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Urinary continence service for the conservative management of urinary incontinence in women

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 service for the conservative management of urinary incontinence in women.

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

- NICE clinical guideline CG40 ‘Urinary incontinence: the management of urinary incontinence in women’.

The clinical guideline covers clinical and cost effectiveness in detail and underpins the content of this guide.

Although urinary incontinence affects predominantly women, commissioners may wish to consider the needs of their whole population, especially older people (including those living in nursing homes), when commissioning urinary continence services.

The guide:

- makes the case for commissioning a urinary 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 here. 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: urinary continence service**
Commissioning a urinary continence service for the conservative management of urinary incontinence in women

Urinary incontinence (UI) is a common condition that can affect women of all ages. It is defined by the International Continence Society as ‘the complaint of any involuntary leakage of urine’ and is wide ranging in its severity and features. Urinary incontinence may occur as a result of abnormalities of function of the lower urinary tract or as a result of other illnesses that tend to cause leakage in different situations.

The conservative management of UI refers to treatment therapies that do not involve surgery. Conservative management is recommended in NICE clinical guideline CG40 Urinary incontinence: the management of urinary incontinence in women as a first-line, cost effective option for women with UI. It includes lifestyle interventions, physical, behavioural and drug therapies, and may also include preventive strategies such as pelvic floor muscle training for women in their first pregnancy.

Although rarely life-threatening, UI can seriously influence the physical, psychological and social well-being of affected individuals. The impact of the condition on the families and carers of women with UI may be profound, and the resource implications for the health service can be considerable. The Department of Health publication Good practice in continence services published in 2000 reported that incontinence is often a major reason for the breakdown of the relationship between the carer and the person they are caring for, and this can lead to the affected person being admitted to residential or nursing home care; incontinence is second only to dementia as an initiating factor for such moves.

Where data exist, most estimates of prevalence of UI in the adult female population (15 years and older) vary between 25% and 45%[1]. However, UI may be significantly underreported because of the associated embarrassment.

Although UI affects predominantly women, commissioners may wish to consider the needs of their whole population, especially older people (including those living in nursing homes), when commissioning urinary continence services. These services should be organised in an integrated way, with various professionals often employed by health and social care agencies, providing a service that has agreed clinical governance principles.

The 2001 National service framework for older people called for the establishment of integrated continence services for older people by 2004. However, evidence suggests that there has been limited action towards
fulfilling this aim, and that the provision of services remains extremely variable\(^2\).

**Benefits**

The potential benefits of robustly commissioning an effective urinary continence service for the conservative management of UI include:

- **Reducing unnecessary treatment and inappropriate reliance on products for the containment of UI** – for example, pads and other equipment\(^3\).
- **Providing the best possible outcomes for women and their carers** through identification and intervention, resulting in alleviation of UI symptoms and/or cure.
- **Reducing the risk of urinary tract infections, falls, social isolation and depression** and improving the quality of life for older people suffering from UI\(^4\).
- **Reducing inequalities and improving access**, enabling older women, women with physical, sensory or learning disabilities and women who do not speak or read English to have equal access to information and urinary continence services.
- **Improving performance and person-centred clinical care** through implementing the recommendations for the conservative management of UI as outlined in NICE clinical guideline CG40 on urinary incontinence.
- **Better use of resources**, through helping commissioners to commission 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 urinary continence service for the conservative management of UI are:

- **Actively identifying women with UI through the provision of education and training for healthcare workers** across primary and secondary care.
- **Initiating appropriate treatment** following assessment and symptomatic categorisation of the cause of UI by appropriately trained staff.
- **Ensuring that women requiring urgent referrals for suspected cancer** are seen within the 2-week national target for urgent referrals and that appropriate referral pathways are in place for **specialist referral** for more complex cases.
• providing effective and efficient clinical care for the conservative management of UI in line with NICE clinical guideline CG40 on urinary incontinence

• providing a quality assured service.

National priorities

National priorities and initiatives relevant to commissioning a urinary continence service for the conservative management of UI include:

• World class commissioning.
• 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.
• The Expert patients programme.
• 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 urinary continence service for the conservative management of urinary incontinence in women

Service components

The key components of a urinary continence service for the conservative management of urinary incontinence (UI) are:

- identification and appropriate referral of women with UI
- initial assessment and conservative management of UI by trained and competent staff
- developing a high-quality integrated continence service.

Identification and appropriate referral of women with UI

The Department of Health publication Good practice in continence services describes a number of problems across England that affect access to, and delivery of, services. It suggests that:

- systematic effort is required to identify cases of incontinence, regardless of where a person may be residing
- public education and awareness of incontinence is a critical factor in the delivery of good services
- staff trained in the identification and management of incontinence should ensure a proactive approach during clinical consultations and should assist in the identification of women experiencing symptoms associated with UI in nursing/residential homes and across primary and secondary care.

Continence problems will usually present and be identified in primary care. However, older people living in long-stay accommodation should have the same access to services as those living in their own home. Primary care and community teams should have professionals who are trained to carry out initial assessment and conservative management, and/or a referral pathway to a specialist continence service.

All people with UI and symptoms indicating a more complex condition should have access to a specialist continence service that employs, among others, specialist continence nurses and specialist physiotherapists. These health professionals have a number of responsibilities, including the initial assessment and conservative management of UI, awareness raising activities, and the training and education of other healthcare workers across primary and secondary care.
NICE clinical guideline CG40 on urinary incontinence recommends that women with UI who have symptoms indicative of suspected cancer should receive an urgent referral in accordance with the national target for urgent referrals for suspected cancer.

For further information on referral pathways see Delivering the 18 week patient pathway: urology pathway, which includes 'blood in urine pathway version 2.1' and 'female incontinence pathway version 2.1'.

Initial assessment and conservative management of UI by trained and competent staff

NICE clinical guideline CG40 on urinary incontinence recommends the following.

- At the initial clinical assessment, the woman’s UI should be categorised as stress UI, mixed UI or urge UI/overactive bladder syndrome (OAB). Initial treatment should be started on this basis. In mixed UI, treatment should be directed towards the predominant symptom.
- The use of multi-channel cystometry, ambulatory urodynamics or videourodynamics is not recommended before starting conservative treatment.
- Absorbent products, hand held urinals and toileting aids should not be considered as a treatment for UI. They should be used only as a coping strategy pending definitive treatment, as an adjunct to ongoing therapy or for long-term management of UI only after other treatment options have been explored.

The conservative management of UI in women includes:

- Lifestyle interventions.
- Pelvic floor muscle training.
- Bladder training.
- Drug treatment if bladder training is ineffective.
- Bladder catheterisation for women in whom persistent urinary retention is causing incontinence.
- Electrical stimulation and/or biofeedback for women who cannot actively contract their pelvic floor muscles. However, current availability is limited in some areas, so commissioners may wish to consider commissioning services from specialist regional teams.

Commissioners will wish to assure themselves that all health professionals involved in the conservative management of UI have the required skills and access to relevant training and education. See the implementation advice
Developing a high-quality integrated continence service

The Department of Health publication *Good practice in continence services* sets out a model of good practice to help health professionals achieve more responsive, equitable and effective continence services. 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. Appendix 3 of the 2004 Royal College of Nursing publication *Is policy translated into action?* provides an example of a model for an integrated continence service.

Commissioners will need to consider commissioning a service that enables treatment, based on assessment, to be delivered in the most appropriate setting, which is usually primary care in the first instance; and allows easy access to specialist care when it is needed. Mixed models of provision may be appropriate across a local health economy.

The *NICE shared learning database* offers an example of a nurse/physiotherapist-led urinary continence service based in primary care for women in the Bradford and Airedale Teaching Primary Care Trust, which has a large multi-ethnic minority population and areas of wealth and deprivation. Before the introduction of the initiative, many inappropriate referrals were made to urology and gynaecology consultants in secondary care. A single primary care pathway was developed to facilitate referral to the continence service and promote conservative management in accordance with *NICE clinical guideline CG40 on urinary incontinence* and best practice guidelines. An audit of the service is in progress; however, local GPs and health professionals working in primary care have engaged in the pathway and the number of referrals to the continence service has increased.

More general examples can be found at the *Shifting care closer to home demonstration sites – report of the specialty subgroups* for urology and gynaecology. These examples identify innovative ways of delivering urology and gynaecology services that include continence services, and suggest that outpatient treatment can be carried out in community settings, closer to home, by any combination of the following staff: specialist nurses, GPs with a special interest in the condition, ultrasonographers, and consultant urologists and physiotherapists, provided that they have had appropriate training and demonstrate the required competencies. These examples are offered in order to share local practice, but NICE makes no judgement on the compliance of these services with its guidance.

Local stakeholders, including *service users* and their carers, should be involved in determining what is needed from a continence service in order to meet local needs. Commissioners may wish to consider the needs of men, children, and specific groups who are likely to encounter continence problems.
and/or have service access difficulties. These include ethnic minority groups; people with long-term physical disabilities, neurological conditions or learning disabilities; and homeless people and those living in hostels or residential care.

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; ensuring services are accessible to all residents in the area served
- 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.

Further useful sources of information may include:

- Delivering the 18 week patient pathway: 18 week commissioning pathways Female incontinence.
- The Map of medicine provides an information resource that visually organises the latest evidence and best practice guidelines.
- Implementation advice for NICE clinical guideline CG40 on urinary incontinence.
Determining local service levels for a urinary continence service for the conservative management of urinary incontinence in women

**Benchmarks for a standard population**

Available data suggest that the standard benchmark rate for a referral into a urinary continence service for women is **0.80%**, or 800 per 100,000, of the adult female population (aged 15 years or older) per year.

For a **standard primary care trust** population of 250,000, assuming that around 40% are women aged 15 years or older (100,000), the average number of women requiring referral into a urinary continence service would be **800 per year** (0.80% of the female population).

For an **average practice** with a list size of 10,000, assuming that around 40% are women aged 15 years or older (4000), the average number of women requiring referral into a urinary continence service would be **32 per year** (0.80% of the female population).

The adult female population has been defined as women aged 15 years and older. This is due to the availability of activity data and population data at general practice level within certain age bands and its use within the commissioning and benchmarking tool.

This service is likely to fall under the **programme budgeting** category 217X (problems of genito-urinary system).

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

Use the **urinary continence service commissioning and benchmarking 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.

- **Incontinence outcome indicators** (1999) provides health outcome indicators for UI.

- **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.

- **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 referral into a urinary continence service of 0.80% per year are based on the following sources of information:

- **epidemiological data** on the prevalence/incidence of urinary incontinence (UI) and overactive bladder syndrome (OAB) in the adult female population
- **activity data** to establish the rate of surgery for UI in women
- **current practice** to establish the number of women with UI and OAB in contact with GP services
- **published research** on UI and OAB
- **expert clinical opinion** of the topic-specific advisory group, based on experience in clinical practice and literature review.

The adult female population has been defined as women aged 15 years and older. This is due to the availability of activity data and population data at general practice level within certain age bands and its use within the commissioning and benchmarking tool.

**Epidemiological data**

Differences in study populations, definitions and measurements, and the survey methods used result in a wide range of prevalence estimates for UI in the female population. Where the most inclusive definitions have been used (‘ever’, ‘any’, ‘at least once in the last 12 months’) estimates in the adult female population range from 5% to 69%, with most studies reporting prevalence in the range 25–45%.[1]

Stress UI is estimated to be the most prevalent type of UI, accounting for around 41% of cases; urge UI accounts for around 16% and mixed UI for around 34% of the total[2].

OAB is defined as urgency that occurs with or without urge UI and usually with frequency and nocturia. The estimated prevalence of OAB in the UK is around 10% of the adult female population[3]. Around 33% of people with OAB are also believed to have UI[4,5]. The prevalence of UI and OAB increases with age, and some populations – such as those with a higher number of nursing homes – may have a greater prevalence of UI than the population as a whole[6]. However, most people with UI and OAB do not report symptoms to their GP[7].
**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.

In 2005/06 the rate of surgery for female UI was 40 per 100,000 of the adult female population with large variation across the country. The insertion of tension-free vaginal tape (TVT) slings was the most common procedure, accounting for 80% of all procedures for UI.

Surgery is recommended only after failed conservative management of UI. A recent audit of the adherence to the NICE technology appraisal on the use of TVT slings (replaced in 2006 by the NICE clinical guideline CG40 on urinary incontinence) for stress UI, found that conservative measures had not been attempted in around 50% of women undergoing the procedure. This may mean that some of these procedures could have been avoided[8].

If the result of this audit was reproduced across the country, capacity within continence services providing conservative management would need to increase, but the number of surgical procedures performed for UI could be expected to decrease.

**Current practice**

Data from IMS Disease Analyser, a database that holds patient data from a sample of GP practice systems, suggests that around 4% of the female population aged 15 years and older have diagnosed UI; the annual incidence of diagnosed UI (that is, the annual detection rate of new cases) is 0.43% of the adult female population. These estimates include a minority of women who have both faecal incontinence and UI (double incontinence).

Research from the General Practice Research Database (GPRD) suggests that the prevalence of diagnosed OAB is 0.34% of the adult female population and the annual incidence of diagnosed OAB is 0.24% of the adult female population.

Taking into account an estimated 33% overlap between UI and OAB[4, 5], the prevalence of diagnosed UI/OAB is estimated to be around 4.22% of the adult female population aged 15 years and older, and the annual incidence of diagnosed UI/OAB around 0.59% of the adult female population.

The quality of data used in the analysis of diagnosed UI and OAB relies on the information recorded within patients’ medical records. In particular, poor recording of UI and OAB symptoms may have led to an underestimation of the total numbers of women in general practice with diagnosed UI/OAB.
**Published research**

Research based on a large sample of women attending GP services for any reason found that the prevalence of UI was 54% of the adult female population, of whom around 47% reported symptoms to their GP. If this study was a reflection of GP services across the country, estimates of UI based on current practice (see above) represent only half of the population of women with UI that are currently in contact with services[7].

Research from the Leicestershire MRC Incontinence Study (2000) of people over 40 years of age suggested that, at any one time in the population, around 1.28% of the adult female population had significant urinary symptoms and had a preference for some form of treatment.

**Expert clinical opinion**

The consensus opinion of the topic-specific advisory group was that the women with UI identified in GP services are those seeking help for their UI/OAB, and therefore the take up of services would be high, at around 80–90%.

**Conclusions**

Based on the epidemiological data and other information outlined above, it is concluded that the benchmark for referral into a urinary continence service is 0.80% of the adult female population per year. This is based on the following assumptions:

- in current practice the average detection of new cases of UI and OAB per year is 0.59% of the adult female population
- around 1.28% of the adult female population at any one time have significant urinary symptoms and a preference for some form of treatment
- the mid point figure of those noted above is 0.94%
- take up of a urinary continence service would be around 85% (based on the mid point of estimates advised by the topic-specific advisory group).

Therefore the population benchmark for a urinary continence service is estimated to be 0.80% of the adult female population per year.

Use the urinary 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.
References


The commissioning and benchmarking tool

Download the urinary continence service commissioning and benchmarking tool.

Use the urinary 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 urinary continence service is 0.80% of the adult female population per year.

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, or has an ethnic composition different from the national average, you may need to provide services for relatively fewer or more people.

**Review current commissioned activity**

You may already commission a urinary 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.

Use the tool to calculate the level and cost of activity you intend to commission and to consider the settings in which the urinary 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 urinary continence service needs to:

- be effective and efficient
- be responsive to the needs of women and their carers
- provide treatment and care for women based on best practice, as defined in NICE clinical guideline CG40 on urinary incontinence
- deliver the required capacity
- be integrated with other agencies caring for people with incontinence and work to common evidence based policies, procedures, guidelines and referral pathways
- define agreed criteria for referral, local protocols and the care pathway for women requiring a urinary continence service
- be person-centred and provide equitable access, ensuring that women are treated with dignity and respect, are fully informed about their care and are able to make decisions about their care in partnership with health professionals
- 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 UI who are provided with care, and monitoring patient outcomes and complications. See [audit criteria for NICE clinical guideline CG40 on urinary incontinence](#).

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

- **Equipment**: testing and calibration of ultrasound scan, electrical stimulation equipment, biofeedback equipment.

- **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**: number of patients with improved quality of life. See [implementation advice for NICE clinical guideline CG40 on urinary incontinence](#) for examples of quality of life tools.

- **Staff competencies**: individual and team baseline requirements, monitoring and performance. Number of primary care staff trained; numbers of staff competent to carry out initial assessments, catheterisations and vaginal examinations; number of staff competent to teach pelvic floor exercises; number of specialists completing further education in continence care courses.

- **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**.

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**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 urinary continence service 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 RCP ‘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 continence services. See details of the [continence care competency framework](#).

- **British Society of Urogynaecology** provides training and guidelines, and sets standards in conjunction with the [Royal College for Obstetricians and Gynaecologists](#).

- The **Chartered Society of Physiotherapy** provides training and guidelines, and sets standards for physiotherapy practice in conjunction with the Association of Chartered Physiotherapists in Women’s Health and [Chartered Physiotherapists Promoting Continence](#).
Topic-specific Advisory Group: urinary 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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