increased capacity within the Urology Diagnostic Unit for more complex care.

# CONCLUSION

We are all well versed in the challenges facing the NHS. Growing demand and ever tightening budgets mean it is now more important than ever that services are both efficient and successful in achieving high quality patient care.

In order to overcome these challenges, the NHS needs to take up solutions which are transformative, innovative and cost-effective. This is the driving force behind the Unplanned Admissions Consensus Committee's decision to develop and update the Best Practice Guide for reducing unplanned admissions to hospital as a result of urinary incontinence.

The Unplanned Admissions Consensus Committee has worked hard since its conception to determine what best care looks like. The Committee has grown its membership to include all the key individuals involved in the design and delivery of continence services. It is this joint expertise which has enabled us to develop this Best Practice Guide.

This Guide provides recommendations that, if implemented by CCGs and continence services, will ensure patients receive the gold standard of care across the UK and in the process will drive tangible savings.

By aligning the work of the UACC with the Government and NHS' priorities on infection prevention and reduction of UTIs, the Committee hopes to continue its work in sharing best practice that can have a physical impact to the care of continence patients. Furthermore, as the hub for continence expertise the Committee believes it is well-placed to support the Government to deliver these ambitions in the community, and wishes to see wider collaboration between NHS England/

Improvement and bodies such as the UACC to ensure that every patient receives the right care, at the right time, and in the right place. Getting clinical practice right first time will reduce demand on the NHS and social care services.

As the case studies within the Guide demonstrate, there are many areas in the UK driving forward innovative initiatives which improve patient care, and reduce the burden on accident and emergency services. These pockets of excellence can be replicated across the country, to drive regionally consistent high quality continence care.

The Committee hopes that this Guide will provide healthcare professionals and commissioners with tangible examples of how the NHS can deliver value through service reform by the adoption of best practice. We hope to continue building on the success of the first three editions of this Guide, and as a result see a growing number of services taking up these recommendations.

The Committee looks forward to promoting these recommendations and providing 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 [UACC@mailpbconsulting.com](mailto:UACC@mailpbconsulting.com).



# MEMBERS OF THE UACC

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- 2) Liz Booker, Midlands Partnership Foundation NHS Trust
- 3) Chris Bumstead, Sherwood Forest Hospitals NHS Foundation Trust
- 4) Anne Carrol, West Hertfordshire NHS Trust
- 5) Lesley Carter, Age UK
- 6) Amy Cartwright, NHS Supply Chain
- 7) Tracey Cunningham, Torbay & Southern Devon Health Care NHS Trust
- 8) Gill Davey, The Dudley Group NHS Foundation Trust
- 9) Linda Dempster, NHS Improvement
- 10) Sanjay Desai, NHS Berkshire West Clinical Commissioning Group
- 11) Suzanne Evans, Bladder Health UK
- 12) John Firth, Dudley Clinical Commissioning Group
- 13) Louise Fox, Walsall Healthcare NHS Trust
- 14) Sian Fumarola, University Hospitals of North Midlands NHS Trust, Infection Prevention Society
- 15) Rose Gallagher, Royal College of Nursing
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- 18) Michelle Hunt, Berkshire Healthcare NHS Foundation Trust
- 19) Alyson Laws, Newcastle Hospitals NHS Foundation Trust
- 20) Sally Palmer, Sherwood Forest Hospitals NHS Foundation Trust
- 21) Jackie Rees, Newcastle Hospitals NHS Foundation Trust
- 22) Suzanne Ryder, South Manchester's Bowel and Bladder Service
- 23) Amy Walleth, University Hospitals Birmingham NHS Trust
- 24) Catherine Weller, Somerset Partnership NHS Foundation Trust
- 25) Neil Wigglesworth, Guy's and St Thomas' NHS Foundation Trust
- 26) Alison Wileman, Royal College of Nursing Continence Forum
- 27) Ann Yates, Cardiff and Vale University Health Board
- 28) Gill Yaz, SHINE
- 29) Trudie Young, Welsh Wound Innovation Centre

# QUOTES

“From a BHUK perspective we believe that the BPG is evidence that the UACC group are not just about lobbying for change and understanding about continence issues but also determined to make an impact by offering something practical. It is all about improving patient care and outcomes which is at the core of what our charity is about and we are really happy to support and help to promote the BPG.”

Suzanne Evans, Business Director at Bladder Health  
UK

“I’m delighted to be part of the committee, which aims at improving patient care and reducing the number of unplanned admissions. Once again, this updated Best Practice Guide contains excellent case studies that will guide healthcare professionals interested in continence care and infection prevention.”

Catherine Weller, Operational Manager Continence  
and Leg Ulcer Service, South Petherton Community  
Hospital

“I feel proud and privileged to support my fellow members of the UACC, and hope that this new Best Practice Guide will assist healthcare professionals to deliver a continence service of the highest quality.”

Dr John Firth, Dudley Clinical Commissioning Group





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