Developing an interdisciplinary integrated continence service

The importance of integrating continence services in order to promote best practice in continence care is well established (Pomfret, 2001; Department of Health, 2000a; Speakman, 1999), yet many trusts struggle to act on these recommendations (Abrams, 2002a; 2002b; Continence Foundation, 2002; 2000). A number of barriers appear to be causing these difficulties in implementing integrated continence care. For example, a number of reviews identify the appointment of a director of continence services as a key step (CE, 2002; Association for Continence Advice Wales, 2001; DoH, 2000a), but a recent review indicated that only six per cent of trusts in England are planning such an appointment (CE, 2002). Other barriers include funding, skill mix, professional autonomy and problems related to multiprofessional working (Abrams, 2002a; 2002b; CE, 2002).

Within Gwent the proposals to integrate and modernise continence services initially seemed daunting. However, by reorganising existing resources – facilitated by a strategic vision and a systematic approach to change – a fully integrated service has been achieved with minimal financial investment. This article describes how integrated continence services were achieved in Gwent Healthcare NHS Trust (see Box 1, p37).

**Literature review**

The need to integrate continence services between primary and secondary care reflects the broader recognition of the benefits of multi-agency, multiprofessional working (Pomfret, 2001; DoH, 2000a). This type of integrated approach enables patients to gain access to services that are appropriate to their needs, and reduces inappropriate referrals and the length of waiting lists in secondary care (Department of Health, 2000b). The artificial separation of primary and secondary care in continence care is inappropriate and leads to delays in treatment and unnecessary diagnostic pathways being followed for some patients. Shared care can utilise the strengths of primary and secondary services (Speakman, 1999). There are several examples demonstrating the strength of this approach in antenatal care, diabetes, cardiac care and mental health (Isaacs, 1992).

Evidence-based care pathways are now well established within continence care (Bayliss et al, 2000a; 2000b). These aim to increase access to nurse-led services, providing first-level interventions that are managed predominantly by the patient and nurse working in partnership. Patients should only be referred for medical intervention if these interventions are inappropriate or fail to improve continence.

Historically, continence services have been accorded low status and have frequently been associated with the stigma of incontinence (Goldstein et al, 1992). Because the problem is not life-threatening, people running continence services often find it difficult to obtain the resources they need. They are competing with what are perceived to be more pressing priorities produced by the national service frameworks, and this frequently hampers the development of services to the detriment of patients with continence problems.

Pomfret (2001) has proposed a model for the effective multidisciplinary integration of continence services. It advocates a multidisciplinary line management structure that includes physiotherapists and occupational therapists as well as continence nurses. The model was successfully introduced in a community trust in response to opportunities arising from local restructuring, professional interests and opportunistic use of vacancies.

Where it can be introduced, a multiprofessional managed team of continence specialists is likely to be beneficial in meeting the varied needs of targeted populations. However, the range of professionals and agencies involved in continence care means that opportunities to line-manage a multiprofessional continence team may be limited. Such teams may effectively tackle specific areas of high need such as residential homes and the first-line management of female urinary incontinence, but they are unable to integrate continence services for the diverse range of patient groups who use these services.

These groups include children, whose incontinence arises from other pathologies and those with faecal incontinence across the age range. Continence problems cross all specialties, and specialists in all fields, therefore, need access to an effective continence service and should integrate this with their patients’ existing care needs. Gwent Healthcare NHS Trust used integration, networking, vision and leadership to produce an integrated service targeted at all patient groups served by the trust.

**Background**

For the past six years Gwent Healthcare NHS Trust has been working to reduce the use of incontinence pads, and to implement a preventative continence service based on assessment and first-line interventions. The aim has been to ensure that containment of incontinence through the use of pads is truly the last resort for people with continence problems.

Further opportunity for development arose three years ago after the amalgamation of separate community and hospital trusts into one large organisation. This organisational change created an opportunity to review and reorganise the trust’s fragmented continence services into a coordinated service that would be more efficient...
and would improve the standards of care received by service-users. Before the reorganisation the continence services were patchy and individualistic, relying on the resources, motivation, knowledge and initiative of individual practitioners working in isolation.

The system lacked incentives to provide coordinated or effective intervention, despite recommendations for community and hospital directorates to liaise with one another so that they could gain an understanding of each other’s priorities. Such channels of communication facilitate the development of a combined philosophy for overall care in the community (Speakman, 1999).

The reconfiguration coincided with the publication of a policy document on continence services (DoH, 2000a). The government document was crucial to the initiative because, for the first time, it provided a framework to inform policy locally.

An i-grade vacancy in the community was used as an opportunity to fund a leadership post as recommended in the policy document. Internally the position was called head of continence services, as the recommended term ‘director’ created confusion with existing executive posts within the trust. However, the term director is used externally when profiling the role.

The director of continence services was appointed in December 2000, and undertook a leadership role in developing continence services throughout the trust, but based in primary care. In order to take services forward this individual adopted a change management strategy that encouraged team working, new ideas and the innovative use of resources. The importance of establishing a director is recognised in the literature and is only just being addressed in many trusts today (Continence Foundation, 2002).

Gwent Healthcare NHS Trust is one of the biggest integrated trusts in the UK, serving a population of over 600,000 people in south-east Wales. It works in partnership with five local health boards and local authorities and has three district general hospitals and 20 community hospitals. The trust provides:

- Acute care;
- Community services;
- Learning disability services;
- Mental health services;
- Maternity services.

Using the Continence Foundation formulae (CF, 2000) it is estimated that approximately 22,000 people have urinary incontinence in Gwent and 5,000 have faecal incontinence. Annual community and hospital expenditure on incontinence pads is approximately £4.5m, indicating the potential for improvement. The size and complexity of the trust created an opportunity to achieve economies of scale that would accrue from the development of a proactive, integrated continence service.

Gwent is a diverse county spanning the picturesque, affluent rural pastures of Monmouthshire to the industrial scarred, socially deprived valley communities, with mountainous areas creating problems of access for large isolated populations. The area has seen unemployment rise to one of the highest levels in the UK because of the decline of heavy industry. Levels of mortality and ill health in Gwent are higher than the Welsh average (Gwent Health Authority, 1998).

**Aims of the service development**

The service was developed with a number of aims:

- To ensure local access to an effective service for patients;
- To establish an integrated multidisciplinary network with joint working strategies, audits, integrated referral and continence care pathways;
- To use new nurse-led clinics and initiatives to triage patients in primary care, promote appropriate referral to secondary care for urodynamics and surgery, and reduce inappropriate hospital referral utilising resources in a cost-effective way;
- To monitor the quality of service and patient outcomes;
- To develop links with patient and public representatives and community health organisations;
- To implement an educational strategy for primary and secondary care;
- To establish mechanisms that would meet projected budget targets.

**Developing the service**

A systematic approach was undertaken while developing the service, capitalising on opportunities as they arose. We focused on three main areas of development: staffing, multiprofessional working and involving patients and carers.

**Staffing structure**

This was a priority in order to provide equitable services, and was achieved by reallocating existing resources from a variety of sources. Guidelines suggested that for the size of population served by the trust, the ideal staffing level consisted of five clinical nurse specialists (one per local health group or authority) plus the director of services who was responsible for managing the new integrated service (CF, 2000; DoH, 2000a). A service review identified shortfalls in the north and east of the county which were addressed in the following manner:

- An existing i-grade vacancy was filled to lead service integration;
- Three existing G-grade clinical nurse specialists (CNS) in incontinence, funded by different service sectors, were integrated into the team;
- Full funding for a G-grade CNS plus administrative support was provided by a local health group (now replaced by local health boards);
- An F-grade vacancy was upgraded to G grade to cover the north of the county;
- All five CNSs were to be borough-based, holding their own caseloads and educational responsibilities, managed by the director of the service and working to the same service strategy;
- An existing secretarial vacancy was used to create two full-time and three part-time secretaries.

**Keywords**

- Interdisciplinary integration
- Leadership
- Continence services
REFERENCES


Association for Continence Advice Wales (2001) Continence Care: Striving For Excellence in Wales. Cardiff: Regional Welsh ACA/Pharmacia.


The team can also refer to four generalist physiotherapists with a special interest in incontinence and one part-time specialist urotherapist. These practitioners are not managed by the incontinence service.

The above resources were achieved by negotiation with general managers and service directors including lead physiotherapists and consultants, and by transferring money between service budgets.

Multiprofessional working

We identified consultants and other health care specialists in secondary care who had a special interest in continence and established a pan-Gwent multidisciplinary interest group chaired by the director of continence services. This forum debates and agrees service developments, and is supported by the specialists, who recognise the need for and benefits of joint working in obtaining resources and developing services.

Subgroups and splinter groups have formed to progress specific areas of activity. These include:

- Child health;
- Physiotherapy shortfall;
- Postnatal risk assessment (with midwives);
- Urogynaecology joint working;
- Elderly care and stroke;
- Faecal incontinence.

The service also has a general/mental health nurse link network and a learning disabilities link network. The five CNSS take responsibility for these networks.

To ensure equity of access to services and to coordinate the efficient use of scarce resources, it is essential to engage with primary care and bridge the gap between primary and secondary care. These are key roles for the director of continence services, and involve the identification of diverse and fragmented resources and negotiation with stakeholders to integrate resources with activity across the trust.

Although it is time-consuming, interdirectorate collaboration has been most effectively achieved through one-to-one discussion with specialists. This requires the director to have a high level of clinical expertise, diplomacy, professional credibility, vision and patience. In our experience all these components are crucial to effective leadership.

In primary and community care, existing but inappropriate GP referral pathways direct to consultants have been addressed using the following measures:

- Offering an educational programme to GPs and practice staff in their surgeries, which indicates alternative referral pathways directly to the continence service for first-line treatments in primary care;
- Setting up a triage system that enables immediate access to advice close to the patient’s home.

As a result GPs are now increasingly referring patients directly to nurse-led clinics in each of the five boroughs.

The new continence service has also interfaced with social services in the following ways:

- Providing regular free training for social services carers, and residential/nursing home staff;
- Working with lead divisional nurses across the trust to identify how to provide effective services and develop partnerships with social services, local authorities and nursing homes;
- Giving talks to carer associations.

This work is still in the early stages of development but aims to provide equity of access and effective continence care provided at the point where it is needed.

Involving patients and carers

The stigma associated with incontinence leads many people to suffer in silence for many years. There is a need to recognise the public health dimension of continence care and to link with community facilities to provide general education for the population and to open up access to existing provision for those who may fear coming forward. In Gwent we have started to address these issues by:

- Setting up information stalls and open days at local markets, supermarkets, hotels and in the hospital;
- Making presentations at local health watch meetings;
- Establishing a database of interested members of the public who are willing to be consulted in the future on developments and join a focus group;
- Seeking expert advice from patient and public liaison officers who help to consult the public on design and wording of information leaflets;
- Putting up posters with contact numbers for services in public toilets and GP waiting rooms;
- Undertaking patient satisfaction surveys.

Results

The developments described above have gone a considerable way to meeting the aims of the service.

Geographical equity of access

Expanding the clinical team from four to six continence nurses enabled us to increase the number of nurse-led clinics and venues from five to 17, located around the trust. In this way equity of access was achieved.

Interdisciplinary collaboration

A trust-wide integrated care pathway has been developed and will be implemented next year. Joint working and service planning with GPs, child health, physiotherapy and midwifery services, relevant secondary care consultants, local health boards and social services has been established.

A unified management structure

This has been established and all planned staff are now in post.

Transformation of service to strategic management

A shared interprofessional philosophy of care has been established. We have moved from a management culture that was based on line management to one based on networking and collaboration. At the same time the lead
Joint audit and review
As recommended by the Department of Health (2000a), a number of joint audits have been undertaken to review service development. Trust-wide audits were undertaken on the use of catheters and midwives’ knowledge of pelvic floor activities and their competency to teach pelvic floor exercises (Logan, 2001). Patient outcomes were evaluated through an annual audit, using a quality of life and symptom scoring measurement tool on a random sample of patients who attended the nurse-led clinics throughout Gwent.

Discussion
As many documents testify and government policy repeatedly indicates, the implementation of best practice in continence management requires the development of a strategically led, unified approach. This paper has described the systematic change process adopted to develop a unified approach to continence care within Gwent Healthcare NHS Trust.

It reinforces the point made by Abrams (2002a; 2002b) that the achievement of a modern continence service depends upon organisational reform rather than large-scale financial investment. It also illustrates that the implementation of effective continence services does not necessarily compete with other priorities such as those contained in the national service frameworks. Although awareness of organisational structures and proposed changes is needed, with the right leadership it does not need to be disrupted by them – in fact such changes can be used as an opportunity for further developing the service.

The continence service described has been implemented in a large integrated NHS trust, which covers diverse urban and rural populations distributed across a large geographical area. We have illustrated how we addressed these factors in implementing the service. While our recommendations and experiences may be reproducible elsewhere, it is important to recognise the diversity of NHS organisations and to consider local resources, geography, population and context for service delivery.

In retrospect we have recognised that the model of service development described in this article has the potential to be transferable to other specialty services where modernisation is required to reduce waiting lists and improve referral to hospital consultants. The model is particularly suited to services where the presenting problem is enduring and predominantly managed by the patient over time, with the support of a nurse and requiring inter-agency collaboration.

As our integrated continence service gains credibility, we envisage that our bargaining power will increase in line with the expansion and the cohesive support generated by the multidisciplinary team. This will be advantageous when it comes to competing for resources, should we require, for example, a new piece of diagnostic equipment to improve our service, which cannot be accommodated within existing resources.

We are now prepared to face the demands that modernising health care service delivery brings as well as the challenges presented by the development of local health boards in Wales. In readiness we have developed a fully integrated comprehensive continence service as a ready-made package for presentation to the local health boards, as suggested by Abrams (2002a; 2002b).

As a result of these developments, Karen Logan has been shortlisted for the National Primary Care Best Practice Awards.

BOX 1. TIMESCALE FOR DEVELOPING THE SERVICE

DECEMBER 2000 – MAY 2001
■ Appoint service director
■ Undertake scoping exercise
■ Devise strategy for integration
■ Establish individual and group meetings with key stakeholders

JUNE – DECEMBER 2001
■ Highlight specific needs for providing specialist services (child health, physiotherapy, midwifery, mental health)
■ Review geography and location of populations to identify how to provide locally accessible services
■ Negotiate with management to address resource issues
■ Implement an integrated assessment process across primary and secondary care

JANUARY – JUNE 2002
■ Introduce multidisciplinary educational programmes across primary and secondary care at convenient locations
■ Devolve budgetary management
■ Appoint all planned staff to deliver more equitable, accessible nurse-led clinics

JULY 2002 – present
■ Re-evaluate service
■ Plan budget containment
■ Established multiprofessional group to consider continence care pathways
■ Collaboration with midwifery, child-health, physiotherapy, learning disabilities

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Gwent Health Authority/Caerphilly County Borough Council (1998) Caerphilly Health and Social Needs Study. Caerphilly: GHA/CCBC.


