NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Constipation in children and young people

Output: Prioritised quality improvement areas for development.

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Contents

1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for constipation in children and young people. It provides the Committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the Committee in considering potential statements and measures.

1.2 Development source

The key development source(s) referenced in this briefing paper is:

Constipation in children and young people: Diagnosis and management of idiopathic childhood constipation in primary and secondary care. NICE clinical guideline 99 (2010).

2 Overview

2.1 Focus of quality standard

This quality standard will cover the diagnosis and management of idiopathic[1] constipation in children and young people (from birth up to 18 years).

2.2 Definition

Constipation is the inability to pass stools regularly, or for a person being unable to completely empty their bowels. Constipation can also cause a person's stools to be hard, lumpy, large or small. Constipation is common in childhood. The exact cause of constipation is not fully understood but factors that may contribute include pain, fever, dehydration, dietary and fluid intake, psychological issues, toilet training, medicines and familial history of constipation.

Constipation is referred to as 'idiopathic' if it cannot be explained by anatomical or physiological abnormalities.

[1] Idiopathic refers to constipation that cannot (currently) be explained by any anatomical, physiological, radiological or histological abnormalities.

2.3 Incidence and prevalence

Constipation is common in childhood. It is prevalent in around 5–30% of children, depending on the criteria used for diagnosis and has peak prevalence in toddlers. It is estimated that 1 in 100 children and young people aged between 11 and 18 years have idiopathic constipation. Some children and young people with physical disabilities, such as cerebral palsy, are more prone to idiopathic constipation as a result of impaired mobility. Children and young people with Down's syndrome or autism are also more prone to the condition. A higher prevalence also occurs in children and young people in local authority care.

Symptoms become chronic in more than one third of patients and constipation is a common reason for referral to secondary care. Morbidity may be under-reported because people may not seek advice because they are embarrassed.

Continence problems can have a significant emotional impact in children and young people and managing the condition can be stressful for parents and carers.

Analysis of inpatient data from hospital episode statistics (HES) in 2008/09 suggests that there were 12,500 admissions for constipation amongst children and young people, of which 80% were emergency admissions.

2.4 Management

Many people don't recognise the signs and symptoms of constipation and few relate the presence of soiling to constipation. The signs and symptoms of childhood idiopathic constipation include: infrequent bowel activity, foul smelling wind and stools, excessive flatulence, irregular stool texture, passing occasional enormous stools or frequent small pellets, withholding or straining to stop passage of stools, soiling or overflow, abdominal pain, distension or discomfort, poor appetite, lack of energy, an unhappy, angry or irritable mood and general malaise.

Painful defecation is an important factor in constipation but it is not always recognised; withholding behaviours to prevent passage of painful stools are often confused with straining to pass stools. Families may delay seeking help for fear of a negative response from healthcare professionals.

Soiling is debilitating but rarely life threatening so it might be expected to have little impact on healthcare provision. But many children and young people experience social, psychological and educational consequences that require prolonged support.

Without early diagnosis and treatment, an acute episode of constipation can lead to anal fissure and become chronic. By the time the child or young person is seen they may be in a vicious cycle. Children and young people and their families are often given conflicting advice and practice is inconsistent, making treatment potentially less effective and frustrating for all concerned.

The diagnosis and management of idiopathic constipation may be carried out by a number of different healthcare professionals, such as GPs, school nurses, health visitors, practice nurses, continence advisors, paediatricians or a specialist continence service.

See appendices 1–4 for the associated care pathway and algorithms from NICE clinical guideline 99.

See also the NICE Paediatric continence service commissioning guide (2010).

2.5 National Outcome Frameworks

Tables 1–2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 NHS Outcomes Framework 2013/14

Domain	Overarching indicators and improvement areas
4 Ensuring that people have a positive experience of care	***Improvement areas*** ***Improving people's experience of outpatient care*** 4.1 Patient experience of outpatient services ***Improving children and young people's experience of healthcare*** 4.8 An indicator is under development

Table 2 Public health outcomes framework for England, 2013–2016

Domain	Objectives and indicators
1 Improving the wider determinants of health	***Objective*** Improvements against wider factors that affect health and wellbeing and health inequalities ***Indicators*** 1.3 Pupil absence
2 Health improvements	**Objective** People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities ***Indicators*** 2.5 Child development at 2-2.5 years (Placeholder)

3 Summary of suggestions

3.1 Responses

In total 6 stakeholders responded to the 2-week engagement exercise 05/08/13 – 19/08/13, this includes 3 stakeholders who responded but did not suggest any areas for quality improvement.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 3 for further consideration by the Committee.

Full details on the suggestions provided are given in appendix 3 for information.

Table 3 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
History-taking and physical examination • Identifying constipation • Training for clinical staff	RDSHNHS, RCN, SCM
Laxative treatment • First line use of laxatives • Appropriate prescribing	RCN, SCM
Diet and lifestyle • Health lifestyle advice • Availability of education resources	BBF, RDSHNHS
Psychological support	BBF
Information and support	RDSHNHS, RCN, SCM
Access to specialist services • Referral to nurse led specialist services • Importance of community paediatric services • Integrated continence services	BBF, RCN, SCM
BBF, Bladder and Bowel Foundation RDSHNHS, Rotherham Doncaster and South Humber NHS Foundation Trust RCN, Royal College of Nurses SCM, Specialist Committee Member	

4 Suggested improvement areas

4.1 History-taking and physical examination

4.1.1 Summary of suggestions

Identifying constipation

Stakeholders highlighted the importance of early identification of constipation to enable effective treatment and to reduce the incidence of faecal impaction. They also recognised that early identification would result in reduced treatment costs in the long term. Stakeholders suggested it was important that the history taking was recorded to ensure there is a continuity of decision making between different healthcare professionals.

Training for clinical staff

Stakeholders reported that appropriate training of clinical staff to recognise the signs and symptoms of constipation would enable them to make an accurate diagnosis and provide suitable support to children, young people and their families.

4.1.2 Selected recommendations from development source

Table 4 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 4 to help inform the Committee's discussion.

Table 4 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Identifying constipation	**History taking and physical examination** NICE CG99 Recommendation 1.1.1 (KPI) NICE CG99 Recommendation 1.1.2 (KPI) NICE CG99 Recommendation 1.1.3 (KPI)
Training for clinical staff	**History taking and physical examination** NICE CG99 Recommendation 1.1.7 (KPI)

History-taking and physical examination

NICE CG99 – Recommendation 1.1.1 (key priority for implementation)

Establish during history-taking whether the child or young person has constipation. Two or more findings from table 1(appendix 1) indicate constipation.

NICE CG99 – Recommendation 1.1.2 (key priority for implementation)

If the child or young person has constipation take a history using table 2 (appendix 1) to establish a positive diagnosis of idiopathic constipation by excluding underlying causes. If a child or young person has any 'red flag' symptoms, do not treat them for constipation. Instead, refer them urgently to a healthcare professional with experience in the specific aspect of child health that is causing concern.

NICE CG99 – Recommendation 1.1.3 (key priority for implementation)

Do a physical examination. Use table 3 (appendix 1) to establish a positive diagnosis of idiopathic constipation by excluding underlying causes. If a child or young person has any 'red flag' symptoms do not treat them for constipation. Instead, refer them urgently to a healthcare professional with experience in the specific aspect of child health that is causing concern.

NICE CG99 – Recommendation 1.1.7 (key priority for implementation)

Inform the child or young person and his or her parents or carers of a positive diagnosis of idiopathic constipation and also that underlying causes have been excluded by the history and/or physical examination. Reassure them that there is a suitable treatment for idiopathic constipation but that it may take several months for the condition to be resolved.

4.1.3 Current UK practice

Identifying constipation

The All Party Parliamentary Group (APPG) for Continence Care, Continence Care Services in England 2013 survey report[2] found children were particularly poorly provided for in terms of continence care services.

The 2010 Royal College of Physicians (RCP) national audit of continence care report commissioned by HQIP[3] found that healthcare professionals were not consistently providing assessment, diagnosis and follow-through according to standard practice. The survey found there were difficulties in case finding for the continence survey as they were not often coded correctly. They recommended that all healthcare professionals should ensure that bladder and bowel problems are accurately coded in clinical record systems to allow identification of the true extent of the problem.

Training for clinical staff

[2] All Party Parliamentary Group for Continence Care, Continence care services in England 2013.
[3] Royal College of Physicians (2010). National audit of Continence Care, Combined Organisational and Clinical Report.

The APPG Continence Care Services in England 2013 survey report[4] found that there had been a reduction in continence team staff numbers with many senior posts being diluted. Education of the workforce in continence care is of a low priority with poor attendance reported at arranged sessions and most education for clinicians is accessed via professional associations. They found with primary care staff received the most training and pharmacists the least. Most of the services (54 or 68%) reported that their own education needs were being met.

The 2010 RCP national audit of continence care report[5] found provision of training for health care workers to manage bladder and bowel problems is patchy across the nation, and overall occurs in less than 50% of acute hospitals.

[4] All Party Parliamentary Group for Continence Care, Continence care services in England 2013.
[5] Royal College of Physicians (2010). National audit of Continence Care, Combined Organisational and Clinical Report.

4.2 Laxative treatment

4.2.1 Summary of suggestions

First line use of laxatives

Stakeholders highlighted the importance of laxatives being used as first line treatment for disimpaction and maintenance treatment for idiopathic constipation.

Appropriate prescribing

Stakeholders recognised the importance of laxative treatment being prescribed appropriately to ensure effective and efficient treatment outcomes.

4.2.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 5 to help inform the Committee's discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
First line use of laxatives	**Clinical management** **Disimpaction** NICE CG99 Recommendation 1.4.3 (KPI) **Maintenance therapy** NICE CG99 Recommendation 1.4.11
Appropriate prescribing	**Clinical management** **Disimpaction** NICE CG99 Recommendation 1.4.3 (KPI) **Maintenance therapy** NICE CG99 Recommendation 1.4.11

Disimpaction

NICE CG99 Recommendation 1.4.3 (key priority for implementation)

Offer the following oral medication regimen for disimpaction if indicated:

- Polyethylene glycol 3350 + electrolytes, using an escalating dose regimen (see table 4 appendix 1), as the first-line treatment.
- Polyethylene glycol 3350 + electrolytes may be mixed with a cold drink.

- Add a stimulant laxative (see table 4 appendix 1) if polyethylene glycol 3350 + electrolytes does not lead to disimpaction after 2 weeks.

- Substitute a stimulant laxative singly or in combination with an osmotic laxative such as lactulose (see table 4 appendix 1) if polyethylene glycol 3350 + electrolytes is not tolerated.

- Inform families that disimpaction treatment can initially increase symptoms of soiling and abdominal pain.

Maintenance therapy

NICE CG99 Recommendation 1.4.11

Offer the following regimen for ongoing treatment or maintenance therapy:

- Polyethylene glycol 3350 + electrolytes as the first-line treatment.

- Adjust the dose of polyethylene glycol 3350 + electrolytes according to symptoms and response. As a guide for children and young people who have had disimpaction the starting maintenance dose might be half the disimpaction dose (see table 4 appendix 1).

- Add a stimulant laxative (see table 4 appendix 1) if polyethylene glycol 3350 + electrolytes does not work.

- Substitute a stimulant laxative if polyethylene glycol 3350 + electrolytes is not tolerated by the child or young person. Add another laxative such as lactulose or docusate (see table 4 appendix 1) if stools are hard.

- Continue medication at maintenance dose for several weeks after regular bowel habit is established – this may take several months. Children who are toilet training should remain on laxatives until toilet training is well established. Do not stop medication abruptly: gradually reduce the dose over a period of months in response to stool consistency and frequency. Some children may require laxative therapy for several years. A minority may require ongoing laxative therapy.

4.2.3 Current UK practice

First line use of laxatives

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Appropriate prescribing

It is difficult to establish current activity levels in relation to prescription of laxative.

A survey of 25 paediatric consultants in the North West of England undertaken in 2010[6] found that 52% of had increased their use of Movicol and reduced their use of other medications following the publication of the NICE clinical guideline. In addition 88% of responders reported that they used the NICE guidelines to guide their treatment decisions, whereas 12 months previously just 48% of respondents reported using any form of guideline to direct treatment decisions. They also reported that responders perceived treatment decisions occurring within the region among paediatricians as more consistent than 12 months previous (40% vs 27%).

[6] Gordon M et al (2011).Changes in the management of functional constipation by paediatricians after the introduction of NICE guidance. Archive of Disease in Childhood 96 A21-A22

4.3 Diet and lifestyle

4.3.1 Summary of suggestions

Healthy lifestyle advice

Stakeholders reported that nutritional education and lifestyle changes should be the first line treatment. Stakeholders highlighted that general advice on a healthy lifestyle can prevent constipation and minimise the need for drug treatment should constipation occur.

Availability of education resources

Stakeholders highlighted that education and resources about diet and bowel health should be available, these should be provided with the support of continence nurses and school nurses.

4.3.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 6 to help inform the Committee's discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Healthy lifestyle advice	**Diet and lifestyle** NICE CG99 Recommendation 1.5.1 (KPI) (**this recommendation says do not use dietary interventions alone) NICE CG99 Recommendation 1.5.3
Availability of education resources	**Diet and lifestyle** NICE CG99 Recommendation 1.5.4

Diet and lifestyle

NICE CG99 Recommendation 1.5.1 (key priority for implementation)

Do not use dietary interventions alone as first-line treatment for idiopathic constipation.

NICE CG99 Recommendation 1.5.3

Advise parents and children and young people (if appropriate) that a balanced diet should include:

- Adequate fluid intake (see table 5 appendix 1).

- Adequate fibre. Recommend including foods with a high fibre content (such as fruit, vegetables, high-fibre bread, baked beans and wholegrain breakfast cereals) (not applicable to exclusively breastfed infants). Do not recommend unprocessed bran, which can cause bloating and flatulence and reduce the absorption of micronutrients.

NICE CG99 Recommendation 1.5.4

- Provide children and young people with idiopathic constipation and their families with written information about diet and fluid intake.

4.3.3 Current UK practice

Healthy lifestyle advice

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Availability of education resources

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

4.4 Psychological support

4.4.1 Summary of suggestions

Stakeholders highlighted that there was limited access to psychological support for the management of constipation.

4.4.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 7 to help inform the Committee's discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Psychological support	**Psychological interventions** NICE CG99 Recommendation 1.6.2

Psychological interventions

NICE CG99 Recommendation 1.6.2

Do not routinely refer children and young people with idiopathic constipation to a psychologist or child and adolescent mental health services unless the child or young person has been identified as likely to benefit from receiving a psychological intervention.

4.4.3 Current UK practice

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

4.5 Information and support

4.5.1 Summary of suggestions

Stakeholders reported that it is important that information and advice on treatment with laxatives is given to parents to ensure adherence to medication and to help to prevent relapse from occurring.

Stakeholders highlighted that information should be provided on recognising changes in bowel movement so that early action can be taken to prevent impaction from occurring and to reduce emergency hospital admissions.

Stakeholders highlighted that any resources and tools provided to families should be consistent and standardised.

Stakeholders recognised that access to appropriate support and follow up can lead to improved outcomes and can reduce emergency hospital admissions.

4.5.2 Selected recommendations from development source

Table 8 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 8 to help inform the Committee's discussion.

Table 8 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Information and support	**Information and support** NICE CG99 Recommendation 1.8.1 NICE CG99 Recommendation 1.8.2 (KPI)

Information and support

NICE CG99 Recommendation 1.8.1

Provide tailored follow-up to children and young people and their parents or carers according to the child or young person's response to treatment, measured by frequency, amount and consistency of stools. Use the Bristol Stool Form Scale to assess this (see appendix 1 section D). This could include:

- telephoning or face-to-face talks
- giving detailed evidence-based information about their condition and its management, using, for example, NICE's Information for the public for this guideline

- giving verbal information supported by (but not replaced by) written or website information in several formats about how the bowels work, symptoms that might indicate a serious underlying problem, how to take their medication, what to expect when taking laxatives, how to poo, origins of constipation, criteria to recognise risk situations for relapse (such as worsening of any symptoms, soiling etc.) and the importance of continuing treatment until advised otherwise by the healthcare professional.

NICE CG99 Recommendation 1.8.2 (key priority for implementation)

Offer children and young people with idiopathic constipation and their families a point of contact with specialist healthcare professionals, including school nurses, who can give ongoing support.

4.5.3 Current UK practice

The 2010 RCP audit of continence care report[7] found healthcare professionals were not consistently communicating information about causes and treatments of patients' incontinence.

No additional published studies on current practice were highlighted for this suggested area for quality improvement.

The NICE Guideline Development Group noted that families often feel very isolated because conditions such as constipation and any associated soiling are not something openly discussed by parents with other families. Parents often feel that they are the 'only one' with a child with such a problem.

[7] Royal College of Physicians (2010). National audit of Continence Care, Combined Organisational and Clinical Report.

4.6 Access to specialist services

4.6.1 Summary of suggestions

Referral to nurse led specialist services

Stakeholders highlighted the importance of timely referral from primary care to a nurse led specialist service for continence with multidisciplinary input. They recognise that nurse led clinics can provide appropriate, timely and extensive support to families to improve long term outcomes. They can also act as a resource for education settings.

***The NICE Guideline Development Group recognised need for further research to formally examine the cost effectiveness of specialist nurse-led services provided as first referral point if primary treatment regimens have not worked.*

Importance of community paediatric services

Stakeholders reported that community paediatric services can promote early intervention and reduce the number of referrals to secondary care; they can also reduce the risk of future relapse.

Integrated continence services

Stakeholders highlighted that integrate continence services led to an efficient use of resources and expertise.

4.6.2 Selected recommendations from development source

Table 9 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 9 to help inform the Committee's discussion.

Table 9 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Referral to nurse led specialist services	**Information and support** NICE CG99 Recommendation 1.8.2 (KPI) NICE CG99 Recommendation 1.8.4
Importance of community paediatric services	Not directly covered in CG99 and no recommendations are presented.

Integrated continence services	Not directly covered in CG99 and no recommendations are presented.

Information and support

NICE CG99 Recommendation 1.8.2 (key priority for implementation)

Offer children and young people with idiopathic constipation and their families a point of contact with specialist healthcare professionals, including school nurses, who can give ongoing support.

NICE CG99 Recommendation 1.8.4

Refer children and young people with idiopathic constipation who do not respond to initial treatment within 3 months to a practitioner with expertise in the problem.

4.6.3 Current UK practice

Referral to nurse led specialist services

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Importance of community paediatric services

The APPG continence care commissioning guide 2010[8] supports the conclusions within the NICE paediatric continence commissioning guide. The report says a lack of specialist paediatric continence promotion services is linked to increased use of disposable containment products and inappropriate referrals to both secondary care and Child & Adolescent Mental Health Services (CAMHS).

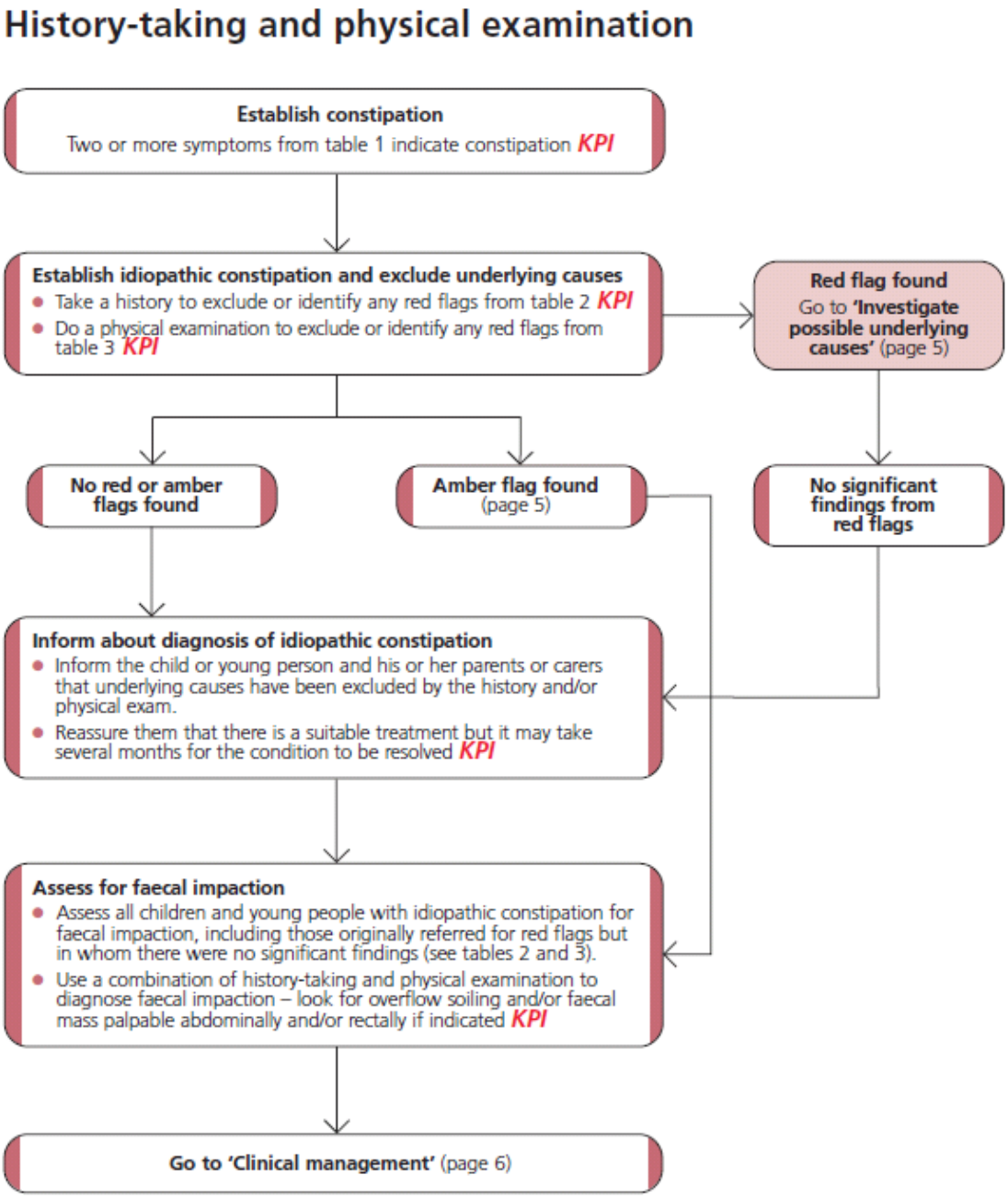
Integrated continence services

The 2010 RCP audit of continence care report[9] found the great majority of continence services are poorly integrated across acute, medical, surgical, primary, care home and community settings, resulting in disjointed care for patients and carers. It found that although 55-80% of services report themselves as integrated across healthcare settings, only 4 services across the country fulfil all of the requirements set out in Good Practice in Continence Services 2000[10].

[8] All Party Parliamentary Group for Continence Care Report (2010). Cost-effective Commissioning for Continence Care.
[9] Royal College of Physicians (2010). National audit of Continence Care, Combined Organisational and Clinical Report.
[10] Department of Health (2000). Good Practice in Continence Services.

Appendix 1: Additional information

Care pathway, tables and appendices from NICE clinical guideline 99



Investigate possible underlying causes

Red flags found

Do not treat for constipation. **Refer urgently** for tests to a healthcare professional experienced in the specific aspect of child health that is causing concern ***KPI***

Faltering growth (amber flag)

If the history-taking or physical examination shows evidence of faltering growth, treat for constipation and test for coeliac disease and hypothyroidism. See 'Coeliac disease', NICE clinical guideline 86, www.nice.org.uk/guidance/CG86

Possible maltreatment (amber flag)

If the history-taking or physical examination shows evidence of possible child maltreatment, treat for constipation and refer to 'When to suspect child maltreatment', NICE clinical guideline 89, www.nice.org.uk/guidance/CG89

Digital rectal examination

- Refer urgently, to a healthcare professional competent to perform a digital rectal examination and interpret features of anatomical abnormalities or Hirschsprung's disease, children younger than 1 year with idiopathic constipation that does not respond to optimum treatment within 4 weeks
- Do not perform digital rectal examination in children or young people older than 1 year with a 'red flag'. Refer urgently to a healthcare professional competent to perform a digital rectal examination and interpret features of anatomical abnormalities or Hirschsprung's disease (see tables 2 and 3) ***KPI***
- Digital rectal examination should be undertaken only by healthcare professionals competent to interpret features of anatomical abnormalities or Hirschsprung's disease
- Ensure:
  - privacy
  - informed consent is given by the child or young person, or the parent or legal guardian if the child or young person is not able to give it, and is documented
  - a chaperone is present
  - the child or young person's individual preferences about degree of body exposure and gender of the examiner are taken into account
  - all findings are documented

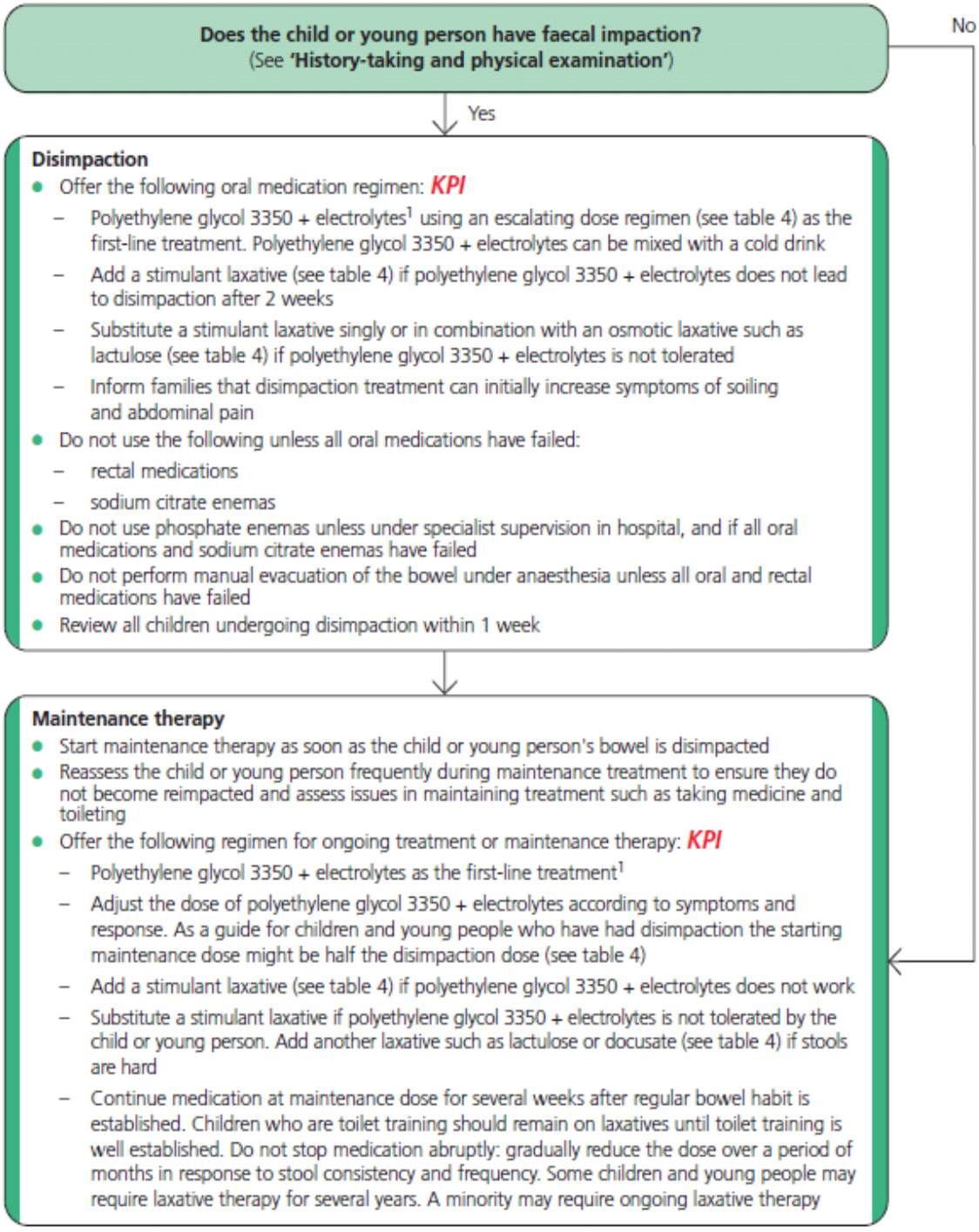
Tests that should not normally be used

- **Rectal biopsy** Do not perform rectal biopsy unless there are or have been clinical features of Hirschsprung's disease, or a family history
- **Manometry** Do not use anorectal manometry to exclude Hirschsprung's disease in children or young people with chronic constipation

Do not use the following to help diagnose idiopathic constipation:

- Abdominal ultrasound
- Gastrointestinal endoscopy
- Plain abdominal radiograph
- Transit studies

Clinical management



[1] At the time of publication (May 2010), Movicol Paediatric Plain is the only macrogol licensed for children under 12 years that includes electrolytes. It does not have UK marketing authorisation for use in faecal impaction in children under 5 years, or for chronic constipation in children under 2 years. Informed consent should be obtained and documented. Movicol Paediatric Plain is the only macrogol licensed for children under 12 years that is also unflavoured.

Diet and lifestyle

Do not use dietary interventions alone as first-line treatment *KPI*

- Treat constipation with laxatives and a combination of:
  - Negotiated and non-punitive behavioural interventions suited to the child or young person's stage of development. This could include scheduled toileting and support to establish a regular bowel habit, maintenance and discussion of a bowel diary, information on constipation, and use of encouragement and rewards systems.
  - Dietary modifications to ensure a balanced diet and sufficient fluids are consumed.
- Advise parents and children or young people (if appropriate) that a balanced diet should include: ***KPI***
  - Adequate fluid intake (see table 5).
  - Adequate fibre. Recommend including foods with a high fibre content (such as fruit, vegetables, high-fibre bread, baked beans and wholegrain breakfast cereals) (not applicable to exclusively breastfed infants). Do not recommend unprocessed bran, which can cause bloating and flatulence and reduce the absorption of micronutrients.
- Give written information about diet and fluid intake to children and young people and their families.
- Start a cows' milk exclusion diet only on the advice of the relevant specialist services.
- Advise daily physical activity that is tailored to the child or young person's stage of development and individual ability as part of ongoing maintenance.

Information and support

- Provide tailored follow-up to children and young people and their parents or carers according to the child or young person's response to treatment, measured by frequency, amount and consistency of stools (use the Bristol Stool Form Scale to assess this, see page 15). This could include:
  - telephoning or face-to-face talks
  - giving detailed information about their condition and its management, such as the 'Understanding NICE guidance' leaflet for this guideline (see back cover for details)
  - giving verbal information supported by (but not replaced by) written or website information in several formats about how the bowels work, symptoms that might indicate a serious underlying problem, how to take their medication, what to expect when taking laxatives, how to poo, origins of constipation, criteria to recognise risk situations for relapse (such as worsening of any symptoms, soiling) and the importance of continuing treatment until advised otherwise by the healthcare professional.
- Offer children and young people with idiopathic constipation and their families a point of contact with specialist healthcare professionals, including school nurses, who can give ongoing support. ***KPI***
- Liaise with school nurses to provide information and support, and to help them raise awareness of the issues surrounding constipation with pupils and school staff.
- Refer children and young people with idiopathic constipation that does not respond to initial treatment within 3 months to a practitioner with expertise in the problem.

Specialist investigations and interventions

Clinical investigations

- Test for coeliac disease and hypothyroidism in the ongoing management of intractable constipation if requested by specialist services. See also 'Coeliac disease', NICE clinical guideline 86, **www.nice.org.uk/guidance/CG86**
- Consider using the following investigations if requested by specialist services in the ongoing management of intractable constipation:
  - radiography
  - transit studies
  - abdominal ultrasound.

Psychological and behavioural interventions

- Do not use biofeedback for ongoing treatment.
- Do not routinely refer children and young people with idiopathic constipation to a psychologist or child and adolescent mental health services unless the child or young person has been identified as likely to benefit from receiving a psychological intervention.

Antegrade colonic enema procedure

- Refer children and young people with idiopathic constipation who still have unresolved symptoms on optimum management to a paediatric surgical centre to assess their suitability for an antegrade colonic enema (ACE) procedure.
- Ensure that all children and young people who are referred for an ACE procedure have access to support, information and follow-up from paediatric healthcare professionals with experience in this procedure.

Table 1 Key components of history-taking to diagnose constipation

Key components	Potential findings in a child younger than 1 year	Potential findings in a child/young person older than 1 year
Stool patterns	Fewer than three complete stools per week (type 3 or 4, see Bristol Stool Form Scale – page 15) (this does not apply to exclusively breastfed babies after 6 weeks of age) Hard large stool 'Rabbit droppings' (type 1, see Bristol Stool Form Scale – page 15)	Fewer than three complete stools per week (type 3 or 4, see Bristol Stool Form Scale – page 15) Overflow soiling (commonly very loose [no form], very smelly [smells more unpleasant than normal stools], stool passed without sensation. Can also be thick and sticky or dry and flaky.) 'Rabbit droppings' (type 1, see Bristol Stool Form Scale – page 15) Large, infrequent stools that can block the toilet
Symptoms associated with defecation	Distress on stooling Bleeding associated with hard stool Straining	Poor appetite that improves with passage of large stool Waxing and waning of abdominal pain with passage of stool Evidence of retentive posturing: typical straight legged, tiptoed, back arching posture Straining Anal pain
History	Previous episode(s) of constipation Previous or current anal fissure	Previous episode(s) of constipation Previous or current anal fissure Painful bowel movements and bleeding associated with hard stools

Table 2 Key components of history-taking to diagnose idiopathic constipation

Key components	Findings and diagnostic clues that indicate idiopathic constipation	'Red flag' findings and diagnostic clues that indicate an underlying disorder or condition: not idiopathic constipation
Timing of onset of constipation and potential precipitating factors	**In a child younger than 1 year:** ● Starts after a few weeks of life ● Obvious precipitating factors coinciding with the start of symptoms: fissure, change of diet, infections **In a child/young person older than 1 year:** ● Starts after a few weeks of life ● Obvious precipitating factors coinciding with the start of symptoms: fissure, change of diet, timing of potty/toilet training or acute events such as infections, moving house, starting nursery/school, fears and phobias, major change in family, taking medicines	Reported from birth or first few weeks of life
Passage of meconium	Normal (within 48 hours after birth, in term baby)	Failure to pass meconium/delay (more than 48 hours after birth, in term baby)
Stool patterns		'Ribbon stools' (more likely in a child younger than 1 year)
Growth and general wellbeing	**In a child younger than 1 year:** ● Generally well, weight and height within normal limits **In a child/young person older than 1 year:** ● Generally well, weight and height within normal limits, fit and active	No 'red flag', but see 'amber flag' below.
Symptoms in legs/locomotor development	No neurological problems in legs (such as falling over in a child/young person older than 1 year), normal locomotor development	Previously unknown or undiagnosed weakness in legs, locomotor delay
Abdomen		Abdominal distension with vomiting
Diet and fluid intake	**In a child younger than 1 year:** ● Changes in infant formula, weaning, insufficient fluid intake **In a child/young person older than 1 year:** ● History of poor diet and/or insufficient fluid intake	

'Amber flag': possible idiopathic constipation (see **'Investigate possible underlying causes'**, page 5)
Growth and general wellbeing:
● Faltering growth (see **'Investigate possible underlying causes'**)
Personal/familial/social factors:
● Disclosure or evidence that raises concerns over possibility of child maltreatment

Table 3 Key components of physical examination to diagnose idiopathic constipation

Key components	Findings and diagnostic clues that indicate idiopathic constipation	'Red flag' findings and diagnostic clues that indicate an underlying disorder or condition: not idiopathic constipation
Inspection of perianal area: appearance, position, patency, etc	Normal appearance of anus and surrounding area	Abnormal appearance/position/patency of anus: fistulae, bruising, multiple fissures, tight or patulous anus, anteriorly placed anus, absent anal wink
Abdominal examination	Soft abdomen. Flat or distension that can be explained because of age or excess weight	Gross abdominal distension
Spine/lumbosacral region/gluteal examination	Normal appearance of the skin and anatomical structures of lumbosacral/gluteal regions	Abnormal: asymmetry or flattening of the gluteal muscles, evidence of sacral agenesis, discoloured skin, naevi or sinus, hairy patch, lipoma, central pit (dimple that you can't see the bottom of), scoliosis
Lower limb neuromuscular examination including tone and strength	Normal gait. Normal tone and strength in lower limbs	Deformity in lower limbs such as talipes Abnormal neuromuscular signs unexplained by any existing condition, such as cerebral palsy
Lower limb neuromuscular examination: reflexes (perform only if 'red flags' in history or physical examination suggest new onset neurological impairment)	Reflexes present and of normal amplitude	Abnormal reflexes

Table 4 Laxatives: recommended doses

Laxatives	Recommended doses[a]
Macrogols Polyethylene glycol 3350 + electrolytes	**Paediatric formula:** Oral powder: macrogol 3350 (polyethylene glycol 3350)[b] 6.563 g; sodium bicarbonate 89.3 mg; sodium chloride 175.4 mg; potassium chloride 25.1 mg/sachet (unflavoured). ● ***Disimpaction*** – Child under 1 year: ½–1 sachet daily (non-BNFC recommended dose) – Child 1–5 years: 2 sachets on 1st day, then 4 sachets daily for 2 days, then 6 sachets daily for 2 days, then 8 sachets daily (non-BNFC recommended dose) – Child 5–12 years: 4 sachets on 1st day, then increased in steps of 2 sachets daily to maximum of 12 sachets daily (non-BNFC recommended schedule) ● ***Ongoing maintenance*** (chronic constipation, prevention of faecal impaction) – Child under 1 year: ½–1 sachet daily (non-BNFC recommended dose) – Child 1–6 years: 1 sachet daily; adjust dose to produce regular soft stools (maximum 4 sachets daily) (for children under 2, non-BNFC recommended dose) – Child 6–12 years: 2 sachets daily; adjust dose to produce regular soft stools (maximum 4 sachets daily)
	Adult formula: Oral powder: macrogol 3350 (polyethylene glycol 3350) 13.125 g; sodium bicarbonate 178.5 mg; sodium chloride 350.7 mg; potassium chloride 46.6 mg/sachet (unflavoured). ● ***Disimpaction*** – Child/young person 12–18 years: 4 sachets on 1st day, then increased in steps of 2 sachets daily to maximum of 8 sachets daily (non-BNFC recommended dose) ● ***Ongoing maintenance*** (chronic constipation, prevention of faecal impaction) – Child/young person 12–18 years: 1–3 sachets daily in divided doses adjusted according to response; maintenance, 1–2 sachets daily
Osmotic laxatives Lactulose	● Child 1 month to 1 year: 2.5 ml twice daily, adjusted according to response ● Child 1–5 years: 2.5–10 ml twice daily, adjusted according to response (non-BNFC recommended dose) ● Child/young person 5–18 years: 5–20 ml twice daily, adjusted according to response (non-BNFC recommended dose) *Continued*

Table 4 Laxatives: recommended doses *(continued)*

Laxatives	Recommended doses[a]
Stimulant laxatives	
Sodium picosulfate[c]	Non-BNFC recommended doses Elixir (5 mg/5 ml) ● Child 1 month to 4 years: 2.5–10 mg once a day ● Child/young person 4–18 years: 2.5–20 mg once a day Non-BNFC recommended dose Perles[d] (1 tablet = 2.5mg) ● Child/young person 4–18 years: 2.5–20 mg once a day
Bisacodyl	Non-BNFC recommended doses By mouth ● Child/young person 4–18 years: 5–20 mg once daily By rectum (suppository) ● Child/young person 2–18 years: 5–10 mg once daily
Senna[e]	Senna syrup (7.5 mg/5 ml) ● Child 1 month to 4 years: 2.5–10 ml once daily ● Child/young person 4–18 years: 2.5–20 ml once daily Senna (non-proprietary) (1 tablet = 7.5 mg) ● Child 2–4 years: ½–2 tablets once daily ● Child 4–6 years: ½–4 tablets once daily ● Child/young person 6–18 years: 1–4 tablets once daily
Docusate sodium[f]	● Child 6 months–2 years: 12.5 mg three times daily (use paediatric oral solution) ● Child 2–12 years: 12.5–25 mg three times daily (use paediatric oral solution) ● Child/young person 12–18 years: up to 500 mg daily in divided doses

[a]All drugs listed above are given by mouth unless stated otherwise. Unless stated otherwise, doses are those recommended by the British National Formulary for Children (BNFC) 2009. Informed consent should be obtained whenever medications/doses are prescribed that are different from those recommended by the BNFC.

[b] At the time of publication (May 2010) Movicol Paediatric Plain is the only macrogol licensed for children under 12 years that includes electrolytes. It does not have UK marketing authorisation for use in faecal impaction in children under 5 years, or for chronic constipation in children under 2 years. Informed consent should be obtained and documented. Movicol Paediatric Plain is the only macrogol licensed for children under 12 years that is also unflavoured.

[c] Elixir, licensed for use in children (age range not specified by manufacturer). Perles not licensed for use in children under 4 years. Informed consent should be obtained and documented.

[d] Perles produced by Dulcolax should not be confused with Dulcolax tablets which contain bisacodyl as the active ingredient.

[e] Syrup not licensed for use in children under 2 years. Informed consent should be obtained and documented.

[f] Adult oral solution and capsules not licensed for use in children under 12 years. Informed consent should be obtained and documented.

Table 5 American dietary recommendations[a]

Age	Total water intake/day (including water in food)	Water from drinks/day
Infants 0–6 months	700 ml assumed to be from breast milk	
7–12 months	800 ml from milk and complementary foods and beverages	600 ml
1–3 years	1300 ml	900 ml
4–8 years	1700 ml	1200 ml
Boys 9–13 years	2400 ml	1800 ml
Girls 9–13 years	2100 ml	1600 ml
Boys 14–18 years	3300 ml	2600 ml
Girls 14–18 years	2300 ml	1800 ml

[a] Institute of Medicine (2005) Dietary reference intakes for water, potassium, sodium chloride and sulfate. Washington DC: The National Academies Press.

The above recommendations are for adequate intakes and should not be interpreted as a specific requirement. Higher intakes of total water will be needed for those who are physically active or who are exposed to hot environments. It should be noted that obese children and young people may also need higher total intakes of water.

Bristol Stool Form Scale[b]

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces; entirely liquid

[b] First published: Lewis SJ, Heaton KW (1997) Stool form scale as a useful guide to intestinal transit time. Scandinavian Journal of Gastroenterology 32: 920–4.

Appendix 2: Key priorities for implementation (CG99)

Recommendations that are key priorities for implementation in the source guideline and that have been referred to in the main body of this report are highlighted in grey.

History-taking and physical examination

Establish during history-taking whether the child or young person has constipation. Two or more findings from table 1 indicate constipation. [recommendation 1.1.1]

If the child or young person has constipation, take a history using table 2 to establish a positive diagnosis of idiopathic constipation by excluding underlying causes. If a child or young person has any 'red flag' symptoms, do not treat them for constipation. Instead, refer them urgently to a healthcare professional with experience in the specific aspect of child health that is causing concern. [recommendation 1.1.2]

Do a physical examination. Use table 3 to establish a positive diagnosis of idiopathic constipation by excluding underlying causes. If a child or young person has any 'red flag' symptoms do not treat them for constipation. Instead, refer them urgently to a healthcare professional with experience in the specific aspect of child health that is causing concern. [recommendation 1.1.3]

Inform the child or young person and his or her parents or carers of a positive diagnosis of idiopathic constipation and also that underlying causes have been excluded by the history and/or physical examination. Reassure them that there is a suitable treatment for idiopathic constipation but that it may take several months for the condition to be resolved. [recommendation 1.1.7]

Digital rectal examination

Do not perform a digital rectal examination in children or young people older than 1 year with a 'red flag' (see tables 2 and 3) in the history-taking and/or physical examination that might indicate an underlying disorder. Instead, refer them urgently to a healthcare professional competent to perform a digital rectal examination and interpret features of anatomical abnormalities or Hirschsprung's disease. [recommendation 1.2.3]

Disimpaction

Assess all children and young people with idiopathic constipation for faecal impaction, including children and young people who were originally referred to the relevant services because of 'red flags' but in whom there were no significant findings following further investigations (see tables 2 and 3). Use a combination of history-taking and physical examination to diagnose faecal impaction – look for overflow soiling and/or faecal mass palpable abdominally and/or rectally if indicated. [recommendation 1.4.1]

Offer the following oral medication regimen for disimpaction if indicated:

- Polyethylene glycol 3350 + electrolytes, using an escalating dose regimen (see table 4), as the first-line treatment[1].

- Adjust the dose of polyethylene glycol 3350 + electrolytes according to symptoms and response. As a guide for children and young people who have had disimpaction, the starting maintenance dose might be half the disimpaction dose (see table 4).

- Add a stimulant laxative (see table 4) if polyethylene glycol 3350 + electrolytes does not work.

- Substitute a stimulant laxative if polyethylene glycol 3350 + electrolytes is not tolerated by the child or young person. Add another laxative such as lactulose or docusate (see table 4) if stools are hard.

- Continue medication at maintenance dose for several weeks after regular bowel habit is established – this may take several months. Children who are toilet training should remain on laxatives until toilet training is well established. Do not stop medication abruptly: gradually reduce the dose over a period of months in response to stool consistency and frequency. Some children and young people may require laxative therapy for several years. A minority may require ongoing laxative therapy. [recommendation 1.4.3]

Diet and lifestyle

Do not use dietary interventions alone as first-line treatment for idiopathic constipation. [recommendation 1.5.1]

Treat constipation with laxatives and a combination of:

- Negotiated and non-punitive behavioural interventions suited to the child or young person's stage of development. These could include scheduled toileting and support to establish a regular bowel habit, maintenance and discussion of a bowel diary, information on constipation, and use of encouragement and rewards systems.

- Dietary modifications to ensure a balanced diet and sufficient fluids are consumed. [recommendation 1.5.2]

Information and support

Offer children and young people with idiopathic constipation and their families a point of contact with specialist healthcare professionals, including school nurses, who can give ongoing support.[recommendation 1.8.2]

Appendix 3: Suggestions from stakeholder engagement exercise

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
01	Bladder & Bowel foundation	Timely referral to Specialist Services with multi-disciplinary team input.	Children & young people struggling with constipation should receive timely referral to an appropriate specialist service.	Children and young people with constipation are developing lifelong issues with defecation leading to on-going issues associated conditions in adulthood	B&BF helpline callers often refer to problems with constipation starting in childhood.
02	Bladder & Bowel foundation	Education	Education and resources about diet and bowel health should be readily available to all children and young people. This may be supported by a Children's Continence Nurse working in clinical settings but also working collaboratively with school nursing team ensuring that best practice is followed / encouraged / promoted.	It is well documented that children and young people develop habits as a result of mirroring their parents / care givers it is essential to re-educate.	Evidence via the Bladder & Bowel Foundation Helpline suggests that many adults do not understand the link between poor diet, lifestyle and altered bowel habits.
03	Bladder & Bowel foundation	Appropriate Management of constipation	Children and young people should not receive laxatives as a first line treatment. Education regarding nutrition and lifestyle changes should be the first line of treatment.	Management of constipation in children and young people varies widely. Often children and young people do not receive adequate support from their GP and their family support is poor due to a fundamental lack of knowledge. Once a treatment is agreed regular review should be factored in.	Recent anecdotal evidence of a two year old that had been on an osmotic laxative for 6 months due to chronic constipation. Mother concerned that her son now has diarrhoea as he regularly soils his nappy with liquid faeces that leaks into his shoes. When suggested that he may not need the laxative

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					anymore the mother stated that 'he needs it though as he has terrible trouble with constipation'
04	Bladder & Bowel foundation	Psychological support	Children and young people may display withholding patterns – clinical pathways for the management of constipation in children and young people should include access to Psychological support.	Access to Psychological support for Bowel disorders is extremely limited across the country. In areas where a Psychologist is part of the multidisciplinary team outcomes generally improve.	It is well documented that psychology services are under pressure and access to services is poor.
05	Royal College of Paediatrics and Child Health	The Royal College of Paediatrics and Child Health to comment on the Constipation in children and young people topic engagement exercise. We have not received any responses for this exercise.	Not applicable	Not applicable	Not applicable
06	The Royal College of Surgeons of Edinburgh	The Royal College of Surgeons of Edinburgh agree with the standards proposed on constipation and young people and would like to endorse this quality standard.	Not applicable	Not applicable	Not applicable
07	Rotherham Doncaster and	Recording of history and examination	Accurate recordings of history assist decision making in	Enable clear working when clients seen by range of practitioners	None provided

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
	South Humber NHS Foundation Trust		subsequent consultations		
08	Rotherham Doncaster and South Humber NHS Foundation Trust	Guidance about effect of diet and fluids in management of constipation and prevention	To promote healthy lifestyle ongoing for child and family and to minimise the need for pharmaceutical interventions	In line with general healthy eating and prevention is better than treating when problems occur	None provided
09	Rotherham Doncaster and South Humber NHS Foundation Trust	Toilets in schools, children put off using toilet in school	Effect of not going to toilet leading to holding, marking and constipation	This is an area that could have major impact on children and should be addressed by the schools	None provided
010	Rotherham Doncaster and South Humber NHS Foundation Trust	Information about recognising changes in bowel movements	To be able to respond early to prevent impaction	Reduce effects of repeated hospital admissions and missing school and psychological effect on child	None provided
011	Rotherham Doncaster and South Humber NHS Foundation Trust	Clear guidelines for practitioners on assessment and management of presenting constipation	To be able to differentiate those that need assessment by paediatrician, facilitate management in primary care	Realistic expectations for parents and plan for parents, reduce referral to paediatrics, improve management in primary care	None provided

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
012	SCM1	Early identification of idiopathic constipation in CYP	Early identification allows for effective treatment of constipation and potentially reduces the incidence and impact of faecal impaction	Robust and effective management of constipation reduces the burden on cost by reducing or removing the need for disimpaction regimes. In children yet to be toilet trained it also decreases the likelihood of there being problems when this stage is reached (faecal soiling/delayed toilet training or encopresis)	NICE Clinical Guideline CG 99 Diagnosis and management of idiopathic childhood constipation in primary and secondary care
013	SCM1	Early referral from GP practice to nurse led specialist clinics	Children will be referred to nurse led specialist clinics with the primary examination having been carried out and documented (i.e. examination and reflexes but not DRE)	GP initial assessment including examination looks for red flags facilitates early and prompt onward referral to tertiary/surgical services	NICE Clinical Guideline CG 99 Diagnosis and management of idiopathic childhood constipation in primary and secondary care
014	SCM1	Appropriate medical treatment using recommended treatment regimens as outlined in NICE guidance	Appropriate treatment alongside robust advice allows clearer understanding of the aims of laxatives and increases adherence. Awareness of who may administer medication can help ensure that this is given appropriately – for example nurseries having policies of water and milk only may result in Movicol Paediatric Plain not being tolerated by the child	Parental understanding of the importance of laxatives in treating idiopathic constipation alongside advice on dietary support and exercise will help reduce the vicious cycle of constipation – impaction – disimpaction – treatment – relapse Improving adherence to the medicine will improve long term treatment of idiopathic constipation	NICE Clinical Guideline CG 99 Diagnosis and management of idiopathic childhood constipation in primary and secondary care
015	SCM1	Increased provision of nurse led services	Nurse led clinic have the facility to provide appropriate, timely and extensive support to families all of which may be necessary in	Empowering parents and CP to manage this condition with appropriate support from consistent and accessible health care professionals may improve long term	NICE Clinical Guideline CG 99 Diagnosis and management of idiopathic childhood constipation in

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			supporting CYP and their families in management	outcomes. Furthermore a nurse led clinic can be a resource for education settings (from early years to secondary school provision) to help with their management of faecal soiling.	primary and secondary care
016	SCM1	Provision of standard and consistent resources for CYP and families	Tools to support the understanding of idiopathic constipation and associated treatment can enable CYP, families and associated health care professionals to provide a considered, consistent and effective approach to both initial treatment and on-going maintenance.	Providing consistent support and advice (such as reassurance that laxative use will not create a lazy bowel) will reduce the vicious cycle of constipation as outlined above.	NICE Clinical Guideline CG 99 Diagnosis and management of idiopathic childhood constipation in primary and secondary care
017	SCM2	Ensuring appropriate laxative treatment as per NICE recommendations	Laxative treatment is a KPI within NICE guidance. Clinical experience has shown that early intervention with laxatives improves treatment outcomes	Idiopathic constipation is a self-perpetuating problem with a risk of becoming chronic if not treated appropriately and the introduction of laxatives is delayed	Clinical experience ChiMat identifies number of children admitted to secondary care admitted to hospital
018	SCM2	Development of community services to appropriately manage children with idiopathic constipation	Community management is recommended within NICE guidance Early intervention is the key to prevent constipation becoming chronic and the availability of paediatric continence promotion services will enable timely	Lack of community based services often results in inappropriate/ineffective initial treatment resulting in eventual secondary care referral Lack of community support can increase the risk of relapse	As above Also lack of paediatric continence services identified within recent APPG survey

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			intervention		http://www.appgcontinence.org.uk/pdfs/Continence%20Care%20Services%20England%20Report%202013.pdf
019	SCM2	Awareness raising of first line treatment intervention	NICE recommends the use of Movicol PP for both dissimpaction and maintenance as evidence suggests this is both effective and appropriate	Appropriate use of recommended laxative treatment facilitates effective dissimpation and prevents relapse	Calls to the PromoCon helpline from families identifies that appropriate laxative treatment with Movicol does not always happen – lactulose still being prescribed as first line and parents being told stimulant laxatives should not be used in children
020	SCM2	Initial assessment to be carried out by appropriately trained staff	The identification of faecal impaction is a KPI	If faecal impaction is not identified then the risk is that any treatment will be inappropriate /ineffective	Calls to PromoCon helpline have identified children with overflow soiling being inappropriately prescribe loperamide and dioralyte for the 'loose stools' – reflecting that initial assessment and thorough history not carried out
021	SCM2	Availability of ongoing	Children with idiopathic	A prolonged treatment time is often required	Calls to PromoCon

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		advice and support	constipation have a high risk of relapse due to stopping laxative treatment too soon	and there is a risk families may reduce/stop laxatives too soon. Also symptoms may wax and wane so families need access to ongoing advice and support	helpline reflect lack of ongoing community advice and support
022	RCN/SCM3	Diagnosis of Idiopathic constipation	Giving due credence to the condition (often ignored or not taken seriously) – by using a thorough history taking to make a positive diagnosis and plan a management programme	Evidence that early diagnosis and effective treatment with follow up improves outcomes for children	None provided
023	RCN/SCM3	Prescribing, titrating drug therapy guided by response to treatment	Prescribers often give small ineffective doses of medication and fail to provide adequate follow up and support	Ineffective medication often results in prolonged treatment and disengagement with health professionals by family – increasing dissatisfaction for all and leads to poor outcomes	None provided
024	RCN/SCM3	Support and Follow Up	Constipation is not well understood, has multifactorial contributing factors that require multi-faceted interventions and on- going support and follow up for families	Service provision is patchy, some areas have no formal support mechanisms – leads to increased use of services – including inappropriate use of A&E	None provided
025	RCN/SCM3	Integrated continence services	Constipation should be managed within the holistic context of continence - potential for much more effective use of resources and expertise	Service provision is patchy – children often have combined bladder and bowel issues and these are much more effectively managed in a joint service	None provided
026	RCN/SCM3	Training and Development	Constipation is not life threatening but if not managed effectively and in a timely way has serious	Evidence that families delay seeking help for this condition because they feel that health professionals will not take them	None provided

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			physical social and psychological consequences that impact on health services and education. Clinical staff need to have appropriate training so that they understand and are able to provide effective diagnosis and support	seriously – delays in diagnosis and treatment result in poor outcomes for children and their families and increase cost to NHS through increased and prolonged use of services	
027	NHS England	Thank you for the opportunity to comment on the draft scope for the above clinical guideline / quality standard. I wish to confirm that NHS England has no substantive comments to make regarding this consultation.			