

The Winston Churchill Memorial Trust of Australia

Report by Ester Barter
2011 Winston Churchill Fellow

The Peter Mitchell Fellowship to investigate models of care for
the delivery of continence services. UK & Denmark.

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Signed: Ester Barter

Date:21/08/2012

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Introduction

Why Does Incontinence Matter?

Urinary Incontinence (UI) is defined as 'involuntary loss of urine' and Faecal Incontinence (FI) as the 'involuntary loss of faeces or flatus' ²⁻¹⁰. It is estimated that the prevalence of all forms of incontinence in the general Australian population is 27%⁷. The prevalence ranges from 2.2-13% in men and 19.3-37% in women, while prevalence rates of FI range from 5.5-20% in women and 5.3-12.9% in men^{7 8}. Because of under reporting of incontinence and the increase in general risk for the development of incontinence the incidence of people seeking and receiving medical care is likely to increase the incidence rates significantly ^{4 6 9}.

The financial costs attributed to incontinence are already substantial but almost certainly underestimated because of under reporting ¹⁰. In recent years the Federal Government made incontinence a national health priority and has directed funding towards initiatives to improve the service gap in this area. Gaining exposure to how other countries provide continence services will enable experience to be shared and inturn improvement of current services, with a goal to provide services to those currently beyond reach and improve efficiency for those currently in the system.

As the physiotherapist responsible for the cross campus multidisciplinary Mater Continence Service, I designed and implemented the current service model of care from inception and am actively pursuing ways to improve the services further. Mater Health Services (MHS) covers a wide range of population groups and the Continence Service goal is to meet these diverse needs. With this in mind the two main goals of the Fellowship were to: explore and gain experience of different models of care for the delivery of continence services that could be adapted and incorporated in to current services; and to establish professional relationships to enable the ongoing exchange of knowledge and experience between relevant clinicians at an international level. Both goals were intended to ensure that this fellowship's impact of gaining and adding new knowledge is enduring and not just a one off.

Acknowledgements

I would like to acknowledge and offer my profound thanks to the following organisations and individuals; my sponsor Peter Mitchell whose Fellowship and support has, and continues to, provide once in a lifetime opportunities for young Australians like myself. The Churchill Fellows Alumni for their generous advice and encouragement. Dr David Winkle and Dr Geof Hirst for providing references and fantastic encouragement. I would also like to acknowledge Dr Mark Waters, Ms Anne-Maree Butter and Dr John Bingley who have provided exceptional support for this project at the Mater. In Denmark I would like to thank my wonderful hosts Ms Inger-Marie Thiele, her family and Dr Gregers Hermann who's warm and generous hospitality gave me the opportunity to gain a 'taster' of Danish life. In the UK, Dr Jalesh Paniker, Ms Elaine Hazel and Ms Leisa Dorras, thank you for the time and effort in providing comprehensive experiences and for welcoming me with open arms in to your teams.

Executive Summary

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The Peter Mitchell Fellowship to investigate models of care for the delivery of continence services.

I have been fortunate to have many professional and personal highlights through this fellowship. They include; observing sacral nerve stimulation and its significant impact on patients, the inspirational nursing team at Guy's, the highly respected Uro-Neurology team at Queens Square & presenting to them about EMG Biofeedback, discovering my voice as an advocate for my profession and finally the amazing opportunity to meet so many like minded professionals in Denmark and the UK who set the bar so high, yet remain open, engaged and collaborative.

Recommendations

1. The Gold Standard for a Continence Service is a Multi-Disciplinary Team
2. The advanced skill set of the specialist continence physiotherapist needs to be recognised
3. Standardised public access to advanced management options for incontinence
4. Focus on the patient when designing services
5. Integrate Community and Acute Continence Services – “Parachute Model”
6. Expedite Assessment, Diagnosis and Management - “One Stop Shop Model”

Dissemination was possible through my blog www.continenceblog.com. Here over 70 of my colleagues from across Australia received regular updates of my findings. I promoted the blog by writing small articles for relevant publications at a local (Mater News, GP alliance), state (QLD HACC / MASS) and national level (Continence Foundation of Australia). Since my return I have completed follow up articles for the same publications, discussing my findings and promoting the work of the Fellowship Trust. I have also written for the International Uro-gynecology Newsletter and plan to submit to the Urological Society and International Continence Society Newsletters. I have also been disseminating my findings by speaking at various education events and meetings (which will continue into 2013 at a local, state and national level), with audiences including, professional bodies, nurses, doctors, allied health, physiotherapists, GP's, managers, academics and researchers.

Implementation of the project recommendations has involved discussing this project with the relevant directors at the Mater Health Services. At the next Continence Service Steering Committee there will be discussions to augment the current model of care in line with project recommendations. Alongside this two separate collaborative continence related research projects between MHS /Queens Square and MHS / Guy's are in their early stages of development. In line with advocacy for physiotherapy, international allegiances have been formed and the physiotherapists from both Denmark and the UK have become members of the Australian online “Continence and Women's Health Network”.

Program Outline

21/05/2012- 01/06/2012 Copenhagen, Denmark

Frederiksberg Hospital

Herlev Hospital

Rishospitalet Hospital

Frederiksberg Community Health Centre

05/06/2012- 22/06/2012 London, UK

University College London Hospitals NHS Foundation Trust – University College Hospital

University College London Hospitals NHS Foundation Trust – National Hospital for Neurology and Neuro-Surgery, Queens Square

Guy's and St Thomas NHS Foundation Trust – Guy's Hospital and St Thomas Hospital

Imperial College Hospitals NHS Trust – Charing Cross, St Mary's & Hammersmith Hospitals

This program included experience of and exposure to:

Different environments; outpatient clinics, outreach clinics, community clinics, inpatient units, operating theatres, diagnostic clinics, MDT meetings, Interest group meetings, lectures and education events.

Diverse people; senior management, business managers, nursing staff, nurse practitioners, educators, researchers, academics, specialist physiotherapists, specialist doctors, registrars, medical students and administrative staff.

Main Report

The Mater Health Services incorporates a network of seven hospitals servicing a local population of over 80,000 patients. It is a charitable organisation that provides public services to Queensland Health and has a degree of autonomy in the way that it provides those services compared to the other public hospitals in Brisbane. It has a reputation for delivering an exceptional continuum of care from inpatient to outreach services. The Mater Continence Service also has to meet the challenge and needs of very large and diverse patient populations including:

- Remote & regional Queensland. The Urology Outreach program supports a population of over 1/2 million people covering a large geographical area: 40% of the landmass of QLD. This is the only hospital in Australia that uses this model of care.
- Largest tertiary referral maternity hospital in Australia (9500 births /year¹) provides a challenge for the delivery of continence services.

Cultural and Economic Structures of the UK and Denmark and Their Healthcare Systems

Denmark, Australia and the UK have many similarities in their health systems and also some polarising contrasts. They are all wealthy 1st world, democratic countries with mixed economies which encourage a free market but also provide for its population with a strong welfare system.

The public spending on healthcare is noticeably different between the three countries, with Denmark the highest at 11.1% of GDP compared to the UK at 9.6% of GDP and Australia at 9.1% of GDP¹⁷. There are stark differences in size of the population compared to landmass. The UK has a staggering population of 63.1 million, equating to 0.003KM² per person¹⁶. Next is Denmark with the smallest population of 5.54 million equating to 0.007KM² per person¹⁸ then Australia with a population of 22.68 million equating to 0.34KM² per person.

All three countries receive the majority of funding for health from government taxation. Australia has only 68.5% public sector services with the rest of healthcare provided privately. This is compared to 83.2% in the UK and 85.1% in Denmark¹⁷. These numbers combined with the per capita spend provides some explanation for the higher taxes in Denmark compared to Australia and UK (base rate of 42% Vs. 15%). In discussion, the Danish people seem at ease with this system, possibly because they know that it underpins the welfare state culture and a belief that "the state will look after me". Interestingly cars are taxed at 180% of their value, hence the high number of bicycles and very small cars in use. Riding a bike was observed to be a way of life in Copenhagen. One might speculate that this "active lifestyle" contributes to the significantly lower rate of obesity in Denmark at 13.4% compared to Australia's 24.6% and the UK at 26.1%¹⁷.

Culturally, I observed the Danish people to be a very trusting and accepting of a state driven culture. In Denmark, healthcare is linked and billed using a person's social security number. A person's social security number is assigned at birth by the state and is required in all aspects of

life; banking, employment, credit cards, healthcare and many more. Interestingly the Danish did not feel uneasy that the state and banks had access to such a wealth of personal data. The UK and Australia have a healthcare number that is not linked to other personal data or used in any sector other than the healthcare system. I did not observe the strong 'belief in the system' by patients in the UK. Although both systems are under inherent financial pressures from the current economic climate with ward closures, reduced job security and considerable changes to the delivery of services, the cultural attitude was less at ease with the strength of the health system in the UK, than compared to Denmark.

Healthcare in Denmark was traditionally run at a local area government level. In recent years there has been a move to restructure and centralise the system, although from my direct observation it appeared the system still retained a moderate level of local control. The central government has overall control of budgets and structure of services with the goal of standardising care and improving quality across Denmark. There are 5 regional areas which have responsibility for running the entire healthcare in those areas.

In the UK the opposite approach is apparent with the central system decentralised in 2006 into 10 strategic health authorities. These health authorities have budgetary control that allow "commissioning" services from providers¹⁴. This year the British government announced plans to further devolve services by abolishing health authorities. The power to make decisions and control budgets will be placed in the hands of the doctors on the front line- the GP's will have responsibility for choosing the services for their patients. It is interesting that in this Fellowship I have been able to observe two open access healthcare systems that are on politically opposite journeys.

Key concepts observed during the Fellowship in reference to Continence Services:

- **Models of inpatient and outpatient services**
- **Multidisciplinary team working in continence services**
- **Clinical skills, processes & perspectives**

Models of Inpatient and Outpatient Services

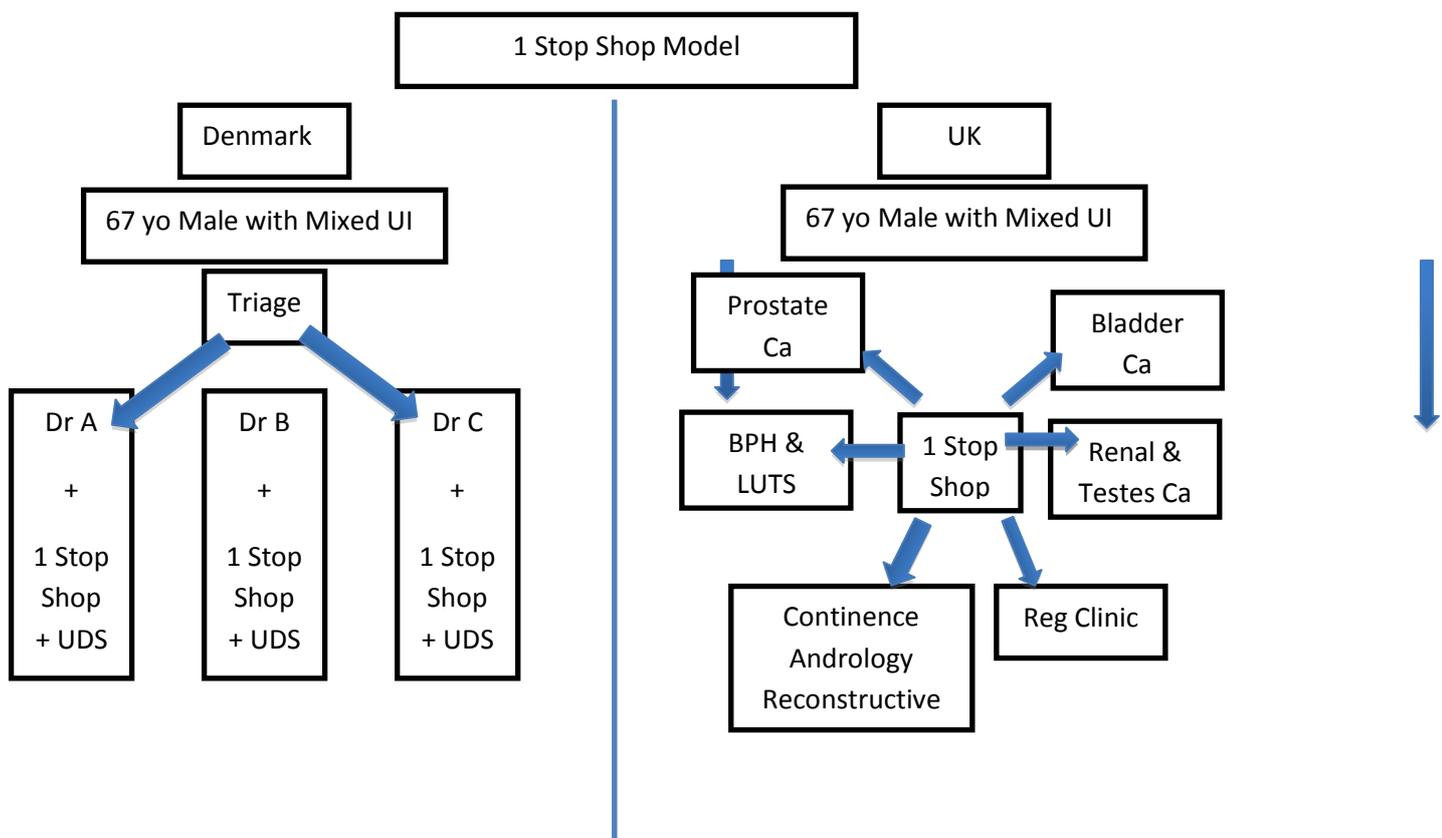
Region H (Region Hovedstaden: The Capital Region of Denmark) in Copenhagen consists of 15 hospitals. I was fortunate to visit three hospitals and one community health care centre in this region. This region provides services to the local population as well as the remote population of Greenland and Faro Islands. Region H is split into primary and acute care with General Practitioners, Community Nurses and Allied Health servicing primary care. There were minimal national 'continence specific' services and no private community nursing or allied health services as compared to Australia. Continence patients were managed in the community at healthcare centres by physiotherapists or nurses and within hospitals either by urology or gynaecology services. A traditional doctor led medical model of care was observed for the delivery of continence services and there was no observable multidisciplinary team in the hospital setting.

NHS London is the strategic health authority responsible for the Units I visited in the UK. I was privileged to observe both "Foundation" Trusts and "Standard" Hospital Trusts. A Trust is a group of hospitals run by a single public sector Board. In 2002 the UK Labour government introduced foundation trusts, and they were set up as non-profit public corporations, with more financial and managerial freedom resulting in autonomy from the strategic health authority. They are run by a board of governors from the local community and can decide how services are provided¹⁵. This is similar to the arrangement at Mater Health Services in Australia.

Standard Hospital Trusts are run by the health authority, which is directed by central Government¹⁴. There were marked observable differences across the continuum of care in many aspects of the Standard Hospitals compared to the Foundation Trusts. Research as an integrated part of daily practice was the norm in the Foundation Trusts but not observable in the Standard Hospital Trust. It was observed and noted that both patient and staff satisfaction was low with staff stress very high in the Standard Trusts - possibly because there appeared to be less money for staff, equipment, time and resources in the Standard Hospital Trusts. For example when equipment is broken, due to financial constraints is not replaced, and this resulted in one Standard Hospital Trust having one bladder scanner for an entire hospital. This had a significant impact on the ability of the clinical nurse specialist attempting to run the continence clinic and trial without catheter clinic.

The outpatient services I observed in Denmark were the "one stop shop" model- with the aim of allowing the patient to receive all required investigations in one time period rather than needing multiple visits to the hospital. I also observed similar models in the UK at Guy's and Charing Cross Hospitals. From discussions with the directors in the UK and Denmark, this model evolved in response to government set targets for assessment, diagnosis and treatment. The "one stop shop" model at Guys operated slightly differently to Denmark and Charing Cross with a Hub and spoke model which linked into the structure of the department of clinical teams which I will discuss further on. The hub is the "one stop shop" clinic where all new referrals go through- from here they are either discharged back to the GP with a management plan or transferred to one of the clinical teams.

I observed a higher turn over of patients in within the hub model. Clinics were large with average 12 patients booked per doctor for a 3-4 hour clinic. In Denmark there were on average 12-14 patient per day in the one stop clinic, however this was a mix of new and review patients. The UK model also included highly skilled Nurse Practitioners and Clinical Nurse Specialists assessing patients alongside Doctors in various clinics, which also contributed to higher turnover of patient numbers.



Both in the UK and Denmark there has been a political push for continence services to be positioned within the community and not in acute care. I observed a different application of the hub and spoke model which integrated community and acute care continence service delivery. It enabled the experienced clinicians from the acute tertiary centres to add value to community services by “parachuting” in to community continence services. In the UK one hospital had a senior nurse run a Lower Urinary Tract Symptoms & Continence Clinic at a local health centre with community nurses and another hospital lent specialist pelvic floor physiotherapists out to various community continence teams for a day per week. This was observed to be an excellent concept as it was reported that highly skilled clinicians don’t want to work in the community full time because they may feel isolated from the colleagues and the support that enables them to sustain their high skill set.

Environmentally, working in the community is vastly different from a large teaching hospital and therefore recruitment and retention of highly skilled staff can be difficult. Another concern is workload and volume- often the community service is not a fulltime position therefore it is highly unlikely to recruit advanced professionals into part time roles. This solution of “parachuting” staff appears to strengthen links between community teams and the acute hospitals. Improving continence outcomes for patients is also facilitated by the sharing of knowledge and skills from the community nurses working alongside highly skilled specialist clinicians. From a regional perspective this is also a novel solution as in both London and Copenhagen the majority of services are provided for those living within 10km from the hospitals. By comparison, it would be difficult to parachute in to a clinic in the Darling Downs from Brisbane – a distance of over 100km.

One hospital in Denmark provided an outreach nursing service in response to community needs. The background to this service is that community nurses did not have catheter management in their skill set, so patients attended their local hospital for 6 weekly catheter changes. The hospital found that there was a group of frail older patients who would fail to attend for their appointments in clinic and decided to take the care to them in their homes – therefore improving the follow up and management of this patient group. Until recently all long term catheterisation was managed by the acute services. This however has recently changed and the community nurses have become up skilled in this area with only difficult IDC and SPC management remaining the responsibility of the acute services. This service improvement is not particularly relevant to Australia as our community nurses have no skill gap in this area, however it is a good example of a service being adapted to meet the needs of its local patients.



The Outreach Service in Copenhagen from Frederiksberg Hospital

I observed continence outpatient services in both the UK and Denmark with a mixture of nurse led and multidisciplinary teams. The teams that appeared to have the most satisfied patients and best clinical outcomes had a focus on multidisciplinary care, behavioural and therapeutic interventions, and improvement in quality of life for patients with continence issues.

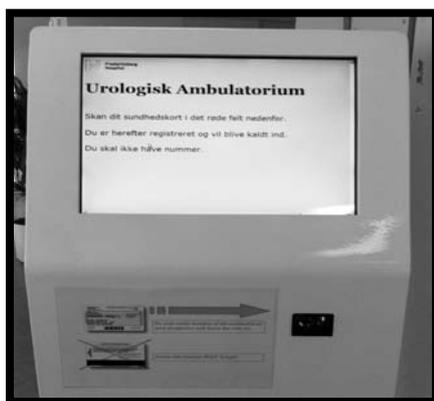
In Denmark continence physiotherapy was based in the community. At a local health centre I met a specialist physiotherapist and continence nurse collaborating in a multidisciplinary service. They provided holistic, evidence based and active management for patients with continence issues. Interestingly this very experienced therapist was part of a government research project looking at whether active intervention and improvements in continence management within the community could save the government money on continence aids. It was a great initiative, designed on the current recommended evidence based practice. A significant issue affecting its success was the lack of awareness about the service provided and therefore it's under utilisation. In the hospital, outpatient services were nurse led and mainly dealt with catheter changes, trial without catheters and continence aids provision. I observed limited use of behavioural or therapeutic interventions to aid the quality of life of these patients who were being managed conservatively. In the UK I observed nurse led and multidisciplinary clinics both in the Hospital and Community settings. Here I observed use of behavioural and therapeutic interventions in all continence outpatient services.

Structure of Outpatient Facilities

In all the hospital settings observed in both the UK and DK, all had single use clinics. This means that the specialist areas had use of that space all the time and the environment was designed for the needs of that clinical patient group. For example there were multiple toilets and they each had flow rate machines and hatches in which urine samples were placed which could be accessed by a nurse in the room on the other side for testing. Patient facilities were excellent with multiple toilets and comfortable café style waiting areas with free refreshments.



The lack of queues in the outpatient environment was very apparent with useful technology in place such as scanning of cards to indicate arrival on the computer system and a simple electronic ticketing system on leaving to rebook or discharge. This compares to Mater Health Services and other hospitals in Australia, where the outpatient specialist clinics are multipurpose / multi specialty use. It became apparent that when environments are designed for specific patient



groups it improves their experience and is an example of patient centred design of services. In Australia the lower patient volume results in fewer doctors working full time hours and a lower utilisation of space – therefore it does not make business sense to have a specific area for a group of patients that will only be used 2.5 out of 5 days a week. It is for consideration though how simple changes in environment and the use of technology to ease processing can improve any patient's experience attending hospital for an outpatient appointment.

Staffing of outpatients was noticeably different in Denmark compared to the UK and Australia. In Denmark each Dr works fairly independently and has a nurse with them at all times in the clinic. There was only 1 administrative staff member and generally 5-8 consultants working all day, each day. In the UK and Australia there are fewer consultants in clinic at the same time, more trainee doctors and nurse practitioners consulting in the clinic together as a "team", and significantly more administrative staff! The trainee doctors are not key figures of the team in Denmark compared to the Australian and UK system. It was viewed that they were ancillary to the services in Denmark where as they are pivotal part of the team in Australia and the UK.

Structure of Inpatient Facilities

The physical structure of the Danish and UK inpatient setting is similar to Australia and is on average 30-32 bed wards with 2 and 4 beds per rooms, plus isolation rooms. The wards were noticeably quieter, which I attributed to the only phone being a mobile that the team leader carries and the administrative staff were separated from the clinical area. This had a marked impact on the ward environment, and potentially on the patient experience. A novel transport concept in Denmark was staff access to scooters to get from one end of the ward to the other.



Team nursing or clinical teams was a concept I was introduced to initially in Denmark and further experienced in the UK. Traditionally a patient attending hospital for a procedure will meet many different staff along their journey all of which work in separate units along the patient pathway. Team nursing is where the structure of the wards and staffing is in clinical teams that look after set clinical conditions and in some hospitals these 'clinical teams' extended from outpatient across admission and theatre to the ward. This places the patient at the centre of the care pathway and creates a cohesive team with a higher skill base. The clinical teams concept included doctors in the UK but not in Denmark. It was observed that the teams that worked well had good managerial support and excellent clinical leadership.

Throughout all hospitals in Denmark and some in the UK, very strict uniform rules apply. All medical, nursing and allied health staff wear uniform, which are changed daily. In Denmark, footwear was slightly different with bright thongs and sandals appearing the most popular choices! The hospital launders and provides fresh uniforms daily and staff are banned from wearing the uniform off site. The explanation for the explanation for this is infection control. There were many discussions in Denmark regarding the belief that there is a link between the strict uniform policy and the low rates of hospital-acquired infections. Interestingly, the EARS – NET Network who carry out surveillance of MRSA rates in Europe report that the rates of MRSA in Denmark sit at 0% compared to UK at 27.3%. I observed some of the hospitals in the UK with a similar relaxed culture to Australia - where staff do not have enough uniforms for a new one every day, the hospital does not launder and uniform is worn off site on the commute to and from work.

Both regions visited provided healthcare to the local populations and also those from further afield. As tertiary centres, both Denmark and the UK had patients attend from all over the country. Once the intervention was complete care was handed back to the local healthcare facility. There was no sharing or working collaboratively in the management of patients requiring specialist services. As mentioned previously, a couple of the units provided services to remote areas a significant distance to their locality (Faro Islands DK and Canary Islands UK for example), negotiated in agreement with the central government. Current service models (one stop shop and hub and spoke) were used for both these patients and the local patients. This is in contrast to the service offered at Mater Health Services in Brisbane, which uses a novel model integrating shared care and telemedicine to provide services to the remote Queensland population. The Mater however, does not have a "one stop shop" model in its local services. This Fellowship has enabled me to recognise the efficiencies of both models and consider elements that could be combined to enable the rural patients to truly receive efficient patient centred care.

Multidisciplinary Team Working in Continence Services

In both countries I observed the best and worst of multidisciplinary team working (MDT) and multispecialty collaboration. At Queens Square in London I visited an exceptional continence team that had been purely designed around the needs of complex neurological patients. The Uro-Neurology unit had highly experienced sub-specialists collaborating and working alongside each other who are focused on reducing the impact of continence issues on the patient. The team included: a Uro-Neurologist; a uro-neurophysiologist; a neuro- gastroenterologist; a neuro-urologist and a neuro- urogynecologist and three clinical nurse specialists (working at the equivalent of the NP level in Australia). At Guy's and St Thomas the pelvic floor unit was a cohesive collaboration between urogynaecology and colorectal specialties and included nursing and physiotherapy in the team. The group of clinicians that clinically collaborated in the hospital formed a pelvic floor interest group which met once a month and also included clinicians from the community services and local universities. I attended one of these meetings and presented a lecture about the Mater Continence Service. It was clear that all members of this interest group had postgraduate training, advanced knowledge and a passion for this area and came from both nursing and physiotherapy.

Other units evidently demonstrated significantly less collaboration with other specialties and other members of the multidisciplinary teams. This was clear when I requested to meet other specialties and disciplines and some units didn't know who they were or if they existed. On reflection, this Fellowship visit helped facilitate networking on a basic local level in some facilities by introducing colleagues who could now potentially collaborate for the benefit of continence patients in the long term.

A key component of multidisciplinary working is MDT meetings. Some units in the UK opened my eyes to a couple of different effective ways of introducing clinical governance and accountability principles in to these meetings as well as how easy it is to integrate teleconferencing in to MDT working. Through videoconferencing with other local hospitals the teams used simple template

sheets with key data and outcomes required from each patient discussion. This was then added in to the electronic health record. From my observation these meetings required a good chairperson to drive the discussion, a timekeeper and an active engagement by the units participating to work well. This was observed to be an excellent way for multidisciplinary communication and education between different units.

I also observed a more specific MDT prior to outpatient clinic that facilitated education of junior staff. It gave exposure to all patients in the clinic and facilitated patient flow by reducing the interruptions to the leading consultants, also highlighting to the team which patients should be seen by the more experienced clinicians. Prior to a clinic the list of patients would be assessed, reviewed and provisional management plans would each be discussed in a short time frame. These meetings required a well functioning team – each clinician would present a different patient so there was no delay and the lead clinician would drive the discussion in a succinct way – but overall it appeared to improve the running of the clinic and the team as well as increasing engagement and education of the junior clinicians in the clinic.

Both in the UK and Denmark the working environments in the hospitals facilitated teams working within departments in different ways. I observed a work culture in the UK that encouraged an 'identity' that people were proud to be part of when part of a unit and hospital. This was facilitated by drinks in the local pub and interdepartmental and inter-hospital football / netball / touch competitions. This engagement of the whole team at all levels improves interpersonal relationships, which appeared to benefit and strengthen the team. In Denmark I received a warm welcome everyday by each team with a healthy breakfast where they share their news and plan the day. This created a warm friendly atmosphere at the beginning of the day which was great to experience as a stranger in a new foreign environment.

Physiotherapy

In all countries I met a cohort of wonderful and innovative physiotherapists who are managing to provide exceptional care despite the many practical limitations that are placed upon them. It became quite apparent to me, as a sub-specialist physiotherapist, that there are many elements of my profession's activities that would benefit from consideration so that we can deliver optimal services for our patients. The mode of delivering pelvic floor physiotherapy in Denmark contrasts starkly with how it is presented in Australia and the UK. In Denmark the majority of services are based in primary care and this seems to translate into a lack of patient awareness of specialist physiotherapy services that may be available in tertiary centres. This in turn means that patients do not benefit from referral to such services. By contrast, in the UK and Australia physiotherapy services are usually delivered in a mix of acute secondary and tertiary centres and primary care facilities and this has allowed the integration of pelvic floor physiotherapy into the clinical pathways of many conditions and procedures. In Denmark I only observed a similar pathway for prostate cancer surgery.

There is considerable variation regarding the representation of physiotherapy on multidisciplinary teams between the two countries. Interestingly physiotherapy is strongly represented on

gynaecology and urogynaecology teams in the UK and Denmark but I have only found them integrated into urology at my home base in Brisbane.

It was my observation that there is a lack of appreciation by our clinical colleagues of the strong level of evidence that supports the benefits of physiotherapy for pelvic floor and bladder dysfunction, especially in regard to its impact on continence outcomes. Sadly there remains an impression that the only measure necessary for a good outcome is the provision of a pamphlet! Clearly there is no evidence that supports this latter approach and it is of course not what is actually provided by specialist physiotherapists.

I also observed and had daily personal experience of the fact that the knowledge and skill base of the specialist pelvic floor physiotherapist is somewhat underestimated, although this was less evident in the multidisciplinary teams. As a consequence we are significantly undervalued by our general physiotherapy colleagues and, more broadly, by our medical and nursing colleagues. In Denmark, the UK and Australia it is agreed additional specialist training is required to be recognized as an expert in pelvic floor physiotherapy. Throughout my Fellowship I found myself passionately advocating for my profession and subspecialty interests by highlighting that my specialist colleagues and I have more strings to our respective bows than a focus on the pelvic floor.

The training required to become a 'continence clinician' is not standardised to a recognised skill set however in physiotherapy a minimum level of comprehensive postgraduate training is required. In contrast to physiotherapy, nursing has significant variation of training required for continence specialisation, ranging from 2 years to 1 day. The more advanced nurses, including the nurse practitioners and clinical nurse specialists, had similar skill sets to the physiotherapists but this was not identified as different to the general nurses who were also considered competent to complete a continence assessment. I observed the quality and skill set of the clinician assessing and managing a patient with continence issues having a significant impact on the outcomes for the patient. In Australia Medicare has recently opened public debate on considering the introduction of a billing code for conservative incontinence management. It is my opinion through the experience of this Fellowship that both continence nursing and physiotherapy skill sets need to be established, recognised, certified and protected at a national scale to ensure the best outcomes for patients and Medicare.

Clinical New Skills, Processes & Perspectives

Evidence Based Practice and Information Sharing.

In Denmark I met some very experienced nurses who were highly involved with their respective professional societies. We had extensive discussions regarding the trials and tribulations around evidence-based practice, the development of guidelines, learning guides as well as patient education. Current literature supports the view that incorporating evidence into daily practice can contribute to improving patient outcomes ^{3 4 11}. The European Urological Association has significantly invested in nursing resources by establishing working parties to standardise

guidelines and has also developed some excellent nursing education guides. On my blog I provide a link to some of the already developed resources and since my return to Australia I have had significant positive feedback regarding the quality and relevance of this resource. Information sharing at an international level is certainly an effective, efficient use of resources and allows the setting of a base line for international best practice.

Leadership.

In all countries I observed an over-arching key factor that significantly impacted on how well services worked - leadership. I observed units with limited leadership attempt to achieve the equivalent of units with the same structure and models of care but without the key missing factor of leadership – and this is where their efforts fell down. On reflection I now understand how important it was to experience both good leadership and absent leadership. Some models of care only work because all the keystones are in place...if a foundation stone is missing it simply won't work.

Budgets and Funding.

Due to the economic climate there was significant financial strain in varying degrees across Denmark and the UK. In Denmark this resulted in one hospital's medical wards being closed and all allied health except physiotherapy being cut. It was here that I observed for the first time in my career, patients in corridors surrounded by screens because there were no wards available. Interestingly the Danes were not terribly concerned about this, which is a stark contrast to the UK and Australia – where this would be front-page news. In many units I saw and heard the clinical impact of reduced budgets and its direct impact on staff satisfaction, their ability to do their job well and the patient's outcomes and experience. In one hospital there was a clear focus on patient experience because there had been consistently poor feedback. Money had been invested in "real time" feedback touch screen technology VDU's to gather more information from the patients about their experience. Yet no money was available for equipment. All but one bladder scanner had broken, so the entire hospital had to share one bladder scanner. The general goal of Governments and Hospital Boards is to provide care to best practice standards. It is worth considering what are the basic requirements to achieve this, including providing staff with the correct equipment to provide the basic level of care, thus providing a good foundation to provide care to best practice standards.



Sacral Nerve Stimulation (SNS).

This is a method of treatment that has been established in both the UK and Denmark for around 10 years. This technique utilises a box similar to a pace maker which is slipped in behind the buttock muscle and attached to a wire that intersects the sacral plexus at a point that can modulate the nerve impulses that control urinary and faecal continence mechanism. There is much debate about how it actually works however the clinical benefits are very clear and evident. In both the UK and Denmark centres I visited, the success rate for resolution of incontinence is 75-80% of patients. The Australian government has

been slow to financially support the high initial outlay cost item. It was clear that the majority of patients receiving SNS are young, had failed multiple other management options and their continence significantly impacted on their quality of life. It is worth considering the cost benefits of a high initial outlay compared to a lifetime of high pad / catheter use, combined with the psychosocial issues of reduced QOL (including reduced physical activity, reduced social activity, reduced working activity, increased anxiety and depression).

Interestingly in Denmark SNS was a day procedure performed under local anaesthetic and in the UK it required a full general anaesthetic and a two-day stay in hospital! The costs per patient were reduced with the utilisation of the day procedure unit approach. Both systems relied heavily on a highly skilled nurse to support the patient before, during and after the surgery and for all follow up. In order for a SNS service to work effectively I observed that it was essential to have the right support staff in place and would suit the day procedure unit setting.

Botox

This is used as an end line treatment in both Denmark and the UK for detrusor overactivity and neurological bladder issues; it is currently un-licensed for this use and therefore not covered by government subsidy funding. Hospitals are able to provide it as a treatment option however by getting permission on a case by case basis. This is similar to the approach in Australia, although some public hospitals in Australia do not grant funding to the case applications. One unit had set up a 'Botox service' in a research framework which resulted in bypassing this process enabling them to provide it in an efficient way in the public setting.

Engagement of The Consumer

One Trust I visited was an exceptional communicator and engager of everyone who entered the hospital. When someone is engaged in communication with a hospital from the moment they enter the doors, it is the start of patient centred care. Guy's and St Thomas' hospital had many initiatives that encouraged dialogue between staff, patients and visitors. This included posters



lining the walls introducing staff members and their roles within the organisation, and interactive website with extensive information available online and patient welcome packs. These included a booklet on what to expect in hospital, the ward routine, what the uniforms mean, information on the admission discharge processes etc. This pack also included earplugs, eye masks, hand wipes, toothpaste and brush and non-slip socks. There were many information cards available across inpatient and outpatient services covering topics such as falls, VTE prevention, medicines and infection control. As a visitor I noticed the very positive impact this had on the environment and experience within the hospital- and it was a positive one.

Continence Aids

In the UK and Denmark, the provision of Aids and equipment is very generous with patients having a large choice, unlimited supply and no "ineligibility". In Denmark, there was an apparent reduced awareness of costs from both clinicians and patients where continence aids are entirely covered by the government with up to three months provided by the acute services and then the costs and supplies are transferred to primary care. This has resulted in increasing costs for the government. This has led to the commissioning of a local community based research project investigating if the intervention of a physiotherapy and nurse combined continence assessment and management intervention can reduce some of these costs. This open free access is in stark contrast to Australia with state and federal schemes, with assessment and re-assessment requirements and strict eligibility criteria. The UK uses the prescription scheme to cover the continence aids, whereby if you met the eligibility criteria you do not pay, but if you do not then you pay a one off charge of 7pounds 80 for up to a year's supply of aids. Reassessment is required once the script runs out. This open access and choice arrangement would be the envy of many Australian consumers however the lack of awareness of costs and generosity leaves a lot less accountability in the system – for example asking the question of, is this the right product for this consumer?

Post Partum Bladder Management

This was a particular interest area of mine prior to the Fellowship and I was interested to discover that there are similar clinical issues to those I have experienced in Australia with postpartum bladder management in both the UK and Denmark. Interestingly one hospital had responded in a very similar way to what was developed at MHS in Brisbane to meet this clinical need to the Mothers Hospital in Brisbane, including implementing an active bladder management and trial of void protocol for all post partum women. This Fellowship initiated the networking that has led to collaboration and information sharing between our units to tackle this significant clinical issue.

Conclusions and Recommendations

This experience has provided and continues to provide many reflections that I'm sure I will continue to learn from for the rest of my lifetime. I use the phrase "On my fellowship..." multiple times a day. It is having a definite impact on my daily practice and my contributions across the board at the Mater and other organisations I belong to. In this report I have outlined key elements of this fellowship that are relevant to my project aims however there are many other experiences not specifically relevant to continence services that I will also share and disseminate with my colleagues. Some of these include the use of Hexvix in bladder cancer, bladder surveillance protocols, the use of the one stop shop model in other specialties, prostatic biopsies using different techniques, different clinical equipment and risk management platforms including barcoded patient identification and drugs administration systems. The experience of this Churchill Fellowship has been wider than just continence services.

The opportunity to establish an international network with like-minded professionals is having a significant impact on both my colleagues and myself in Brisbane. I have facilitated a nurse practitioner colleague to link with senior nurses in both Denmark and in the UK where the NP role has been established for a longer period of time, thereby allowing professional support of the fledgling role in Australia. Also colleagues completing their surgical training have requested contacts regarding their specialist areas of interest during their UK fellowships. Alongside this two separate collaborative research projects with Queens Square and Guy's are in their early stages of development. The physiotherapists from both Denmark and the UK have become invited members of the Australian online "Continence and Women's Health Network". On a personal note, finding my voice as an advocate for my profession I am now on the Publications committee of the International Urogynecological Association (IUGA) and am responsible for the new physiotherapy section of the newsletter, and I am also now a media ambassador for the Continence Foundation of Australia.

My Key recommendations from this fellowship for the design of models of care for continence services in Australian include:

1. The Gold Standard for a Continence Service is a Multi-Disciplinary Team

The services that provided care across disciplines and specialties, with highly skilled staff working collaboratively had better patient outcomes, provided patient centred care, promoted cost-efficient and effective conservative management and an overall improved patient experience.

2. The advanced skill set of the specialist continence physiotherapist needs to be recognised

The highly advanced knowledge, assessment and conservative management skills of physiotherapists extend beyond simply teaching kegels exercises. Medication, surgery and unlimited access to continence aids is not necessarily an evidence based, cost effective, patient centred approach to continence management. Physiotherapists provide conservative

management that can work along side or instead of these interventions and has significant evidence base to support its impact on improvement to Quality of Life for patients with continence issues. Physiotherapy should not be considered as an add-on or ancillary service. It has, I believe, shown itself as being a core member of a broad multidisciplinary clinical service.

3. Standardised public access to advanced management options for incontinence

In Australia, there is a lack of standardised public access to various treatment options that in recent times have been identified as evidence based end line management options for continence issues. These include Botox and sacral nerve stimulation, which in the public system is currently a lottery of access depending on who provides the patient's acute care. These option strategies are only available following a long journey but were accessible to all patients who required them in the public systems in both the UK and DK. The justification provided for providing access to these approaches considers the cost benefits of the impact of a life time of incontinence on both quality of life, co-morbidities, socialisation and utilisation of continence aids compared to a high initial outlay cost.

4. Focus on the patient when designing services

A focus on the patient encompasses different experiences; patient centred care and patient experience improvement. If we can improve the 'experience' of a patient with incontinence as they journey through the system that is designed to help them and their condition, they are likely to have a better experience and have better outcomes for all. This can incorporate many things including, the use of technology, adapting physical environments, models of care and structure of teams.

5. Integrate Community and Acute Continence Services – “Parachute Model”

The integration of community and acute service in some areas provided not only a smoother journey for patient but also a skilled multidisciplinary team for their management. Currently the structure of funding in Australia cannot support the parachute model that enabled this integration of services to occur. It is proposed that this model could work well in Australia if the funding supported such a move.

6. Expedite Assessment, Diagnosis and Management - “One Stop Shop Model”

The various applications of the “one stop shop” model worked differently but they all met the goal of expediting the length of time from receiving a referral of a patient to commencing a management plan. This model can impact on both patient outcomes and the patient experience across the board. It is a dynamic model that could be adapted for many environments – not just continence services.

Dissemination

Real time dissemination was possible through my blog www.continenceblog.com. Here over 70 of my colleagues from across Australia received regular updates of my findings. I promoted the blog by writing small articles for relevant publications at a local (Mater News, GP alliance), state (QLD HACC / MASS) and national level (Continence Foundation of Australia). Since my return I have completed follow up articles for the same publications, discussing my findings and promoting the work of the fellowship trust. I have also written for the International Uro-gynecology Newsletter and plan to submit to the Urological Society and International Continence Society Newsletters.

There has been great interest in this fellowship by my professional colleagues from all disciplines across the State and their support has been invaluable. Through this professional network I have and will continue to promote the great work of the Churchill Trust. I have also shared my findings and experiences by speaking at various meetings and education events, which will continue to do so into the future at a local, state and national level. Audiences will include, professional bodies, nurses, doctors, allied health, physiotherapists, GP's, managers, academics and researchers. Implementation has involved discussing my findings with all the relevant directors at the Mater Health Services. The current plan to recommend augmentation of the current model of care will be discussed at the next Continence Service Steering Committee in line with the project recommendations.

Once again my deepest thanks go to Dr Geof Hirst and Dr David Winkle for supporting my vision with this Fellowship. You have and continue to facilitate and nurture me to aim higher than I realise is possible. The learning and growth opportunities this Fellowship has provided I believe will be enduring for years to come, and I am sincerely grateful to the Churchill Trust and The Peter Mitchell Foundation for giving me the honour to have this wonderful experience.

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