Commissioning for incontinence, lower urinary tract and bowel symptoms - an audit
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Foreword

Continence, lower urinary tract (LUTS) and bowel symptoms are part of daily life for millions of people across the UK - but as a society, we continue to struggle with the continence taboo. People living with continence problems often put off seeking help until symptoms become more severe, and are more likely to become depressed, anxious and socially isolated. Accessible, responsive and integrated community continence services that manage symptoms early, close to, or in, a person’s own home, are a compelling alternative to hospital visits and long term residential care for patients and commissioners alike, but they remain the exception rather than the norm.

Despite the prevalence of these conditions, continence provision has never been a priority for NHS improvement or investment and as a result there has been limited progress in establishing the high quality services and support that people with continence problems rely on to lead a normal life. That there are gaps and variations in the quality of services is well known, and the ongoing work of the Royal College of Physicians and the All Party Parliamentary Group on Continence Care to raise awareness of the priorities for improvement is extremely welcome.

This report is based on a Freedom of Information request which was sent to every PCT in England to uncover new data about the way that LUTS and continence services are commissioned. The overwhelming majority of PCTs took part, and I am pleased that the findings establish some clear imperatives for change. Our goal was to bridge some of the gaps in our knowledge of the commissioning process, and we hope the report will stimulate an honest debate about how we can develop high quality, cost effective services in line with increasing population needs. The NHS is changing, and we need to embrace the opportunity to strengthen the way that services are commissioned now and in the future.

The expert group on LUTS, which I chair, has already looked in detail at how services for people with continence, lower urinary tract and bowel symptoms could be improved in context of the reformed NHS. We hope that this report will demonstrate how comprehensive, accurate and timely data collection can help to support high quality commissioning that is organised around the needs and preferences of local patients, wherever they may live. Although continence can, and does, affect people of all ages, incidence increases with

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age. With an ageing population, the number of people affected across England is set to rise - the need for action is now pressing.

Professor Paul Abrams
Director, Bristol Urological Institute
Executive summary

Although it is estimated that two in three adults will suffer from some form of lower urinary symptoms in their lifetime\(^1\), comparatively little is known about the way in which services are planned and delivered around the country, the extent to which these services improve the lives of patients, and whether they represent good value for money.

A number of conditions are associated with the existence of continence, lower urinary and bowel symptoms. These include urinary incontinence, overactive bladder syndrome, faecal incontinence and benign prostatic obstruction (BPO). Although each of these conditions is distinct, people with continence, lower urinary and bowel symptoms often have similar needs. For example many benefit from a personalised, shared approach to their care, which enables effective self-care and condition management, as well as early access to specialist interventions when this is clinically appropriate.

The National Audit of Continence Care, conducted by the Royal College of Physicians (RCP) contains valuable information about the provision of services and the quality and consistency of services around the country\(^2\). This report, based on a Freedom of Information (FoI) Act request issued to every primary care trust (PCT) in England, seeks to build on the work of the Royal College of Physicians (RCP) and others, to enrich our knowledge of the commissioning and provider landscape and provide further insights into the key priorities for service improvement now and in the future.

The purpose of the study is to:

- Address some of the gaps in our knowledge of services provided to people with continence, lower urinary and bowel symptoms services
- Prompt wide discussion about the variations and gaps in provision around the country, and how these should be addressed in future
- Highlight the need for comprehensive, accurate and timely data collection - both in relation to local population needs and the performance of services. This would support:
  - Effective, evidence-based commissioning based on quality and cost effectiveness
  - Routine benchmarking by commissioners and providers of their performance in relation to that of their peers

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Each PCT was issued with 19 FoI requests for data, exploring the following topics (the full list of requests is included within Annex 2 of this report):

- Identification and assessment of local needs
- Understanding the provider landscape for continence, LUTS and bowel symptoms services
- Expenditure on local services
- Evaluating the cost effectiveness of services
- Defining and implementing standards of care
- Monitoring performance
- Incentivising improvements

In total 109 PCTs responded to the FoI Act requests, representing a response rate of 72% (a full list of all those PCTs that responded is available in Annex 3)
Key findings

- Only 5% of PCTs included continence in their joint strategic needs assessment (JSNA) and even fewer used their JSNA to consider the impact of lower urinary tract symptoms (LUTS) (1%) and bowel symptoms (4%)

- In developing the JSNA, the overwhelming majority of PCTs made no local estimate of prevalence, no evaluation of local service use and there was no evidence of consultation with patients and service-users about local continence needs

- 59% of PCTs do not hold information on expenditure on LUTS, and 38% do not hold information on expenditure on continence services

- There is significant variation in expenditure on continence services among those PCTs that do hold data - £12,571 per 100,000 of population in NHS Enfield to £2,196,524 per 100,000 of population in NHS Hartlepool

- Of those PCTs who provided information about their planned budgeted expenditure, the majority (68%) projected either the same, or a lower level of spending for the next financial year compared to 2010/11

- One in five PCTs have identified continence as an area of excessive or inappropriate admissions to secondary care. Of those PCTs, many have taken action to address this, including ensuring the availability of appropriate community support

- Only 20% of PCTs have conducted an assessment of compliance of providers against NICE clinical guidelines on urinary incontinence in women, lower urinary tract symptoms in men or faecal incontinence

- Just over a third of PCTs have taken action to implement NICE guidelines on urinary incontinence in women (33%), LUTS in men (38%) or faecal incontinence (36%)

- Over 75% of PCTs have taken action to implement some aspects of the National Service Framework for older people
• 45% of PCTs were unable to provide specific details of assessments of the overall performance (including operational performance) of continence services, and over 60% were unable to do so for both LUTS and bowel symptoms services

• Some community services provide monthly updates to their commissioners on key performance indicators, including waiting times and patient satisfaction

• 25% of PCTs have used Commissioning for Quality and Innovation (CQUINs) indicators to incentivise improvements in continence services

The findings have helped to identify a number of priority areas for improvement, which span the commissioning cycle, the delivery of services and the development of policy levers at a national level. A series of recommendations are included on page 8 of this report. The expert group looks forward to working closely with policymakers, commissioners and providers to take these recommendations forward as a priority.

About the audit

The FoI Act requests were issued by MHP Health Mandate, a health policy consultancy working in partnership with Astellas Pharma Ltd. and the expert group on LUTS. Astellas provided funding to support the administration of the FoI Act requests, including the collation and analysis of the data received, and drafting of the report by MHP Health Mandate. The expert group on lower urinary tract symptoms (LUTS) consists of leading clinicians, GPs, nurses and patients. Full editorial control rests with members of the expert group who reviewed and approved the content ahead of use.

About the expert group

The expert group consists of health professionals and individuals with expertise in LUTS. A full list of the members of the expert group is included in Annex 1.

In December 2011, the group published 2 in 3: Delivering World Class Services for people with continence, lower urinary tract and bowel symptoms. This report provided an assessment of the current state of services for people with continence, LUTS and bowel symptoms and included a series of 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 current reforms to health and social care services.
About Astellas

The expert group is supported by funding from Astellas Pharma Ltd., however full editorial control of all outputs rests with members of the group alone. Astellas is an research and development driven global pharmaceutical company that develops and markets effective therapies for diseases where there is an unmet clinical need, such as the treatment of lower urinary tract symptoms (LUTS), including overactive bladder. The European and UK operation is based in Staines, Middlesex, and the company has a UK workforce of 250.

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.
Summary of recommendations

1. Health and wellbeing boards should monitor the performance of any qualified provider (AQP) in their area, holding commissioners to account on delivery and ensuring involvement of patients and the public in reviewing the specification of AQP

2. The AQP specification should include a series of key quality markers to enable commissioners to benchmark the performance of providers. These should complement the national quality standards on LUTS in men, urinary incontinence in women and faecal incontinence, and the development of local and national CQUINs

3. Health and wellbeing boards should have a duty to ensure that all continence services are commissioned within the framework of an integrated continence service across primary and secondary care, as set out in *Good practice in continence services*.

4. Health and wellbeing boards should undertake an assessment of the needs of people with continence, lower urinary tract and bowel symptoms as part of the JSNA

5. Health and wellbeing boards should establish a clear process for identifying local population needs, as well as garnering the views and experiences of people living with continence, LUTS and bowel symptoms in their local area

6. 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 area
7. Commissioners should ensure that they are in a position to analyse the cost effectiveness of services for people with continence, LUTS or bowel symptoms by collecting disaggregated data to inform their analysis.

8. Commissioners reporting significant fluctuations in expenditure on continence, LUTS or bowel symptoms services should evaluate the reasons for this and should publish explanations in their annual reports.

9. Commissioners which are outliers in terms of low expenditure should assess whether the amount of funding they allocate continence, LUTS or bowel symptoms services is sufficient.

10. Health and wellbeing boards need to take a proactive role in coordinating a fully integrated approach to continence, LUTS and bowel symptoms services across all care settings and this should be reflected in the health and wellbeing strategy.

11. Commissioners should proactively review secondary care activity and identify ways in which patients with continence, LUTS or bowel symptoms could be more effectively supported within community settings.

12. Providers should be required to collect and publish information and data to demonstrate adherence to NICE guidance.

13. Adherence to NICE quality standards should form part of the basic provider contract, and commissioners should be held responsible for holding providers in their area to account for delivery against the standards.

14. PCTs and emerging clinical commissioning groups (CCGs) should ensure they have robust measures in place to monitor and assess the outcomes being delivered by all providers of continence, LUTS and bowel symptoms services in their locality.
15. Indicators on continence, LUTS and bowel symptoms should be included in future *NHS Outcomes Frameworks* and the *Public Health and Adult Social Care Outcomes Frameworks* to support quality improvement and performance management

16. Local HealthWatch groups should consider services for patients with continence, lower urinary tract and bowel symptoms as priority areas for attention, given the impact across public health, the NHS and social care services of these conditions

17. The NHS Commissioning Board should develop a suite of potential CQUIN indicators on continence, lower urinary and bowel symptoms for use by local commissioners

18. As they begin to take on responsibility for commissioning, CCGs should assess the need to incentivise services for people with continence, lower urinary and bowel symptoms in their area
LUTS services: the provider landscape

Continence, lower urinary tract and bowel symptoms range from relatively mild to severe, and the services that are needed to manage them are diverse - from supported self-care in the community, to pharmacological interventions and acute interventions including surgery. To gain a picture of the services that are being commissioned, we asked PCTs what contracts they hold with providers of continence, lower urinary tract and bowel symptom services.

We found that PCTs across the country are commissioning services largely from their local acute services, with a promising number of trusts also commissioning community services in their area - a sign that patients are being supported to manage their condition closer to home rather than in the acute setting. For example, in NHS Heart of Birmingham, community-based continence services are commissioned from Birmingham Community Health Care Trust which provides services across the PCT in health centres, nurse-led clinics, clients’ own homes and residential homes4.

Community continence services have been identified by the Government as one of 25 services to be opened up to the any qualified provider model (AQP)5. This will mean that patients have greater choice over their provider, with the expectation that this will drive up quality and “enable innovation” in service provision.

Figure 1 shows that a number of areas across the country have selected community continence services as part of the first phase of the roll out of AQP. This reflects the appetite among some commissioners to use the model to drive improvements in service provision in their area.

Figure 1: PCT clusters selecting community continence services as a priority under AQP

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Figure 2 provides a breakdown of the number of services chosen for provision under AQP by PCTs. Despite, almost two in three adults experience some form of LUTS, continence services are only the seventh most selected therapy area for implementation in 2012/13, with 21% of PCTs designating it as one of its AQP services for the next financial year.

**Figure 2: AQP services for implementation in 2012/13**

Following the first year, where commissioners will focus on a small number of locally chosen services in which to introduce AQP, commissioners across the country will be expected to introduce choice in continence services. It is therefore likely that the diversity of providers will increase. As this happens, it will be important that commissioners have mechanisms in place to ensure that all providers, whether from the public, private or third sector, meet minimum requirements of quality and outcomes. In doing so, it will be necessary to hold providers to account on how they meet the service specification set out as part of the AQP process.
This sets out a number of requirements on services, including that they should:
- operate within an integrated model, working in partnership with primary and secondary care and children’s service such as education
- encourage the active identification of people with bladder and bowel dysfunction
- improve awareness of the community service through provision of education and training to other health care professionals
- provide triage daily, Monday to Friday, within 24 hours of receipt of referral and provide an initial assessment for all new patients referred and accepted into the service

Health and wellbeing boards should take oversight of this process, holding commissioners to account on the successful operation of AQP in their area.

**Recommendation 1**: Health and wellbeing boards should monitor the performance of any qualified provider (AQP) in their area, holding commissioners to account on delivery and ensuring involvement of patients and the public in reviewing the specification of AQP

**Recommendation 2**: The AQP specification should include a series of key quality markers to enable commissioners to benchmark the performance of providers. These should complement the national quality standards on LUTS in men, urinary incontinence in women and faecal incontinence, and the development of local and national CQUINs

**Recommendation 3**: Health and wellbeing boards should have a duty to ensure that all continence services are commissioned within the framework of an integrated continence service across primary and secondary care, as set out in Good practice in continence services

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Identifying and addressing local needs effectively

Assessing the needs of people with continence, lower urinary tract and bowel symptoms is critical to the commissioning process, and underpins the provision of high quality, cost-effective and person-centred care. In short, a robust assessment of needs enables the NHS to:

- evaluate existing levels of service provision against the requirements of the local population, and identify any gaps
- set strategic priorities for local action and improvement
- ensure that resources are directed to areas of greatest need, and in particular to help tackle health inequalities, and key clinical, health and community outcomes
- re-design services to achieve improved patient outcomes, more cost-effectively

Since 2007, the production of a Joint Strategic Needs Assessment (JSNA) has been a statutory duty for the NHS and local government. The JSNA should “analyse health needs of populations to inform and guide commissioning of health, well-being and social care services within a local authority area.” This should underpin current and future planning and provision and should be based on a range of quantitative and qualitative data garnered through patient and public involvement in the process.

A robust JSNA should enable commissioners to identify and support a broad range of health and social care needs within local communities including those relating to continence, as identified by the All-Party Parliamentary Group for Continence Care in Cost-effective Commissioning For Continence Care which offered a guide for planning, procuring and monitoring integrated continence services. Continence problems are relatively common with up to two in three adults suffering from at least one form of LUTS in their lifetime. Continence affects people of all ages, and varies in severity - interventions range from simple lifestyle changes, conservative management which includes pharmacological treatment, through to complex surgery.

The extent to which commissioners have a good understanding of the needs of people in their community living with continence, lower urinary tract and bowel symptoms, and how they should support them is therefore going to be critical to their ability to deliver the best possible services. We asked PCTs...
whether continence, lower urinary tract and bowel symptoms services were included in their local JSNA. The results are disappointing – with the majority not including the services within their local JSNA. As demonstrated in Figure 2, LUTS services were included in just one PCT’s JSNA, 95% of PCTs did not look at continence at all within their needs assessment and only 4% of PCTs addressed bowel symptoms. This is concerning given the significant human and social impact of continence problems, and the fact that an average general practice, with a list size of 10,000, is likely to see 700 women per year with some form of LUTS.

Figure 3: Percentage of PCTs that included continence services, lower urinary tract symptoms services and bowel symptoms services included within their JSNA

Just seven PCTs confirmed that some, or all three services, were included in their JSNA. An analysis of the JSNAs reveals a lack of substance and depth of analysis in relation to continence, LUTS and bowel symptoms. In all but two instances (NHS Northamptonshire and NHS Oxfordshire) there was no local estimate of prevalence, no evaluation of local service use and no evidence of consultation with patients and service-users on local needs and service provision.

However, good practice does exist. NHS Northamptonshire’s JSNA included a dedicated chapter on incontinence, with a discussion of the human and social impact of continence problems taken from Department of Health guidance. It
also provided an estimate of prevalence in the over-65 age group up to 2025, as set out in Figure 3. This is a good start and provides the basis for a needs assessment in the area, but more could be done to ensure that the needs of those in different age groups (e.g., under-65) are considered, as well as the service needs of all groups.

**Figure 4:** Total population aged 65 and over predicted to have incontinence using the highest predicted prevalence estimate - Northamptonshire and most similar PCTs - 2008 to 2025°

NHS Oxfordshire also provided specific detail about continence within a subsection of its JSNA, *An assessment of healthcare needs for older people in Oxfordshire*°. This included a description of the impact of continence problems on individuals and the wider society, and a brief estimate of prevalence rates in Oxfordshire. The fact that continence problems may be under-diagnosed, and that people could be managing symptoms unsupported, is noted within the JSNA, though there is little evidence of an accompanying action to address the challenge.
Urinary incontinence affects a far higher proportion of women than men, and may be a major contributory factor leading to residential care admission. Urinary incontinence is considerably under-diagnosed due to social stigma, embarrassment, lack of knowledge and an acceptance of it being inevitably associated with ageing. Urinary incontinence can have a major impact on quality of life for sufferers, yet evidence suggests that the condition responds well to interventions, including behavioural techniques such as exercise.

Only 2.3% of the older population were registered with having a continence problem, 1,711 women compared with 440 men. Nationally this condition affects more females than males and worsens with age for both sexes. Observed rates are similar across the patch, apart from the West Oxfordshire locality where rates are lower than average.

In 2005 HSE it was reported that 21% of men and 22% of women aged 65 and over had some sort of bladder problem. This would equate to 11,108 women and 8,674 men in Oxfordshire. It would appear therefore that this problem may remain relatively under-recorded, possibly due to self management and/or embarrassment about the issue and patients not reporting the condition to their GP. Potentially, a large number of patients are managing this condition alone and unsupported by primary or community services.

It is encouraging that NHS Oxfordshire provided a copy of the results of the National Audit of Continence Care as part of its response to the FOI request. Commissioners of continence, LUTS and bowel symptoms services across England should proactively use the data included in the audit to create a baseline assessment of services in their areas as part of their JSNA.

These findings show that PCTs are failing to conduct a comprehensive and timely assessment of population needs in relation to continence, LUTS, and bowel symptoms. Where these symptoms are included, the information provided falls far short of the key requirements of an effective JSNA which could inform evidence-based commissioning and create a catalyst for the service improvement that is needed.
As NHS structures are reformed, the JSNA will continue to play an important role in the development of local commissioning strategies, with health and wellbeing boards (HWBs) required to conduct a needs assessment to underpin the development of a health and wellbeing strategy. Through the strategy, HWBs should identify where joint commissioning across health and social care could improve the outcomes of people with a range of symptoms and scrutinise the performance of CCGs and local authorities in their commissioning of integrated services. In developing the JSNA for people with continence, LUTS and bowel symptoms, health and wellbeing boards should ensure that they include the following information:

- Population-level demography
- Epidemiology
- An estimate of the level of unmet need
- Service access and utilisation (across different settings eg acute, care homes, schools)
- Evidence of effectiveness (using the National Audit of Continence Care as a baseline)
- Views of patients, service users and the community

Given that continence problems are often under-reported, JSNAs should extend beyond service AQP has the potential to drive up presentation rates, particularly if the option of self-referral is extended.

JSNAs will be critical in addressing the legacy of neglect in the commissioning of continence services, and to creating the right foundation for continuous quality improvement.

**Recommendation 4:** Health and wellbeing boards should undertake an assessment of the needs of people with continence, lower urinary tract and bowel symptoms as part of the JSNA

**Recommendation 5:** Health and wellbeing boards should establish a clear process for identifying local population needs, as well as garnering the views and experiences of people living with continence, LUTS and bowel symptoms in their local area

**Recommendation 6:** 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 area

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Expenditure on LUTS services

Given the high prevalence of continence, LUTS and bowel symptoms across the country, it is surprising that services have not been a priority for either improvement or investment\(^2\).\(^{13}\). This lack of prioritisation creates challenges as the NHS is undergoing a period of reform. In particular:

- Without an established local service infrastructure in place, NHS reorganisation could destabilise delivery, leading to further fragmentation and a lack of timely, person-centred care
- Services which are not perceived to address ‘big ticket’ health priorities, or are deemed to be of lower value within a local health economy, are more likely to be subject to cuts in the drive to achieve £20bn efficiency savings by 2015

“The Nicholson Challenge is the key issue facing the health and care system... to ensure that new initiatives to tackle alcohol misuse are targeted and based on the facts, long-term manner that will maintain high quality, efficient care in the future\(^{14}\).”

Rt Hon Stephen Dorrell, Chair of the Health Select Committee

In order to understand more about the potential impact of these challenges on services for people with continence, LUTS and bowel symptoms, we sought to uncover data about the level of investment in services and support across each PCT. In particular:

- Whether PCTs routinely collect data on continence services, LUTS services and bowel symptoms services
- The level of expenditure in each PCT for the services listed above
- The planned budgeted expenditure across the three areas for 2011-12

Collection of data on expenditure

Overall there were a number of limitations and significant gaps in the collection of data on expenditure. Of the PCTs that responded, a significant number were unable to provide data on expenditure for continence services, LUTS services and bowel symptoms services (seen Figure 4).
As demonstrated in Figure 4, fewer than two thirds of PCTs told us that they hold information on expenditure for continence services, and the numbers were even lower for services for people with LUTS or bowel symptoms (41% and 42% respectively). The responses provided show that there is significant scope for improvement in the collection of data. Among those PCTs that did hold data, some were unable to break these down further across different services. For continence services, 55% of PCTs were unable to provide disaggregated expenditure data. This is even higher for LUTS (82%) and for bowel services (80%). Some PCTs stated that they were unable to provide the data broken down by area “on the grounds of confidentiality” or because services are “part of a block contract”.

“At the moment this service is part of a block contract with no identified costs for individual services”

NHS Solihull PCT

Evidence-based commissioning should be based on an accurate understanding of expenditure, and the outcomes that have been achieved as a result of that investment. It is important that commissioners have a firm grasp on expenditure across continence, LUTS and bowel symptoms to support cost effective decision-making. This will be increasingly important as the AQP model will lead to the end of the inclusion of continence services in block contracts.
Analysing the level of expenditure

Due to the gaps in the data provided, a comparison of the level of expenditure for continence services, LUTS services and bowel symptoms services focuses on those PCTs who were able to provide data on expenditure across continence, LUTS and bowel symptoms for 2010/11.

The definitions used by PCTs for each of the three areas were discretionary, and will therefore depend on how budgets are organised and services are coded at a local level. The services included under each area of spend are therefore not necessarily uniform, and the terms allow for some overlap, making direct comparison between PCTs difficult. However, acknowledging these factors, the data nevertheless provide a useful marker of expenditure and the broad variations across the country. In total 19 PCTs provided data on expenditure for continence, LUTS and bowel symptoms services in 2010-11. An analysis of the data shown in Figures 5, 6 and 7 reveals that the average spend for continence was £462,201 per 100,000 of population, for LUTS it was £198,025 and for bowel symptoms services it was £543,837. These data reveal significant variations in expenditure per 100,000 of the weighted population between PCTs:

- Continence services - expenditure ranged from £12,571 per 100,000 of population in NHS Enfield to £2,196,524 per 100,000 population in Hartlepool
- LUTS symptoms services - expenditure ranged from £648 per 100,000 of population in NHS Oxfordshire to £671,450 per 100,000 population in NHS East Lancashire
- Bowel symptoms services - expenditure ranged from £25,183 per 100,000 of population in NHS Hull, compared to £2,773,957 per 100,000 population in NHS Hartlepool

It is also worth noting, that the variation in data provided by PCTs on spending for these services could also be attributed to inconsistencies in the practices employed by PCTs for recording data on expenditure. Operating effective processes for monitoring levels of expenditure are in place is key to enabling commissioners to make informed decisions regarding the allocation of funding based on levels of local need and ensuring that they can be held accountable for their use of budgets.
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Figures 5, 6 and 7 clearly illustrate the significant variation in expenditure per capita across continence, LUTS and bowel symptoms services. For LUTS services there is a more than 200-fold variation in the reported expenditure per capita across the PCTs analysed.

In addition to expenditure in 2010/11, a number of PCTs were able to provide information about their planned budgeted expenditure for 2011/12. As demonstrated in

Figure 9, of those who responded (28 PCTs in total), 39% projected a lower level of expenditure compared to 2010/11, 32% projected a slight increase in

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expenditure, and 29% project the same level of expenditure for the next financial year.

Figure 9: Budgeted expenditure on continence services in 2011/12 compared to 2010/11

Given the prevalence of continence and LUTS symptoms amongst older people\(^3\), combined with an increasingly aging population, there is likely to be increasing demand for continence services over time, it is important to note that a flat, or inflation-only increase in investment is likely to create additional pressures on services. This expenditure will need to be managed effectively to ensure that efficiencies are achieved without compromising the overall quality of care and support. This will require active redesign of services based on a comprehensive assessment of local need, rather than a more arbitrary approach to cost containment, which could exacerbate the gaps in services and result in poorer outcomes and experiences among patients.

It is clear that the majority of commissioners do not have a clear picture of the level of expenditure across continence, LUTS and bowel symptoms services in their locality. This makes it difficult for commissioners to assess the value of their services, that is the outcomes achieved by patients in relation to costs of

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the service. Although there are a number of limitations to the data available, the analysis shows significant regional variations in the level of expenditure. These variations cannot be explained by differences or changes in need alone. They require further examination, across a more comprehensive set of data, but it is possible to draw a number of general conclusions:

- There are worrying inequalities in the level of expenditure for continence, LUTS and bowel symptom service
- These inequalities could potentially be caused by inadequate or inaccurate assessments of local needs
- There are likely to be variations in the cost and efficiency of services around the country
- There are variations in the way that services are coded - problems with coding and recording expenditure could result in commissioners being given inaccurate information about spending

**Recommendation 7:** Commissioners should ensure that they are in a position to analyse the cost effectiveness of services for people with continence, LUTS or bowel symptoms by collecting disaggregated data to inform their analysis

**Recommendation 8:** Commissioners reporting significant fluctuations in expenditure on continence, LUTS or bowel symptoms services should evaluate the reasons for this and should publish explanations in their annual reports

**Recommendation 9:** Commissioners which are outliers in terms of low expenditure should assess whether the amount of funding they allocate continence, LUTS or bowel symptoms services is sufficient
Delivering integrated, cost effective services

Good practice in continence services\(^3\) outlines the principles that underpin good continence service delivery and provides specific recommendations on how services should be designed across primary care, secondary care and local authorities. The guidance emphasises the importance of close cooperation between primary, secondary and social care to ensure a fully integrated care pathway from initial assessment, through to diagnostic tests, medical management and surgical interventions if appropriate.

Despite the existence of this guidance, The National Audit of Continence Care\(^2\), carried out by the Royal College of Physicians (RCP) in 2010, found that only four services across the country fulfil all the requirements for integration. This is particularly concerning as data show that those services that do comply with these specifications provide higher quality care for their patients\(^16\).

Continence symptoms often go undiagnosed, this in part due to individuals often being too embarrassed to come forward and seek help for their symptoms\(^17\). Given the nature of many continence issues, primary care staff have a central role in the diagnosis and management of symptoms. To ensure that people with continence, LUTS and bowel symptoms receive optimal care, primary care professionals need to be trained in assessing and managing symptoms and evaluating care according to individual needs. This can include the provision of conservative management and lifestyle advice and, where clinically appropriate, drug treatment options. The delivery of effective services in primary care by informed healthcare professionals should result in a reduction in unnecessary referrals to secondary care, examples of inappropriate treatment\(^18\) and therefore more cost effective services.

Achieving efficiencies in care for people with continence, LUTS and bowel symptoms will therefore require timely identification and management of symptoms, and the avoidance of unnecessary treatment in secondary care settings. We therefore asked PCTs if they have identified excessive or inappropriate secondary care activity across these services. As set out in Figure 9, there was significant variation across the country.
As Figure 11 demonstrates, a number of commissioners have identified continence, LUTS and/or bowel symptoms as areas of excessive or inappropriate secondary care activity. In particular:

- Oxfordshire PCT (part of Buckinghamshire and Oxfordshire PCT cluster which has selected continence services as one of their three areas for AQP implementation in 2012/13) revealed that bladder and bowel services have been redesigned with the aim of shifting provision towards community services and reducing reliance on secondary care\textsuperscript{11}
- NHS Cambridgeshire detailed how Addensbrooke’s Hospital and Hinchingbrooke Health Care NHS Trust have been working with the local PCT, Cambridge Community Services NHS Trust and local GPs to develop a new male LUTS community pathway\textsuperscript{19}
- NHS Leeds has identified a proportion of referrals for continence problems as an area of inappropriate secondary care activity. Work is now underway with the main secondary care providers, Leeds Teaching Hospitals Trust and Leeds Community Healthcare to develop a care pathway for continence that enables patients to be treated in the most appropriate clinic\textsuperscript{20}
Each of these examples sets out a positive picture in which PCTs have identified the need to ensure appropriate, early community support and taken action to address this. However, this is only the case in some areas - 20% of PCTs had identified excessive or inappropriate secondary care activity in continence and LUTS. The fact that other PCTs have not identified the issue could be due to a number of reasons. Some PCTs will have already established an integrated service which means that secondary care admissions are managed at an appropriate level. However, it could also be indicative of the low proportion of commissioners actively monitoring the delivery of continence services. As a consequence these conditions are not viewed as a priority for service re-design that could result in improved quality and cost effectiveness.

As set out in the earlier chapter on identifying and addressing local needs effectively, health and wellbeing boards will have a critical role in assessing the needs of the local community in relation to continence, LUTS and bowel symptoms through the Joint Strategic Needs Assessment (JSNA). They should also take a clear role in driving a joined-up approach to the delivery of services, identifying instances and causes of excessive secondary care activity and ensuring appropriate measures are taken to address such cases. These bodies are intended to be a forum for local commissioners across the NHS, public health and social care, elected representatives, and representatives of HealthWatch to discuss how to work together to better the health and wellbeing outcomes of the people in their area.

**Recommendation 10:** Health and wellbeing boards need to take a proactive role in coordinating a fully integrated approach to continence, LUTS and bowel symptoms services across all care settings and this should be reflected in the health and wellbeing strategy

**Recommendation 11:** Commissioners should proactively review secondary care activity and identify ways in which patients with continence, LUTS or bowel symptoms could be more effectively supported within community settings
Delivering high quality services

Defining and delivering quality

Much work has already been undertaken to set out what constitutes high quality care for people with continence, LUTS and bowel symptoms. The National Institute for Health and Clinical Excellence (NICE) has published clinical guidelines that cover the treatment of urinary incontinence in women, LUTS in men and faecal incontinence, while the National Service Framework for Older People\(^{21}\) sets out key standards of care for older people, including those with continence. More detail on the range of guidance available is set out in an earlier report, *2 in 3: Delivering world class services for people with continence, lower urinary tract and bowel symptoms*\(^{13}\). Despite the existence of these guidelines, evidence of implementation by local commissioners and providers has been limited. For example, a recent survey has shown that only 46% of GPs say that they are adhering to NICE Clinical Guideline 97 on the management of LUTS in men\(^{22}\).

To understand more about the way national guidance is being implemented, we asked PCTs what (if any) action they have taken to assess compliance of providers against NICE clinical guidelines, and what steps they had taken themselves to ensure that guidelines are implemented. As Figures 10 and 11 illustrate, most commissioners have not taken action to either assess or implement guidelines.

**Figure 11: Percentage of PCTs that conducted an assessment of compliance against NICE guidance**

<table>
<thead>
<tr>
<th>CG97 (lower urinary tract symptoms in men)</th>
<th>CG40 (urinary incontinence in women)</th>
<th>CG49 (faecal incontinence)</th>
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<tr>
<td>Yes</td>
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The apparent lack of local leadership in evaluating performance in line with agreed national guidance is a concerning trend. However, there are examples of good practice across the country, where commissioners are actively working with providers of LUTS services in their area to ensure that guidelines are met.

For example, in NHS Blackpool, assessment of services against the clinical guidelines “*included resource implications, barriers to implementation, training and equipment implications*”, while NHS Milton Keynes has audits of the guidelines planned, using the tools contained in the guidance. As Figure 12 sets out, while there are problems with assessment and implementation in some areas of the country, there are others where PCTs are able to report action in implementation against all three relevant guidelines.
Figure 13: Number of clinical guidelines which PCTs have taken action to implement

A more promising picture exists in terms of monitoring and action taken to implement the National Service Framework for older people. As set out in Figure 4 below, over 75% of PCTs that responded to our FOI request said that they had taken action to implement the National Service Framework for older people.
Ensuring that commissioners are holding providers to account on the services they provide will be essential to reducing inequalities in the level of service provided across the country and making sure that every person with continence, LUTS or bowel symptoms is able to access the best possible care. This will be particularly important as the provider landscape evolves and as new quality levers within the NHS take shape.

*Equity and excellence: Liberating the NHS* set out a number of new mechanisms by which commissioners and providers will be held to account\(^2^3\). Important among them are quality standards, which are clear statements of quality produced by NICE which set out what quality care looks like. In February 2012, the Department of Health referred the quality standard on LUTS to NICE for development\(^2^4\). Furthermore, NICE has also committed to creating quality standards for urinary incontinence in women and faecal incontinence\(^2^5\). This is a welcome development, but will only improve services if more is done to ensure that they are fully implemented within the NHS. One way of achieving this objective would be to make adherence to quality standards part of the basic provider contract, with the collection and publication of data to demonstrate that adherence.

**Recommendation 12:** Providers should be required to collect and publish information and data to demonstrate adherence to NICE guidance

**Recommendation 13:** Adherence to NICE quality standards should form part of the basic provider contract, and commissioners should be held responsible for holding providers in their area to account for delivery against the standards
**Monitoring performance**

One of the central principles of the Government’s health and social care reforms has been a focus on patient outcomes, supported by the introduction of outcomes frameworks for the NHS, public health and social care\(^{26, 27, 28}\). Commissioners have a responsibility to ensure that the services they commission offer the best possible outcomes for patients, as well as value for money. All commissioners should therefore develop robust monitoring and quality assurance mechanisms to ensure that high quality services are being delivered by service providers and all components of the patient pathway are functioning effectively.

To assess the outcomes currently being delivered in continence, LUTS and bowel symptoms services, the expert group asked PCTs to confirm and provide details of an assessment which looked at the operational performance and the outcomes currently being delivered by services in their area. The findings revealed that 45% of PCTs were unable to provide specific details of assessments for continence services, whilst over 60% were unable to do so for both LUTS and bowel symptoms services.

**Figure 15: PCTs monitoring performance of continence services, LUTS services and bowel symptoms services**

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Nevertheless a proportion of PCTs have taken steps to monitor the performance of continence, LUTS and bowel symptoms services commissioned in their locality. For example:

- NHS Bassetlaw has monthly key performance indicator reports and annual reports from their provider. These cover a range of quality and productivity metrics including interactions per month, response times, service user experience and reducing referrals into secondary care\(^9\).
- NHS Nottingham City confirmed that the Community Continence Advisory Service supplies monthly reports detailing waiting time to assessment (against a 28 days target), number of new patient referrals, percentage of new patients contacted within two weeks of referral, percentage of new patients seen within 4 weeks of referral, and patient satisfaction surveys\(^10\).
- For continence services, regular contract monitoring meetings are held by NHS Warrington with Bridgewater Community Health Care NHS Trust. In addition, the provider has implemented a patient experience monitoring programme\(^11\).

Overall, the lack of specific scrutiny and evaluation of these services, being conducted by commissioners, raises questions about the arrangements PCTs have in place to measure the quality of the services they are commissioning.

Mechanisms for quality assurance at a local level for services covering continence, LUTS and bowel symptoms should aim to include service and performance targets, clinical governance arrangements, clinical quality criteria (appropriateness of referral and clinical protocols), audit arrangements, patient satisfaction, patient outcomes, staff competencies and information requirements\(^12\). As well as monitoring patient pathways and outcomes, performance indicators are also key to identifying the possible effects on budgets as well as invoicing, data validation and audit\(^13\).

Greater accountability for the quality of services can also be achieved by placing requirements on providers to include details of their performance on key metrics for continence, LUTS and bowel symptoms within their quality accounts. Measures should also be introduced to ensure that service users are involved in evaluating the performance of services. HealthWatch, the new consumer health organisation, will have a key role in monitoring local and national health and social care services by seeking feedback from patients and the public.
**Recommendation 14:** PCTs and emerging clinical commissioning groups (CCGs) should ensure they have robust measures in place to monitor and assess the outcomes being delivered by all providers of continence, LUTS and bowel symptoms services in their locality.

**Recommendation 15:** Indicators on continence, LUTS and bowel symptoms should be included in future NHS Outcomes Frameworks and the Public Health and Adult Social Care Outcomes Frameworks to support quality improvement and performance management.

**Recommendation 16:** Local HealthWatch groups should consider services for patients with continence, lower urinary tract and bowel symptoms as priority areas for attention, given the impact across public health, the NHS and social care services of these conditions.
Incentivising improvements in care

The quality improvement system for the NHS includes a number of mechanisms that are designed to incentivise the provision of high quality, cost effective treatment and care. A range of incentives can be used, including:

- The Commissioning Outcomes Framework, which will be used to reward improvements in outcomes delivered by commissioners
- The Quality and Outcomes Framework, which rewards GPs for their role in providing high quality care
- The Commissioning for Quality and Innovation (CQUIN) scheme, which rewards improvements in quality delivered by secondary care providers

Our audit focused on the latter of these incentive schemes. Introduced in 2009, Commissioning for Quality and Innovation (CQUIN) schemes allow commissioners to incentivise the achievement of local quality improvement goals by linking a proportion of healthcare providers’ income to performance. The schemes have already proved to be useful tools in placing incentives on providers to improve outcomes for patients. We have previously argued that 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.

To get a picture of the current use of the scheme to incentivise performance in this area, we asked PCTs whether or not they have established CQUIN payment frameworks with providers that are related to continence services (lower urinary tract symptoms (LUTS) services and bowel symptoms services). Figure 16 demonstrates that only a small proportion of commissioners have used the scheme to incentivise performance: 24% in continence services, 16% in LUTS and only 6% for services for bowel symptoms.
Figure 16: CQUIN payment framework indicators in place with providers commissioned by PCTs for continence services, LUTS services and bowel symptoms services

**Continence**

- Yes: 24%
- No: 76%

**LUTS**

- Yes: 16%
- No: 84%

Those PCTs using CQUIN schemes to incentivise performance in this area were able to provide details of the schemes - which vary from “improving the care of stroke patients with continued loss of bladder control” in NHS Tees to a “Safety Express initiative for Catheter acquired Urinary Tract Infections” in NHS East Lancashire. The inclusion of these indicators is welcome, and must be combined with robust performance management to ensure that improvements in care are being developed.

Despite these areas of good practice, a number of areas clearly do not have appropriate performance management and incentivisation schemes in place. There is therefore scope for indicators relevant to continence, lower urinary and bowel symptoms to be taken up across the country. This is particularly important, given the need for oversight and improvements in services which have been identified through this audit and others, including the National Audit of Continence Care.

**Recommendation 17:** The NHS Commissioning Board should develop a suite of potential CQUIN indicators on continence, lower urinary and bowel symptoms for use by local commissioners

**Recommendation 18:** As they begin to take on responsibility for commissioning, CCGs should assess the need to incentivise services for people with continence, lower urinary and bowel symptoms in their area

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Annex 1: 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.

**Any Qualified Provider (AQP):** A procurement model that primary care trusts (PCTs) can use to develop a register of providers accredited to deliver a range of specified services within a community setting.

**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 services provided by the NHS, local authorities, private companies and voluntary organisations in England.

**Clinical commissioning groups (CCGs):** A group of GPs and other clinicians responsible for planning and purchasing health services for their local communities, including commissioning hospital services (elective, acute and emergency) and most community health services (for example district nurses), and mental health services. From early 2013, CCGs will be responsible for commissioning NHS services for patients in England, replacing primary care trusts (PCTs). All GPs will need to be part of a CCG.

**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.

**Commissioning for Quality and Innovation (CQUIN):** A payment framework that enables commissioners to link a proportion of healthcare providers' income to the achievement of local quality improvement goals.

**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).
HealthWatch England: National body to be established in October 2012 that will enable the collective views of the people who use NHS and adult social care services to influence national policy, advice and guidance.

Joint Strategic Needs Assessment (JSNA): The means by which local commissioners and local authorities evaluate the future health, care and well-being needs of their community. The JSNA aims to support action to improve local people's well-being by ensuring that services meet their needs. It is designed to inform and drive future investment priorities and thereby help to plan services more effectively.

Local HealthWatch: From October 2012, these local organisations will be involved in championing patients’ views and experiences, promoting the integration of local services and improving choice for patients through advice and access to information. These bodies will replace existing Local Involvement Networks (LINks).

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.

National Institute for Health and Clinical Excellence (NICE): The independent provider of national guidance for promoting good health and preventing and treating ill health.

NICE quality standards: A set of specific, concise statements and associated measures. They detail markers of high-quality, cost-effective patient care, covering the treatment and prevention of different diseases and conditions.

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.

Primary care trusts (PCTs): The statutory NHS bodies responsible for commissioning most health services and for improving public health. The Government’s NHS reforms will see PCTs abolished by April 2013, with clinical commissioning groups (CCGs), the NHS Commissioning Board and local authorities assuming PCTs’ commissioning and public health responsibilities.
**Provider**: An organisation that provides health or social care services, e.g. 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).
Annex 2: Expert group members

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
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<tbody>
<tr>
<td>Professor Paul Abrams</td>
<td>Director, Bristol Urological Institute</td>
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<tr>
<td>Karen Logan OBE</td>
<td>Consultant Nurse Continence Care and Head of Continence Services, Aneurin Bevan Health Board</td>
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<tr>
<td>Dr. Matthew Parsons</td>
<td>Consultant Obstetrician and Gynaecologist, Birmingham Women’s Hospital</td>
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<tr>
<td>Dr. Raj Shekhar</td>
<td>Consultant Stroke Physician, the Queen Elizabeth Hospital, King’s Lynn</td>
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<tr>
<td>Hilary Shields</td>
<td>Patient representative</td>
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<tr>
<td>Dr. Julian Spinks</td>
<td>General Practitioner at Court View Surgery, Rochester</td>
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<tr>
<td>Annette Woodward</td>
<td>Chair, Chartered Physiotherapists Promoting Continence (CPPC)</td>
</tr>
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Annex 3: Freedom of Information Act questions

Request 1: Please confirm or deny whether you hold contracts with providers of (i) continence services (ii) lower urinary tract symptoms (LUTS) services and (iii) bowel symptoms services

Request 2: Please disclose names of providers with whom you hold contracts for (i) continence services (ii) lower urinary tract symptoms (LUTS) services and (iii) bowel symptoms services and the nature of services that they provide

Request 3: Please confirm or deny whether your PCT monitors the performance of (i) continence services (ii) lower urinary tract symptoms (LUTS) services and (iii) bowel symptoms services commissioned by your PCT

Request 4: Please supply details held regarding the performance of (i) continence services (ii) lower urinary tract symptoms (LUTS) services and (iii) bowel symptoms services commissioned by your PCT

Request 5: Please confirm or deny whether you hold information on expenditure on (i) continence services (ii) lower urinary tract symptoms (LUTS) services and (iii) bowel symptoms services for (a) 2007-8 (b) 2008-9 (c) 2009-10 and (d) 2010-11

Request 6: Please supply information on expenditure on (i) continence services (ii) lower urinary tract symptoms (LUTS) services and (iii) bowel symptoms services for (a) 2007-8 (b) 2008-9 (c) 2009-10 and (d) 2010-11

Request 7: Please supply information on budgeted expenditure for (i) continence services (ii) lower urinary tract symptoms (LUTS) services and (iii) bowel symptoms services in 2011-12

Request 8: Please confirm or deny whether (i) continence services (ii) lower urinary tract symptoms (LUTS) services and (iii) bowel symptoms services were included in your Joint Strategic Needs Assessment

Request 9: Please supply your Joint Strategic Needs Assessment

Request 10: Please confirm or deny whether you have Commissioning for Quality and Innovation (CQUIN) payment framework indicators in place with providers commissioned by your PCT that are relevant to (i) continence services
(ii) lower urinary tract symptoms (LUTS) services and (iii) bowel symptoms services

Request 11: Please supply details of any Commissioning for Quality and Innovation (CQUIN) payment framework indicators in place with providers commissioned by your PCT that are relevant to (i) continence services (ii) lower urinary tract symptoms (LUTS) services and (iii) bowel symptoms services

Request 12: Please confirm or deny whether your PCT has carried out an assessment of compliance against (i) NICE clinical guideline CG97 (The management of lower urinary tract symptoms in men) (ii) NICE clinical guideline CG40 (Urinary incontinence: the management of urinary incontinence in women) and (iii) NICE clinical guideline CG49 (Faecal incontinence: the management of faecal incontinence in adults)

Request 13: Please disclose details of any assessment(s) of compliance carried out by your PCT against an assessment of compliance against (i) NICE clinical guideline CG97 (The management of lower urinary tract symptoms in men) (ii) NICE clinical guideline CG40 (Urinary incontinence: the management of urinary incontinence in women) and (iii) NICE clinical guideline CG49 (Faecal incontinence: the management of faecal incontinence in adults)

Request 14: Please confirm or deny whether your PCT has taken action to implement (i) NICE clinical guideline CG97 (The management of lower urinary tract symptoms in men) (ii) NICE clinical guideline CG40 (Urinary incontinence: the management of urinary incontinence in women) and (iii) NICE clinical guideline CG49 (Faecal incontinence: the management of faecal incontinence in adults)

Request 15: Please disclose details of action that has been taken to implement (i) NICE clinical guideline CG97 (The management of lower urinary tract symptoms in men) (ii) NICE clinical guideline CG40 (Urinary incontinence: the management of urinary incontinence in women) and (iii) NICE clinical guideline CG49 (Faecal incontinence: the management of faecal incontinence in adults)

Request 16: Please confirm or deny whether your PCT has taken action to implement recommendations set out in the National Service Framework for older people (Department of Health, May 2001)

Request 17: Please disclose details of action that has been taken by your PCT to implement recommendations set out in the National Service Framework for older people (Department of Health, May 2001)
Request 18: Please confirm or deny whether your PCT has identified (i) continence (ii) lower urinary tract symptoms (LUTS) and (iii) bowel symptoms as an area of excessive or inappropriate secondary care activity

Request 19: Please disclose details of action that has been taken by your PCT to reduce this excessive or inappropriate secondary care activity
Annex 4: List of primary care trusts that responded to the Freedom of Information Act questions

<table>
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<tr>
<th>Trust Name</th>
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<tr>
<td>Ashton, Leigh and Wigan PCT</td>
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<td>Greenwich Teaching PCT</td>
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Halton and St Helens PCT
Haringey Teaching PCT
Hartlepool PCT
Hastings and Rother PCT
Havering PCT
Heart of Birmingham Teaching PCT
Herefordshire PCT
Hull Teaching PCT
Isle of Wight NHS PCT
Islington PCT
Kingston PCT
Knowsley PCT
Lambeth PCT
Leeds PCT
Leicester City PCT
Leicestershire County and Rutland PCT
Lewisham PCT
Lincolnshire Teaching PCT
Liverpool PCT
Luton Teaching PCT
Medway PCT
Mid Essex PCT
Middlesbrough PCT
Milton Keynes PCT
Norfolk PCT
North East Essex PCT
North Lancashire PCT
North Lincolnshire PCT
North Staffordshire PCT
North Tees PCT
North Yorkshire and York PCT
Northamptonshire Teaching PCT
Nottingham City PCT
Oldham PCT
Oxfordshire PCT
Peterborough PCT
Plymouth Teaching PCT
Portsmouth City Teaching PCT
Redbridge PCT
Redcar and Cleveland PCT
Rotherham PCT
Salford Teaching PCT
Sandwell PCT
Sefton PCT
Shropshire County PCT
Solihull Care Trust
South Birmingham PCT

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South Tyneside PCT
Southampton City PCT
Stockport PCT
Stoke-on-Trent PCT
Suffolk PCT
Sunderland Teaching PCT
Surrey PCT
Sutton and Merton PCT
Swindon PCT
Tameside and Glossop PCT
Telford and Wrekin PCT
Torbay Care Trust
Wakefield District PCT
Walsall Teaching PCT
Waltham Forest PCT
Wandsworth Teaching PCT
Warrington PCT
West Essex PCT
West Hertfordshire PCT
West Sussex PCT
Western Cheshire PCT
Wirral PCT
Worcestershire PCT
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