



CONTINENCE CARE SURVEY

Undertaken by AHPMA

Absorbent Hygiene Products Manufacturers Association

Survey conducted Winter 2007
Publication 2008

AHPMA is the trade association which represents the absorbent hygiene product sector of the UK continence care industry. AHPMA is engaged in a lobbying programme to encourage better provision for services and products, sustainable procurement practices and awareness of continence care issues.

This survey, undertaken during late 2007, was to establish whether NHS cost pressures are leading to compromised continence care provision.

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SUMMARY

The 2007 AHPMA Continence Care Survey reflects the current state of Continence Services in the UK. AHPMA thanks the 148 respondents across the UK who took the time to complete the questionnaire.

This survey paints a bleak and unacceptable picture in many Trusts with cost savings being made in this, a service dealing with basic bodily functions, the patient group often the most vulnerable. Over half of Trusts reported staff morale lower than five years ago, with increased workloads and staff vacancies not being filled. Often, increasing patient numbers are being managed with fewer resources. It demonstrates a wide variance in Continence Services and shows that many Trusts have paid little heed to The *Good Practice in Continence Care* document from the Department of Health (DoH, 2000).

Waiting times are alarming, in that a patient with incontinence has to wait, sometimes for several months, before assessment and the issue of any required products. One Trust has some patients who have been waiting for over 12 months, and waiting lists are increasing in almost two-fifths of Trusts.

Over half of Trusts exclude certain patient groups from receiving products. One group listed is those with light urinary incontinence, however, this is without quantifying what volume of loss relates to 'light' as opposed to 'moderate' or 'severe'. Patients will perceive urine loss differently. Some Trusts will not supply if the need is for less than 2 or 3 pads a day, yet others will only supply a maximum of 3 pads per 24 hours.

Patient choice is restricted. Some Trusts will not allow pull-up type of products, whilst others will supply pull-ups, but fewer than if the patient were using other types of product.

With an ageing population and more patients receiving care at home, demands on continence services will continue to increase, and ways to adequately fund services, and to provide quality and equity must be investigated.

AHPMA proposes a radical review of Continence Services at Government level, with strategic planning for the future demands on the services, and mandatory targets for Trusts.

INTRODUCTION

Incontinence affects all age groups and does not respect social status. Worldwide there are over 200 million people who have significant incontinence and many more with mild bladder problems (Abrams et al, 2002a). Incontinence affects all age groups, however prevalence increases with age.

In the UK, urinary incontinence affects more people than those with diabetes [1.4 million] or asthma [3.4 million], (Continence Foundation, 2000), yet it receives little publicity. There are no exact figures available for the number of people who suffer from incontinence as so many choose not to seek help, however it is generally accepted that between 4 – 6 million people will be affected at some point in their lives. It is not a symptom readily discussed on television or the radio, because incontinence is still a taboo subject, misunderstood and sometimes ridiculed by those ignorant of it.

Urinary incontinence is defined as 'the complaint of any involuntary leakage of urine' (Abrams et al, 2002). There is always an underlying cause for incontinence and often other factors contribute to the symptoms, however it can often be successfully treated, improved or better managed.

Incontinence is a symptom; therefore conditions within the bladder or bowel need accurate diagnosis. Appropriate treatment can then be given. Sometimes incontinence is associated with other illness such as diabetes, multiple sclerosis or stroke. Spinal injury which interferes with nerve impulses between the bladder and bowel, and the brain, also results in incontinence. Those with severe physical or learning disabilities are often unable to achieve complete bladder and/or bowel control due to such disabilities.

When incontinence is not easily resolved, a comprehensive continence assessment is necessary, undertaken by a health care professional competent to diagnose the reason for the bladder dysfunction. This is usually a specialist nurse, doctor or physiotherapist.

SPECIALIST CONTINENCE SERVICES

The role of Continence Advisor developed rapidly during the 1980's, following work done by a handful of Specialists raising awareness of continence issues and promoting the advantages of such services, at Government level. Over the following decade, most Health Authorities (now Trusts), developed Continence Services. The role of Continence Services varied, depending on the organisation of the Health Authority and working arrangements with other associated disciplines, but often included a clinical role for the assessment of patients with complex symptoms, implementing specialist treatment if indicated, and a role in the education of staff in the assessment process. The Continence Specialist was often a nurse but other healthcare professionals such as physiotherapists also took on this role. This was very much a role to promote continence by thorough assessment and treatment of the underlying dysfunction. The Continence Service often developed working arrangements with others such as uro-gynaecologists and urologists.

The Continence Services of the 1980's and 1990's would often cover all patient age groups, however now expertise in specialised areas such as paediatrics is essential.

Services have continued to develop, but all are different. Some are a 'single handed' service whilst others have a multi-disciplinary team, and some teams are led by a Nurse Consultant. Most will be accountable for the budget spent on absorbent products for incontinence, and have Trust policies for product supply.

Trusts which have merged have their own challenges for the Continence Services coming together. There may be several previously separate Continence Services, all with different staffing levels, each with their previous Trust policies for product supply with varying levels of product provision; having to merge policies which are poles apart.

Wendy Colley OBE, RGN, DN Cert, FETC

‘A Call to Action’ by Dr Judith Wardle PhD, former Policy Director, Continence Foundation.

This should be an opportune time for the development and strengthening of continence services, but this APMHA survey reveals that for much of the UK the opportunities are not yet being capitalised upon.

The last time such opportunities presented themselves was in the late 1990s when many organisations in the continence field – organisations of doctors, nurses, physiotherapists and patients as well as companies – united to fight the imposition of VAT on continence products. Their efforts coalesced in the National Continence Campaign, which was able to build on the parliamentary lobbying already carried out by the Continence Foundation since its inception in 1992. The Continence Campaign drew widespread support because, while the financial arguments around VAT might be rather dull, those campaigning could point to the impact on patient care: continence services losing a significant portion of their budget to VAT were having to reduce staffing levels. Apart from the partial victory regarding VAT (no longer charged for individual purchases but still to organisational purchasers including the NHS) the main positive outcome of the energetic campaign was the setting up of a Working Party chaired by the eminent urologist, Professor Paul Abrams, and the resultant Department of Health document, *Good Practice in Continence Services* (2000). This document is generally known as the “Guidance” because, unfortunately, the government decided between the drafting of the document and its publication that the recommendations should not be mandatory. Nevertheless, those recommendations have been behind much of the subsequent development of continence services.

The Guidance document, and the appearance in the 2001 *National Service Framework for Older People* of mandatory target dates for the creation of ‘integrated continence services’, provided a focus to speed the development of continence services: the most innovative services were already led by dedicated continence nurse specialists working closely with local consultants and, in some cases, Social Services. By the early years of this century, every postcode in the UK was covered by a community continence service, and in almost all cases the public had the right to self-refer to those services.

However, the situation revealed now by the APMHA survey comes as no surprise to this writer: the drive towards better services has been undermined by other developments. The decrease in morale in 55% of services revealed in the answers to Q.3 is a result of those pressures. Repeated re-organisations have slowed down the movement towards integrated services: when management at primary care level was in flux it was enormously difficult to design closer working with secondary care and the local authority. As noted by the Commons Health Committee, “it takes on average eighteen months for organisations to ‘recover’ after restructuring”.¹ Also there were financial pressures on PCTs, coming to a head in 2005 with Patricia Hewitt’s insistence that they balance their books. Unfortunately, in many places, continence services were seen as an easy target: hence my decision to conduct a survey in June/July 2005 of waiting times to first appointment in continence clinics and of criteria for the issuing of continence products. While the average waiting time was good (about 6 weeks), the range was enormous, with services that provide outreach clinics or a high level of home visits (both to be commended) having waiting times up to 6 months. A repeat survey at the end of 2006 showed no increase in the average waiting time but an increase in the range of answers. As I wrote in the Foundation’s *Review* (Issue 12, Spring 07), “The pressures on the system are revealed by the number of services that told us waiting times went up where there was no cover for sickness, annual leave, maternity or study leave. In other places, posts are frozen. There are particular pressures where the service is run by a single continence

specialist (some said they put in unpaid overtime just to keep up).” Now AHPMA has found (Q.2) that nearly 38% of services have waiting lists that are increasing.

Criteria for the issuing of pads in the Foundation’s 2005 survey were enormously variable, with only 3 having a validated scoring system. While the best referred to “clinical need” as recommended in the Guidance and two-thirds mentioned assessment, there were already a third of the respondents admitting to a having a standard figure for the number of pads issued per day. In that survey the range was 3 to 6 pads, with the majority saying 4. While APHMA ‘s survey shows no significant deterioration since 2005, there has been a reduction from the 5 pad average quoted in the Guidance (p.9), citing a survey from 1997. The Guidance took the “gross difference” in criteria noted then as a suitable proxy measure of the variable nature of services: this argument is still valid.

As in 2000, we now have opportunities arising from the publication of national documents about continence. Two clinical guidelines in this field have recently been produced by the National Institute for Health and Clinical Excellence (NICE) *The Management of Urinary Incontinence in Women* in October 2006 and *The Management of Faecal Incontinence in Adults* in June 2007.² While NICE guidelines are not mandatory, NHS Trusts must “have regard” to them and are required by the Healthcare Commission to show that they are trying to move towards implementation. All NICE guidelines are accompanied by “implementation tools” to help Trusts assess the impact on their services and finances of putting the recommendations into practice. For both of these guidelines there is an additional tool which should particularly draw the attention of planners to the subject of incontinence: this is a “commissioning guideline” which not only specifies the number of people with continence problems that a PCT or practice can expect to refer to continence services per year (800 per PCT for urinary problems and 200 for faecal problems), but provides detailed information on service design and monitoring tools, and gives access to detailed local information including financial data (not accessible to the general public) that is needed for the commissioning of continence services. Since NICE has so far produced only fifteen of these detailed commissioning tools, the fact the two of them are in the continence field should be publicised to all commissioners, who are currently being urged by the government to produce “world class commissioning”.³

A further parallel with the 1990s is that there is a another high-profile battle with the finance side of the NHS that has had the potential for serious effects on the care of people with continence problems, and again the battle has caught the attention of parliamentarians. This is the long battle regarding Part IX of the Drug Tariff: appliances used for the containment of incontinence or management of retention (such as a stoma bag, urinary sheath or catheter). Part IX was caught up in a wider drive by the Treasury to save money on everything “procured” by the NHS: part of the “Supply Chain Excellence Programme” which began in 2004, aiming to save £500 million a year by 2007/08. This is not the place to go into the long history of inconclusive consultations since 2003: the relevant matter here is that by originally tying their suggested formula for saving money on payment for these appliances to a wholesale re-classification which was full of mistakes⁴, the Commercial Directorate risked making many appliances economically unviable, appliances which are essential in some cases to patient survival, and always to patient quality of life. Whilst the level of protest was fairly muted at first, once patient groups were alerted to the full implications, they joined with clinical organisations and manufacturers to lobby members of the House of Commons and Lords.

There are now many, many more parliamentarians with a renewed interest in the whole subject of incontinence, including more than 200 parliamentarians who had either been involved in the earlier campaign or had shown more recent interest. While Early Day Motions have focussed on the single issue of the potential impact of the Part IX consultations, Parliamentary Questions have raised much wider issues

concerning the provision of continence services and especially, there have been two wide-ranging debates, led by Graham Allen on 24 October 2007 and Earl Howe on 24 January 2008.

The momentum that has been built up around a single issue affecting people with continence problems must not be allowed to falter. And especially the opportunities must now be seized to extend campaigning to reverse the erosion of continence services and to boost the morale of beleaguered practitioners. This survey is potentially an excellent tool for this campaign.

References

¹ *Changes to Primary Care Trusts*, Stationery Office January 2006, p.4.

² The suite of guidelines will eventually cover the majority of adults once a guideline on Lower urinary tract symptoms in men is completed – expected February 2010. There will also be guidelines for some aspects of continence care in children: *Urinary tract infection in children* appeared in August 2007, and *Idiopathic childhood constipation* is expected in March 2010.

³ *World Class Commissioning: Vision*. DH, December 2007.

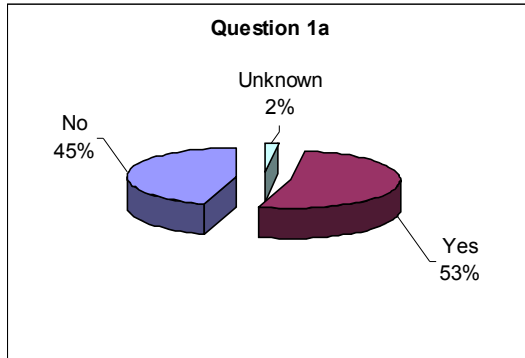
⁴ The Commercial Directorate has now promised that, in what everyone hopes is the final consultation document in May, price reduction will not be dependent on the reclassification process.

SURVEY RESULTS

Questionnaires were sent to Continence Services in the UK and 148 questionnaires were returned.

Question 1a

Are you part of a recent Trust merger?



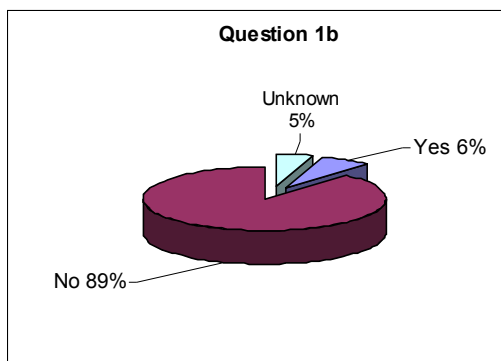
This showed a fairly even spread with just over half (53%) of responses from those working in a Trust which had recently merged. Trust mergers occurred in October 2006, twelve months before this survey.

Comments from respondents included:

- Same. 2 Trusts merged but already covered by one service only
- Merger still in progress
- May go into a merger at some point
- Merging soon
- In process
- Currently in consultation
- Merged with part of Social Services
- 4 PCT's merged but we provide a city-wide service anyway
- Reconfiguration

Question 1b

If "Yes", overall are staffing levels in the Continence Service better?



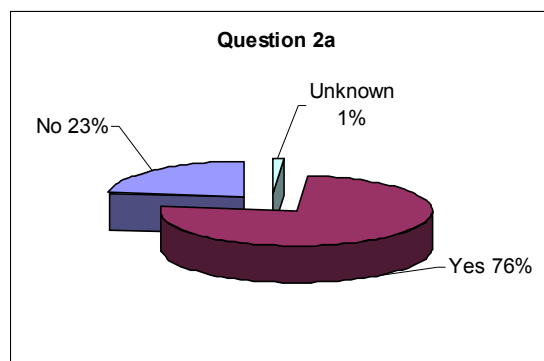
Of the 53% working in a merged Trust, 89% said that staffing levels were worse.

Comments made included:

- Vacancies are not being filled
- Staffing levels worse! More work – no more staff
- Due to retirement / changeover of staff, almost all temporary at present
- Team depleted by staff leaving and not being replaced
- One full-time staff not replaced
- Worse – unfilled vacancies
- Manager putting in business plan for extra staff – awaiting outcome
- Staff resignations leave us much worse off
- Luckily we are able to recruit and replace staff
- We have integrated two teams and raised our shared knowledge

Question 2a

Do you have a waiting list to see patients for Clinical Assessment?



Over three-quarters (76%) of Continence Services have a waiting list for Clinical Assessment.

Of those NOT in a Trust merger, 44 out of 67 Continence Services have a waiting list.

Of those IN a Trust merger, 69 out of 78 have a waiting list.

If so, how long?

Waiting times varied with an even spread between one week, up to 'within 18 week limit', with some greater: one response stating 6 months, another response 10 months and a third over 12 months. In one area some patients have to wait longer to see the Continence Specialist, but may be seen sooner by the District Nurse. In other areas it may take longer to be seen by the DN.

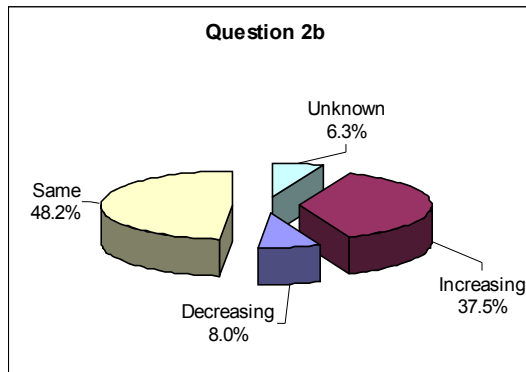
Respondents stated:

- Some District Nurses Teams take 3 months before products are ordered
- Referrals up by 50%
- I try to prioritise, however some have been waiting over 12 months. This is due to a long history over the last two years of long-term sickness within the team that wasn't covered
- More referrals for clinic over last 12 months
- 10 months wait for home visits. Number of community link nurses decreasing due to movement of staff, also demands on care services

- We are actively promoting the service, therefore leading to an increase in referrals

Question 2b

If 'Yes' is this increasing, decreasing or the same?

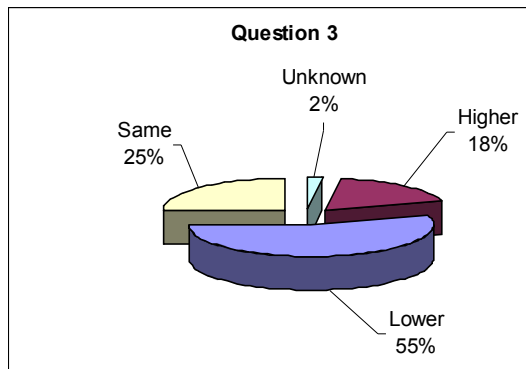


Almost 38% of respondents stated that their waiting lists were increasing and stated:

- Increasing due to long term sickness in the team
- Increasing. Personally I find this upsetting. Patients need to be seen a.s.a.p.
- Waiting list 6 – 16 weeks depending on area. Increasing in some areas

Question 3

Compared to 5 years ago would you describe morale in the service as higher, lower or the same?



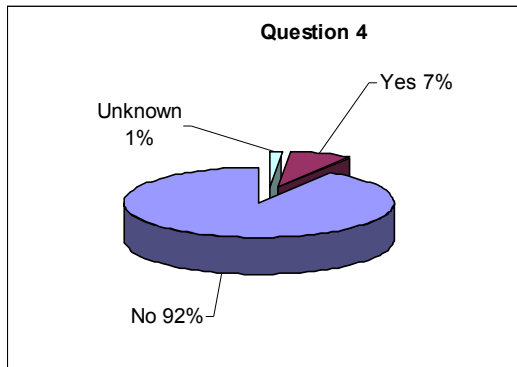
In more than half of Continence Services who responded, morale is lower than it was 5 years ago. The reasons given included:

- Overspend. Staff having to do more jobs and not replacing staff when they leave
- Less job security
- ↑ Pressure, ↑ Change, ↓ Security
- Due to increased workload – higher patient expectations and lower interest of management in continence care
- Over worked
- Less staff, more work
- Clinical specialists are at risk
- Now there is a fear that the commissioners would not want to purchase an 'expensive' Continence Nursing Service
- Very low morale. Progress on continence care pathways halted due to PCT merger and management restructuring

- Change of Manager – seems more conscious on cost rather than patients
- Never known it this bad!

Question 4

Do you have a waiting list for supplying products?



The *Good practice in continence care* document (DoH, 2000:p38) states that 'It is unacceptable to have waiting lists for pads as a means of rationing the service'. Although the majority of Trusts do not have a waiting list as such for products, patients usually have to wait until an assessment has been undertaken to identify the reason for the leakage and to advise on treatment. Following assessment, an appropriate product may be prescribed, based on the assessment. Therefore, any delay in supplying products is due to the length of wait for assessment. However, 7% of Trusts do have a waiting list for product supply

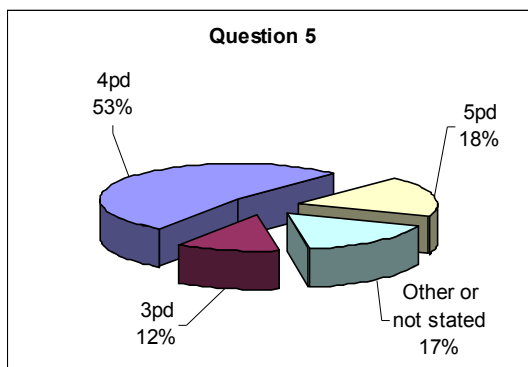
Comments included:

- Dependent on waiting list for assessment
- 10 months for those who require home visits
- District Nurse not having enough time to see patients
- Admin staff sickness so cannot process work quickly

Question 5

What is your allowance per patient per day?

This question asks how many pads are allowed per patient for a 24 hour period. When costs are calculated, this is described as cost per patient per day. 'Per day' equates to the 24 hour period. The *Good practice in continence care* document (DoH, 2000:p38 and p37) states that 'Pads should be provided in quantities appropriate to the individual's continence needs. Arbitrary ceilings are inappropriate' and 'Consideration should be given to patient choice.'



Just over half (53%) of patients are allowed up to 4 products for a 24 hour period; less than one fifth of respondents, allowed up to 5 products in 24 hours and 12% of respondents restrict supply to 3 products in 24 hours. Some Trusts allow products up to capacity limits, and may supply more if supported by a bladder chart. Other Trusts supply to 'clinical need'. A number of respondents stated that the supply to children was higher than that of adults. Others did restrict certain products for example pull-ups. Some respondents stated monetary value, such as:

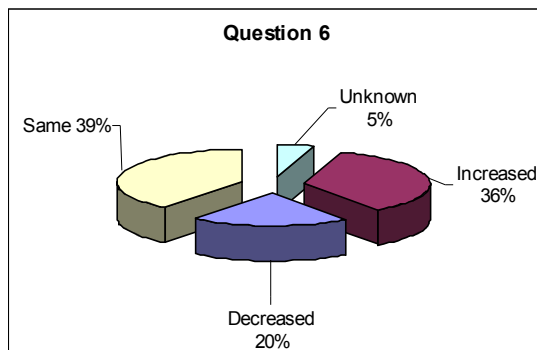
- £2.36 per week (just under 0.34p per day)
- 0.44p per day
- 0.37p comm. 50p com (no 68)
- 0.55p Care Home, 0.37p Community
- 0.86p

Comments included:

- Annual budget £159,000. Number of patient's works out at £2.36 / week. Budget is overspent
- Have been asked to save a considerable amount of money this financial year
- 5 pads / day, or 3 pull-ups for the day & nappy overnight
- Agreed at Board level to do financial restrictions – levels above this (4 pads) can be supplied for clinical need only

Question 6

Has your budget increased or decreased over the last 5 years?



Just over one-third of respondents (36%) reported an increase in the budget over the last 5 years. One fifth of respondents (20%) reported a decrease in the budget, whilst almost two-fifths (39%) stated that the budget had remained the same.

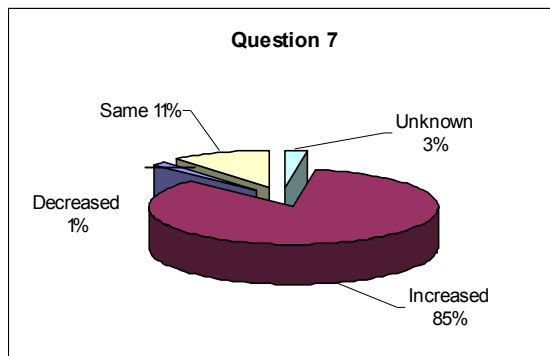
Respondents stated:

- No increase effectively means a cut!
- Financial savings have been made due to tender contracts but also budget has been reduced
- But have just been asked to save £28,000 despite being under budget last 3 years
- If we save money for the Trust – I am unsure whether the saved monies will be ploughed back or swallowed up in the cost efficiencies due to the Trusts overspend
- Have no budget (for) stationary etc. Get a bursary and teaching fees to use (for) training etc

- It remained the same for 3 years, till we put together a document pointing out that the number of users had increased
- Business case presented ↑15% budget
- Good support from PCT
- There has only been an increase this financial year

Question 7

Has the number of patients requiring products increased or decreased during the last 5 years?

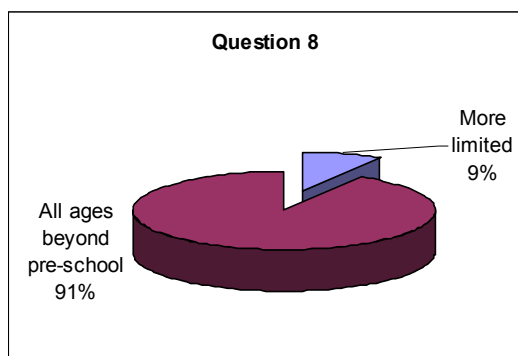


Respondents in 85% of Trusts stated that the number of patients requiring products had increased over the last 5 years. Comments included:

- Average of 50 – 100 a year
- 12% in last 12 months
- Average 100 a year
- Increasing rapidly
- Ageing population
- We now provide a more limited range of pads due to budgetary constraints
- Gradual rise year on year
- We are seeing lots more terminally ill and long-term conditions in Nursing Homes
- Over the past 5 years the number of patients has increased by 30%
- We have remained in budget constantly the last 5 years

Question 8

What age groups are you supplying products to?



The *Good practice in continence care* document (DoH, 2000:p38) states that 'In most cases it would not be appropriate to provide free pads before the age of four, but flexibility should be allowed for special cases

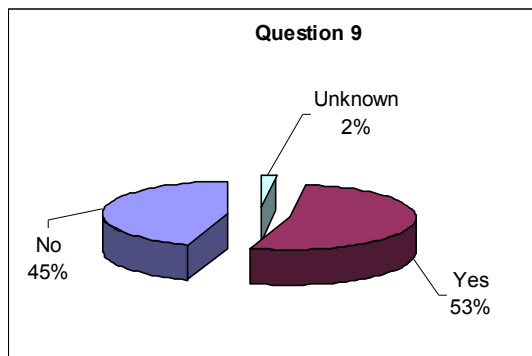
Most respondents are supplying products to children from 4 years of age; slightly younger in some Trusts, and some show flexibility for those younger with terminal illness or special need. There is no upper age limit for being supplied with products; however one respondent stated the 20 – 60 age group are less likely to be supplied to.

Other comments included:

- 100 clients over 100 years of age
- All ages
- 4 – 105
- 4 years upwards – changed last year at Board level
- 5+. In exceptional circumstances <5
- Children supplemented from age 3 yrs by 1 pad per day, age 4 yrs by 2 pads per day, age 5 yrs by 3 pads per day, age 6 yrs by 4 pads per day.
- 3 – 19 years (Special Needs Children Service)

Question 9

Are there any exclusions to who receives products?



53%, so over half of respondents do exclude certain individuals from receiving products. Generally, children with primary nocturnal enuresis (bedwetting) and no other medical condition will not be supplied with products. Others who are excluded include those with 'light incontinence', 'stress incontinence', those requiring a small number of products per day and those using products for social use or 'just in case'.

The *Good practice in continence care* document (DoH, 2000:p38 and p37) states that 'Pads should be provided in quantities appropriate to the individual's continence needs. Arbitrary ceilings are inappropriate' and 'Consideration should be given to patient choice.'

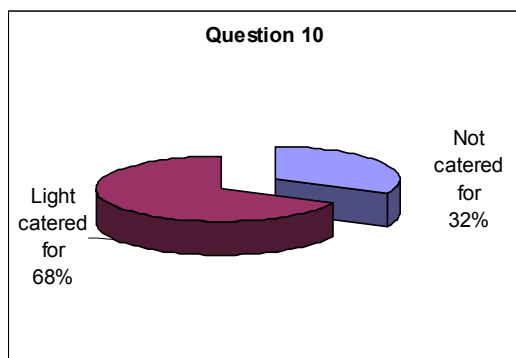
Respondent's comments for excluding patient groups from receiving products included:

- Light incontinence
- Primary nocturnal enuresis, unless a medical condition
- Nursing Home patients. Patients using less than 3 light inco products
- Patients who have 'light incontinence' cannot have pads. They buy own
- Not provided for stress leakage

- Occasional users i.e., 1 pad when going out
- Minor stress incontinence / 'just in case' patients. Some post-op patients
- No supply for light incontinence only moderate – severe
- Not supplied to people requiring less than 3 pads in 24 hours for light incontinence
- Light urinary incontinence / occasional faecal
- If treatment is refused / non-compliance, 'just in case', or if leakage is minimal
- Children who want pull-ups, we don't provide
- Light incontinence – must require 3 per day
- Bleeding P/V or P/R
- Those with light incontinence needing less than 2 pads / day
- Light need, stress incontinence, less than 2 pads required daily, children under 4/5
- Those who score below 35 using a research based continence assessment scoring tool (indicating that treatment may be of benefit rather than containment)
- We do not provide for light incontinence
- We do not supply for stress incontinence
- We supply for chronic incontinence only

Question 10

What levels of incontinence do you cater for?



Almost one-third of respondents (32%) stated that they do not provide disposable products for patients with 'light urinary incontinence'. Some offer or recommend washable / reusable products.

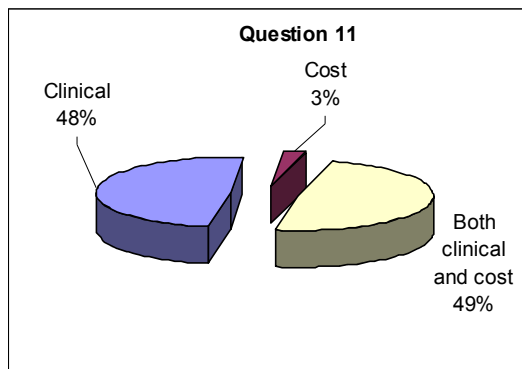
The *Good practice in continence care* document (DoH, 2000:p38) states that 'Since reusable pads are not suitable for everyone, their availability should not be to the exclusion of disposable pads'.

Comments included:

- No longer supply light inco products
- Light are only offered reusables
- Light are offered advice and given info re where to buy disposables or washables
- No pads for light incontinence
- Washables provided for light if required
- Reusables offered for light incontinence with exercise programmes

Question 11

Is your choice of product made on a clinical need or cost basis?



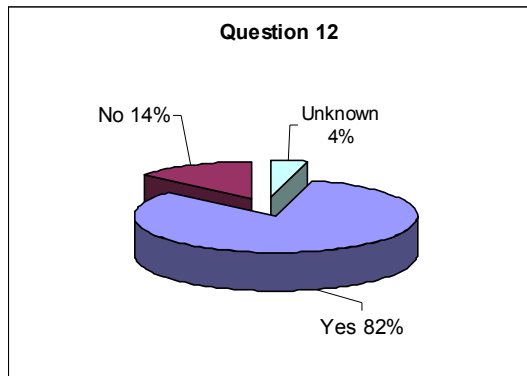
There was an almost 50/50 split in responses between product choice being made on a purely clinical basis (48%) and a mix of a clinical and cost basis (49%). 3% of respondents stated that product choice was made on a cost basis only. The *Good practice in continence care* document (DoH, 2000:p37) states that 'Consideration should be given to patient choice.'

Comments included:

- Cost is increasingly influential in forward planning / tender process
- In the current climate, cost has to be a large consideration
- We have recently had to limit the use of all-in-one products to reduce the overspend on continence products
- (Choice made on clinical basis) At present. However this will change due to financial constraints imposed by Trust
- Choice directed more on cost savings than quality / or on clinical opinion
- Pull-up style products are not supplied at all, neither are male-specific disposable pads
- Cost does not come into it as we do not offer pull-ups
- (Choice made on clinical basis) However, the Trust do look at cost
- Clinical basis – within a specified formulary under an agreed contract with the manufacturer. Cost basis – the contract agreed between PCT and the manufacturer
- Absorbency is based on clinical need
- We aim to keep a core range. Exceptions only after discussion with CA (Continence Advisor)

Question 12

Are your provision policies adequate for good patient care?



82% of respondents stated that their provision policies are adequate for good patient care; however 14% said they were not.

Of those who answered 'Yes', there were some comments which were causing them concern, such as:

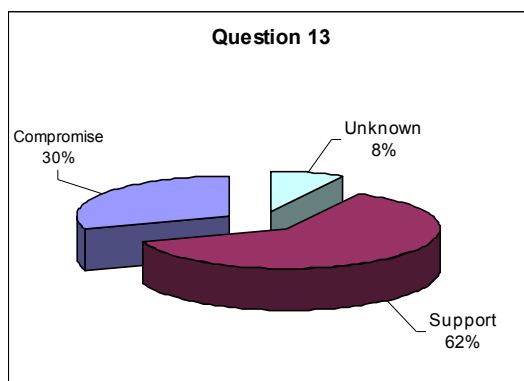
- Areas for improvement
- Only adequate
- On the whole
- May have to change because of budget savings
- But I feel they need updating
- Only because currently I write the policy – once materials management take over it will be different
- Adequate
- At the moment, however I feel that commissioning may well face (force) us to reduce the level of provision we currently have

Comments from those who answered 'No' include:

- Policies need updating
- 4 (products) is not enough for some. Nothing to offer now
- Not flexible enough
- Clinicians work very hard despite the budget to provide good patient care

Question 13

Does your available budget support or compromise the quality of patient care?



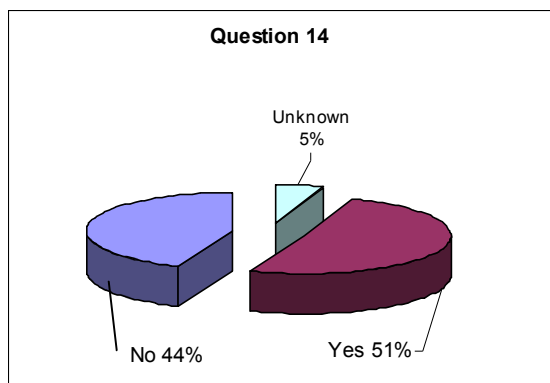
Of respondents, almost two-thirds (62%) stated that their available budget supported the quality of patient care, whilst almost one-third (30%) stated that their available budget compromised the quality of patient care.

Comments included:

- Neither supports nor compromises
- Support but not fully meet care needs
- The PCT is in a poor financial situation, therefore budget is restrictive
- Neither – it allows us to function – no room for expansion
- We cannot provide high absorbency products
- It is becoming increasingly difficult to work within the budget constraints and I anticipate product provision will be cut
- Unable to give pull-ups
- No funding for Paediatric Continence Nurse Specialist
- Many patients 'top up' themselves
- Pressured to reduce constantly
- Budget currently overspent and now having to find ways of reducing same
- Need more staff especially for nursing / residential homes
- Not able to offer full patient choice
- Our budget is quite good, in two ways. 1. it is enough so that clients that need pads can have them 2. but not too much that pads will be given in preference to treatment

Question 14

Is there a link between inadequate provision and poor skin health?



51% of respondents said there was a link between inadequate provision, whilst 44 % said there was not. Comments included:

- Products supplied are of good quality, if quality was compromised skin health is also compromised
- There is a link between poor skin health and inappropriate pad provision
- Yes – but we are not experiencing problems in this area
- Anecdotal
- We ensure the quality of product does not affect skin care
- Not proven
- Currently we do not have problems with poor skin health but if we are forced to reduce our provision, that could become a problem

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ACKNOWLEDGEMENTS

In the preparation of this report, AHPMA acknowledges the contribution from:

Wendy Colley OBE, RGN, DN Cert, FETC

Dr Judith Wardle PhD, former Policy Director, Continence Foundation

AHPMA also acknowledges independent comment from:

Sharon Eustice on behalf of Association of Continence Advice

Thanks go also to the respondents to this survey.

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