Local contract ref.	
Goal number	
Goal name	Improving Urinary Continence Care (find, assess, investigate and refer)
Indicator weighting (% of CQUIN scheme available)	10%
Description of indicator	Improving care for patients with urinary incontinence in (a) hospital in patient setting and (b) GP practices, by recording and reporting the number of patients with urinary incontinence; assessing, diagnosing and treating urinary incontinence; and initiating treatment and on-going care.
Numerator	 1.Number of inpatients per hospital wards, or at risk primary care patients per GP surgery who are recorded as having urinary incontinence or who have been asked a screening question e.g. 'do you ever leak urine' 2.Number of patients with urinary incontinence and have: a) Urine test to exclude infection b) Completion of a 4-question bladder tool to include (1) Frequency of incontinence and pad usage (2) Urgency (sudden urge and needing to rush to the toilet) (3) Stress leakage (on coughing, standing etc.) (4) difficulty emptying bladder (straining, feeling of incomplete emptying, dribbling after emptying) c) Fluid intake and output chart ideally for 3 days, but minimum 24 hours if patient / carers are able to complete d) Post void bladder scan
Denominator	A minimum of 25 hospital inpatients and 25 at risk community patients will be surveyed quarterly (at risk is defined by age 65+, pregnancy, any long term condition) 1. % of patients in hospital wards or at risk primary care patients in community with recorded incontinence and/or % who are asked screening question) 2. % of patients with urinary incontinence who have: a) Urine test to exclude infection a) Completion of a 4-question bladder tool b) Fluid intake and output chart c) Post void bladder scan
Rationale for inclusion	It is estimated that urinary incontinence affects 1 in 3 women aged 18+ and lower urinary tract symptoms (LUTS) affects 2.7% of men aged 18 and over and 35% of men over 60 years old . Despite continence problems being relatively common, people are often embarrassed and reluctant to discuss their incontinence and therefore detection in the community can be difficult. However, 80% of continence problems are treatable and the low cost of conservative treatments is offset by the reduced need for containment products, surgery and social care. It is intended that this CQUIN will reduce the number of patients with Incontinence Associated Dermatitis (IAD) and reduce the number of admissions with hospital-acquired urinary tract infections (UTI), particularly as the mortality associated with the latter condition is about 10 %. Good continence care is critical in delivering the 3 national CQUINs for 2014: dementia programmes (30-90% of patients with dementia have incontinence depending on

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	degree of impairment), NHS Safety Thermometer (catheterassociated UTI and pressure sores and falls are <i>all</i> related to
	urinary incontinence), and Friends and Family survey (22 out of the
	33 cases presented as oral evidence in the Francis report included
	"significant concerns" about continence care).
Data source	Patient records (including electronic) for all inpatients and/or GP
	practice patients. The screening questions should be part of the routine assessment document for inpatients (nursing and or
	medical) and should therefore be asked in all inpatients. For
	primary care patients, those at risk should be routinely screened.
	Risk factors are: age 65+, pregnancy, any long-term condition.
	Data can be collected on a quarterly basis examining a minimum of
	25 cases in each setting.
	To include:
	a) Total number of inpatients recorded as having urinary incentionals.
	incontinence b) Total number of patients asked a screening question
	c) Total number with urinary incontinence who have had a:
	I. Urine test to exclude infection and
	II. Completed 4-question bladder tool
	III. Fluid intake and output chart
	IV. Post void bladder scan
	c) Number of patients who received any type of treatment for incontinence
	d) Number of patients referred to local continence services (can
	include urology, gynaecology, geriatrics, continence specialists in
	community)
	d) Number of patients with in Incontinence Associated Dermatitis –
	based of provider Tissue viability care records.
	e) Continence care information provided to patients (and carers
	where relevant) in any form — this can include hospital discharge letters, clinic letters, GP encounters
Frequency of data	3 Monthly
collection	o Montany
Organisation	All relevant NHS-funded providers [Insert Provider name].
responsible for data	Designated continence leads should be identified one in acute
collection	Trust and one in community to ensure accountability for CQUIN
	delivery. The purpose of this CQUIN is to improve continence care
	across the acute and community boundaries (especially important for at risk patients such as those with dementia) and the
	designated leads will use the data to optimise integrated care.
Frequency of reporting	Quarterly
to commissioner	-
Baseline period/date	Based on audit of 25 sets of notes in hospital inpatients and in
	community when in each month April, May and June 2013 (total 75
Baseline value	sets of notes) to be agreed by
Final indicator	,
period/date (on which	April 2014 – March 2015
payment is based)	
1	1

Final indicator value	a) 20% Increase in patients who have a continence assessment
(payment threshold)	which includes all of the three/four elements:
	d) Urine test to exclude infection
	e) Completion of a 4-question bladder tool
	f) Fluid intake and output chart
	g) Post void bladder scan
	% increase per element should be recorded so local problems with
	implementation of any one of these (e.g. access to hand held
	bladder scans) can then be identified and resolved
	b) 20% increase in patients undergoing treatment related to urinary
	incontinence
	c) Increase number of patients referred to local services for on-
	going care
	d) Reduction in Incontinence Associated Dermatitis – based of
	provider Tissue viability care records.
	e) Include continence assessment outcomes (urine test, 4-question
	bladder tool, intake and output chart and post void bladder scan)
	and treatment and referral plan in documentation that is shared
	with patient (and carer where relevant)
Rules for calculation of	Evidence: Provider reports showing:
payment due at final	number of patients with continence problems;
indicator period/date	number of patients whose continence problems have been
(including evidence to	assessed;
be supplied to	
commissioner)	
Final indicator	March 2015
reporting date	
Are there rules for any	no
agreed in-year	
milestones that result	
in payment?	
Are there any rules for	no
partial achievement of	
the indicator at the final	
indicator period/date?	

Example 4-questions

Is the person bothered by the number of times they need to pass urine during the day?

Is the person bothered by the number of times they need to pass urine during the night?

Does the person leak urine?

Does the person have any other bladder problems? (i.e. difficulties passing urine, infection and/or pain)

Examples of initial treatments for incontinence

Treatment of UTI
Pelvic floor exercises
Bladder retraining / antimuscarinic medications for overactive bladder
Medications for benign prostatic enlargement
Vaginal oestrogen