Faecal continence service for the management of faecal incontinence in adults

Commissioning guide
Implementing NICE guidance

April 2008
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Faecal continence service for the management of faecal incontinence in adults

This commissioning guide provides support for the local implementation of NICE clinical guidelines through commissioning, and is a resource to help health professionals in England to commission an effective faecal continence service for the management of faecal incontinence (FI) in adults.

This commissioning guide should be read in conjunction with the following NICE guidance:

- NICE clinical guideline CG49 Faecal incontinence: the management of faecal incontinence in adults

This clinical guideline covers clinical and cost effectiveness in detail and underpins the content of this guide. Implementation of the guidance noted above is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement this guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in the guidance should be interpreted in a way which would be inconsistent with compliance with those duties.

Nearly two thirds of people with FI are also expected to have urinary incontinence (known as double incontinence). Commissioners of any faecal continence service should therefore consider commissioning an integrated continence service to meet the needs of their whole population including people with urinary incontinence in line with Good practice in continence services. See also the commissioning guide on Urinary continence service for the conservative management of urinary incontinence in women.

The guide:

- makes the case for commissioning a faecal continence service
- specifies service requirements
- helps you determine local service levels
- helps you ensure corporate and quality assurance.

The full text of this commissioning guide is accessed from the navigation menu on the right hand side of the screen. The associated commissioning tool is available until 25 June 2010 to primary care organisations in England who are already registered to use the tool. New registrations for the existing commissioning tool will not be possible after 31 March 2010.
From 1 April 2010 the new freely available commissioning and benchmarking tool can be downloaded. There is no need to register.

We are keen to improve the commissioning guides in order to better meet the needs of commissioners. Please send us your ideas for future topic-specific guides or other comments.

Read the NICE disclaimer for information on the use and accuracy of content on the NICE website.

- **Topic-specific Advisory Group: faecal continence service**
Commissioning a faecal continence service for the management of faecal incontinence in adults

Faecal incontinence (FI) is a stigmatising condition that is likely to affect over half a million men and women in the UK. Current epidemiological information shows that between 1% and 10% of adults are affected. It is likely that 0.5–1.0% of adults experience regular FI that affects their quality of life. FI is closely associated with age (prevalence is about 15% in adults aged 85 years living at home) and is even more common in residential and nursing homes (prevalence ranges from 10% to 60%)\(^1\).

Because of fear and embarrassment, FI remains a largely hidden problem, particularly for people where there are associated cultural/religious issues. People with FI often experience social exclusion, and frequently suffer from stress, anxiety and depression, which can cause them to delay seeking help. A proactive approach to case-finding is needed because people with FI and their carers may not be aware that there are treatment options available that often result in the alleviation of symptoms and/or a cure.

Faecal continence services should be provided as part of an integrated continence service and people with FI should be offered care by healthcare professionals who have the relevant skills, training and experience. The management of FI usually starts with addressing reversible factors using a conservative approach that includes advice about diet, bowel habit and/or medication. Only if this fails to restore continence does it progress to specialised options and investigations.

The specialised management of FI includes non-surgical interventions such as pelvic floor muscle training, bowel retraining, specialist dietary advice, biofeedback, electrical stimulation and rectal irrigation. Frequently, specialised continence services are provided by specialist continence nurses and/or physiotherapists.

Nearly two thirds of people with FI are also expected to have urinary incontinence (known as double incontinence). The Good practice in continence services and the National service framework for older people have called for integrated continence services to be established to address the needs of people with urinary incontinence and/or FI. However, in 2005 and 2006 the National audit of continence care for older people, sponsored by the Healthcare Commission, reported that a basic infrastructure is currently in place to deliver improved continence services, but that there has been little progress in the pursuit of truly integrated continence services as envisaged. There is a suggestion from hospital trusts that there is a reduced availability of continence specialist nurses. This is a cause for concern because continued inadequate assessment of incontinence, with an emphasis on containment rather than cure, does not indicate high-quality care. Also, it is expensive from a financial and a health perspective. In the face of the great daily cost of containing continence, the audit indicates a missed opportunity to assess,
treat and reduce the numbers of incontinent people and the associated financial costs.

Benefits

The potential benefits of robustly commissioning an effective faecal continence service for the management of FI in adults include:

- **providing the best possible outcomes** for people and their carers through identification and intervention, resulting in alleviation of FI symptoms and/or cure
- **improving perceived quality of life**, preservation of dignity and, where possible, independence and mobility
- **providing long-term management** for people who do not wish to continue with active treatment or who have intractable FI
- **reducing the risk of urinary tract infections, falls, social isolation and depression** in older people suffering from FI
- **reducing inappropriate reliance** on disposable pads and other products for the containment of FI in older people
- **reducing inappropriate referrals to specialised services**
- **reducing inequalities** and improving access to services that are culturally sensitive and meet the needs of people with physical, sensory, mental or learning disabilities.
- **better value for money**, through helping commissioners to manage their commissioning budgets more effectively – this may include opportunities for clinicians to undertake local service redesign to meet local requirements in novel ways.

Key clinical issues

Key clinical issues in providing an effective faecal continence service for the management of FI in adults are:

- **actively identifying people** with FI
- **conducting a clinical baseline assessment** identifying any contributory factors before any treatment for FI is considered
- offering a combination of **initial management interventions** and condition-specific interventions before any specialised treatment
- **providing effective and efficient clinical care to high-risk and specific groups and those requiring specialised and long-term management** in line with NICE clinical guideline CG49 on faecal incontinence
- **providing a quality assured service**.
National priorities

National priorities and initiatives relevant to commissioning a faecal continence service for the management of FI in adults include:

- **National service framework for older people.**
- **Good practice in continence services.**
- **Referral guidelines for suspected cancer.**
- **Delivering the 18 week patient treatment pathway.**
- The Care closer to home initiative outlined in chapter 6 of the white paper ‘Our health, our care, our say’.
- **Commissioning framework for health and well-being.**
- **World Class Commissioning.**
- **The NHS in England: The operating framework for 2009/10.**
- Considering the impact of patient choice.
- **A stronger local voice: a framework for creating a stronger local voice in the development of health and social care services.**
- Implementation of NICE clinical and public health guidelines. These are core standards, and performance against these standards will be assessed by the Care Quality Commission in line with Standards for better health.

Although many or all of these priorities may be relevant to the services nationally, your local service redesign may address only one or two of them.

**References**

Specifying a faecal continence service for the management of faecal incontinence in adults

Service components

The key components of a faecal continence service for the management of faecal incontinence (FI) in adults are:

- identifying, assessing and initial management of FI
- developing a high-quality integrated continence service for the management of FI.

Identifying, assessing and initial management

Because FI is a stigmatising condition, NICE clinical guideline CG49 on faecal incontinence states that active case-finding will often be needed. It recommends that healthcare professionals should actively yet sensitively enquire about symptoms in high-risk groups including, for example, frail older people and people with urinary incontinence. The clinical guideline also recommends a proactive approach to bowel management for specific groups including people with limited mobility, faecal loading and constipation. Therefore, it is important that clinical teams work with local and national organisations to raise public awareness of the causes, prevalence and symptoms of FI and encourage people with FI to seek appropriate help.

Continence problems usually present in primary care; however, some people will present or be identified for the first time during a hospital admission. Commissioners will need to be confident that primary care staff, community teams and hospital staff are trained to identify people with FI and carry out a clinical baseline assessment to identify contributory factors. They should be able to offer initial management tailored to individual circumstances and adjusted to personal response and preference.

The recommended interventions include information about diet, bowel habit, toilet access, medication and coping strategies. In addition, advice should be offered on the use of continence products such as disposable body-worn pads and toilet access cards, and a RADAR key to allow access to ‘disabled’ toilets in the National Key Scheme.

There will be some symptomatic people who do not wish to continue with active treatment or who have intractable FI. These people will require long-term management and NICE clinical guideline CG49 on faecal incontinence recommends that their symptoms should be reviewed at least every 6 months. Commissioners will wish to be assured that healthcare professionals are competent to offer this advice and support.
Developing a high-quality integrated continence service for the management of FI

NICE clinical guideline CG49 on faecal incontinence recommends that people who continue to have episodes of FI after initial management should be considered for specialised management. This may involve referral to a specialist continence service, which may include:

- pelvic floor muscle training
- bowel retraining
- specialist dietary assessment and management
- biofeedback
- electrical stimulation
- rectal irrigations.

People with continuing FI after specialised conservative management should be considered for specialist assessment, including:

- anorectal physiology studies
- endoanal ultrasound; if this is not available, magnetic resonance imaging, endovaginal ultrasound and perineal ultrasound should be considered
- other tests, including proctography, as indicated.

Therefore, commissioners will need to ensure that there is appropriate local access to, and capacity for, the investigations required, and that people who report or are reported to have FI are offered the appropriate care. This care should be managed by healthcare professionals who have the relevant training and experience and who work within an integrated continence service. These healthcare professionals, who are usually specialist continence nurses and specialist physiotherapists, may have a number of responsibilities, including the specialised assessment and management of FI, awareness raising activities, and the training and education of other healthcare workers across primary, secondary and residential care. Commissioners will wish to assure themselves that all healthcare professionals involved in the management of FI have the required skills and access to relevant training and education. See the implementation advice for NICE clinical guideline CG49 on faecal incontinence for information on initiating awareness raising activities and on training and education.

The Good practice in continence services sets out a model of good practice to help healthcare professionals achieve more responsive, equitable and effective continence services, including principles for commissioning a properly integrated continence service. It suggests that, locally, a strategic lead or director may be responsible for coordinating the development and implementation of common policies and procedures across relevant healthcare sectors and with local authorities. It also suggests that commissioners will need to consider a cohesive and comprehensive service that enables treatment, based on assessment, to be delivered in the most
appropriate setting. This is usually primary care in the first instance, which then allows easy access to specialist care when needed. Therefore mixed models of provision may be appropriate across a local health economy. Appendix 3 of the 2007 Royal College of Nursing publication Is policy translated into action? provides an example of a model for an integrated continence service.

Local stakeholders, including service users and carers, should be involved in determining what is needed from a faecal continence service in order to meet local needs. The service should be patient-centred and integrated in line with the recommendations set out in Good practice in continence services.

The service specification needs to consider:

- the required competencies of, and training for, staff responsible for providing the service
- the expected number of patients (this should take into account how quickly any changes in service provision are likely to take place)
- ease of access and service location; commissioners should engage with service users and other relevant individuals and organisations locally
- care and referral pathways
- information and audit requirements, including IT support and infrastructure
- planned service improvement, including redesign, quality, equitable access, and referral-to-treatment times according to the 18 week patient pathway or equitable waiting times locally for those services currently outside 18 weeks
- service monitoring criteria.

Useful sources of information may include:

- Delivering the 18 week patient pathway: 18 week commissioning pathways: Rectal bleeding commissioning pathway 2008 and Change in bowel habit commissioning pathway 2008
- The NHS networks: learning from practice database offers examples of innovative commissioning across the NHS and its partners.
- The Map of medicine provides an information resource that visually organises the latest evidence and best practice guidelines.
- The NICE shared learning database offers examples of how organisations have implemented NICE guidance locally.
• NICE implementation advice for NICE clinical guideline CG49 on faecal incontinence.
Determining local service levels for a faecal continence service for the management of faecal incontinence in adults

**Benchmarks for a standard population**

Available data suggest that the standard benchmark rate for a referral into a faecal continence service is 0.1%, or 100 per 100,000, of the adult population (aged 15 years or older) per year.

For the purposes of this guide the adult population has been defined as people aged 15 years and older. This is due to the availability of population data at general practice level within certain age bands and its use within the commissioning tool. Approximately 80% of the English population is aged 15 years or older.

For a **standard primary care trust** population of 250,000 (around 200,000 people are aged 15 years or older), the average number of people requiring referral into a faecal continence service would be **200 per year** (0.1% of the population aged 15 years or older).

For an **average practice** with a list size of 10,000, (around 8,000 are 15 years or older) the average number of people requiring referral into a faecal continence service would be around **10 per year** (0.1% of the population aged 15 years or older).

This service is likely to fall under the **programme budgeting** category 213X (problems of gastrointestinal system).

Examine the **assumptions used in estimating these figures**.

Use the faecal continence service **commissioning and benchmarking tool** to determine the level of service that might be needed locally and to calculate the cost of commissioning the service using the indicative benchmark and/or your own local data.

**Further information**

Sources of further information to help you in assessing local health needs and reducing health inequalities include:

- Annex A of the [Commissioning framework for health and well-being](#) outlines the process and data needed to undertake a joint strategic needs assessment.
- Department of Health [Delivering quality and value – focus on benchmarking](#).
- NICE [Health equity audit – learning from practice briefing](#).
- **National audit of continence care for older people** provides access to individual site reports and data, and material to support the dissemination of results.

- **The essence of care: patient-focused benchmarking for health care practitioners** provides benchmarking tools related to eight aspects of nursing care, including continence, bladder and bowel care.

- **Delivering the 18 week patient pathway: 18 week commissioning pathways**.

- The **No delays achiever** provides access to service improvement tools aimed at reducing time between referral and treatment.

- The **Practice-based commissioning comparators reporting service** provides access to a range of indicators and activity data at practice level, enabling a better understanding of local commissioning activity, referral patterns and outcomes.

- **PRIMIS+** provides support to general practices on information management, recording for, and analysis of, data quality, plus a comparative analysis service focused on key clinical topics.
Assumptions used in estimating a population benchmark

The assumptions used in estimating a population benchmark rate for new referrals into a faecal continence service are based on the following sources of information:

- **epidemiological data** on the prevalence of faecal incontinence (FI)
- **activity data** to establish current rates of surgery for the treatment of FI
- **current practice** on the current detection rate of FI
- **expert clinical opinion** of the topic-specific advisory group, based on experience in clinical practice and literature review.

**Epidemiological data**

It is very difficult to define a robust benchmark based on the true incidence for FI because the true incidence of FI is not known.

There is a range of prevalence estimates for FI in the adult population. This is caused by several factors, including different study populations, different ways of defining FI, different types of measurement and different survey methods used. Estimates based on symptoms of FI can range between 1% and 17%[1].

The prevalence estimates of FI with impact on quality of life may provide a better indication of the need for services than those based on symptoms alone. This is because many people who have episodes of FI are unlikely to report it to their GP until the symptoms produce a considerable impact on their quality of life.

Perry and co-workers (2002)[2] estimated that the prevalence of FI with impact on quality of life was 1.4% of the population aged 40 years or more, whereas the prevalence of any FI was around 2%. Figure 1 below illustrates the age-specific prevalence of FI by severity, disability and request for help. Research from Edwards and Jones (2001) suggested that less then 50% of people aged 65 years or older with FI had discussed the problem with a healthcare professional in the past 2 years[3].
Activity data – ‘Hospital episode statistics’ data

The ‘Hospital episode statistics’ (HES) database contains details of all admissions to NHS hospitals in England. It includes private patients treated in NHS hospitals, patients who were resident outside England and care delivered by treatment centres (including those in the independent sector) funded by the NHS.

Surgery may be indicated for a minority of people with FI. It has been suggested that sacral nerve stimulation (SNS) might become the treatment of choice in patients with FI that has not responded to conservative management[4].

The NICE costing report for CG49 on faecal incontinence states that following implementation of NICE clinical guideline CG49 on faecal incontinence, SNS may be used in preference to sphincter repair for a percentage of patients who currently receive sphincter repair procedures.

In 2006/7 the mean rate of episodes of SNS for FI was around 4 per million population, and the rate for sphincter surgery for FI was around 20 per million population.

It can be assumed that an increase in patients receiving treatment for FI would be reflected in an increase in SNS, although quantifying the additional numbers is subject to a high degree of uncertainty.

Current practice

IMS Disease Analyser is a database that holds data from a sample of GP practice systems. Data were extracted to give a snapshot of 1 year's activity within general practice.
Results of analysis of these data suggest that around 0.1% of the adult population (aged 15 years or over) come into contact with GP services per year and have FI recognised. This is likely to be an underestimate because some people who experience episodes of FI as a symptom of some underlying conditions may not have the FI recorded in their medical records. Moreover, the topic-specific advisory group considered that older people with many comorbidities are unlikely to have FI recorded on their GP medical records.

**Expert clinical opinion**

The consensus opinion of the topic-specific advisory group was that:

- There is considerable under recognition and recording of FI in primary care, in particular among those with multiple comorbidities.
- Based on clinical practice an average of around 0.1% of the adult population may present to services and may require specialist intervention such as referral to a continence service (this will require investigation at a local level). However, the numbers presenting to services who may require a baseline assessment and initial management are likely to be much higher.
- The use of focused baseline assessments and active case finding may result in an increase in the detection rate of FI in the community. The estimation of this potential increase is subject to a high degree of uncertainty. However, based on clinical practice and prevalence levels of felt need in the community it should be possible to increase the detection of FI several fold.
- Communities with a higher number of residential and nursing homes are likely to have a higher prevalence of FI with significant unmet need.

**Conclusions**

Based on the epidemiological data and other information outlined above, it is concluded that the rate of new referrals into a specialist faecal continence service is 0.1% or 100 per 100,000 adult population, per year. This is based on the following assumptions:

- the prevalence of FI in the community population aged 40 years or more is approximately 2%
- the rate of annual detection of new cases requiring referral to a specialist continence service based on current clinical practice could be around 0.1%.

Therefore the population benchmark for new referrals of people with FI into a specialist continence service is estimated to be 0.1%.
Use the faecal continence service commissioning tool to determine the level of service that might be needed locally and to calculate the cost of commissioning the service using the indicative benchmark and/or your own local data.

References


The commissioning and benchmarking tool

Download the faecal continence service commissioning and benchmarking tool

Use the faecal continence service commissioning and benchmarking tool to determine the level of service that might be needed locally and to calculate the cost of commissioning the service, as described below

**Identify indicative local service requirements**

The indicative benchmark based on the national average for a faecal continence service is 0.1%.

The commissioning and benchmarking tool helps you to assess local service requirements using the indicative benchmark as a starting point. With knowledge of your local population and its demographic, you can amend the benchmark to better reflect your local circumstances. For example, if your population is significantly younger or older than the average population, you may need to provide services for relatively fewer or more people.

**Review current commissioned activity**

You may already commission a faecal continence service for your population. You can download your own up-to-date secondary care activity data into the tool and data specifications and user notes are provided to help. You can review and amend the downloaded data for your population to calculate the service levels and cost of the service you currently commission. When commissioning outpatient appointments or activity outside of secondary care the tool provides you with tables that you can populate to help you calculate your total current commissioned activity and costs.

**Identify future change in capacity required**

Using the indicative benchmark provided, or your own local benchmark, you can use the commissioning and benchmarking tool to compare the activity that you might need to commission against your current commissioned activity. This will help you to identify the future change in capacity required. Depending on your assessment, your future provision may need to be increased or decreased.

**Model future commissioning intentions and associated costs**

You can use the commissioning and benchmarking tool to calculate the capacity and resources needed to move towards the benchmark level, and to model the required changes over a period of 4 years. You can also use the tool to calculate the level and cost of activity you intend to commission and to consider the settings in which the faecal continence service may be provided, comparing the costs of commissioning the service across the various settings.
The tool is pre-populated with data on the potential recurrent and non-recurrent cost elements that may need to be considered in future service planning, which can be reviewed and amended to better reflect your local circumstances.

Commissioning decisions should consider both the clinical and economic viability of the service, and take into account the views of local people. Commissioning plans should also take into account the costs of monitoring the quality of the services commissioned.
Ensuring corporate and quality assurance

Commissioners should ensure that the services they commission represent value for money and offer the best possible outcomes for patients. Commissioners need to set clear specifications for monitoring and assuring quality in the service contract.

Commissioners should ensure that they consider both the clinical and economic viability of the service, and any related services, and take into account patients' and carers views and those of other stakeholders when making commissioning decisions.

A faecal continence service needs to:

- **be effective and efficient**
- **be responsive to the needs of patients** and carers
- **provide treatment and care based on best practice**, as defined in NICE clinical guideline CG49 on faecal incontinence
- **deliver the required capacity**
- **be integrated** with common policies and procedures across primary and secondary care and include people with urinary incontinence, people living in the community and those in residential care
- **define agreed criteria for referral**, local protocols and the care pathway for people with faecal incontinence (FI). Enable local referral to consultants using agreed protocols via continence services or specialist teams that include continence nurse advisers or physiotherapists
- **be patient-centred and provide equitable access**, ensuring that patients are treated with dignity and respect, are fully informed about their care and are able to make decisions about their care in partnership with healthcare professionals and their carers
- **demonstrate how it meets requirements under equalities legislation**
- **demonstrate value for money**.

Local quality assurance

Any mechanisms for quality assurance at a local level are likely to refer to the following.

- **Service and performance targets**, including estimated activity levels and case mix, waiting and referral-to-treatment times (ensuring that patients and carers do not experience unnecessary delays), complaints procedures.
Clinical governance arrangements, including incident reporting.

Clinical quality criteria: appropriateness of referral, consenting procedures, clinical protocols.

Audit arrangements: frequency of reporting, reporting route and format, and dissemination mechanisms; this should include auditing the proportion of eligible people with FI who are provided with care, and the monitoring of patient outcomes and complications. See audit criteria for NICE clinical guideline CG49 on faecal incontinence for further information.

Health, safety and security: infection control, waste management, confidentiality procedures, legislative requirements.

Equipment: testing and calibration.

Accreditation requirements: for some or all elements of the service, the premises and/or staff.

Patient satisfaction: patient and carer perspective and perception of service provision, complaints.

Patient outcomes: improved quality of life, alleviation of symptoms and/or cure, improved independence and mobility, reduced inappropriate referrals, reduced complications and associated hospital admissions.

Staff competencies: individual and team baseline requirements, monitoring and performance.

Information requirements, including both patient-specific information (NHS number, referring GP, provision of high-quality information to patients/carers) and service-specific information (referral-to-treatment times, workload trends, number of complaints).

The process for reviewing the service with stakeholders, including decisions on changes necessary to improve or to decommission the service.

Achieving targets associated with equalities legislation.

Further information

General information on quality and corporate assurance can be obtained from the following sources:

- The National Patient Safety Agency (NPSA) oversees the implementation of a system to report and learn from adverse events and near misses occurring in the NHS. The publication ‘Seven steps to patient safety’ provides an overview of patient safety and gives updates on the tools that the NPSA is developing to support patient safety across the health service.
- **NHS Alliance online resources.** NHS Alliance is the representational organisation of primary care and primary care trusts, and provides them with an opportunity to network and exchange best practice. The alliance supports its members with an open-access helpline, in-house and joint publications and briefings, internal newsletters and a website.

- The **DH commissioning framework** provides guidance on the commissioning process in the context of the NHS reform agenda.

- **Delivering the 18 week patient pathway** provides a range of resources to support the key NHS objective to deliver an 18 week patient pathway from GP referral to the start of treatment by the end of 2008.

- NHS Institute for Innovation and Improvement support for commissioners, includes **Commissioning for Health Improvement** products to accelerate the achievement of world class commissioning; **The Productive Leader** programme to enable leadership teams to reduce waste and variation in personal work processes, and **Better care, better value indicators** to help inform planning, to inform views on the scale of potential efficiency savings in different aspects of care, and to generate ideas on how to achieve these savings.

- **10 Steps to your SES: a guide to developing a single equality scheme.** This guidance has been developed to assist NHS organisations that have a duty, as public authorities, to comply with the race, disability and gender public sector duties, and in anticipation of new duties in relation to age, religion and belief, and sexual orientation.

**Specific information** on quality and corporate assurance for a faecal continence service for the management of FI in adults can be obtained from the following sources:

- **Better metrics** is a pragmatic project that provides clinically relevant measures of performance to support the development of measurable local targets and indicators for local quality improvement projects. See older people metric 10.05 ‘Reducing falls’ and primary care nursing metric 12.2.

- The Royal College of Physicians **National audit of continence care for older people** provides a tool that enables health professionals to check the current status of local services and progress against national standards, and a template continence policy that covers competencies, governance and audit.

- **The essence of care: patient-focused benchmarking for health care practitioners** offers benchmarking tools for the
fundamentals of nursing care, including continence, bladder and bowel care.

- **Skills for health** works with employers and other stakeholders to ensure that those working in the sector are equipped with the right skills to support the development and delivery of healthcare services. See details of the [continence care competence framework](#).

- **Burdett Institute of Gastrointestinal Nursing** provides information in relation to validated professional courses including bowel continence and biofeedback for continence care.

- **The Association of GI Physiologists** offers training in gastrointestinal physiology.
Topic-specific Advisory Group: faecal continence service

A topic-specific advisory group was established to review and advise on the content of the commissioning guide. This group met once, with additional interaction taking place via email.

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