

Implementation of the NICE guidance for the management of urinary incontinence in women

A joint guide on behalf of the Section of Female and Reconstructive
Urology of the British Association of Urological Surgeons and the British
Society of Urogynaecology



July 2007

Contents

Introduction	p2
Aims and principles	p2
NICE's own implementation guidance	p4
NICE guidance chapter by chapter	p6

Abbreviations

BAUS	British Association of Urological Surgeons
BSUG	British Society of Urogynaecology
IDO	Idiopathic detrusor overactivity
OAB	Overactive bladder
SNS	Sacral nerve stimulation
SFRU	Section of Female and Reconstructive Urology
SUI	Stress urinary incontinence

This implementation guide has been produced by the BAUS Section of Female and Reconstructive Urology and the BSUG.

BAUS is a registered charity, no 210505, 35-43 Lincoln's Inn Fields, London WC2A 3PN. Tel: 020 7869 6950. Email: admin@baus.org.uk

The British Society of Urogynaecology, 27 Sussex Place, Regent's Park, London NW1 4RG. Tel: 020 7772 6211. Email: BSUG@rcog.org.uk

Introduction

This document has been produced jointly by the SFRU of BAUS and by BSUG, to facilitate the implementation of the NICE guidance on the management of urinary incontinence in women that was issued in October 2006 (www.nice.org.uk/CG040). Both felt that it was appropriate that they should comment on how to implement the guidance, to help their members and also others involved in implementation.

Aims and principles

Aims

The aims of this document are as follows:

- To facilitate the implementation of the NICE guidance
- To help to produce consistency in the implementation of the guidance
- To assist SFRU and BSUG members to achieve local implementation of the guidance

Principles

The principles that underpin this document are as follows:

- The NICE guidance is welcomed by SFRU and by BSUG. It represents the output of a vast amount of careful work, and it will help those who practice in the area served by the guidance, to work towards a structure for service delivery that will benefit patients.
- SFRU and BSUG wish to help in the implementation of the guidance, and to provide professional assessment and feedback on this process in real life clinical practice
- Given the size of the topic, and the scope of the guidance, it is inevitable that some individuals or groups will have concerns about some aspects of it. However, it is clear that the guidance is something that is to be taken as a whole: trying to negotiate over aspects that raise individual concerns is neither possible nor appropriate.

- The implementation guidance that NICE itself has produced, both generically and for this clinical guidance specifically, is designed for implementation into clinical practice at a local level. The strong emphasis from NICE for Board level support in local implementation cannot be overstated and clearly SFRU and BSUG strongly advocate the use of these documents in local implementation.
- There should be multidisciplinary work, in all aspects, in both service and service delivery. This should involve both urologists and urogynaecologists working together, and with colleagues, in both primary and secondary care, from the following disciplines:-
 - Specialist nursing
 - Specialist physiotherapy
 - Continence advisory service
 - General Practice
 - Pharmacy
 - Formulary Committees
 - Clinical Governance Committees
 - Service Management
 - Trust Boards
 - Commissioners
 - Patient representatives
- Multidisciplinary work is built on strong local relationships between different disciplines who work closely together in a collaborative and non-competitive fashion. In some localities, this will require collaboration that has not existed thus far, and a positive approach from all is essential. Both Trusts and Commissioners will be entitled to expect that all relevant healthcare professionals will collaborate and work together in this way.
- The guidance is a means of helping to build and strengthen local cases for the development of service delivery; often in ways that have already been envisaged or partly established, and should be used as a guide to service provision in such discussion with Trusts and with Commissioners.

NICE’s own implementation guidance

NICE gives generic advice for implementing its guidance ([How to put NICE guidance into practice](#)), as well as specific advice relating to this guidance ([CG40 Urinary incontinence - implementation advice](#)). This underlines the need for providers to comply with NICE guidance, as set out by the Department of Health in “[Standards for Better Health](#)”.

How to put NICE guidance into practice

NICE stress that for successful implementation of their guidance, this typically requires that there should be an identified Board-level leader, and a clear implementation policy. They also advise that an individual appointed as a NICE manager, to drive implementation locally, has been found to be very helpful. The implication is that such a person may work on NICE guidance in general, helping on several published guidance documents. Funding for such a post may be agreed between the various stakeholder organisations. Financial planning, a systematic approach to implementation, and evaluation of outcomes are also recommended by NICE.

CG40 Urinary incontinence - implementation advice

The document that NICE have produced on implementing this guidance recommends the following key steps:

- Identify implementation leads
- Identify an implementation group
- Carry out a baseline assessment
- Assess costs and savings
- Develop an action plan
- Key areas for implementation

This should be the framework on which local implementation is based, although there will also be an additional preliminary step of ensuring that those for whom the guidance is relevant locally (set out under “Principles”), are aware of the guidance

and are familiar with its outline or detail, as necessary. This is likely to involve presentation to senior management and to PCTs, as well as in what are, or what will become, multidisciplinary clinical teams. NICE have produced a slide set to facilitate this ([CG40 Urinary incontinence: Presenter slides](#)).

“CG40 Urinary incontinence - implementation advice” includes an example of an Action Plan, setting out how individual aspects of the guidance may be addressed locally. This example seems to be a very useful basis to work on, and contains references to other published guidance and material that should help local implementation.

NICE guidance chapter by chapter

Chapters 1 and 2 Introduction and Summary of recommendations & practice algorithm

- No specific comment is made, because these chapters are an introduction to, and summary of the guidance.

Chapter 3 Assessment and investigation

- The recommendations in this chapter up to and including pad tests, for the assessment and investigation of women presenting with incontinence are entirely appropriate. Given that these women will present to Primary Care, a key issue for implementation of this part of the guidance will be working with Primary Care to help set up the means for this: there will be a key role for education of those in Primary Care who will see women at this stage.
- It seems unlikely that many women will have been having urodynamics before the initiation of conservative treatment. However, those specialists who have done urodynamics before offering surgery for the small percentage of women with “pure” stress urinary incontinence would need to justify their practice locally within their Trust if this was to continue. The routine use of symptom questionnaires that assess storage symptoms, amongst others, would help to detect symptoms of bladder overactivity, and this is recommended. Although there is no adequate evidence base at present which evaluates the role of urodynamic assessment in predicting outcomes from surgery, clearly every individual patient has to be evaluated in the most effective fashion from the individual clinician’s perspective and based on an individual patient’s clinical profile.
- The provision of videourodynamics and ambulatory urodynamics varies considerably. This should be discussed on a regional basis amongst specialists with a view to discussion with Trusts and commissioners, so that an

acceptable degree of provision is available within each region. These facilities should be made available particularly for those specialists who deal with complex cases, so that these women are able to have appropriate investigation before management decision are made. It is likely that overall provision is inadequate at present for videourodynamics and clearly ambulatory urodynamics has a very limited role in routine clinical practice. Neither urethral pressure profilometry nor valsalva leak point assessment has been clearly established to be either adequately reproducible or predictive of clinical outcome.

- Written information should be provided about management options for women with incontinence.
- The research recommendations in this chapter, relating to pelvic floor assessment, the influence of urodynamics on outcomes and cost-effectiveness, and the role of ultrasound in the overactive bladder should be considered regionally and nationally by specialists and specialist bodies.

Chapter 4 Conservative management

- Once again, a key issue for implementation of the recommendations on lifestyle interventions, physical therapies and behavioural therapies will be working with Primary Care to help set up the means for this, including education of professionals.
- Local negotiation will need to consider which professionals offer pelvic floor muscle training, and the level of specialist physiotherapy provision will need to be addressed locally. The provision of pelvic floor muscle training as a preventative measure for women in a first pregnancy needs particular attention.
- The recommendations on medical therapy for OAB have taken cost into account and may differ from what many specialists would choose, based on feedback from our members. This will need to be discussed locally, so that if

local implementation differs from the guidance, this has to be agreed with commissioners.

- The recommendation on the use of desmopressin in OAB should be formally implemented.
- The use of Duloxetine should be discussed locally in the implementation plan, but there appears to be a limited role for this therapy based on current knowledge in its use.
- The use of topical oestrogens may not be widespread at present, and awareness of the importance of this should be raised in the local implementation plan.
- The recommendation on pads, devices, catheters, complimentary therapies, and preventive use of conservative therapies should be implemented.
- The research recommendations in this chapter, relating to physical, behavioural and medical therapies, lifestyle interventions, cost-effectiveness of medical therapy, and the use of preventive therapies should be implemented wherever possible both regionally and nationally by specialists and specialist bodies.

Chapter 5 Surgical management

- The recommendations for surgical treatment of IDO, with the exception of that for SNS, are entirely in keeping with current practice, and implementation is likely simply to involve confirming that this is so locally. The use of intravesical botulinum toxin is likely to acquire a more robust evidence base in the next two years, and it would be appropriate to make Trusts and commissioners aware that this is likely to become a more widely used treatment in the medium term, subject to the planned review by NICE of this guidance within four years or sooner.
- The recommendation for the use of SNS is likely not to be in keeping with current practice in most parts of the country, and whilst the recommendation from NICE is greatly to be welcomed, this is one area of the guidance that will

present considerable challenges to achieve implementation. The development of a SNS service should be considered on a regional basis, with the aim of the development of services that have a workload that is appropriate for the development and maintenance of a quality clinical service. In most regions, this is likely to be provided in one Trust, subject to local negotiation. The availability of an enthusiastic Medical Physics/Clinical Measurement team is regarded as an essential prerequisite to the establishment of such a service, together with collaboration with an existing provider, and subject to clear agreed local strategies about resourcing of the service.

- The recommendations for surgical treatment of SUI are likely to be consistent with most current practice. This recommendation should be discussed locally with a view to the appropriate use of the surgical techniques recommended in the guidance.
- The research recommendations in this chapter, related to intravesical botulinum toxin and to the surgical treatment of SUI, should be implemented wherever possible both regionally and nationally by specialists and specialist bodies.

Chapter 6 Competence of surgeons performing operative procedures for urinary incontinence in women

- The recommendations relating to the competence of surgeons will require discussion between local urologists and urogynaecologists in collaboration with Clinical Governance Committees with the formulation of a clear local plan as to which surgeons should perform surgery for incontinence. This will need to be approved by the Trust in question. It is suggested that in most Trusts, there will be one surgical lead, but that role might be rotated, perhaps annually in a planned way, between those surgeons who are deemed to be competent to operate on women with urinary incontinence.