“New continence guidance has the power to make real change”

Those of us who have worked in continence for years could feel a little cynical at the publication of NHS England’s guidance Excellence in Continence Care at the end of last year. We have had many worthy publications in the last 20 years but still hear of continence services closing, specialist roles being downgraded and budgets cut. And all without even mentioning poor-quality care as exposed by the Francis report. So why will this be different?

This guidance, as many before, has been a collaboration of professional forums, patient voices and NHS commissioners. The significant differences may be in the acknowledgement of previous guidance, the timing and target audience. It doesn’t merely replicate previous statements, it endorses and references them, pulling much evidence together. It may be the first to discuss both adults’ and children’s needs, providing credence to the view that all continence services should be integrated and, as it is electronic, it can remain current, with links updated as appropriate.

Publication timing can be critical to successful implementation. In 2000, Good Practice in Continence Services was comprehensive and many of its recommendations remain relevant. Unfortunately, it had no statutory mandate and, coming at a time when health authorities were transitioning to primary care trusts, it lost momentum.

Likewise Cost-effective Commissioning for Continence Care was written for PCTs but came when these were changing to clinical commissioning groups. Again recommendations were infrequently implemented.

While providers may be in a state of flux due to contract negotiations, most CCGs have stabilised. The Five Year Forward View is now beginning to be implemented, the UK is entering a period of political stability - no general elections are planned until 2020 – and the political arena is key to NHS implementation and change cycles. There should now be time for commissioners to investigate their local situation and provide incentives for necessary changes.

Finally, the new guidance acknowledges that no single provider is responsible for all service delivery and argues for system-wide incentives to achieve appropriate outcomes. It calls for involvement from public health to develop a better understanding of local demographics and population needs, education for health and social care staff and signposting so patients can self-help.

Incontinence seldom makes headlines but the guidance was discussed briefly on BBC’s breakfast news at the end of last year. Floods in Cumbria meant the full interview wasn’t aired but it can be seen online – a far cry from the Association for Continence Advice’s first attempts to promote Continence Awareness Week some 15 years ago, when GMTV refused to discuss continence issues for fear of causing offence.

With the power of social media to raise its profile, committed practitioners to educate and enthuse colleagues, endorsement from professional and patient organisations, this guidance could become a powerful tool to improve continence provision for many patients. Fingers crossed.

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Involving patients in research is a fairly new and exciting idea. Ten years ago the Department of Health’s national research strategy noted that engaging patients and the public “leads to research that is more relevant to people’s needs and concerns, more reliable and more likely to be put into practice”.

Despite this, our article on page 15 notes that people with learning disabilities are often excluded from involvement in research. This is a concern as several scandals have revealed deficits in the care of people with learning disabilities. The inevitable reports that follow such scandals clearly illustrate the need for service users’ involvement so they can help shape the services they use.

The author of our article explores the development of inclusive research and how it can give people with learning disabilities a voice that will help to inform their care.

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