

2 in 3

Delivering world class services for people with continence, lower urinary tract and bowel symptoms



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1. Introduction

About the report

The changes taking place within the NHS provide both an opportunity and a challenge to improving outcomes for people affected by continence, lower urinary and bowel symptoms. This report has been developed by a group of health professionals that came together to consider the current provision of services for people with LUTS, as well as how this might be improved. The purpose of the report is to:

- Assess the current state of services for people with continence, lower urinary and bowel symptoms
- Consider the reforms to health and social care services and how they might impact upon services for people with continence, lower urinary and bowel symptoms
- Develop recommendations on the steps which need to be taken to improve outcomes for patients with LUTS, a subset of continence, lower urinary and bowel symptoms, taking into account the reforms
- Identify a series of actions to encourage policymakers and commissioners to take action to improve services

The hosting and facilitation of the meeting on which this report is based were supported by Astellas Pharma Limited. With the exception of a review by Astellas Pharma Ltd. for overall compliance with the ABPI Code of Practice, editorial control rests with the members of the expert group, who are listed in Appendix 1.

Continence, lower urinary and bowel symptoms

Continence, lower urinary and bowel symptoms consist of a range of conditions ranging from faecal incontinence to overactive bladder syndrome, urinary incontinence and benign prostatic obstruction (BPO). One study of 19,165 people found that a subset of these symptoms, lower urinary tract symptoms (LUTS) affected 2 in 3 people aged 18 and over¹.

Continence, lower urinary and bowel symptoms can have a considerable impact on people's physical, mental and economic wellbeing². In

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addition to causing significant health complications, failure to manage symptoms can lead to people being socially isolated and withdrawn from society³.

The good news is that there are a range of effective interventions which can help most patients manage their condition^{2,4,5}. Yet despite this, the management of continence, lower urinary and bowel symptoms has often been given a low priority within the NHS, leading to many people suffering in silence, damaging their health and quality of life.

There are many similarities and links between different urinary and bowel conditions, and continence problems can be a common underpinning theme. It therefore makes sense to join up the commissioning and delivery of these services where possible, despite the fact that there are important differences between bowel and lower urinary tract conditions. This report primarily addresses lower urinary tract symptoms, as this is where the expertise of the group that developed the recommendations is centred.

There are significant gaps in the services available to patients with continence, lower urinary and bowel symptoms. The gaps in services for people with continence, which is one of the conditions associated with these symptoms, were illustrated by a national audit carried out in 2010⁶ which found that:

- Only four services in England met the requirements set out in *Good practice in Continence Care*³ and reiterated in the *National Service Framework for Older People*⁷
- No diagnosis was made in a significant number of older patients, 38% of those in mental healthcare and 19% in primary care, limiting the scope of treatment
- Across the board, older patients (aged 65 years and above) are less likely to have evidence based assessment and management
- Structured staff training in managing incontinent individuals only takes place in a minority of acute hospital and mental health care settings

These data underline the need to rapidly improve services for people with continence, lower urinary and bowel symptoms. The roadmap exists for how to achieve this: there is a consensus on the standards of care which should be provided for people affected by the symptoms. Guidance from the Department of Health and NICE sets out the standards that commissioners and providers should reach in supporting people affected by continence, lower urinary or bowel symptoms^{3, 4, 5, 7}.

An appropriate care pathway should include providing patients with a full initial assessment of their symptoms from a trained professional, together with a detailed care plan to manage their condition. Where symptoms do not respond to conservative management, patients are offered referral for specialist assessment, which may lead to surgery.

The challenge, therefore, is not about developing evidence on what works, but rather in translating this into action. The current healthcare environment, with potential disruption to services created by both reform and the imperative of finding savings, presents both challenges and opportunities. This report sets out the constructive recommendations of experts about how services can be improved in a sustainable, consistent and affordable manner, using the opportunities created by the NHS reforms whilst also mitigating the risks posed by these organisational changes and financial pressures. The case for acting now to improve services and outcomes is compelling: without improvement, the health and economic impact of continence, lower urinary and bowel symptoms will continue to grow. Put simply, the NHS cannot afford *not* to improve services.

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2. Summary of recommendations

1. Commissioners of continence, lower urinary and bowel symptoms services should use the data included in the National Audit of Continence Care to create a baseline assessment of services in their areas, benchmarking performance against that of others
2. Providers should use the findings of the National Audit of Continence Care to identify and spread good practice
3. The National Audit of Continence Care should be extended to cover all LUTS as well as continence issues and participation should be included in the national model contract, ensuring that it is a condition of payment for all providers
4. A national audit of LUTS and continence services should take place on an annual basis to ensure that the information can be used to drive up the quality of services
5. Detailed quality measures should be developed to help commissioners assess the contribution of continence, lower urinary and bowel symptoms services towards delivering on the high level outcomes goals described in the public health, NHS and social care outcomes frameworks.
6. All providers should be required to collect information on Patient Reported Outcome Measures and Patient Reported Experience Measures. These data should be submitted to commissioners and also provided to the Health and Social Care Information Centre
7. NICE should prioritise the development of quality standards for LUTS in men, incontinence in women and faecal incontinence
8. The Department of Health should develop a commissioning support pack to assist clinical commissioning groups in commissioning high quality services for lower urinary tract, continence and bowel symptoms
9. National tariffs should be introduced for continence services to encourage providers to develop, maintain and promote high quality care provision, as well as to seek out those patients who require help

10. The Department of Health should introduce an incentive to reward the delivery of high quality care for the management of continence, lower urinary and bowel symptoms through the CQUIN payment framework
11. Commissioners should promote details of what services are available locally and how to access them
12. Information on local services should be added to the NHS Choices website www.nhs.uk under the 'Find services' directory
13. Commissioners and providers should publicise details of patient support services such as that operated by the Bladder and Bowel Foundation - www.bladderandbowelfoundation.org
14. With responsibility for delivering services for people with continence, lower urinary and bowel symptoms cutting across public health, the NHS and social care services, local HealthWatch groups should consider lower urinary tract, continence and bowel symptom services as an early candidate for attention
15. The Care Quality Commission should publish all data relating to the quality of continence care in individual residential care homes collected as part of its Meeting the healthcare needs of people living in care homes investigation
16. Where failings are identified as a result of the Care Quality Commission's Meeting the healthcare needs of people living in care homes³² investigation, providers should be required to develop and publish action plans setting out how these failings will be addressed
17. The Care Quality Commission should include metrics of quality in LUTS services within its Quality Risk Profile process

3. About continence, lower urinary tract and bowel symptoms

Continence, lower urinary and bowel symptoms includes a range of symptoms, from lower urinary tract symptoms to urinary and bowel incontinence. Table 1 sets out these conditions in more detail and associated clinical guidance.

Table 1: Breakdown of the symptoms and clinical guidance for continence, lower urinary tract and faecal incontinence^{2, 3, 4, 5, 7}

Condition	Symptoms	Relevant guidance
Urinary incontinence and Lower Urinary Tract Symptoms (LUTS)	Symptoms associated with LUTS include: <ul style="list-style-type: none">- symptoms of urgency, with or without urgency incontinence- slow stream, hesitancy and terminal dribble- loss of a few drops of urine after the main stream when the bladder appears to be empty- involuntary urine leakage on effort or exertion or on sneezing or coughing	Good practice in continence care, National Service Framework for older people, NICE Clinical Guideline 40, NICE Clinical Guideline 97
Faecal incontinence	The involuntary loss of solid or liquid stool	Good practice in continence care, National Service Framework for older people, Clinical Guideline 49

The impact on patients

Continence, lower urinary and bowel symptoms can have a considerable impact on physical, mental and social wellbeing. Many people suffer in silence or believe that it is an inevitable part of ageing. Continence, lower urinary and bowel symptoms are linked with depression and many patients are socially isolated by their condition⁸.

The Department of Health's *Good practice in continence services* details the negative impact of incontinence on people's lives and on society³. It states:

“Faecal and urinary incontinence is distressing, unpleasant and frequently socially disruptive...As a social issue, failure to manage

faecal and urinary incontinence can lead to bullying of...adults in the workplace and older people in residential care and nursing homes; restrict employment, educational and leisure opportunities; lead to social embarrassment and social exclusion; result in people moving to residential and nursing homes - incontinence is second only to dementia as an initiating factor for such moves; cause conflict between the individual and their carer.”

As well as affecting mental and social wellbeing, continence, lower urinary and bowel symptoms are frequently associated with comorbidities which also have a negative impact on a patient’s quality of life, including skin infections, urinary tract infections, falls and fractures. Stroke, obesity, diabetes, congestive heart failure and dementia all have been found to increase an individual’s risk of urinary incontinence⁹.

Patient case study

Emma is a married mother with four grown-up children and the director of a successful business. As well as being a member of local charities and skills exchange schemes, she enjoys a busy and active professional and social life. However, she developed urge urinary incontinence (UUI) following a tension-free vaginal tape (TVT) procedure, first noticing urge symptoms when travelling in the United States shortly afterwards. Emma described her experience as a ‘private hell’ and the impact on her life as ‘enormous’, confessing to going to great lengths to hide her symptoms due to embarrassment and the false presumption that she could not be helped.

Whilst abroad, she was prescribed antibiotics, advised to increase her fluid intake and instructed to visit her GP when returning home. For the remainder of her trip, the symptoms deteriorated to the extent that she was visiting the toilet on an hourly basis. Despite experiencing significant discomfort and disruption, Emma failed to visit her GP when she returned home after becoming accustomed to ‘managing’ her symptoms and convincing herself there was no major problem.

After months of tolerating LUTS, Emma finally arranged an appointment with her GP after being prompted by a friend.

Following an initial consultation, her doctor prescribed another course of antibiotics, indicated the symptoms were likely to be the side effects of the earlier operation and suggested an appointment with the Practice Nurse who recommended incontinence pads.

A month later, Emma organised an appointment with a different, female GP. She recommended keeping a daily diary of toilet visits. This exercise served to demonstrate the significant impact her condition was having on her daily life including disrupted sleeping patterns, curtailed meetings at work, prolonged car journeys due to regular bathroom breaks, and being forced to switch to First Class rail travel in order to have better access to the onboard toilet facilities.

On the advice of the GP, Emma made a concerted effort to help monitor her condition by keeping a bladder diary that required her to urinate into a measuring jug to accurately record her symptoms. At the same time she also limited her fluid intake being careful to avoid caffeine, fizzy drinks and alcohol, embarked on a weight loss programme and cut out any strenuous physical activities. Additionally Emma paid for private physiotherapy sessions to help strengthen her pelvic floor muscles and underwent cognitive behavioural therapy with minimal effect.

After two years of various interactions with health professionals, significant lifestyle changes and personal sacrifices, Emma had not seen any noticeable improvements in her condition. Finally after suffering a 'break down' whilst driving, she sought the help of a Consultant Urogynaecologist she had met through work who contacted her GP to request a pharmacological intervention, urodynamic tests and a meeting with his specialist continence advisor.

Emma ended up paying for this treatment privately which allowed her to 'get her life back' and now leads a full and active life, confident in the fact that her condition is under control. She admits to feeling let down by the healthcare professionals she would expect and trust to be able to identify her symptoms and take the necessary action to treat them.

Subsequently Emma has had conversations with both of the GPs she initially saw to relay her experiences and discuss what pathways and protocols they would typically follow for a patient presenting with LUTS symptoms.

Emma appreciates that GPs face many pressures on their time, however both admitted to having little or no contact with the district nurse who organises the local continence services and that in their eyes she was 'too young to be a continence patient'.

It seems clear to her that they would have acted more positively or

proactively to a problem with clearer guidance and if they were better equipped to identify such problems.

A failure to treat symptoms adequately can have a significant impact on the quality of life for older patients and can lead to falls and fractures. The National Service Framework (NSF) for older people⁷ made the reduction of falls and their impact a priority and recognised urinary incontinence as a contributory factor. People who suffer from urinary incontinence often have to rush to the toilet to avoid an incontinence episode, which could be several times during the night if they have nocturia. About 25% of falls occur at night and more than half of these occur in relation to toilet visits¹⁰. Furthermore the Royal College of Physicians national audit of falls and bone health in older people found that over a third of hip fracture patients were identified as having impaired urinary function¹¹.

As well as its impact on patients, annual NHS expenditure on treating urinary and faecal incontinence in adults is estimated at £500 million¹².

Prevalence

Given the wide range of symptoms and conditions experienced by people with continence, lower urinary and bowel symptoms, estimates of prevalence can vary. LUTS, which form a significant part of the overall burden of continence, lower urinary and bowel symptoms; are a range of symptoms that commonly affect both men and women of all ages. The 2006 EPIC study of 19,165 people in Canada, Germany, Italy, Sweden, and the United Kingdom aged 18 and over revealed that 62.5% of men and 66.6% of women suffered from at least one form of LUTS¹. Applied to the UK this would mean that more than 31.6 million suffer from LUTS¹³. A more conservative estimate puts the prevalence of regular LUTS in men aged 40 and over in the UK at 47%, with the prevalence amongst women aged 40 and over being 46%¹⁴. In the UK, this would represent 6.8 million men and 7.4 million women aged 40 and over experiencing regular LUTS¹³.

Prevalence of LUTS is known to increase as people grow older, with 90% of men aged 50 to 80 years old reported to suffer from potentially troublesome LUTS¹⁵. The prevalence of urinary incontinence alone amongst men and women living in residential homes is particularly high, with a third of people in residential care and almost two thirds in nursing homes suffering from the condition³.

Faecal incontinence is estimated to affect up to 10% of adults, with prevalence rising with age and those in long-term care¹⁶. It is likely that over 200,000 adults in the UK experience regular faecal incontinence which impacts significantly on their quality of life^{13, 17}. However these figures are likely to be significantly higher as many cases go under-reported as people feel too embarrassed to present symptoms to healthcare professionals¹⁸.

Continence, lower urinary and bowel symptoms in numbers^{1, 13, 17, 12}

Up to 2 in 3

Adults will suffer from at least one form of LUTS in their lifetime

Over 30 million

Adults in the UK may experience LUTS in their lifetime

Over 200,000

Incidence of faecal incontinence in adults over 40 in the UK

£500m

Estimated NHS annual expenditure on urinary and faecal incontinence

4. The management of LUTS

It is important that the provision of LUTS and bowel services is coordinated; given the similarities between the conditions and that some patients will experience a range of symptoms. The focus of this report is on LUTS, as this is where the group has the most expertise, although many of the recommendations set out in this report will be applicable to bowel services as well as LUTS.

The symptoms experienced by people with LUTS vary, and there are a number of interventions that are used to help them to manage their condition, depending on its severity. These interventions can vary from simple lifestyle changes to complex surgery, and often patients will move along a 'ladder of intervention' until they find the most appropriate way for them to manage their condition. The interventions involved will be different for men and women. Set out in Figure 1 below are key levels of intervention for the management of LUTS in women and men. All discussions about management and treatment should be based on a partnership between the professional and the patient, involving patients in decisions about their own care.

Figure 1: The typical ladder of intervention for the management of urinary incontinence in women² and for the management of LUTS in men⁴



The interventions involved in each of these steps will vary by patient. Table 2 sets out some of the key interventions that should take place at each step of the ladder.

Table 2: Some interventions involved in the management of LUTS

Stage	Interventions
<p>Initial assessment and investigation</p>	<p>An initial assessment is generally made within a primary care setting to review a patient's general medical history and identify the possible causes of LUTS. This will typically involve an abdominal exam, urinalysis and the completion of a bladder diary. Part of the assessment will also include the exclusion of acute or chronic infections and blood tests.</p> <p>Men: For men assessment should involve a urinary frequency volume chart, examination of the abdomen and external genitalia and a digital rectal examination. Men who have suspected renal impairment or urological cancer will be referred for specialist assessment⁴.</p> <p>Women: For women, assessment should include completing a bladder diary and categorising symptoms. A urine dipstick test should be used to detect blood, glucose, protein, leucocytes and nitrites².</p>
<p>Conservative management</p>	<p>Initial management can involve providing patients with lifestyle advice on losing weight, taking exercise, and reducing caffeine and alcohol intake. For both men and women it may also involve providing temporary containment products.</p> <p>Men: Supervised bladder training may be offered to men with OAB. Men with stress urinary incontinence should be offered supervised pelvic floor muscle training⁴. Conservative management can also involve drug treatment. For men this may include alpha blockers, an anticholinergic for OAB, a 5-alpha reductase inhibitor or a combination of these⁴.</p> <p>Women: First-line treatment for women with stress or mixed UI should be supervised pelvic floor muscle training. Women with OAB may be offered supervised bladder training².</p> <p>Conservative management can also involve drug treatment. Women with overactive bladder should be treated with antimuscarinic drugs. Drug treatments are of limited use for women with stress urinary incontinence².</p>

Surgery	<p>Patients with severe symptoms that have not responded to either conservative management or drug treatment may be offered surgery.</p> <p>Men: For men this could include implantation of an artificial sphincter, cystoplasty or injection of botulinum toxin into the bladder wall⁴.</p> <p>Women: For women surgery can involve retropubic suspension. Women with stress urinary incontinence treatment can have procedures including synthetic tapes or intramural bulking agents².</p>
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Ensuring the optimum configuration of services

There is guidance on how health services should be designed to deliver high quality care for patients with LUTS, ensuring that they have access to the most appropriate interventions for them, at the time when they need it. *Good practice in continence services*³ establishes both the principles that underpin good continence service delivery and provides specific details on how continence services should be organised across primary care, secondary care and local authorities. The guidance describes an integrated approach to care that is based on local continence advisory services, facilitates user involvement in planning and delivery, enables treatment delivery to normally take place in a primary care setting and provides access to specialist care.

The guidance includes a description of integrated care that underlines the importance of identification and assessment of people with LUTS by primary care staff, those working in nursing and residential homes, and hospital nurses. Given the nature of many LUTS, general practice plays a critical role in the diagnosis and management of symptoms. The average general practice, with a list size of 10,000, could potential see 700 women per year with some form of LUTS¹⁹. The quality of care provided in general practice will therefore be a key determinant not only of patient outcomes but also of health service costs.

Services should have arrangements in place for referral to specialist units that can provide sophisticated investigative procedures and perform appropriate invasive surgery when required.

Care homes, in order to provide for residents with LUTS, should employ staff trained to identify and assess residents' continence status and maintain accurate details on:

- The presence and severity of symptoms
- Whether an assessment has been made
- Whether a management plan is in place
- Outcomes from treatment
- Patient-reported measures of progress

5. Gaps in services

It is clear that there is good evidence of how services for people with LUTS should be managed, as there is for faecal incontinence¹⁶. Despite the availability of this guidance⁷, many gaps in service provision remain. These gaps⁶, some of which are identified in the *National Audit of Continence Care*, can have a direct impact on patient outcomes.

The *National Audit of Continence Care*⁶ is carried out with the aims of:

- Improving care for people with continence problems as highlighted in *Good practice in Continence Services*
- Monitoring the *National Service Framework for Older People* milestone for establishing integrated continence services
- Monitoring the implementation of NICE guidelines on urinary incontinence in women (CG40) and faecal incontinence (CG49)
- Providing a baseline assessment with respect to the NICE guidelines on the management of lower urinary tract symptoms in men

Commissioned by the Healthcare Quality Improvement Partnership (HQIP) and carried out by the Royal College of Physicians' Clinical Effectiveness and Evaluation Unit (CEEU), the 2010 Audit found serious shortcomings in continence services across England, with significant variations in the level and quality of care available.

All NHS trusts in England, Wales and Northern Ireland were potentially eligible to take part in the audit. Once sites signed up to participate they were required to register and then designate a site (or sites) from within their trust to collect the data. Independent care home providers were also invited to become involved.

This chapter sets out some of the key areas where improvement is needed. We believe that these gaps in continence services also apply to people with other symptoms included in LUTS.

Integration of services

Care for patients with LUTS takes place across different NHS and social care settings. Reflecting this fact, *Good practice in Continence Services*³ underlines the importance of integrating care across healthcare settings. However, the Audit found that only four services across the country fulfil all the requirements for integration that are set out in the document⁶, for example, it advocates that services should have a director of integrated services, continence nurse specialists and specialist continence physiotherapists³. This is particularly concerning as data show that those services that do comply with these recommendations provide higher quality care for their patients²⁰.

Diagnosis and assessment

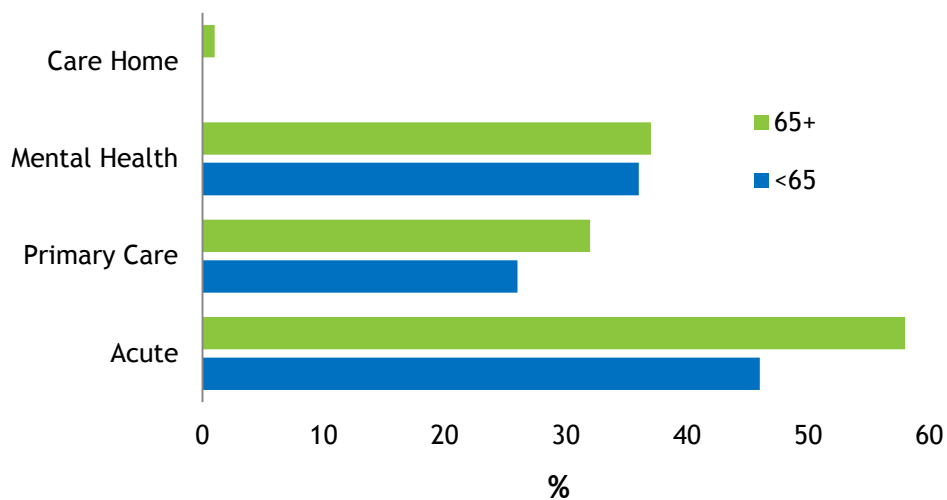
LUTS and continence often go undiagnosed, partly because individuals are often too embarrassed to come forward and seek help for their symptoms. The 2010 Audit found that no diagnosis was documented in a large proportion of older patients who had consulted a healthcare professional, ranging from 19% in primary care to 38% in mental health care⁶.

Treatment

Gaps in the treatment of people with bladder and bowel incontinence have been identified, including poorly documented care plans, lower rates of some bladder treatments than would be expected, and lack of referrals to specialist care for older patients⁶.

As Figure 2 demonstrates, only 42% of over 65s and 54% of under 65s in acute care had a documented continence care plan. Where care plans were in place in acute settings, these were rarely shared with patients (only 15% of patients over 65 and 22% under 65s had a care plan shared with them). While the figures are higher in primary care, it is clear that many patients have not had a care plan developed for them. This is particularly worrying given the critical role that self-management can play in delivering good and affordable outcomes for continence, lower urinary and bowel symptoms. The audit also found significant variation according to provider. For example, 100% of patients at Derby Hospitals NHS Foundation Trust had a documented care plan compared to only 8% of patients with a recorded care plan at Cambridge University Hospitals Foundation Trust⁶.

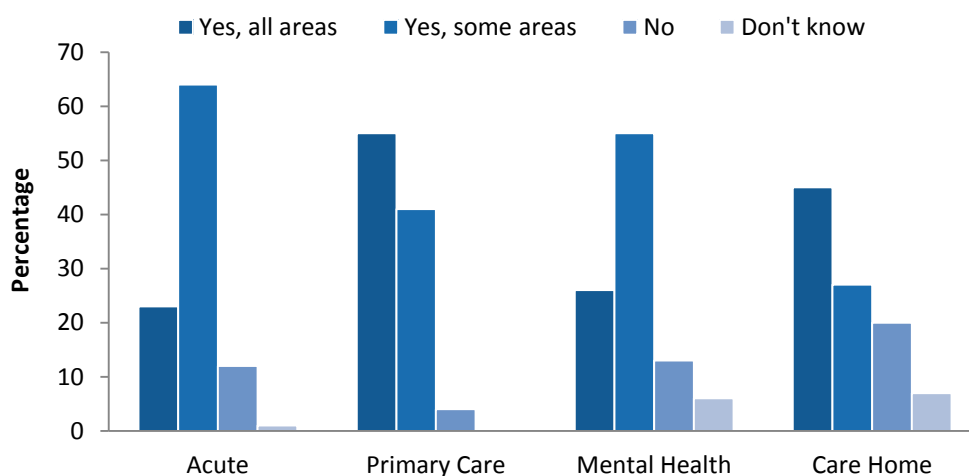
Figure 2: Patients without a documented care plan⁶



Communication with patients

The audit also highlighted gaps in the availability of information for patients. Figure 3 shows that across care setting there were patients and carers missing out on evidence-based information about their care. The research for the audit found that where written information is provided to patients it is unclear that this is followed up with further communication⁶.

Figure 3: Access to evidence-based information about bladder and bowel care patients and carers⁶



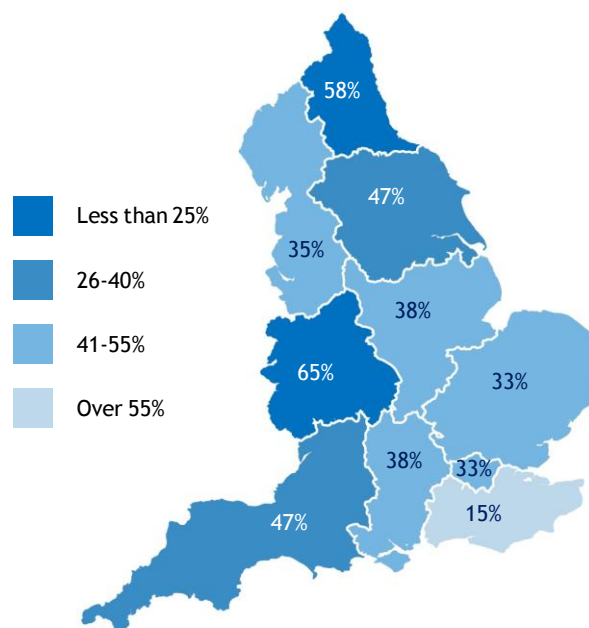
Inequalities

The Audit paints a clear picture of inequalities in the provision of continence services. Older patients (aged 65 years and above) are less likely to have evidence-based assessment and management, and communications with older people (particularly in acute settings) is poor⁶. This is particularly concerning as prevalence increases significantly in older age groups³.

The care that patients receive also depends on the service that they use. For example, while some acute services have a written policy for the management of continence and make use of an integrated pathway, others have failed to develop a strategy in this area. Figure 4 shows how the percentage of acute trusts with a policy in place for the management of continence varies by Strategic Health Authority (SHA). In the South East Coast SHA area only 15% of acute services have a written policy in place for the management of continence, compared to 65% in the West Midlands.

Therefore there are opportunities for trusts to learn from examples of good practice elsewhere in the country.

Figure 4: Percentage of acute trusts with a written policy in place for the management of continence⁶



Recommendation 1: Commissioners of continence, lower urinary and bowel symptoms services should use the data included in the National Audit of Continence Care to create a baseline assessment of services in their areas, benchmarking performance against that of others

Recommendation 2: Providers should use the findings of the National Audit of Continence Care to identify and spread good practice

Need for further audit

National audit of clinical and organisational practice has been shown to drive up the quality of services in the NHS. For example:

- The Society for Cardiothoracic Surgery has associated the introduction of an audited electronic database of outcomes of all adult cardiac surgical operations in the United Kingdom with a more than 50% improvement in risk-adjusted mortality²¹
- The National Bowel Cancer Audit saw an increase in the involvement of cancer nurse specialists in bowel cancer care from 41% to 51% between 2007 and 2008, demonstrating a clear benefit to patients in the process²²

While the National Audit of Continence Care provides a useful insight into the state of continence services in the UK, there are clear limitations in

terms of data quality, particularly regarding the commissioning of services. For example, the audit does not have universal participation and so provides an incomplete picture. As the survey is not carried out on an annual basis it is difficult to get a clear picture of the rate at which services are developing.

It is essential that a comprehensive assessment of the commissioning of services for continence, lower urinary and bowel symptoms is undertaken. Better participation could be incentivised by linking inclusion in the audit to the payment that a service attracts.

Given the findings of the National Audit of Continence Care, it will be important that the exercise is repeated and extended to include all forms of LUTS as well as continence so progress in improving services for all people with LUTS can be assessed. Such an audit would provide commissioners with a mechanism for managing the performance of providers on this area of care.

Recommendation 3: The National Audit of Continence Care should be extended to cover all LUTS as well as continence issues and participation should be included in the national model contract, ensuring that it is a condition of payment for all providers

Recommendation 4: A national audit of LUTS and continence services should take place on an annual basis to ensure that the information can be used to drive up the quality of services

6. Delivering world class outcomes for people with lower urinary tract symptoms

As described in Chapter 5 there is compelling evidence that a step change in the quality of care for people with LUTS is needed urgently. There are significant variations in the way patients are assessed and very few services are designed in a way that mirrors the guidance on how care should be delivered. A recent survey found that only 46% of GPs say that they are adhering to NICE Clinical Guideline 97 on the management of LUTS in men²³. Nonetheless, it is important that the need to improve services for people with LUTS is seen within the context of the reforms that are currently taking place in the NHS, as well as the imperative to achieve significant savings. This period of considerable change provides a real opportunity to raise the profile of LUTS and to improve the quality of care. However, there is also the potential for care to become more disjointed if LUTS is allowed to remain largely ignored by many parts of the service.

Focusing on the outcomes that matter

The Government has made clear its intention to focus on health outcomes rather than process measures. Given the time lag that can exist in measuring definitive outcomes, it will be important to assess the quality of services as a good proxy for outcomes. In the past, services for lower urinary tract symptoms and continence issues have been largely ignored in NHS performance management because they do not readily lend themselves to process measurement. It will be important that this does not occur in relation to measures of quality or outcomes.

The Government has published a series of outcomes frameworks for public health, NHS and social care services in either draft or final form, which set out the high level outcomes against which services will be assessed^{24, 25, 26}. Table 2 shows that improving services for LUTS will help to deliver better outcomes in many of the domains contained in these outcomes frameworks.

Table 2: Relevance of improving outcomes for LUTS to delivery of the NHS²⁴, public health²⁵ and social care²⁶ outcomes frameworks

	Domain Indicator	Domain number	Supported by good quality care for patients with LUTS
Public Health	Helping people to live healthy lifestyles	3	Good care supports conservative management of symptoms, thus reducing admissions to secondary care and unnecessary treatments ⁴
	Reducing the number of people living with preventable ill health	4	For most people LUTS are treatable with a proper assessment and a personalised care plan ³
NHS	Enhancing quality of life for people with long-term conditions	2	Good quality care for patients with LUTS allows them to manage their condition and lead a less restrictive life ³
	Helping people recover from periods of ill-health or injury	3	Good management of LUTS reduces the risk and severity of co-morbidities ⁸
	Ensure that people have a positive experience of care	4	Early identification and assessment supported by access to clinical nurse specialists provides a better care experience ³
	Treating and caring for people in a safe environment and protecting them from avoidable harm	5	Good quality care for people with LUTS who live in residential care reduces the risk of falls ¹¹ and the occurrence of pressure sores ³
	Promoting personalisation and enhancing quality of life for people with care and support needs	1	Personalised care plans based on proper diagnosis allow people to enjoy a better quality of life and not have their daily lives restricted by their condition ³
Social Care	Preventing deterioration, delaying dependency and supporting recovery	2	Good care enables people to better manage their own condition ⁴
	Ensuring a positive experience of care and support	3	Early identification and assessment supported by access to clinical nurse specialists provides a better care experience ³
	Protecting from avoidable harm and caring in a safe environment	4	Good quality care for people with LUTS who live in residential care reduces the risk of falls ¹⁰ and the occurrence of pressure sores ³

The outcomes frameworks set out high level outcome measures, but it will be important to develop more detailed measures to assess the contribution made by different services towards delivering on the high level goals.

Recommendation 5: Detailed quality measures should be developed to help commissioners assess the contribution of continence, lower urinary

and bowel symptoms services towards delivering on the high level outcomes goals described in the public health, NHS and social care outcomes frameworks.

Table 3 outlines a series of indicators that could be used to measure the quality of the management of LUTS, mapped against the overarching domains in the NHS Outcomes Framework. These indicators reflect the elements of good care described in *Good practice in Continence Services*³.

Table 3: Suggested indicators for measuring the quality of the management of LUTS

Indicator	NHS Outcomes Framework Domain	Source for measurement
Proportion of patients identified with LUTS where this is recorded in the patient record, as a proportion of estimated prevalence	2	General Practice patient records
Proportion of patients with a recorded diagnosis of LUTS treated in accordance with NICE guidance	2	General Practice patient records
The % of patients who present with LUTS who are offered an assessment from a trained professional	2, 3 and 4	The National Audit of Continence Care
The % of patients given advice on lifestyle interventions following initial assessment	2 and 4	Provider audit
The % of patients with a care plan	2, 3, 4, and 5	Provider audit
The % of patients with access to a specialist continence nurse, or specialist continence physiotherapist for advice and support in the management of their condition	2,3 and 4	Patient reported data
Enabling patients to manage their conditions at home	2,3 and 4	Patient reported data
Referring patients who have recurrent LUTS that have not responded to conservative management or drug therapy for specialist assessment.	2 and 4	Hospital episode statistics
Reducing the referral rates to secondary care	2, 4 and 5	Hospital episode statistics
People entering residential homes provided with a LUTS assessment by a trained professional	2, 4 and 5	Provider audit
Volume of specialist procedures undertaken by providers	1	Hospital episode statistics

These metrics could be used to measure the performance of individual providers of LUTS interventions, as well as the commissioners of services,

through NICE quality standards and the Commissioning Outcomes Framework.

Given the long-term nature of LUTS and the impact that they can have on a person's quality of life, patient reported feedback should also play a critical role in measuring outcomes. This is consistent with the approach set out in Domain 4 of the NHS Outcomes Framework²⁴. Patient-reported feedback can take two main forms:

- **Patient Reported Outcome Measures (PROMs)**, whereby patients provide feedback on changes to their functional status and quality of life. An example is the International Consultation on Incontinence Modular Questionnaire (ICIQ) which provides brief and robust measures to evaluate the impact of lower urinary tract dysfunction, vaginal symptoms and lower bowel dysfunction on a patient's quality of life and outcome of treatment^{27, 28}
- **Patient Reported Experience Measures (PREMs)**, whereby patients provide feedback on their experience of care, including whether they felt different needs (such as information) were met effectively. An example is the National NHS Inpatient Survey²⁹

The importance of collecting patient reported outcome measurements (PROMS)

With patient outcomes at the heart of recent health policy it is unsurprising that clinicians and commissioners are talking about PROMS. Measuring the impact treatment has on a patient's quality of life, rather than scoring the reduction in physical symptoms is not common practice. However, there is a desire amongst many clinicians to implement routine PROMS collection. PROMs can be used by the patient to monitor how their treatment is affecting their day to day life by comparing their scores to scoring prior to treatment. Also, patients can look at the anonymised scores of other patients to decide which treatments will have the greatest positive impact on their lives. Clinicians can potentially use PROMS to evaluate the success of the treatments offered, bench mark their clinical practice against colleagues and utilise the information for revalidation. Commissioners can use the data to monitor the success that a service is having on patients' wellbeing.

Recommendation 6: All providers should be required to collect information on Patient Reported Outcome Measures and Patient Reported Experience Measures. These data should be submitted to commissioners and also provided to the Health and Social Care Information Centre

Threats to improving outcomes

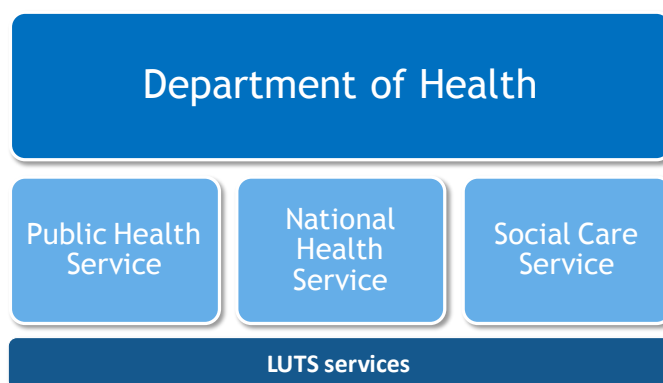
Whilst the health reforms provide an opportunity to improve the quality of care for people with LUTS, there are also inherent risks which need to be addressed in order to avoid the already disjointed standard of care deteriorating further. These threats can be summarised as service destabilisation, fragmentation and financial.

Within the new organisational structure, the Department of Health will oversee separate services for public health, the NHS and social care services (see Figure 5). The responsibility for delivering services for people with continence, lower urinary and bowel symptoms will straddle these three services:

- Prevention and awareness campaigns will be the responsibility of the new public health service
- Diagnosis and treatment will sit within the NHS
- Many people with symptoms will be cared for within a social care setting

Although this structure could create clarity of accountability, it does give rise to the possibility that services will become further fragmented, compromising the integration of care across the pathway and placing organisational and funding barriers in the way of high quality, seamless care.

Figure 5: Integration of LUTS services across the NHS, public health and social care³⁰



The financial situation facing health services also poses a risk too as the NHS has been instructed to make savings of £20 billion over the next four years and both commissioners and providers are under enormous pressure to make savings. This situation is replicated in social care, with local authorities also under pressure to realise cost savings.

Financial pressures, changes in organisational structures and the introduction of competition all have the potential to destabilise providers of LUTS services unless financial flows are designed in a way which fully reflects the cost of providing high quality care.

Ensuring that the right guidance, incentives and accountability measures are in place for both commissioners and providers will therefore be critical in ensuring that short-sighted cuts are not made to LUTS services which compromise patient care and outcomes and lead to further downstream costs.

Commissioning and incentives

Enabling commissioners to exercise strong oversight of providers and to make decisions based on population need and service quality rather than cost alone will be critical to delivering better outcomes for people with LUTS. In order to ensure that clinical commissioning groups are able to do this, it will be necessary to provide these groups with clear statements about what good care looks like. Whilst there is guidance in existence it can be overlooked by commissioners tasked with managing services for many different conditions.

Quality standards provide commissioners with short, simple statements of what good quality care is and how it should be measured. NICE has published a proposed library of NHS healthcare topics for quality standard

development which includes both urinary incontinence (women) and lower urinary tract symptoms (men)³¹. As clinical guidance on LUTS is already in existence⁴, developing a quality standard should be a relatively straightforward exercise. NICE is also in the process of updating its guidance on urinary incontinence in women², this presents an ideal opportunity to develop a quality standard simultaneously.

There are a range of initiatives that could be undertaken to support commissioners. Ultimately, the quality of commissioning will be measured against the Commissioning Outcomes Framework, which in turn will be drawn from quality standards developed by NICE and the high level outcomes described in the NHS Outcomes Framework.

Recommendation 7: NICE should prioritise the development of quality standards for LUTS in men, incontinence in women and faecal incontinence

The list of indicators listed above in Table 3 could be included in a quality standard for LUTS. Other potential measures include:

- Primary care practitioners receiving patients presenting with LUTS to be trained in assessing LUTS and evaluating care according to individual needs
- Drug treatments could be offered to patients with LUTS in conjunction with conservative management options or where they have been unsuccessful and clinically appropriate
- Surgeons who perform procedures for urinary incontinence, overactive bladder (OAB) and Benign Prostatic Obstruction (BPO) should have the relevant training and carry out a sufficient case load to maintain their skills

A quality standard alone will not, however, provide sufficient support to commissioners. Although the greater clinical involvement in commissioning which will result from clinical commissioning groups should be of benefit to the management of LUTS, it is important to note that many commissioners may still have little or no experience of LUTS.

The Department of Health has announced that it intends to provide a range of commissioning support packs to assist clinical commissioning groups and others in commissioning services for specific conditions and this approach should be extended to LUTS. The All-Party Group on Continence Care has developed a guide for commissioners on the commissioning of continence services, setting out the importance of strategic planning and monitoring and evaluating services¹⁹.

This expert group was organised and sponsored by Astellas Pharma Ltd. MHP Health Mandate were funded by Astellas to chair, facilitate and write up a report of the expert group meeting. Members of the expert group have reviewed and approved the content of the report ahead of use. Astellas has had no input to the report.

Commissioning support packs for lower urinary tract, continence and bowel symptoms would ensure that the new commissioning organisations do not overlook LUTS. Relevant information could include the following:

- A model patient pathway
- Specifications for different services required on the patient pathway
- Data on prevalence and need as well as economic impact illustrations
- Summary of NICE guidance
- A summary of the quality standard for LUTS when it is produced
- Outcomes metrics as described above
- Patient Reported Outcomes measures

Recommendation 8: The Department of Health should develop a commissioning support pack to assist clinical commissioning groups in commissioning high quality services for lower urinary tract, continence and bowel symptoms

High quality commissioning will be supported by the development of appropriate national tariffs for LUTS care as part of the move to the Any Qualified Provider system. A tariff should:

- Incentivise providers to reach out to potential patients as this would generate more income, encouraging the identification of those patients needing help but who are simply unaware of their treatment options or who are too embarrassed to seek help
- Reduce the transactional costs associated with establishing community continence services
- Create a mechanism for rewarding quality rather than simply commissioning services on the basis of cost

The establishment of national tariffs is important as it prevents competition being based on price rather than the quality of service provided to patients. Currently, community LUTS services are mainly reimbursed through block contracts, so it should be recognised that the introduction of national tariffs represents a major shift.

Recommendation 9: National tariffs should be introduced for continence services to encourage providers to develop, maintain and promote high quality care provision, as well as to seek out those patients who require help

In addition to the development of national tariffs, the NHS Commissioning for Quality and Innovation (CQUIN) framework provides an opportunity for commissioners to financially reward providers for delivering

improvements in quality. There are a range of potential measures that could be employed in the CQUINs framework to enable commissioners to incentivise providers to deliver high quality care for patients with LUTS and might include the proportion of at risk patients receiving a basic LUTS assessment.

Recommendation 10: The Department of Health should introduce an incentive to reward the delivery of high quality care for the management of continence, lower urinary and bowel symptoms through the CQUIN payment framework

Patient choice and information

The introduction of choice of Any Qualified Provider for continence services will make it possible for patients to choose, where appropriate, from a range of providers that are qualified to provide safe, high quality care and treatment - and select the one that best meets their needs³².

This extension of choice to patients with LUTS has the potential to act as a driver for improvement in the delivery of good quality care. However, it is important that such choice is informed and one of the barriers to good quality care is the lack of public awareness about LUTS. The low levels of awareness will need to be addressed if informed choice is to become a reality. Crucially, people must be made aware that LUTS are not simply a natural consequence of ageing and that the condition can be managed effectively. The most important informed choice patients can make is to present themselves to a health professional that is qualified to make a proper assessment of their condition and prepare a treatment plan for the management of the condition.

Because of the current disjointed nature of many LUTS services, speed of access to high quality services is important and choice could play a significant role in improving the accessibility of services, creating a variety of different entry mechanisms to the care pathway. Whilst for many a visit to their local GP will be the normal choice, patients should also be able to self-refer to a continence advisor or specialist continence physiotherapist, in the same way that they can to other NHS services such as family planning services.

Once on the care pathway, patients should be given the opportunity to make informed decisions about changes in lifestyle behaviour, the interventions offered following referral for specialist assessment, and where and when interventions are delivered.

Recommendation 11: Commissioners should promote details of what services are available locally and how to access them

Recommendation 12: Information on local services should be added to the NHS Choices website www.nhs.uk under the 'Find services' directory

Recommendation 13: Commissioners and providers should publicise details of patient support services such as that operated by the Bladder and Bowel Foundation - www.bladderandbowelfoundation.org

Accountability and regulation

Commissioners and providers of LUTS services should be fully accountable to patients and carers, as well as local communities. This will require the collection and publication of appropriate information on the performance of services, including on the measures of quality identified earlier in this report.

Accountability for the quality of services should take a number of forms, including:

- Local health and wellbeing boards should scrutinise the LUTS commissioning plans of clinical commissioning groups and, where these are divergent from the standards set out in the commissioning support pack, they should refer the plans to the NHS Commissioning Board
- Providers should include details of their performance on key LUTS metrics within their quality accounts
- Benchmarked performance data should be published on NHS Choices and other providers of health information so that patients can make an informed assessment of the quality of care available from different providers

In addition to accountability for performance and applying data to improving quality, steps should be taken to ensure effective user involvement in the development of services. HealthWatch, the new consumer health organisation, will have an important role in monitoring local and national health and social care services by seeking feedback from users of services.

Recommendation 14: With responsibility for delivering services for people with continence, lower urinary and bowel symptoms cutting across public health, the NHS and social care services, local HealthWatch groups should consider lower urinary tract, continence and bowel symptom services as an early candidate for attention

Effective regulation can also play an important part in ensuring that services are of sufficient quality. However, it is to be hoped that mechanisms such as stronger commissioning, the measurement of outcomes, the appropriate use of incentives and the impact of informed patient choice should make the need for regulatory intervention redundant.

There will be three main regulators who will be of relevance to LUTS services:

- The Care Quality Commission is the independent regulator for the health and social care sector and will have an important role to play in inspecting all providers of LUTS services. The CQC is currently conducting an investigation into the provision of healthcare in care homes³³, which is due for publication later in 2011. Significantly, one of the key themes of the investigation is that people in care homes should be able to access healthcare which promotes dignity, a measure which is to be tested through continence care. It is to be hoped that this study will assess the performance of care homes in relation to the treatment of patients with LUTS

- Monitor will assume the role of competition regulator for health services. It will be important that Monitor discharges its functions in such a way which promotes appropriate collaboration between providers, as well as intervening if their providers behave in a way which is damaging to patients
- The professional regulators, such as the Nursing and Midwifery Council, have an important role to play in promoting high standards of professional practice, particularly in relation to issues such as dignity in care

Recommendation 15: The Care Quality Commission should publish all data relating to the quality of continence care in individual residential care homes collected as part of its *Meeting the healthcare needs of people living in care homes*³² investigation

Recommendation 16: Where failings are identified as a result of the Care Quality Commission's *Meeting the healthcare needs of people living in care homes* investigation, providers should be required to develop and publish action plans setting out how these failings will be addressed

Recommendation 17: The Care Quality Commission should include metrics of quality in LUTS services within its Quality Risk Profile process

7. Conclusion

A step change in the quality of care for people with LUTS is needed urgently. The quality of care and services varies significantly across the country, and there is little evidence that services are being planned and delivered in line with the best practice guidance available.

The current NHS reforms pose both an opportunity and a challenge for the provision of LUTS services. It is vital that action is taken now to raise the profile of LUTS and improve the quality of care. Using levers in the system it will be possible to achieve these improvements, including by supporting the commissioning of effective LUTS services, through to defining the outcomes that matter to people with LUTS.

We believe that the recommendations set out in this report provide a clear way forward for policymakers, commissioners and clinicians to work together to address the physical, social and financial impact of LUTS, and improve the outcomes and experiences of patients no matter where they live.

Annex 1: Membership of the expert group

Name	Organisation
Professor Paul Abrams	Director, Bristol Urological Institute
Karen Logan OBE	Consultant Nurse Continence Care and Head of Continence Services, Aneurin Bevan Health Board
Dr. Matthew Parsons	Consultant Obstetrician and Gynaecologist, Birmingham Women's Hospital
Dr. Raj Shekhar	Consultant Stroke Physician, the Queen Elizabeth Hospital, King's Lynn
Hilary Shields	Patient representative
Dr. Julian Spinks	General Practitioner at Court View Surgery, Rochester
Annette Woodward	Chair, Chartered Physiotherapists Promoting Continence (CPPC)

In attendance at expert group

Professor Paul Abrams, Director, Bristol Urological Institute
Karen Logan OBE, Consultant Nurse Continence Care and Head of Continence Services, Aneurin Bevan Health Board
Dr. Raj Shekhar, Consultant Stroke Physician, the Queen Elizabeth Hospital, King's Lynn
Matthew Parsons, Consultant Obstetrician and Gynaecologist, Birmingham Women's Hospital
Hilary Shields, Patient representative
Dr. Julian Spinks, General Practitioner at Court View Surgery, Medway PCT
Annette Woodward, Chair, Chartered Physiotherapists Promoting Continence (CPPC)
Elizabeth Riches, Astellas
Julie Mallaby, Astellas
Mike Birtwistle, MHP Health Mandate
Guy Lavis, MHP Health Mandate
Andrew Brown, MHP Health Mandate

ABOUT MHP

Astellas Pharma Ltd has supported the engagement of MHP Health Mandate in facilitating the expert group meeting and drafting subsequent outputs. MHP Health Mandate is an award winning specialist health policy and communications consultancy that specialises in advising a wide range of commercial, NHS and voluntary sector organisations on some of the most high profile issues of the day.

Annex 2: Glossary

Acute care: Care administered in a hospital, for the treatment of a serious injury or illness. Medical conditions requiring acute care are typically characterised by rapid onset, severe symptoms and brief duration.

Benign Prostatic Obstruction (BPO): The enlargement of the prostate gland caused by the effects of male sex hormones. Some men begin to have difficulty in passing water, because the enlarged prostate gland squashes the tube leading from the bladder. This causes the tube to narrow, obstructing urine flow from the body.

Care Quality Commission (CQC): The independent regulator of health and social care in England provided by the NHS, local authorities, private companies and voluntary organisations.

Commissioning: The term used to describe the process of specifying, securing and monitoring of health and care services to meet the needs of a people at a strategic level including assessing population requirements, prioritising health outcomes, procuring products and services and managing service providers.

Continence: The inability to control the bodily evacuative functions of urination or defecation. Incontinence can involve the loss of normal control of the bladder (urinary incontinence) or the bowel (bowel or faecal incontinence).

CQUIN framework: A payment framework that enables commissioners to link a proportion of healthcare providers' income to the achievement of local quality improvement goals.

Lower Urinary Tract Symptoms (LUTS): Classified generally as storage, voiding, and postmicturition symptoms and refer to overactive bladder, urinary incontinence, interstitial cystitis and benign prostatic hyperplasia.

Monitor: The independent regulator of NHS foundation trusts.

NICE: The independent provider of national guidance on promoting good health and preventing and treating ill health.

Overactive Bladder Syndrome: A urological condition that results from sudden, involuntary contraction of the muscle in the wall of the urinary bladder. Overactive bladder causes a sudden and unstoppable need to urinate (urinary urgency), even though the bladder may only contain a small amount of urine.

Primary care: The range of services that are normally the first point of contact for patients - including GP practices, pharmacies and dentists.

Provider: An organisation that provides health or social care services, eg a hospital or nursing home.

Secondary care: Refers to specialist medical care or surgery provided in a hospital setting either as an in-patient or outpatient service. Patients seen in hospitals are generally under the care of a consultant rather than a GP.

Social care: Care services which are provided by local authorities to their residents, or which are commissioned by local authorities (for example, from community & voluntary organisations and from independent providers).

References

- ¹ Irwin D et al, Population-based survey of urinary incontinence, overactive bladder, and other lower urinary tract symptoms in five countries: results of the EPIC study, *European Urology* 2006, 50(6):1306-14
- ² NICE, Clinical Guideline 40: The management of urinary incontinence in women, October 2006
- ³ Department of Health, Good practice in Continence Services, April 2000
- ⁴ NICE, Clinical Guideline 97: The management of lower urinary tract symptoms in men, May 2010
- ⁵ NICE, Clinical Guideline 49: Faecal incontinence: the management of faecal incontinence in adults, June 2007
- ⁶ Royal College of Physicians, National Audit of Continence Care, September 2010
- ⁷ Department of Health, National Service Framework for Older People, May 2001
- ⁸ Darkow T, Fontes C, Williamson T, Costs Associated with the Management of Overactive Bladder and Related Comorbidities, *Pharmacotherapy*, 2005; 25(4): 511-519
- ⁹ Hunskaar S et al, Epidemiology and Natural History of Urinary Incontinence (UI) in Abrams P et al, 2nd International Consultation on Incontinence, 2nd edition: Health Publication Ltd, 2002, 165-201
- ¹⁰ Asplund R, Nocturnal giddiness in relation to nocturia and other symptoms and to medication in the elderly, *Archives of Gerontology and Geriatrics*, 2005, 40: 103-111
- ¹¹ Royal College of Physicians, Falling standards, broken promises - Report of the national audit of falls and bone health in older people 2010, May 2011
- ¹² NICE, The management of faecal incontinence in adults - Draft Scope, 2005
- ¹³ Based on calculations using data from the Office for National Statistics, Mid-2010 Population Estimates: United Kingdom; estimated resident population by single year of age and sex, June 2011
- ¹⁴ Coyne K et al, Prevalence, Bother, and Overlap of LUTS in the US, UK, and Sweden: EpiLUTS, 23rd Annual European Urological Association Congress, March 2008
- ¹⁵ NICE, Full guidance: The management of lower urinary tract symptoms in men, May 2010
- ¹⁶ NICE, Full guidance: The management of faecal incontinence in adults, 2007
- ¹⁷ Perry S et al. Prevalence of faecal incontinence in adults aged 40 years or more living in the community. *Gut* 2002, 50(4):480-4
- ¹⁸ Edwards N, Jones D, The prevalence of faecal incontinence in older people living at home, *Age and Ageing*. 2001, 30: 503-507
- ¹⁹ All Party Parliamentary Group For Continence Care Report, A guide for commissioners written by continence care professionals, May 2011
- ²⁰ Wagg A et al, Do self-reported 'integrated' continence services provide high-quality continence care? *Age Ageing*. 2009, 38(6):730-3
- ²¹ The Society for Cardiothoracic Surgery in Great Britain & Ireland, Maintaining patients' trust: modern medical professionalism 2011, March 2011
- ²² NHS Information Centre, National Bowel Cancer Audit 2009, 2009

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- ²³ Opinion Health, NICE LUTS guideline GP survey, June 2011. See: <http://www.nice.org.uk/newsroom/news/GPsFollowingNICELUTSGuidance.jsp>. (Accessed 24 August 2011)
- ²⁴ Department of Health, NHS Outcomes Framework 2011/12, December 2010
- ²⁵ Department of Health, Healthy Lives, Healthy People: Transparency in Outcomes, March 2010
- ²⁶ Department of Health, Transparency in Outcomes: A framework for adult social care, November 2010
- ²⁷ ICIQ Group, International Consultation on Incontinence Modular Questionnaire (ICIQ) - ICIQ MLUTS: ICIQ-Male Lower Urinary Tract Symptoms, 2005
- ²⁸ ICIQ Group, International Consultation on Incontinence Modular Questionnaire (ICIQ) - ICIQ FLUTS: ICIQ-Female Lower Urinary Tract Symptoms, 2005
- ²⁹ Picker Institute Europe, Inpatient Survey Results 2008, June 2009
- ³⁰ Department of Health, Equity and Excellence: Liberating the NHS, July 2010
- ³¹ NICE, National Quality Board engagement exercise - Annex A proposed library of topics, August 2011
- ³² Department of Health, Operational Guidance to the NHS : extending patient choice of provider, July 2011
- ³³ Care Quality Commission, Meeting the healthcare needs of people living in care homes 2009/10, March 2010. See: <http://www.cqc.org.uk/aboutcqc/whatwedo/improvinghealthandsocialcare/specialreviewsandstudies/reviewofhealthcareforpeopleincarehomes2009/10.cfm> (Accessed 24 August 11)

