2014

Commissioning guide:

Faecal Incontinence

Sponsoring Organisation: Association of Coloproctology of Great Britain and Ireland
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Commissioning guide 2014

Faecal Incontinence

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Introduction

- Faecal incontinence occurs when a person loses control of their bowel and is unable to retain faeces in their rectum.
- It affects over 10% of adults[1], with 1-2% reporting major symptoms.[2]
- It is a symptom not a disease that necessitates efficient and effective assessment at the time of onset of symptoms and identification of risk factors for underlying pathologies.
- Early identification and proactive management of the condition needs to be aimed at fulfilling patient outcomes in terms of reducing embarrassment and allowing time for exploration of the effect of symptoms on daily living.
- The aim of treatment for faecal incontinence is the promotion of optimal functioning and improved quality of life for patients.
- Patients with faecal incontinence should have direct, timely access to community based continence services that are equipped with the knowledge, skills and expertise to meet their individual needs.
- Community Continence Advisors should be trained to look for high risk symptoms of bowel cancer and immediately refer for GP/medical specialist opinion when further guidance is required and commence any conservative treatments accordingly.
- NICE Guidance CG49 : Management of Faecal Incontinence (2007)[3] clearly identifies the highly distressing and major impact it has on a person's quality of life and supports the role of specialist management, including biofeedback, when other conservative measures fail to restore continence.[4]
- Referral to secondary/tertiary care services is indicated when conservative treatments have been tried and failed in the community. A recent Cochrane review has shown a benefit from nurse led therapies.[5] A large majority of patients will not be offered any surgery before a trial of nurse- or therapist-led therapies.
- In the best resourced units 3-5 sessions of nurse- or therapist-led treatment result in patient satisfaction rates in excess of 80% with the majority of patients not seeing a doctor and avoiding surgical intervention. Results also remain stable at one year. Posterior tibial nerve stimulation should be offered as part of these treatments.
- The commissioning of Sacral Nerve Stimulation (SNS) sits outside of this guide as it is commissioned nationally by NHS England. However, the low morbidity of this intervention is currently favoured by colorectal surgeons and gives high level patient satisfaction and Patient Recorded Outcomes Measures (PROMs) that negate the need for costly lifelong continence management and product usage.
- This document has been prepared with the aid of NICE guidance, which is based on best available evidence.

1. High Value Care Pathway for faecal incontinence

Exclusion criteria:

Faecal incontinence occurring exclusively secondary to diarrhoea (e.g. inflammatory bowel disease, cancer, diverticular disease) needs to be managed by treating the underlying cause of the diarrhoea first. Such patients are excluded from this guidance as management should be possible in any colorectal unit. However it is important to not forget that incontinence may be multifactorial, so if symptoms persist despite the diarrhoea being controlled, then referral may be appropriate.

Level 1:

Systems are in place to ensure that patients who are at high risk of faecal incontinence are identified.[8]

To be addressed in primary care and community by an appropriately trained continence advisor or by healthcare professionals competent in carrying out a baseline assessment.

Assessment: (see appendix 1)

- History of bowel symptoms including any red flags/signs of bowel cancer
- Bowel habit and medication review
- Visual anal and digital rectal examination to exclude faecal impaction and overflow and assess anal tone and squeeze

Initial bowel management

- Dietary modification
- Medication
- Advice on use of continence products (see appendix 2)

Offer all patients:

- reassurance and lifestyle advice
- access to help with relevant physical, emotional, psychological and social issues
- advice about relevant support groups
- advice on self-management of symptoms

All individuals who continue to experience symptoms of faecal incontinence should be asked if they wish to have further treatments and be considered for specialist management at Level 2. It is acknowledged that some treatments that are available at level 2 may be available at Level 1. Although initial bowel management is undertaken by a continence advisor, referrals will come from general practitioners to ensure that there is appropriate funding.

Indications for referral:

- Refractory symptoms
- Gross sphincter pathology identified (congenital malformation)
- Relevant co-morbidity (neurological disease)
- Patient request

Level 2:

At this level the majority of patients will need anorectal physiological testing and an endoanal ultrasound to assess sphincter function and anatomy. The majority can then go straight to a nurse- or therapist-led specialised bowel management clinic.

A minority of patients will go directly to a colorectal clinic to discuss surgery. Indications for this are:

- Full thickness rectal prolapse. These patients will usually have anorectal physiological testing and an endoanal ultrasound to assess the prognosis for future continence and may require a gastrograffin enema to look for redundancy of the sigmoid colon. These patients should then go straight to a colorectal surgeon and not to nurse- or therapist-led treatment to discuss a repair.
- Major sphincter pathology
- Trapping rectocele with passive faecal soiling
- Megarectum or megacolon requiring disimpaction
- Reparable external anal sphincter defect and patient opts for surgery. Of note: the majority of patients do not have a reparable defect
- Complex patients such as those with a history of imperforate anus should all be seen by a colorectal surgeon

Nurse or therapist-led specialised bowel management

A comprehensive nurse or therapist-led service should provide a full assessment and access to a range of modalities of treatment, tailored to the needs of the individual patient, based on specialised bowel, lifestyle and dietary assessment.

- Pelvic floor muscle training
- Bowel retraining
- Biofeedback
- Electrical stimulation
- Trans-anal irrigation
- Hypnotherapy – For patients with IBS[6,7]
- Posterior tibial nerve stimulation
- Anal plugs
- Skin care
- Helpline
- Counselling/ psychological support

Individuals who continue to experience symptoms of faecal incontinence should be asked if they wish to have further treatments and be considered for specialist management at Level 3. Referrals would come from the nurse or therapist- led service.

Level 3:

Surgical interventions

RECTAL PROLAPSE

Rectal prolapse regularly coexists with other rectal evacuatory disorders and can compromise faecal continence. After having the prolapse treated patients will often need to go onto specialist nurse- or therapist-led treatment for other symptoms. Treatment should therefore be undertaken in centres with access to the whole range of services.

COLOSTOMY

Assessment and advice regarding the formation of a stoma may be aided by a complete pelvic floor assessment and maximised through non-operative treatment via the nurse-or therapist-led specialised bowel management service and the stoma nurse service.

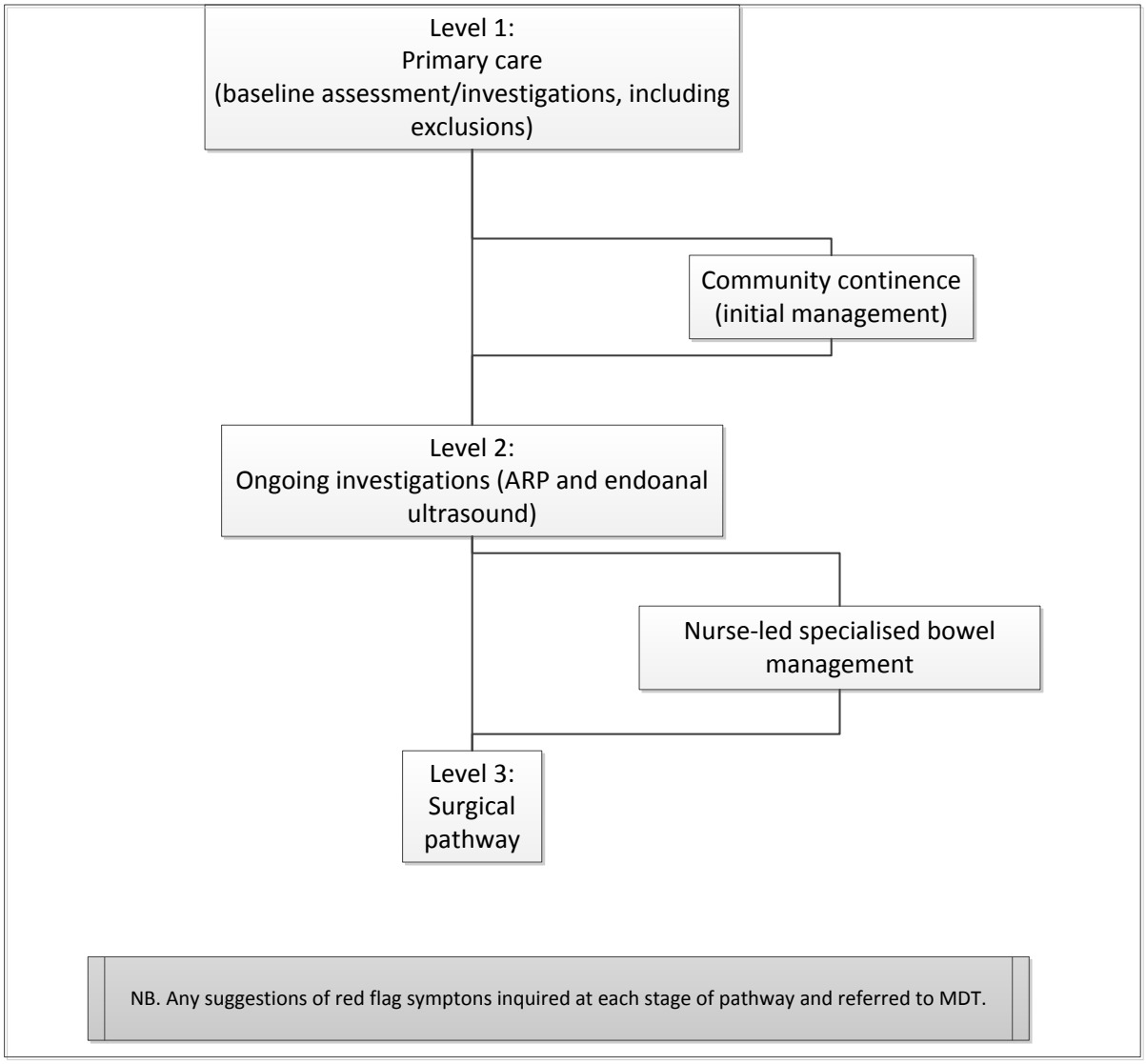
This is a disfiguring operation with a significant long term complication rate. It should be reserved for patients who have failed other therapies or for those who choose to opt for a stoma having been given extensive information on this and all other options. The formation of a stoma is not a specialist operation and can be done in a local hospital. It should be noted that without adequate counselling up to one third of patients having a colostomy may subsequently come to rectal excision for anal leakage.

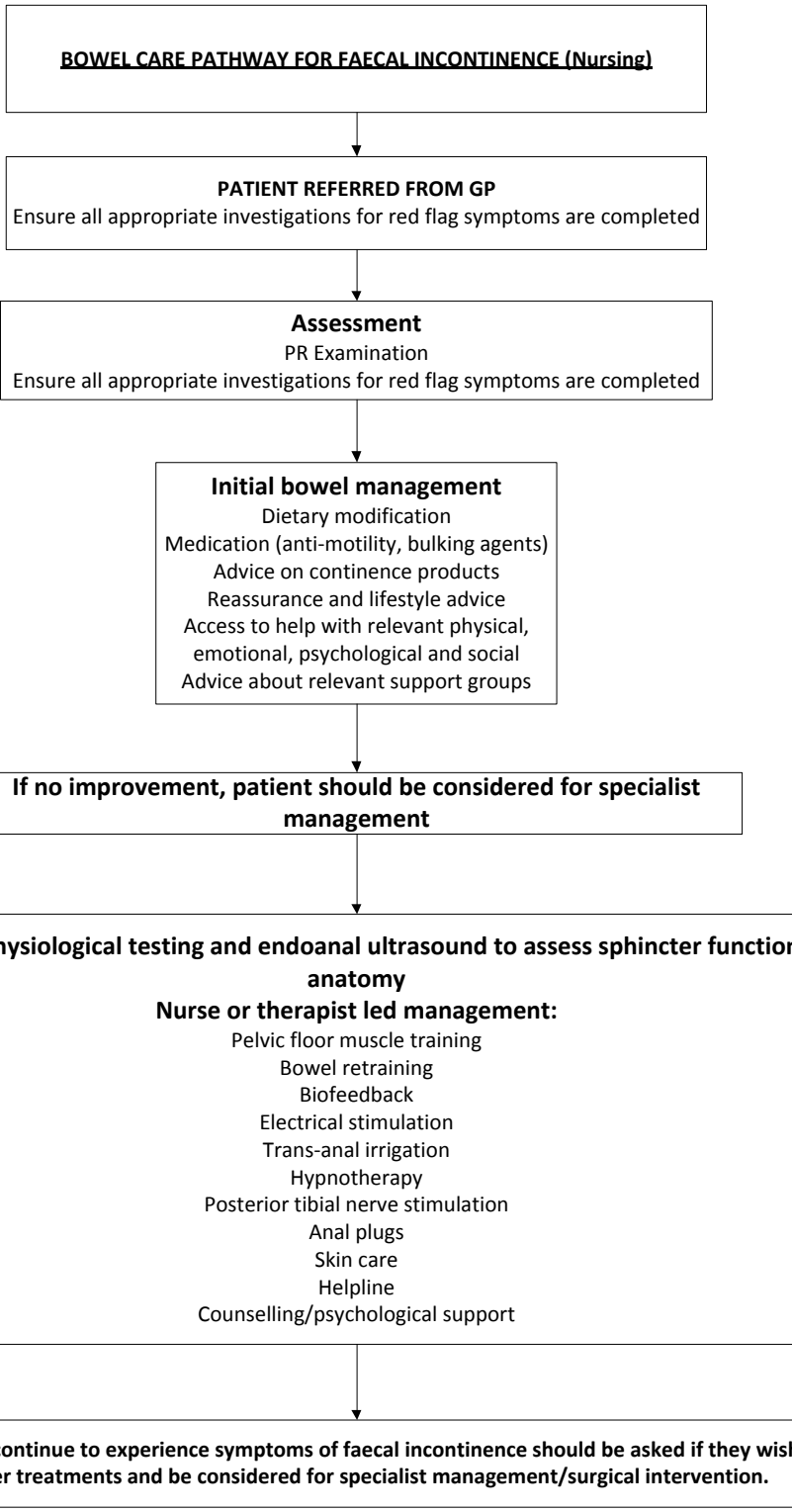
ANTEGRADE CONTINENCE ENEMA

This should be used rarely in adults as results are variable.

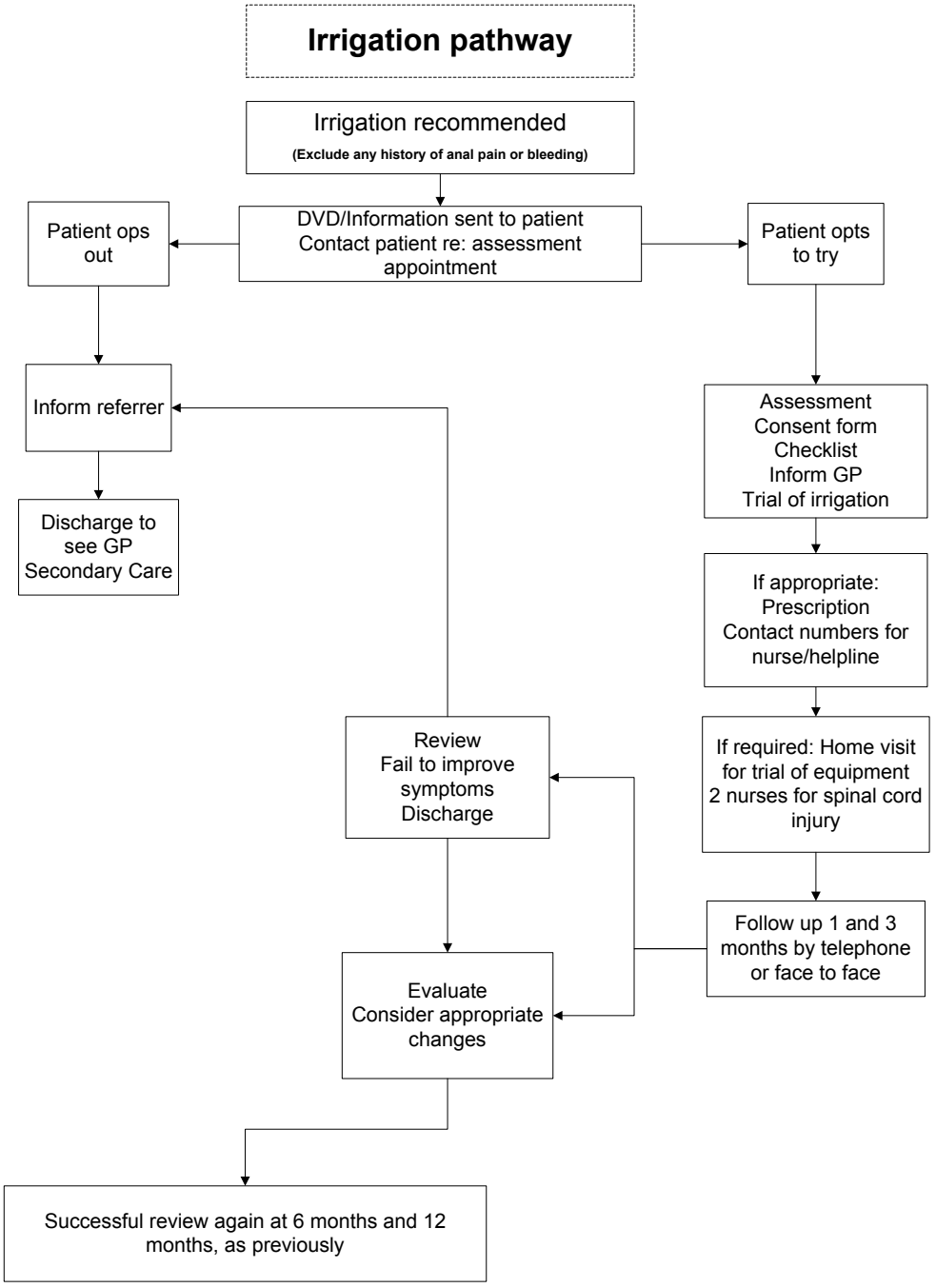
INJECTABLE BULKING AGENTS, SECCA, SACRAL NERVE STIMULATION , ARTIFICIAL BOWEL SPHINCTER IMPLANTATION & ANAL SPHINCTER REPAIRS are commissioned on a national basis as a specialised service by NHS England and do not need to be considered in this document.

Pathway for faecal incontinence




BOWEL CARE PATHWAY FOR FAECAL INCONTINENCE (Nursing)
PATIENT REFERRED FROM GP
Ensure all appropriate investigations for red flag symptoms are completed
Assessment
PR Examination
Ensure all appropriate investigations for red flag symptoms are completed
Initial bowel management
Dietary modification
Medication (anti-motility, bulking agents)
Advice on continence products
Reassurance and lifestyle advice
Access to help with relevant physical, emotional, psychological and social
Advice about relevant support groups
If no improvement, patient should be considered for specialist management
Anorectal physiological testing and endoanal ultrasound to assess sphincter function and anatomy
Nurse or therapist led management:
Pelvic floor muscle training
Bowel retraining
Biofeedback
Electrical stimulation
Trans-anal irrigation
Hypnotherapy
Posterior tibial nerve stimulation
Anal plugs
Skin care
Helpline
Counselling/psychological support
Individuals who continue to experience symptoms of faecal incontinence should be asked if they wish to have further treatments and be considered for specialist management/surgical intervention.

Based on Kent Community Health NHS Trust



2. Procedures explorer for faecal incontinence

Users can access further procedure information based on the data available in the quality dashboard to see how individual providers are performing against the indicators. This will enable CCGs to start a conversation with providers who appear to be 'outliers' from the indicators of quality that have been selected.

The Procedures Explorer Tool is available via the Royal College of Surgeons website.

3. Quality dashboard for faecal incontinence

The quality dashboard provides an overview of activity commissioned by CCGs from the relevant pathways, and indicators of the quality of care provided by surgical units.

The quality dashboard is available via the Royal College of Surgeons website.

4. Levers for implementation

4.1 Audit and peer review measures

The following measures and standards are those expected at primary and secondary care. Evidence should be able to be made available to commissioners if requested.

	Measure	Standard
Primary Care	Referral	Do not refer patients with red flag bowel symptoms or significant ano-rectal pathology, recent obstetric history of third or fourth degree tear or rectal prolapse to primary care continence services. They should go straight to secondary care.
	Patient Information	Patients should be directed to appropriate information
	Referral	Assessment and treatment by a nurse-led specialised bowel management service unless patient has red flag bowel symptoms or significant ano-rectal pathology, recent obstetric history of third and fourth degree tears or rectal prolapse
	Identification	Proportion of adults in groups at high risk of faecal incontinence

		who have been asked whether they have bowel control problems
Secondary Care	Staffing	Centres providing service should show evidence of an appropriately staffed multi-disciplinary team as described below: • 2 Colorectal Surgeons with a specialist interest in Faecal Incontinence • Specialist nurse or physiotherapist entirely dedicated to functional bowel problems and with a specialist interest in Faecal Incontinence, Ano-rectal physiological testing and endoscopic anal ultrasound • Radiologist with an interest in pelvic floor imaging • Urogynaecology support • Gastroenterology support • Psychological support All involved should take part in 50+ cases a year (NHS England Service Specifications for complex surgery interventions for faecal incontinence)
	Patient satisfaction and outcomes	Nurse-led service can demonstrate collection of information on patient satisfaction and outcomes
	Audit	Providers collect data on rates of SNS procedures against number of secondary and tertiary patients referred
	Intervention	Patients who are considered for colostomy should have exhausted all other management options and understand the long term consequences and complications associated with stoma formation.
	Training	Providers should raise awareness among healthcare professionals carrying out the assessments of the many forms and causes of faecal incontinence

4.2 Quality Specification/CQUIN (Commissioning for Quality and Innovation)

Measure	Description	Data specification (if required)
Referral	Patients referred to nurse-led specialised bowel management in community, to be seen within 6 weeks or hospital service within 18 weeks	

5. Directory

5.1 Patient Information for faecal incontinence

Name	Publisher	Link
Faecal Incontinence	Patient.co.uk	http://www.patient.co.uk/doctor/Faecal-Incontinence.htm
Bowel Incontinence	NHS Choices	http://www.nhs.uk/conditions/incontinence-bowel/pages/introduction.aspx
Bowel and Bladder Foundation	Bowel and Bladder Foundation	http://www.bladderandbowelfoundation.org/bowel/bowel.asp
Keeping control: What you should expect from your NHS bladder and bowel service	Royal College of Physicians	http://www.rcplondon.ac.uk/resources/keeping-control
Promocon	Disabled Living	http://www.disabledliving.co.uk/PromoCon/About

5.2 Clinician information for faecal incontinence

Name	Publisher	Link
CG49 Faecal Incontinence: the management of faecal incontinence in adults	NICE	http://publications.nice.org.uk/faecal-incontinence-cg49
NICE Quality Standard 54: Faecal Incontinence	NICE	http://publications.nice.org.uk/faecal-incontinence-qs54
Clinical Commissioning Policy: Sacral Nerve Stimulation for Faecal Incontinence in Adults	NHS England	http://www.england.nhs.uk/wp-content/uploads/2013/04/a08-ps-b.pdf
Service Specifications: Complex surgery intervention for faecal incontinence	NHS England	http://www.england.nhs.uk/wp-content/uploads/2013/06/a08-colore-faecal-incon-adult.pdf
Biofeedback and/or sphincter exercises for the treatment of faecal incontinence in adults	Cochrane Incontinence Group	http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD002111.pub3/full
Management of lower bowel dysfunction, including DRE and DRF	Royal College of Nursing	http://www.rcn.org.uk/__data/assets/pdf_file/0007/157363/003226.pdf

Cochrane review	Cochrane Library	http://www.thecochranelibrary.com/details/browseReviews/578581/Faecal-incontinence.html

6. Benefits and risks of implementing this guide

Consideration	Benefit	Risk
Patient outcome	Ensure access to effective conservative, medical and surgical therapy	
Patient safety	Reduce chance of missing colorectal malignancy	
Patient experience	Improve access to patient information, support groups	
Equity of Access	Improve access to effective management and procedures in a primary and secondary setting	
Resource impact	Reduce unnecessary referral and intervention; streamline primary and secondary services	Resource required to establish primary care service or community specialist provider

7. Further information

7.1 Research recommendations

- National reporting of nurse- or therapist-led treatment success rates
- Development of a national registry for sacral nerve stimulation

7.2 Other recommendations

- Use of standardised assessment forms for primary and secondary care (see appendices)
- Dissemination of information on availability of community continence services through posters in GP surgeries
- Universal training of all medical staff concerned with bowel incontinence in the use of appropriate patient friendly terminology and maintaining patient dignity

7.3 Evidence base

1. Whitehead WE, Borrud L, Goode PS, Meikle S, Mueller ER, Tuteja AK, et al. Fecal incontinence in US adults: epidemiology and risk factors. Gastroenterology 2009;137:512-7.
2. Perry S, Shaw C, McGrother C, Flynn RJ, Assassa RP, Dallosso H, et al. The prevalence of faecal incontinence in adults aged 40 years or more living in the community. Gut 2002;50:480-4.
3. Norton C, Thomas L, Hill J. Management of faecal incontinence in adults: summary of NICE guidance. British Medical Journal 2007;334:1370-1.
4. National Institute of Clinical Excellence. Management of faecal incontinence in adults: CG 49. London: NICE; 2007.
5. Norton C, Cody JD, Hosker G. Biofeedback and/or sphincter exercises for the treatment of faecal incontinence in adults. Cochrane Database of Systematic Reviews 2006;Issue 3(Art. No.: CD002111. DOI: 10.1002/14651858.CD002111.pub2.).
6. National Institute of Clinical Excellence. Irritable bowel syndrome: NICE guidance; CG 61. London: NICE; 2008.
7. Bremner H, Nurse-led hypnotherapy: an innovative approach to Irritable Bowel Syndrome. Complement Ther Clin Pract. 2013 Aug; 19(3):147-52. doi: 10.1016/j.ctcp.2013.01.001. Epub 2013 Mar 23.
8. National Institute of Clinical Excellence. Faecal incontinence: NICE Quality Standard 54. London: NICE; 2014.

7.4 Guide development group for faecal incontinence

A commissioning guide development group was established to review and advise on the content of the commissioning guide. This group met three times, with additional interaction taking place via email and teleconference.

Name	Job Title/Role	Affiliation
Miss Carolynne Vaizey	Chair, Consultant Colorectal Surgeon	ACPGBI
Miss Karen Nugent	Consultant Colorectal Surgeon	ACPGBI
Miss Brigitte Collins	Lead Nurse Biofeedback, Physiology Unit	St Mark's Hospital
Mr Anthony Brooks	Bladder and Bowel Specialist Nurse	Royal College of Nursing
Ms Lynne Hall	Clinical Advisor and Patient representative	
Mr John McWilliam	Patient representative	
Dr James Dalrymple	Partner, Drayton and St Faiths Medical Practice	*Primary Care Society for Gastroenterology*
Dr Anton Emmanuel	Sr Lecturer & Consultant Gastroenterologist	British Society of *Gastroenterology*
Ms Jo Church	Patient representative	ACPGBI

7.5 Funding statement

The development of this commissioning guidance has been funded by the following sources:

- Department of Health Right Care funded the costs of the guide development group, literature searches and contributed towards administrative costs.
- The Royal College of Surgeons of England and the Association of Coloproctology of Great Britain and Ireland (ACPGBI) provided staff to support the guideline development.

7.6 Conflict of Interest Statement

Individuals involved in the development and formal peer review of commissioning guides are asked to complete a conflict of interest declaration. It is noted that declaring a conflict of interest does not imply that the individual has been influenced by his or her secondary interest. It is intended to make interests (financial or otherwise) more transparent and to allow others to have knowledge of the interest.

- No interests were declared by the group.

APPENDIX 1

ASSESSMENT SHEET FOR CONTINENCE ADVISORS

Advisor name	
Date of first appointment	
Patient's name	
Date of birth	
Hospital number	
Address	
Telephone home/work	
Referred by	
GP	
Marital status	
Occupation	
Ethnic group	
Next of Kin	

Main complaint:

Reasons for seeking help now / goals for treatment:

Duration of symptoms	
Usual bowel pattern	

Recent change in bowel habits	
Previous bowel pattern if altered:	
Usual stool consistency: FROM Bristol Stool Scale:	
Faecal Incontinence relating to certain times and instances and how often?	Yes No If yes when and how often?
Urgency?	Yes No
Urge incontinence:	Yes No If yes when?
Post defaecation soiling:	Yes No How long for?
Passive soiling: Are you aware of the need to defacate?	Yes No When? Yes No
Control of flatus:	Yes No
Straining:	Yes No
Incomplete evacuation:	Yes No
Nocturnal bowel problems?	Yes No
Rectal bleeding?	Yes No If yes, describe:
Pads?	No Tissue Pant line Pad No. per day:
Bowel medication?	Yes No If yes type and how much?
What bowel medication has already been tried / failed?	
Other current medication: Consider alternatives to drugs that may contribute to faecal incontinence, antidiarrhoeal medication e.g. loperamide should be offered for associated loose stools, exclude over use	

of laxatives.	
Has your bowel habits changed since taking new medication?	Yes No
How they manage problem, how have they managed the problem (aside from products) eg not eating when going out?	
Past medical and surgical history (include psychological)	
Obstetric history: para: Type of delivery: Gynecological history – to include history of prolapse, obsectric history, gynecological history Leakage during intercourse	
Dietary and fluid intake (inclusive of caffeine) + alcohol: taking into account existing therapeutic diets, overall nutrient intake is balanced; consider a fluid/food diary to help to establish a baseline.	
Breakfast	
Lunch	
Dinner	
Weight/Height/BMI	
Smoker?	Yes No How many?
Drink alcohol	Yes No How many units?
Intake of caffeinated drinks and artificial sweeteners	Yes No How much?
Food allergies?	Yes No
Swallowing difficulties	Yes No

Weight loss or gain	Yes No If yes specify:
Digital rectal examination:	
Is the rectum loaded? Examination of the perineum to identify prolapse and excoriation, assessment of pelvic floor contraction: for the purpose of pelvic floor exercises, inclusive of evacuation and positioning.	
Plan	
1. Problem and agreed action	
2. Problem and agreed action	
3. Problem and agreed action	

APPENDIX 2

RANGE OF CONTINENCE PRODUCTS

- Pads.
- Anal Plugs.
- Wind protection pants.
- Peristeen anal irrigation.
- Qufora range of anal irrigation.
- Hollister faecal collectors.