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| **NHS Halton Clinical Commissioning Group**  **NHS Liverpool Clinical Commissioning Group**  **NHS St Helens Clinical Commissioning Group**  **NHS South Sefton Clinical Commissioning Group**  **NHS Southport and Formby Clinical Commissioning Group**  **NHS Warrington Clinical Commissioning Group** |
| **Policy for Transanal Irrigation** |
| Transanal irrigation systems are a highly specialist management option and should not be initiated by GPs in primary care, without specialist management. Comprehensive training for the individual plus on-going structured support is essential for safe and efficient long-term use of rectal irrigation1.  Rectal irrigation should only be used after medication has been tried (oral drugs, suppositories and enemas), changes to the diet have been made and various physiotherapy and retraining sessions have taken place. Patients have to be motivated and determined to succeed with rectal irrigation.  The evidence is weak2. The best evidence comes from a trial of 87 patients with neurogenic bowel dysfunction as a result of spinal cord injury3 but even this is limited as the outcome measures are reported by the patients. The NICE costing model is based on adults with neurogenic bowel dysfunction from the trial above and NICE admits there is considerable uncertainty in the costing. The estimated savings are £2,867 per patient over 37 years, based on it being used every other day. The savings are based on fewer hospital visits, fewer healthcare professional visits, less carer time, reduced faecal incontinence leading to fewer incontinence pads and fewer urinary tract infections. |

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| **Proposed criteria for the revised, future policy** | |
| **Intervention** | **Policy for Transanal Irrigation** |
| **Policy Statement** | **Restricted** |
| **Minimum eligibility criteria** | **Transanal irrigation is commissioned for adults and children with neurogenic bowel dysfunction, post anterior resection syndrome, congenital bowel malformations, slow transit bowel, obstructive defaecation and a limited number of patients with faecal incontinence. All patients should meet the eligibility criteria below.**  **ALL the following criteria must be met and apply to all patients whether referred to the specialist service by the GP or by another secondary care specialty:**   * Only commissioned for adults and children who have already undergone an adequate trial of all other less invasive management options such as diet, lifestyle, defecation dynamics, pelvic floor re-education, bowel retraining, cognitive behavioural therapy and drug therapy have been maximised but proved unsuccessful.   • All appropriate laxatives should have been tried at adequate doses and for several months at a time. See [Pan Mersey Constipation Guidelines](https://www.panmerseyapc.nhs.uk/media/1586/constipation_201801_g44_v0101.pdf) .   * All appropriate investigations should have been carried out, includingsigmoidoscopy, colonoscopy, defecating proctogram, biofeedback to strengthen the sphincter or transit studies.   • Prescribing should be initiated by a consultant-led multidisciplinary specialist service and the most cost-effective system should be used.   * The patient should be established on alternate day use by the specialist service and the irrigation system should be stopped if the patient does not use it regularly or does not want to continue with it. * There should be a demonstrable improvement in validated measures of bowel function such as the Cleveland Clinic constipation scoring system, St Mark’s faecal incontinence score or neurogenic bowel dysfunction score * It may take 4-12 weeks to establish a reliable and effective routine. If success has not been achieved by 8-12 weeks, a re-evaluation needs to be undertaken. The specialist service should retain prescribing until the training and support criteria below have been met.   • The patient, carers and NHS staff supporting the patient should receive specialist training in the use of the irrigation system.   * Ongoing structured patient support including written information, risk-awareness and action to take and contact telephone numbers must be established before the specialist requests a transfer of prescribing to primary care. * The patient’s Primary Care Clinician must be supplied with sufficient written supporting material to monitor compliance and effectiveness and to be able to provide ongoing prescribing and supervision, plus a contact telephone number. GPs do not have to take over prescribing if they do not feel confident and competent to do so.   • The specialist service should be available for advice and support for both patients and Primary Care Clinicians.  A balloon pump should be used if possible. Electric pumps should only be used for patients that meet all the other criteria but have very poor dexterity eg as a result of spinal injury, MS or CVA and are unable to use a balloon pump. |
| **Evidence for inclusion and threshold** | * PrescQIPP Bulletin 171 February 2017. Rectal Irrigation (DROP-List) * NICE Medical Technology Guidance February 2018. Peristeen transanal irrigation system for managing bowel dysfunction. * Christenson P et al. A randomized, controlled trial of transanal irrigation versus conservative bowel management in spinal cord-injured patients. Gastroenterology 2006;131:738-747 |