Association of Coloproctology of Great Britain and Ireland

Constitution

Date Revised: July 2024

Revised by: Graham Branagan, Secretary

Contents

Appendices - MCC Subcommittees Terms of Reference

1.a) Title

The Association shall be called “The Association of Coloproctology of Great Britain and Ireland”. Henceforth in this document it will be referred to as “The Association”.

1.b) Definitions

“Articles” means the articles of association of The Association as adopted from time to time.

2. Objectives

The objectives of The Association shall be to prevent the suffering of people with, and prevent the occurrence of, disease and conditions of the lower gastrointestinal tract to include all lesions of the small bowel, appendix, large bowel, rectum, anal canal and perianal region by:

- *advancing the science and practice of coloproctology for the public benefit*
- *promoting best clinical practice in coloproctology amongst members of the medical and allied professions including through the advancement of education and training*
- *promoting the most efficient and effective use of healthcare resources*
- *providing and disseminating information and advice to healthcare professionals and members of the public on matters relating to coloproctology and:*
- *promoting the study of, and research into, coloproctology and facilitating the publication of the useful results thereof.*

3. Membership

There shall be **TEN** forms of membership, namely:

Ordinary Member, Overseas Member, Associate Member, Staff Grade Member, Student Member, Patient Liaison Group Member, Senior Member, Honorary Member, Affiliate Member and Trustee Member

An **ORDINARY MEMBER** shall be a medical practitioner on the Specialist Register or an Associate Specialist or a non-medically qualified scientist holding a permanent appointment in Great Britain or Ireland or a medical practitioner in a long term locum consultant post in Great Britain or Ireland, all of whom must have a demonstrable interest in Coloproctology. An Ordinary Member shall have full voting rights and receive the journal Colorectal Disease as part of his/her membership. Non-surgical Ordinary Members may pay a smaller subscription as determined by Council and will not receive the journal Colorectal Disease but will retain full voting rights. However, a Non-surgical Ordinary Member could receive the journal by paying an additional subscription fee.

An **OVERSEAS MEMBER** shall be a duly registered medical practitioner, residing and practising outside of Great Britain and Ireland, who has a demonstrable interest in Coloproctology and who shall have full voting rights. An Overseas Member will receive a subscription to the journal Colorectal Disease as part of his/her membership dues.

An **ASSOCIATE MEMBER** shall be a duly registered medical practitioner in a training appointment and who has a special interest in Coloproctology. An Associate Member shall not have voting

rights. An Associate Member will be entitled to receive the journal Colorectal Disease as part of his/her membership dues.

A **STAFF GRADE MEMBER** shall be a duly registered medical practitioner in a staff grade appointment and who has a special interest in Coloproctology. A Staff Grade Member shall not have voting rights. A Staff Grade Member will receive a subscription to the journal Colorectal Disease as part of his/her membership dues.

A **STUDENT MEMBER** will be defined as any individual currently studying for a degree in medicine, as well as any nursing or allied health care professional studying for their respective degrees. International student members will require a letter of recommendation from their medical school and an institutional e-mail. Membership will apply up until the award of the degree or cessation of studies, after which time the individual may elect to apply for Associate or Affiliate membership as applicable. A Student Member shall not have voting rights. A Student Member will receive a subscription to the journal Colorectal Disease as part of his/her membership dues.

A **PATIENT LIAISON GROUP (PLG) MEMBER** will be defined as a member of the patient liaison group. A PLG member will not be entitled to receive the journal Colorectal Disease as part of their membership dues. However, a PLG Member could receive the journal by paying an additional subscription fee. A PLG member will not have voting rights

A **SENIOR MEMBER** shall have retired from active practice in the field of general surgery and its associated specialties (NHS and Private) or have reached the age of seventy, whichever is earlier. He/she may be elected by Council at the member's request. A Senior Member shall not have voting rights. A Senior Member will not be entitled to receive the journal Colorectal Disease as part of his/her membership dues. However, a Senior Member could receive the journal by paying an additional subscription fee.

An **HONORARY MEMBER** shall be elected by Council after selection by the Executive. He or she will have made an outstanding contribution to the field of Coloproctology. If elected before retirement, voting rights may be retained up to the point of retirement from clinical practice (NHS or private) or the age of seventy, whichever is earlier. An Honorary Member will not be entitled to receive the journal Colorectal Disease as part of his/her membership dues However, an Honorary Member could receive the journal by paying an additional subscription fee.

An **AFFILIATE MEMBER** shall be an allied health professional with an interest in the field of coloproctology. An Affiliate Member will not be entitled to receive the journal Colorectal Disease as part of their membership dues. However, an Affiliate Member could receive the journal by paying an additional subscription fee.

A **TRUSTEE MEMBER** shall be a member with the rights set out in the Articles.

4. Mode of Election

4.1 Candidates for all categories of membership other than Honorary or Senior membership shall complete an online application on which particulars of his/her involvement in Coloproctology are included. These must be supported by one member of any membership category acting as referee and submitted to the Honorary Secretary.

4.2 The Honorary Secretary will verify that such applicants are eligible for membership for ratification by the Council under powers delegated to them by the Trustees.

4.3 Only Ordinary and Overseas Members, and those Honorary Members with voting rights, ratified by Council on or before the day of the Annual General Meeting shall be entitled to vote at that and all subsequent Annual General Meetings. Honorary Members will be elected annually by the Council at the Council Meeting immediately preceding the Annual General Meeting, at which they will be specifically announced.

5. Subscriptions

5.1 The annual subscription for each category of membership shall be payable to the Honorary Treasurer from the day they join. The subscription year runs from 6th of January for 1 year The subscription will be collected annually on the 6th of January.

5.2 The Honorary Treasurer will have discretion occasionally to waive part or all of the subscription for the current financial year in the event of elections late in the year.

5.3 Any Ordinary Member, Overseas Member, Associate Member, Staff Grade Member, Affiliate Member or Senior Member whose subscription is three months in arrears, and who has been duly notified thereof, shall cease to be a Member of The Association.

5.4 He/she may be reinstated on payment of arrears, up to a maximum of 12-month membership dues.

6. Removal from the Membership List

6.1 The Council may in its absolute discretion and utilizing powers delegated to it by the Trustees of The Association (but noting that such powers may be revoked at any time by the Trustees of the Association) terminate the membership of any individual or organisation whose continued membership would in its reasonable opinion be detrimental to the Association. Such decision shall be made at a meeting of the Council of the Association.

6.2 At least fourteen clear days before the Council meeting to consider the proposed termination, the Council shall advise the individual or organisation in writing of its intention and reasons. It shall also offer the member the opportunity to put forward any written representation for consideration before a decision is made.

6.3 A member's written representations shall be delivered at least seven clear days before the Council considers the proposal to terminate the membership.

6.4 If the member is an office holder or Council member, he/she shall be suspended and ineligible to vote from the date of the proposal to terminate the membership until the Council's decision.

7. General Meetings

7.1 These shall consist of an Annual General Meeting and such other meetings as Council may decide.

7.2 In addition a special meeting must be called by the Honorary Secretary within one month from the receipt of a request by at least FIFTY members with full voting rights stating the purpose for which the meeting is to be summoned.

7.3 At the Annual General Meeting, normally held during the clinical meeting, the business shall be:

- To elect Officers and members of Council.
- To receive the Report of the President which will include reports from the other Chairs.
- To receive the Report of the Honorary Secretary.
- To receive the Report of the Honorary Treasurer and the audited accounts for the previous financial year.
- Such other business as Council may decide.

7.4 Fuller details relating to the proceedings of members, including general meetings, are set out in the Articles, and must be complied with at all times.

8. Notice of Business

Any member who wishes to move a resolution at the Annual General Meeting shall give notice in writing to the Honorary Secretary not less than 21 days before the date of the meeting.

9. Quorum at Annual General Meeting

Twenty members shall form a quorum.

10. Clinical Meeting

At least one clinical meeting of The Association must be held each year.

11. Chapters

11.1 Chapters of The Association of Coloproctology of Great Britain and Ireland shall be responsible for nominating Ordinary Members for election onto Council. They shall be known as Regional Chapter Representatives.

11.2 Regional Chapter Representatives shall include two for Scotland, two for Ireland (one from Northern Ireland and one from the Republic of Ireland), two for Wales and one from each of the remainder of the English regions as defined in 1998, before NHS reorganisation.

11.3 Regional Chapter Representatives may belong to disciplines other than surgery.

11.4 The roles and responsibilities of the chapter representative are detailed in another document.

12 Officers of the Association

12.1 Officers of The Association shall consist of:
President (one year)
President Elect (one year)
President in Waiting (one year)
Honorary Treasurer (three years)
Honorary Assistant Treasurer (two years – see 12.3) Honorary Secretary (two years)
Honorary Assistant Secretary (two years – see 12.4)
Chair of Education and Training Committee (three years) Chair of Multidisciplinary Clinical Committee (three years) Chair of Research and Audit Committee (three years) Chair of External Affairs Committee (three years)
Chair of the Independent Health Committee (three years) Chair of the Pelvic Floor Society (two years)

all of whom shall be elected or ratified by Council and confirmed at the Annual General Meeting. The initial term of office is indicated in brackets and for all officers other than the President, the President Elect, the President in Waiting, the Treasurer and Secretary this may be extended on a yearly basis up to a maximum of three years following a recommendation from the relevant Committee and Council and confirmed at the Annual General Meeting.

12.2 The President and President Elect, the President in Waiting shall be installed in Office at the end of the Annual General Meeting at which he/she is elected and shall hold office until the end of the next Annual General Meeting. The President Elect, the President in Waiting will succeed the President.

The Secretary will seek nominations for the President in Waiting from all ordinary members, no later than 4 months before the Annual General meeting. The nominee will require a proposer and a seconder both of whom should be Ordinary members. The nominee will:

i) be a current Ordinary Member

ii) have previously been a voting member of ACPGBI Council or Chair of an MCC subcommittee

iii) not have any significant conflict of interest such as concurrent President of the ASGBI, ESCP and any other general surgical association.

All applications will be reviewed by the current President and Honorary Secretary to make sure eligibility criteria are met. All eligible names will be put forward to a vote by the whole ACPGBI membership via an independent e-voting company using single transferable voting. For clarity this includes all categories of membership with full voting rights where members are not in arrears with their membership. The applicant with the most votes will become President in Waiting. In the

unlikely event of a tie then a vote of President, President Elect and President in Waiting will decide the outcome. If there is only 1 candidate, then no vote is required.

12.3 Treasurer and Secretary

The Honorary Treasurer or Honorary Secretary, at the end of his/her two-year period, will normally be replaced by their respective assistant on the recommendation of Council and the appointment confirmed at the Annual General Meeting. All Ordinary Members of The Association will be eligible for election.

The Honorary Secretary will seek nominations from all ordinary members. The proposer should be on Council, but any ordinary member can be a seconder. The Assistant Treasurer or Assistant Secretary will then be elected by members of Council who have voting rights. In the event of two candidates achieving equal votes, the final recommendation will be made by the current President, President Elect, the President in Waiting, Honorary Secretary and Honorary Treasurer.

The Assistant Treasurer or Assistant Secretary will serve for two years sitting on Council and Executive prior to his/her appointment to Honorary Treasurer. He/she will have voting rights and proxy voting rights in the absence of the Honorary Treasurer. In the event of two candidates achieving equal votes, the final recommendation will be made by the current President, President Elect, the President in Waiting, Honorary Secretary and Honorary Treasurer.

12.5 Single candidate for office
In the event of there being only one candidate for the post of the President in Waiting, Assistant Treasurer or Assistant Secretary, the President, current President Elect, the President in Waiting, Honorary Secretary and Honorary Treasurer will confirm that the applicant has sufficient experience for this position and the appointment will be confirmed without a need for an election.

12.6 The roles and responsibilities of the Officers are detailed in a separate document.

13. Council

13.1 The Trustees have, pursuant to the Articles, delegated the conducting of the day to day business of The Association to the Council consisting of the Officers of The Association, the International Affairs Representative, Chapter Representatives (including the International Chapter Representative), chairs of the MCC subcommittees, three other non- surgical representatives (Oncology, Histopathology, Radiology, Chairs of the Early Years Consultant Network (EYCN) and of the Association of Coloproctology Nurses (ACPN)(or his or her representative), President of the Dukes 'Club (or his or her representative), Chair of The Pelvic Floor Society, Chair of the Ethnicity, Diversity and Inclusivity Committee and the ASGBI representative.

13.2 Representatives from disciplines other than surgery, namely oncology, histopathology, radiology and nursing, shall be nominated or elected on the recommendation of their respective specialist group, or forum, and be elected for a period of three years and then be eligible for re-election for a further period of three years, making a total of six years served sequentially. Thereafter a representative shall not be eligible for re-election for a further period of three years unless appointed an Officer of The Association. In the event of there being no nomination from a forum or discipline other than surgery, Council shall be empowered to fill the vacancy.

13.3 All Officers and Ordinary Members of Council together with Chairs of the Early Years Consultant Network, the Association of Coloproctology Nurses, The Pelvic Floor Society, Ethnicity, Diversity and Inclusivity Committee and the President of the Dukes 'Club shall have full voting rights on Council.

13.4 On Council all former NHS regions in England (as at 1998) shall be represented by Chapter Representatives:

Northern, North West, Yorkshire, Mersey, West Midlands, Wessex, Trent, East Anglia, Oxford, North West Thames, South West Thames, North East Thames South East Thames

13.5 Wales, Scotland, and Ireland (one from Northern Ireland and one from the Republic of Ireland) shall have two representatives each. The International Chapter shall have one representative

13.6 Chapter Representatives will be elected initially for a period of three years and then be eligible for re-election for one further period of three years making a total of six years served sequentially. Thereafter he/she shall not be eligible for re-election to Council for a further period of three years unless appointed an Officer of The Association. At least six months before the end of their term of office, Chapter Representatives will organise the election of their successors. In the case where the Chapter Representative is seeking a further period of office, he/she should ask a deputy to arrange the election. Nominations shall be submitted by Ordinary Members to the Regional Chapter Representative, proposed and seconded with the written consent of the nominees. A postal or electronic ballot of the Ordinary Members of the Chapter will be organised by the current Chapter Representative in the event of more than one nomination being received. The name of the elected member will be sent to the Honorary Secretary not less than six weeks before the Annual General Meeting. In the event of two candidates achieving equal votes, the final decision will be made by the current President, President Elect, the President in Waiting, Honorary Secretary and Honorary Treasurer. In the event of there being no nomination from a Chapter for a given region, Council shall be empowered to investigate and to fill the vacancy from that region.

13.7 The Council shall be empowered to co-opt for a specified purpose and a limited time relevant individuals from within the membership of The Association who have a special expertise required by The Association at that time. The number of such individuals on Council shall not exceed two at any time, other than in exceptional circumstances.

13.8 Inter-relationships with similar bodies and societies (for example, the Royal Colleges of Surgeons, the BSG and The Association of Surgeons) shall be established, developed or maintained by representatives of The Association, usually nominated from existing Council members.

13.9 A lay person shall be appointed to the council to provide advice to the Council from the perspective of patients and carers. This appointment will not be time limited and will be an honorary position. The appointment will be made by the Officers of the Association following a process of advertisement and interview.

13.10 Executive Committee of Council
The Executive Committee will be the body responsible for the day to day running of the Association. In addition, it will be responsible for collating issues relating to Coloproctology in general that should be discussed by the Council of ACPGBI and the Annual General meeting The President, President Elect, the President in Waiting, Honorary Secretary, Assistant Secretary,

Honorary Treasurer, Assistant Treasurer, Chair of the Education and Training Committee, Chair of the Multidisciplinary Clinical Committee, Chair of the Research and Audit Committee and Chair of the External Affairs Committee shall form the Executive Committee to resolve urgent and all matters to be discussed at the next Council Meeting. The Executive will normally meet some time before a Council meeting. The Immediate Past- President may be invited to attend meetings when appropriate. Four members of the Executive Committee will form a quorum.

13.11 If a member occupies an official post within ACPGBI and is either unavailable or suspended from their usual place of employment, for whatever reason, they should step down from their official post. The Executive will arrange for a temporary deputy to be appointed. If the member becomes available to take up office again, they should be reinstated to their role in ACPGBI, including usual limit of tenure of that official post immediately. Normal terms of service will apply.

13.12 Each member will be given a description of the duties of their respective positions on election to council. If a member occupies an official post within the ACPGBI and is felt by the executive to not be fulfilling these duties, then this will be brought to the attention of the member by the Honorary Secretary. This will include attendances at meetings as well as engagement and carrying out tasks. If the duties are still not fulfilled, then that member may be asked to step down. A temporary deputy may be appointed pending further election.

13.13 If a member of Council is unable to attend a Council meeting, they should submit a written report and arrange a deputy who should be briefed regarding relevant issues and should report back to the member of Council. It is expected that appointing a deputy should not be a regular occurrence.

14. Quorum of Council:

The quorum for a meeting of Council shall be eight.

15. Trustees

The Trustees are the supervisory board of The Association, and their powers are detailed in and derived from the Articles.

16. Financial Year

The financial year of The Association shall end on 31st day of December each year, to which day the accounts of The Association shall be balanced.

17 Cheques /Digital banking

17.1 A bank account shall be opened with any bank. The Executive/Council may decide to change bankers from time to time if it is deemed to be in the best interests of the Association. The majority of banking is carried out electronically with no less than two authorized digital signatures for payments to creditors.

17.2 The Council shall authorise the Honorary Treasurer, President, Honorary Secretary, the Assistant Treasurer, and the Administration Manager to sign cheques/digitally authorise on behalf of The Association. The Council can authorise the addition of one signatory from a contracted agent to be one of the signatories on the account for a temporary period. All cheques must be signed by not less than two of the six authorised signatories. In addition, there will be facilities for electronic banking whereby payments to creditors are authorised by no less than two signatories.

18. The Equality, Diversity and Inclusivity (EDI) Committee

18.1 The role and working of the Equality, Diversity and Inclusivity Committee are set out in full in separate articles. This document provides a summary of its role in EDI matters.

18.2 The committee will address and improve inequality in ACPGBI's Committees, Officer applications and at ACPGBI functions and courses.

18.3 The Committee will work with other sub-specialty organisations, the four Colleges of Surgery, and RSM Coloproctology Chapter to address all areas of inequality in surgical practice.

18.4 The Committee will address issues within training and liaise with the Deanery/JCST/Royal Colleges regarding exam inequality. See separate EDI articles.

19. President

The President, or in his/her absence the President Elect, the President in Waiting, or in the absence of both a member elected by the meeting, shall preside at all General and Council meetings, and shall have a casting vote.

20. Honorary Treasurer

The Honorary Treasurer shall receive subscriptions, pay all bills, and present the accounts at the Annual General Meeting. In his or her absence the Assistant Treasurer will assume this duty.

21. Honorary Secretary

The Honorary Secretary shall summon meetings, prepare agendas, and keep minutes of the proceedings. In his or her absence, the Assistant Secretary will assume these duties.

22. System of committee election from 2021

22.1 Appointment to the major committees of the Association (Education and Training, Research and Audit, Multidisciplinary Clinical, External Affairs), as well as the Early Years Consultant Network, the Ethnicity Diversity and Inclusivity Committee and the Independent Health Care Committee shall follow a similar process:

22.2 The Chair will sit on Council, but the other members need not necessarily do so. The Chair will normally be elected by and from within the Committee but not necessarily and will normally have had previous experience of this Committee. The tenure as Committee Chair should be initially for three years but may be extended on a yearly basis up to a maximum of a further three years following a recommendation from the Committee, confirmed by Council, and ratified at the AGM. If a nomination for the post of Chair of the Committee is not forthcoming from the membership of the Committee, the Honorary Secretary will seek nominations for the post of Chair from all ordinary members. The proposer should be on Council, but any ordinary member can be a seconder. The nominee should have experience on Council or of the work of the Committee. The Chair will then be elected by those members on Council with voting rights. In the event of two candidates achieving equal votes, the final recommendation will be made by the current President, President Elect, the President in Waiting, Honorary Secretary and Honorary Treasurer.

22.3 The elected members of the Committee will serve for a period of three years and will normally be eligible for election for a further three years of office. If a member is elected as Chair, he/she will continue until the period of office as Chair ends.

22.4 Six months before the term of an elected member of a committee expires, the Chair will inform the Honorary Secretary. The vacancy will be advertised to Ordinary Members, Overseas Members and Honorary Members who have voting rights and applications will be invited. Younger consultants should be encouraged to apply for these elected posts to promote wider representation within the Association. Applications must also be seconded by Members of The Association having voting rights and sent with a short Curriculum Vitae of the candidate to the Honorary Secretary not less than six weeks before the Annual General Meeting. Where there are more applicants than posts available, the Honorary Secretary will organise a secret ballot of all members of Council with voting rights, four weeks before the Council meeting immediately preceding the Annual General Meeting. In the event of two candidates achieving equal votes for one vacant position, the final decision will be made by the current President, President Elect, the President in Waiting, the Honorary Secretary and Honorary Treasurer. The successful applicant(s) will be ratified at the Council meeting and their names will be announced at the Annual General Meeting.

22.5 An Ordinary member can only serve on a maximum of 2 elected committees at any one time. This applies to all committees and subcommittees of the MCC.

23 Education and Training Committee

23.1 The Education and Training Committee shall:

- *consider any matters referred by Council and, in particular, consider matters relating to education and training in coloproctology and advise Council accordingly.*

- *bring forward ideas concerning education and training in Coloproctology. and advise Council accordingly.*

- *consider matters relating to Continuing Professional Development and advise Council accordingly.*

- *liaise with other bodies as deemed appropriate with regard to training and education matters.*

- *produce a verbal report for each Council meeting, which may be written if absent from the meeting.*

23.2 Membership of the Committee shall consist of a Chair, a Surgical Advisory Committee representative (SAC) (if not already represented by an ordinary member), a representative of the Dukes 'Club, the ACPGBI, the Chair of the Colonoscopy Sub-group, the ACPN representative and five other elected members.

23.3 The Medical Students Committee shall be a subcommittee of the ACPGBI Education and Training Committee.

The Medical Students Committee shall:

- Be responsible for supporting and holding events for medical student members
- Hold regular meetings among members of the committee
- Produce an annual report
- Membership of the Committee shall consist of a Chair (agreed by the Medical Student Committee members) and five other elected members
- Committee shall be overseen by a representative on the Education and Training Committee

Medical Students Committee members will serve for a maximum of 3 years limited by their graduation from medical school. Membership of the committee will be reviewed by the Chair on an annual basis.

24. Multidisciplinary Clinical Committee

24.1 The Multidisciplinary Clinical Committee shall:

- *consider any matters referred by Council and, in particular, consider matters relating to the provision of coloproctology services within both the State and private sectors and advise Council accordingly.*
- *shall advise on the efficient and effective provision of a multi-professional team based coloproctology service and set standards for all aspects of this service.*
- *liaise with other bodies as deemed appropriate with regard to the provision of coloproctological services.*
- *produce a verbal report for each Council meeting, which may be written if the Chair or a representative are absent from the meeting.*

MCC has sub-committees. The Terms of reference for all of the sub-committees is found in the Constitution appendices.

24.2 The Multidisciplinary Clinical Committee shall be led by a Chair elected by Council vote. The Chair shall hold the position for a period of 3 years. This may be extended on a yearly basis up to a maximum period of 3 years following a recommendation from the subcommittee chairs. All Ordinary Members will be eligible to stand for MCC Chair but it is expected that they will have had previous experience on a Subcommittee or ACP Council.

The following sub-committees shall report to the MCC Chair: Abdominal Wall / Advanced Malignancy / Colonoscopy / Cancer / Emergency General Surgery / Guidelines / Inflammatory Bowel Disease / Intestinal Failure / Peritoneal Malignancy / Proctology / Robotic. Sub-committee members should have interest & experience in the provision of relevant coloproctological services.

25 Research and Audit Committee

25.1 The research and Audit Committee shall:

- *be responsible for supporting and collecting information on the research and audit projects done by the membership.*
- *produce a verbal report for each Council meeting, which may be written if absent from the meeting.*
- *hold regular teleconferences amongst members of the committee.*
  hold an Annual Meeting of the Committee at The Association Annual Meeting.

25.2 Membership of the committee shall consist of a Chair and eight other members. Five will be elected and have voting rights. One will be nominated by the ACPN. One will be nominated by the Dukes 'Club who shall be in a training grade or within 2 years of appointment to the post of consultant and will serve for two years or until no later than two years after appointment as a consultant. One representative will be from the Pelvic Floor Society. Invited advice will be sought from non- surgical members of Council (eg oncology, pathology and radiology) when considering a topic in these specialties. Other members will be co-opted as appropriate when particular projects are being considered or supported.

25.3 The Chair will sit on Council but the elected members and representatives of the ACPN and Dukes' Club need not necessarily do so.

26 External Affairs Committee

26.1 The External Affairs Committee shall:

- *be responsible for the way the ACPGBI is presented to the outside world; deal with the press and other external bodies that may contact the Association for information and comments on matters related to coloproctology; consider matters of public concern, public relations, ethical practice and medico-legal matters in coloproctology and advise Council accordingly.*

- *liaise with other bodies as deemed appropriate regarding public relations and ethical matters.*

- *produce a verbal report for each Council meeting, which may be written if the Chair is absent from the meeting.*

26.2 Membership of the Committee shall consist of a Chair, six elected members, a representative for International Affairs, AUGIS and BSG representatives as well as the Chair of the Information Technology Group and the Independent Health Care Committee, one lay member, at least one member from a non-surgical discipline usually on Council, the Chair of the Clinical Governance Board and one nominated member of the ACPN. The AUGIS representative will be appointed on the recommendation of their Council, usually for three years. The Gastroenterology representative will be appointed on the recommendation of the Council of the British Society of Gastroenterology, usually for three years.

26.3 Members shall have an interest and experience in matters pertaining to issues of public concern, public relations, ethical and medico-legal practice.

27 The Journal Committee

27.1 The journal Committee shall:

- *formulate, present, and implement the views and policies of The Association in liaison with the publishing house and Editorial Board.*
- *have a close supervisory, non-editorial role in its financial management and other matters relating to the Journal.*
- *advise Council and the publishing house on appointments to the Editorial Board.*
- *advise on the responsibilities and tenure of the Editorial Board members.*
- *advise Council on the appointment of the Editors and Chair of the Editorial Board.*
- *have regular discussions to consolidate the above policies and advance new ones as time and circumstance dictate.*

27.2 Membership of the Journal Committee shall consist of the President who is the Chair, the Honorary Secretary, the Honorary Treasurer, the President-Elect and the President-in-Waiting of The Association, the Chair of the Editorial Board, and the Editor-in-Chief.

28. The Pelvic Floor Society is a specialist sub-committee within ACPGBI that is represented on and reports to Council and focuses on the management of patients with pelvic floor disorders and works closely with health care professionals belonging to other disciplines.

28.1 The Pelvic Floor Society shall*:*

- *provide a forum for members to engage in critical discussion on the investigation, diagnosis, management, and epidemiological studies of pelvic floor problems.*

- *support relevant clinical, and will occasionally promote, collaborative trials to address specific problems.*

- *facilitate the interchange of information on pelvic floor disorders between members of the Pelvic Floor Society and other interested parties in the Great Britain & Ireland as well as worldwide.*

- *define and monitor the standards of pelvic floor investigation and medical/surgical management throughout the Great Britain & Ireland.*

- *engage with external organizations including the Department of Health and NICE to develop a strategic policy approach to colorectal pelvic floor dysfunction and the commissioning of a robust service.*

- *provide an advisory role to and work with other interested bodies including commissioners etc to promote the sub-specialty.*

- *support and develop educational initiatives (including scientific meetings) to disseminate the issues around these aims to a broader audience. Develop a training curriculum and courses in the investigation and management of pelvic floor problems*

- *organise and arrange funding for Great Britain pelvic floor clinical fellowships & provide opportunities for suitably qualified trainees to undertake formal research projects.*

- *produce a verbal report for each Council meeting, which may be written if absent from the meeting*

28.2 Membership of the Pelvic Floor Society will be available to all full members of ACPGBI who have an interest in pelvic floor disorders.

28.3 Membership is welcome from other clinical disciplines involved in the management of pelvic floor disorders such as uro-gynaecologists, urologists, radiologists, physiologists, specialist nurses, physiotherapists, chronic pain specialists, psychologists etc. Such members could also join ACPGBI as an Affiliate Member.

28.4 The Pelvic Floor Society will normally meet twice year in May and October. The AGM will follow the October meeting. In addition, the Pelvic Floor Society will usually be asked to organize a Pelvic Floor Symposium to take place during the Annual Scientific meeting of ACPGBI.

28.5 The Pelvic Floor Society shall be run by a Committee comprising the Chair, Secretary, Treasurer, Membership Secretary Training Lead, Programme lead, Research Lead and Quality

Assurance lead, plus one co-opted member (as deemed appropriate). All Officers must be members of Pelvic Floor Society.

28.6 The Pelvic Floor Society Committee shall meet regularly by teleconference to discuss the business of the society and matters relating to pelvic floor disorders

28.7 The Chair will serve for 2 years and will not be eligible for re- election. The remaining officers will serve for 3 years and may be re-elected but cannot hold an officer position for more than 6 consecutive years. Terms will end at the General Meeting held at the Annual Scientific Meeting.

28.8 Six months before the end of the Chair's term of office, the Chair and Secretary of the Pelvic Floor Society will seek nominations for Chair. The Secretary will circulate the list of nominations, together with the papers for the October meeting. Election will be by postal ballot of the membership of the Pelvic Floor Society and the result will be decided by simple majority. In the event of a tie, the retiring Chair of the Pelvic Floor Society together with the President, President Elect, the President in Waiting and Secretary of ACPGBI will exercise casting votes.

28.9 Nominations for the other officers should be made to the Secretary of the Pelvic Floor Society, 90 days prior to the October AGM. Where more than one candidate is proposed, postal ballot of the membership will take place with a simple majority required. In the event of a tie, the retiring Chair of the Pelvic Floor Society together with the Pelvic Floor Society Committee will exercise casting votes.

28.10 The finances of the Pelvic Floor Society will be maintained under the umbrella of the ACPGBI as a separate account. Authorised signatures to approve payment will consist of the Administration Manager, the Pelvic Floor Society treasurer and ACPGBI treasurer and assistant. The ACPGBI has no obligation to underwrite this account should funds run out, unless by agreed negotiation.

29. Early Years Consultant Network (EYCN)

The transition to independent practice is challenging and whilst training *per se* equips individuals to deal with the majority of clinical scenarios, there is a need for support for surgeons in the first few years of consultant practice in other areas. The aim of EYCN is to provide support in all respects for Consultants within the first 5 years of independent clinical practice and senior colorectal trainees in making the transition to Consultant practice.

29.1 The EYCN will be managed by 8 elected members including the Chair. Each member will fulfil a specific role. These are:
1. *Chair*
2. *Vice-Chair*
3. *Honorary Secretary*
4. *Honorary Treasurer*
5. *Social media/Moderator lead*
6. *Mentorship lead*
7. *Events & sponsorship lead*
8. *Website lead – will sit on Website Subcommittee*

They will be supported by an *ex officio* member of the ACPGBI Executive who will not have voting rights on EYCN elections.

29.2 The Chair of EYCN will sit on and report to ACPGBI Council and is a member of the External Affairs committee.

29.3 Individuals may remain on EYCN Committee for a maximum of 3 years, unless they become Vice chair in their last year, in which case maximum time will be 4 years. The demitting Chair will leave the EYCN Committee once the year has been completed. Committee members who have over 60 months of clinical activity as a consultant (including locum positions) are no longer eligible to remain on the committee and would normally demit at the time of the next annual election. Exceptional circumstances may be considered by the Chair whose decision is final.

29.4 Meetings will be held three times each year. At least one face-to-face meeting will take place at the annual meeting of ACPGBI. Other meetings will be held by teleconference. ACPGBI members attending the annual meeting are responsible for their own expenses.
The agenda will be coordinated by the Chair, and the Honorary Secretary will be responsible for minutes that should be submitted to ACPGBI Council.

29.5 EYCN will seek sponsorship from industry and other relevant bodies to fund EYCN activities. On those occasions where this is not possible then the final decision regarding funding rests with the Honorary Treasurer and Executive of ACPGBI.

29.6 All members of ACPGBI who are within 5 years of consultant appointment are eligible for membership of EYCN. Allowances may be made for career breaks. Senior trainees who are ST8, post-CCT or in Fellowship posts are also eligible if members of ACPGBI.

30. Independent Healthcare Committee

30.1 The Independent Healthcare Committee shall:

- *consider matters referred by Council and the Multi-disciplinary Clinical Committee pertaining to independent healthcare practice.*
- *foster and encourage relationships with the agencies involved in the provision of independent healthcare practice.*
- *promote the highest standards of professional practice and surgery in the independent health care sector.*
- *support the concept of independent healthcare practice.*
- *produce a verbal report for each Council meeting, which may be written if absent from the meeting.*
- *hold at least three meetings per year or teleconferences, one of which shall be in proximity to the Annual General Meeting of The Association.*
- *produce an annual report which would be presented at the Annual General Meeting.*
- *through the Chair or his named deputy, represent The Association at meetings of the Independent Healthcare Committee of The Association of Surgeons of Great Britain & Ireland and the Federation of Independent Practitioner Organisations.*

30.2 Membership of the Independent Healthcare Committee shall consist of a Chair and up to three co-opted members on recommendation of the committee and three elected members.

31. The Association of Coloproctology Nurses

The constitution of the ACPN is detailed in a separate document.

32. Annual Scientific Meeting Programme Committee

32.1 The Programme Committee shall assist the President in organising the programme on behalf of The Association at other Scientific Meetings.

32.2 The Chair of the Programme Committee shall be the President.
32.3 The other members are: The Honorary Secretary, The Honorary Treasurer, Chairs, Education and Training and Research and Audit Committees, the Chair of ACPN, the President of the Dukes ' Club and other co-opted representatives at the discretion of the President.

32.4 When the Tripartite Meeting is held in Great Britain and Ireland the relevant officers of the Section of Coloproctology, Royal Society of Medicine, shall together with representatives from The Association, usually the President and Secretary and Treasurer who will be in post at the time of the Tripartite Meeting, will form the Programme Committee.

32.5 The Programme Committee shall meet as often as necessary to conduct its affairs.

33. Sub-committees

If there is felt to be a need for a sub-committee to be formed the same process for appointment as that for major committees will be followed (see section 21). Each subcommittee except for the Peritoneal Malignancy Subcommittee and the External Affairs Committee will consist of a chair and 5 other elected members as well as 1 nominated representative from each of the Associate and Affiliate Membership categories (nominated by the Dukes Club and ACPN). There may also be co-opted members with specialist interests in Oncology, Pathology and Radiology as required.

The Peritoneal Malignancy Subcommittee will consist of a representative from each of the peritoneal malignancy centres in Great Britain and Ireland as well as 1 nominated representative from each of the Associate and Affiliate Membership categories (nominated by the Dukes Club and ACPN). External Affairs will consist of a chair and 7 elected members.

34. Amendment to the Rules

Alterations to this constitution shall receive the assent of two-thirds of the members present and voting at an Annual General Meeting or a special General Meeting. A resolution for the alteration of the constitution must be received by the Honorary Secretary of The Association at least twenty-one days before the meeting at which the resolution is to be brought. At least fourteen days ' notice of such a meeting must be given by the secretary to the membership and must include notice of the alteration proposed. Provided that no alterations shall be made to Clause 2 (Objectives), Clause 35 (Dissolution) or this Clause until the approval in writing of the Charity Commissioners or other authority having charitable jurisdiction shall have been obtained, and no

alterations shall be made which would have the effect of causing The Association to cease to be a charity in law.

35.Dissolution

The Association may be dissolved by a resolution passed by a two-thirds majority of those present and voting at a Special General Meeting convened for the purpose, of which twenty- one days ' notice shall have been given to the members. Such resolution may give instructions for the disposal of any assets held by or in the name of The Association, provided that if any property remains after the satisfaction of all debts and liabilities, such property shall not be paid to or distributed among the members of The Association but shall be given or transferred to such other charitable institution or institutions having objectives similar to some or all the objectives of The Association if and in so far as effect cannot be given to this provision then to some other charitable purpose.

36. Conflict

In the event of any inconsistency or conflict arising between the provisions of this document and the Articles the provisions of the Articles shall prevail.

Constitution Dated: *July 2024 Graham Branagan*

Appendix 1

Terms of Reference for the Abdominal Wall Sub-Committee

Colorectal surgical patients suffer a large burden of morbidity and an impaired quality of life due to problems related to their abdominal wall. Colorectal surgeons represent a large part of the emergency on call rota and perform many emergency laparotomies with or without stomas. Elective colorectal operations are also associated with a relatively high incidence of surgical site infections (SSI) and subsequent incisional hernia formation. Incisional hernias and recurrent incisional hernias are common. Parastomal hernias are also common and problematic and there is no satisfactory method of prevention or repair. Reoperative colorectal operations with or without intestinal failure can lead to abdominal wall failure with complicated and problematic incisional hernias. There is probably no other surgical subspecialty that is associated with as much abdominal wall morbidity and many colorectal surgeons in the UK are involved in incisional hernia repair and a minority have developed a practice in abdominal wall reconstruction (AWR).

Purpose & Objectives

The purpose of the Abdominal Wall subcommittee is to represent and support ACPGBI members in matters relating to the abdominal wall during or after elective and emergency colorectal or other abdominal surgery. This subcommittee is not an Abdominal Wall Reconstruction (AWR) subcommittee. It is an inevitability that some of the members will have an AWR practice and AWR will be within the remit, but this is a subcommittee which is to dedicate itself to education and best practice in matters relating to the abdominal wall in the broadest sense. This will include supporting best clinical practice as well as education, training, clinical audit, and research. This will include but is not limited to SSI prevention, wound formation, and closure in open and MIS surgery (both elective and emergency), incisional hernia prevention and prophylaxis, parastomal hernia prevention and treatment, prevention and management of the open abdomen, abdominal wall management in intestinal failure as well as mechanisms and methods of hernia repair including AWR. It is envisaged that the subcommittee will form collaborative links with existing hernia and plastic surgery societies as appropriate to support best practice.

Membership & Structure

There will be 6 elected members including the Chair. The initial chair shall be elected by ACPGBI executive and subsequently by the members of the subcommittee. The first and subsequent chairs may be in post for 3 years only, unless exceptional circumstances dictate otherwise. There will be elected representation from Dukes and nursing as well as the PLG (Patient Liason Group). Other co- opted members will be recruited as required and Stoma nurse and tissue viability involvement and representation will be encouraged as will formal representation from an appropriate plastic surgery society.

The subcommittee will sit within the Multidisciplinary Committee. In this regard it mirrors all other clinical subcommittees that similarly report through MCC. The chair will report to Council and Executive via the Chair of the Multidisciplinary committee (MCC), though may on occasions be asked to present directly. They will work closely with the Education & Training committee as well as the elected members of MCC.

Interactions

• Multidisciplinary Clinical Committee (MCC). The subgroup reports to ACPGBI Council and Executive through the MCC Chair. • Nursing and Allied Health Professionals (NAHP) Group
• Royal College of Surgeons Getting It Right First Time (GIRFT) initiative
• Association of Surgeons of GB&I, AUGIS & BSG& British Hernia Society

• AWR Europe
• British Society of Plastic Surgery or other plastic surgery society as appropriate • Charities and patient support groups & Commissioning bodies

Accountability
The Chair of the subcommittee will report to the Chair of the MCC.

Meetings
Meetings will be held three times each year. At least one face-to-face meeting will take place at the annual meeting of ACPGBI. Other meetings will be held by teleconference. The agenda will be coordinated by the Chair, who will be responsible for minutes that will subsequently be submitted to the Chair of MCC and ACPGBI Council.

Reimbursement of expenses
The ACPGBI will reimburse reasonable day travel expenses and second-class rail fares. Overnight accommodation and subsistence will be covered if required.

Charles Maxwell-Armstrong, Ciaran Walsh and Nicola Fearnhead
May 2020

Appendix 2 Terms of Reference for the Advanced Malignancy Sub-Committee

Purpose

Management of advanced colorectal cancer is becoming increasingly specialised and important. Its provision within Trusts is of strategic importance to improve the efficiency and quality of care for patients. It is a key hospital service that requires substantial development.
The purpose of the Advanced Malignancy Sub-Committee is to represent and support ACPGBI members.

This Advanced Malignancy Sub-Committee mirrors IBD, Emergency Surgery and Endoscopy Sub-Committees that similarly report through MCC.

Interactions

- Multidisciplinary Clinical Committee (MCC). The Sub-Committee reports to ACPGBI Council and Executive through the MCC Chair.
- Nursing and Allied Health Professionals (NAHP) Group
- Association of Surgeons of GBI
- AUGIS
- Association of Cancer Physicians
- The National Bowel Cancer Audit
- Charities and patient support groups
- Commissioning bodies

Objectives

- Representation of views of professional and patient groups in shaping strategy for the management of patients with advanced colorectal cancer.
- Promotion of expert provision, management structure, resources and quality improvement in local delivery of advanced colorectal cancer surgery.
- Provision of oversight, direction, governance and promotion of advanced colorectal cancer databases, audits, research and initiatives.
- Address issues related to training and the performance of advanced colorectal cancer surgery. Working with the Education and Training Committee to ensure appropriate governance of Fellowships in this area.
- Collaboration with other bodies and charities with shared interest in the management of advanced colorectal cancer

Membership

- The membership of ACPCBI will be invited to apply for 5 positions on the Sub-Committee. These will be voted by Council following submission of an abridged CV. Each post will be for three years.
- The Chair will be appointed by the Executive of the ACPGBI in the first instance. This may or may not be from elected members. At the end of the term of office of this inaugural Chair, members of the sub-committee will elect the next Chair.
- A patient representative will be nominated by the Patient Liaison Group.
- A trainee representative will be appointed by the Dukes' Club.
- The radiology and oncology representatives of MCC will be co-opted onto this committee.
- Other co-opted members will be recruited as required.

Accountability

The Chair of the subcommittee will report to the Chairman of the MCC.

Meetings

Meetings will be held twice each year. At least one face-to-face meeting is encouraged each year usually at the annual meeting of ACPGBI
Other meetings will be held by Zoom.
The agenda will be coordinated by the Chair in conjunction with members and the Chair of MCC.

Reimbursement of expenses

The ACPGBI will reimburse reasonable day travel expenses and second-class rail fares. Overnight accommodation and subsistence will not be covered.

Ciaran Walsh/Charles Maxwell-Armstrong
2019

Appendix 3 Terms of Reference Cancer Sub-committee

Purpose

Provision of cancer services as part of a multidisciplinary team is a core activity of most colorectal surgeons and a critical element of training. Competency in the management of colorectal cancer is determined by easily measured indicators, and the Association has a long history of supporting and promoting excellence in this field. The management of colorectal cancer is increasing in complexity with more treatment options and the potential for personalising these for our patients. It is vital that we offer this wider choice to patients, be this access to supra-radical surgery, organ preservation or ensuring equitable access to novel therapies. The focus of this sub-committee will be colorectal cancer and precancerous lesions, but will also consider gastrointestinal stromal tumours (GIST), neuroendocrine tumours (NET) and precursor lesions and cancer of the anus.

Interactions

The subcommittee reports to the ACPGBI council and Executive through the Chair of the MCC. Other interactions include:

- Association of Coloproctology Nurses (ACPN)
- Robotic subcommittee, Advanced Malignancy subcommittee, Peritoneal Malignancy Cancer subcommittee, Emergency General Surgery subcommittee, Colonoscopy subcommittee.
- Charities and patient support groups
- Commissioning bodies
- Industry
- Dukes' Club
- Other committees as required as ex-officio members (R+A, External affairs, E+T)
- Early Years Consultant Network (EYCN)

Objectives

- Understand and reduce unwarranted variation in care of patients with colorectal cancer, with reference to equality of access.
- Improving the use of technology across the patient pathway, be this patient selection and consent, optimising the operating environment and improving long term assessment and management of our patients after surgery.
- Support the provision of information and education for patients and clinicians in relation to colorectal neoplasia.
- Promotion and engagement in research opportunities.
- Contributing to the ACPGBI's position over subspecialisation in some areas of practice.

Membership

- The ordinary membership of ACPCBI will be invited to apply for 6 positions on this subgroup. The applicants will be elected by Council following submission of an abridged CV in the event of more than 6 applications. Three-year terms are encouraged to ensure continuity. Members may apply for a second term of 3 years, subject to successful re-election.
- A Chair will be appointed from among the successfully elected members of the Subcommittee by the sub-committee.
- A patient representative will be nominated by the Patient Liaison Group.
- A trainee representative will be appointed by the Dukes Club.
- A SAS doctor will be appointed.
- Other co-opted members will be recruited as required.

Meetings

- Meetings will be held quarterly, with at least one face -to-face meeting at the annual meeting of the ACPGBI and ideally a second face-to face “winter” meeting. Additional interval meetings may be required but it is anticipated most work will be undertaken by email and shared documents.
- The agenda will be coordinated by the chair, who will be responsible for the minutes that will be subsequently submitted to the Chair of the MCC and ACPGBI Council.
- The Chair of the subcommittee may be required to present their activities to Council and/or Executive on occasion, either in person or by videoconference.

Reimbursement of expenses

- The ACPGBI will reimburse reasonable day travel expenses and second-class rail fares. Overnight accommodation and subsistence will be covered if required and agreed in advance.
- Attendance at the Annual Meeting is a personal expense.

Chris Cunningham
June 2024

Appendix 4 Terms of Reference Clinical Governance Board (Committee)

Increasingly frequently over recent years officers of ACPGBI have been approached by a variety of external people (Royal College officers, Trust officials, university personnel, etc.) and asked to nominate senior consultants "in good standing with the Association" to act as advisors or assistants in governance, investigatory or disciplinary processes in the workplace involving clinicians involved in colorectal practice.

Such nominations may be made in an *ad hoc* and piecemeal fashion which can be unsatisfactory for all parties, particularly if the ultimate conclusions of the judgmental process prove to be controversial.

This Clinical Governance Board is an active body within the ACPGBI and is becoming increasingly involved with governance matters to do with the Consultant Outcome Publication as well as other matters of investigation. It also acts in a mentoring capacity for surgeons in difficulty. It works with the Invited Review Mechanism of the RCS England and is available to work with the Review Mechanisms of other Colleges.

The Board is appointed and functions in an open and transparent manner within the bounds of confidentiality towards the parties concerned.

The Board

1. The composition of the Board shall be never less than three nor greater than five Consultant members of ACPGBI. All must hold a GMC License to Practise.

2. It is permissible for the Board to contain two ACPGBI members who have retired from active clinical practice but for less than 3 years.

3. Places and vacancies on the Board shall be advertised openly among the membership of ACPGBI.

4. The ACPGBI Council shall elect the members of the Board

5. The Chairman of the Board would be appointed for 3 years, renewable by election for a maximum term of 6 years.

6. Board membership shall be for 3 years, with an option to stand for re-election for a further 3 years

7. The Chairman of the Board should prepare a short Annual Report on the activities of its members, which should be presented to the Executive. A balance needs to be struck between maintaining confidentiality (especially where the disciplinary outcome is exoneration) and transparency.

8. The Board will be answerable to Executive and Council but will normally report through the Multidisciplinary Clinical Committee via its Chairman.

9. The Chairman of the Board will sit on the Multidisciplinary Clinical Committee.

June 2021

Appendix 5 Terms of Reference for the Colonoscopy Sub-Committee

Endoscopy has always been an integral part of colorectal practice. The purpose of this subgroup is to ensure that the highest standards of practice are maintained going forward, training is maintained, and that new techniques can be supported appropriately. The Colonoscopy subcommittee mirrors IBD, peritoneal malignancy and proctology subgroups that similarly report through MCC.

Interactions

- Multidisciplinary Clinical Committee (MCC). The subgroup reports to ACPGBI Council and Executive through the MCC Chair.
- Nursing and Allied Health Professionals (NAHP) Group
- Royal College of Surgeons Getting It Right First Time (GIRFT) initiative ·Association of Surgeons of GB&I
- Charities and patient support groups
- Commissioning bodies

The Association of Coloproctology of Great Britain and Ireland Objectives

- Promotion of expert provision, resources and quality improvement in colonoscopy nationally
- Provision of oversight, direction, governance and promotion of colonoscopy-related databases, audits, research and initiatives.
- Address issues related to training and the performance of colonoscopy by colorectal surgeons.
- Collaboration with other bodies and charities with shared interest in colonoscopy.

Membership

The membership of ACPCBI will be invited to apply for 6 positions on the subgroup. These will be voted by Council following submission of an abridged CV. Three-year terms are encouraged to ensure continuity. The Chair will be appointed by the members of the subcommittee.
A patient representative will be nominated by the Patient Liaison Group.
A trainee representative will be appointed by the Duke's Club. Other co-opted members will be recruited as required.

Accountability

The Chair of the subcommittee will report to the Chair of the MCC.

Meetings

Meetings will be held four times each year. At least one face-to-face meeting will take place at the annual meeting of ACPGBI. Other meetings will be held by teleconference. The agenda will be coordinated by the Chair, who will be
responsible for minutes that will subsequently be submitted to the Chair of MCC and ACPGBI Council.
Reimbursement of expenses The ACPGBI will reimburse reasonable day travel expenses and second-class rail fares. Overnight accommodation and subsistence will be covered if required

October 2020

Appendix 6 Terms of Reference for the Emergency General Surgery Sub-committee

Purpose

Emergency surgery and its provision within Trusts is of paramount importance. The purpose of the Emergency Surgery Subgroup (EGS) is to represent ACPGBI members ensuring that emergency colorectal surgery is performed to the highest standard and that their contribution to the generality of emergency surgery is similarly recognised. This group mirrors IBD, peritoneal malignancy and endoscopy subgroups that similarly report through MCC.

Interactions

MCC. The subgroup reports to Council through MCC Chair
The nursing Allied Professionals Group, The Royal College of Anaesthetists
Representatives of NELA/PQUIP, AUGIS, ASGBI, BSG
Charities and patient support groups Commissioning bodies

Objectives

Representation of views of professional and patient groups in shaping
strategy for emergency colorectal and general surgery.
Provision of oversight, direction, governance and promotion of emergency surgery-related databases, audits, research and initiatives.
Address issues related to training and the performance of emergency colorectal surgery by non-specialists. Collaboration with other bodies and charities with shared interest in Emergency surgery, including but not limited to NELA and PQUIP.

Membership

The membership of ACPCBI will be invited to apply for 4 positions on the subgroup. These will be voted by Council following submission of an abridged CV. All members should be currently involved in the provision of emergency general/colorectal surgery in their Trusts. Three-year terms are encouraged to ensure continuity.
The Chair will be appointed by the Executive of the ACPGBI.
A patient representative will be nominated by the Patient Liaison Group. A trainee representative will be appointed by the Dukes 'Club.
Other co-opted members will be recruited as required.

Accountability

The chair of the subcommittee will report to the Chairman of the MCC

Meetings

Meetings will be held twice each year. At least one face-to-face meeting is encouraged each year either at the annual meeting of ACPGBI or at the Royal College of Surgeons of England in London with teleconferencing available. Other meetings will be held by teleconference.
The agenda will be coordinated by the Chair and Honorary Secretary, but any member of the subcommittee may propose items for the agenda if the Chair agrees.

Reimbursement of expenses

The ACPGBI will reimburse reasonable day travel expenses and second-class rail fares. Overnight accommodation and subsistence will not be covered.

Charles Maxwell-Armstrong and Nicola Fearnhead October 2015
October 2015

Appendix 7 Terms of Reference for the Guidelines sub-committee

Background

The production of guidelines is a fundamental role of the ACPGBI: Guidelines underpin modern clinical practice and its governance. It is essential that ACPGBI produces robust and evidence-based guidelines to support its members and the wider clinical community.

• Guidelines provide an additional role in supporting the development and relevance of the Association's own journal, Colorectal Disease.

The journal's editor Neil Smart has noted that in the 2 leading colorectal journals that published guidelines differing impacts are felt on the journals at present.
Colorectal Disease (CODI) – 0% of top 10 / 9% of top 100 cited papers 2016-2020
Diseases of the Colon and Rectum (DCR) – 50% of top 10 / 15% of top 100 cited papers 2016-2020

• The requirements for Guideline Development have significantly changed in recent years and there has been a "step-change" in the methodology with use of AGREE II, AGREE-S and GRADE. This has increased the volume and complexity of work required to produce a guideline and many Colorectal Specialists are unfamiliar with this methodology. An ACPGBI Guidelines Committee will be established to lead and support ACPGBI guideline development.

Purpose and Objectives of the ACPGBI Guidelines Committee:

The Committee has several roles (Ref: Roles of ACPGBI Guidelines Committee) and their work will be undertaken within a Guideline Development Framework (Ref: Process for Delivering ACPGBI Guidelines).

A) Roles of the ACPGBI Guidelines Committee:

1. Develop a Guideline Development Framework.
This will be an initial role for the committee to guide ongoing activity.

2. Select areas for ACPGBI Guideline Development: *a. Define areas where guidelines are required.*
b. Review of published evidence.
c. Prioritisation of areas for guideline development.

3. Define requirement of the membership eg Guideline or Consensus Statement: *a. The type of guidance will be determined by the Guideline Committee based on evaluation of the quality of published literature using the Guideline Development Framework.*
b. The Guidelines Committee may require external specialist input to support this process (Subject Area & Methodology).
c. Consider whether the guideline would benefit from joint development with other professional bodies eg. JAG, ESCP, ASGBI.

4. Support Selected Guideline Development: *a. Selection of Guideline Development Group and Chair.*
b. Define meeting process.
c. Methodological support – engage expert and / or provide expertise (PICO / Recommendations / Delphi / Grading).
d. Support guideline writing.

5. Review of New (External) or Existing Guidelines:
a. New (from External Organisations) – initiate contextualisation process.
b. Existing – initiate update process.

6. Communication:
a. Provision of regular updates on Guideline activity to Executive and Council.
b. Communication to allied organisations re potential joint guidelines.
c. External communication of new guidelines (Website, Publication, Twitter etc).

B) Process for Delivering ACPGBI Guidelines:

• **Guideline development framework**

The ACPGBI should have its own framework for guideline development. This should use the AGREE-S framework as its basis, but this should be enhanced with a greater emphasis according to our own priorities including patient involvement, EDI, and subject matter expertise. This will minimise bias in panel selection and will delineate a clear process of development enabling those who wish to take part in guideline creation to expand their skills and experience.

The framework should include the following areas:
1) Choice of guideline development group members
2) Drafting of the protocol/proposal (including AGREE-II and AGREE-S)
3) Managing conflicts of interest
4) Outcome selection: There should be a prioritisation of outcomes. This consists of not only voting on the importance of outcomes, but also setting minimal important differences per outcome, as described by GRADE working group.
5) Formulating the questions and development of PICOs
6) Evidence retrieval, including development of a framework that will outline steps for reviewing systematic reviews, to avoid using poor-quality reviews as a basis for recommendations. If no good quality review exists, then a new systematic review may be commissioned, which is detailed in the WHO handbook for guideline development.
7) Evidence assessment (GRADE)
8) Development of recommendations
9) Guideline writing
10) Guideline implementation, adaptation (including potential barriers) and monitoring/evaluation.
11) Setting a date for updating the guideline

• **Framework for identifying and selecting topics for guideline development.**

Without a robust selection process and assessment of need, valuable time, expertise and financial resources will be wasted on developing guidelines which go unused.
In assessing the need for a guideline, consideration needs to be given to three broad questions in a stepwise fashion, only progressing to the next stage if the answer at each stage is yes (see figure 1).

Following a robust and transparent framework for identifying and selecting areas for guideline development ensures that:
1. The initial longlisting is broad and inclusive minimizing the potential for important areas to be overlooked.
2. Potential for waste/duplication is minimized.
3. The wider ACPGBI membership are engaged early increasing awareness of and confidence in any guidelines produced and subsequent good uptake/utilisation.

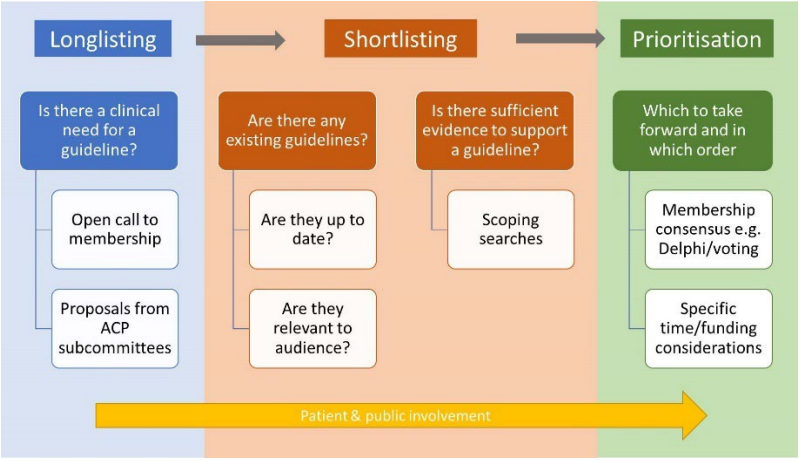

Figure 1: Framework for identifying and selecting areas for guideline development.

• Format of Guidance Produced:

The Guideline committee can decide upon the format of the guideline and whether the topic is suitable for a guideline or a consensus statement. If there is poor quality or no evidence then a high quality guideline cannot be produced and a consensus statement is more appropriate. The Accurate Consensus reporting document (ACCORD) from the Equator network (Enhancing the Quality and Transparency of health research) is due to be published in 2023. This guidance should help ensure a degree of methodological rigour when producing consensus statements.

• Updating Guidance:

There will be a need to update older guidelines. This work will need to be prioritised alongside the development of new guidelines. Updating guidelines that have been conducted with more transparent methods should be easier when updating search strategies and including new evidence. The process for updating should be clearly outlined in the ACPGBI Guideline protocol and the guideline.

1) The timing of guideline updates may be different depending on guideline type; a rapid guideline or consensus statement could be updated more frequently than a standard guideline (e.g 3-5yrs). If new evidence is available, then the guidelines should be updated sooner.

2) For standard guidelines, it is also not always necessary to update the whole guideline, (unless it has not been subject to the current standards of Methodology). The focus should be on areas where there is new evidence available.

3) Periodic searches, using the guidelines search strategy should be conducted, to highlight new evidence. This lies within the remit of the Guideline committee.

• Guideline Development Groups Structure:

Guideline development groups (GDGs) should have a Chair, a methodology expert, a number of subject matter experts and a number of stakeholder representatives. GDGs should number around 12-16 members, but this may vary according to the nature of the guideline work being undertaken.

• **The Chair's role** is to lead the GDG, monitor costs, report to the Guideline Committee, and organise meetings, voting, dissemination and reporting. Inguide level 3 training would certainly be valuable as something to aspire to in time but is not a prerequisite. Methodological experience, Inguide level 1 training and subject matter interest demonstrated by publication or committee membership will be required by the chair. A co-chair may sometimes be valuable.

• **The methodologist's role** is to maintain the methodological integrity of the guideline, according to the framework in use, advising and supporting the actual method being employed. They should have Inguide level 2 or equivalent training and may be supervising a trainee methodologist in addition.

• **The Subject matter experts' role** is to provide interpretation of the evidence and voting in expert consensus processes. Subject matter experts would ideally have or be working towards level 1 Inguide training or equivalent. Defining subject matter experts is difficult and this should be based on publication, tertiary practice and evidence of reflective practice, rather than committee or administrative experience alone. They might come from any professional group (surgeons, nurses, gastroenterologists etc.) and any hospital setting (DGH, teaching hospital etc.). Around 6-10 subject matter experts may be appropriate, depending on the nature of the guideline and subject.

• **Stakeholder representatives** are crucial to ensure that the guidance produced is relevant to patients and across the range of HCPs using them, including any combination of colorectal surgeons (including from DGH and teaching hospital settings), specialist nurses, gastroenterologists, AHPs and GPs, for example.

• **Higher trainees** may be involved in guideline development groups as part of their own training or academic work. In this setting, they will be invested in undertaking a substantial portion of the work required in evidence identification/assessment, and data extraction and may attend GDG panel meetings.

• **GDGs should demonstrate:** active engagement & representation with equality, diversity & inclusion (EDI).

ACPGBI Guideline Committee Strategy:

The ACPGI Guidelines Committee should define a strategy for a 5-year period. This should recognise the need to develop the training of individuals in guideline methodology. This strategy should be consistent with the Strategy Document currently in production for the whole Association.

The strategic directions should include:

• **Development of an ACPGBI framework for guideline development** and the appointment of the GDG members

• **Prioritisation and planning of defined areas for guideline development** over a rolling period of 2 years, so that the output is always current and relevant to the needs of the general membership of the ACPGBI.

• **Development of methodological expertise within the ACPGI:**

o *Training for specific methodologists to the level of the current contracted expertise*

o *Training for a small group to a level of leadership of GDGs*

o *Training for a large group of individuals to a level of GDG panellist*

o *Individuals should be selected based on application.*

• **Identification of subject matter expertise within the ACPGBI.** This may be difficult to achieve, and it would be useful for the Association to delineate a benchmark for expertise, which might have wider application beyond guideline work.

• **Development of a trainee group** to create a source of trained guideline panellists which might undertake subprojects of SR writing and grading of existing SRs to gain relevant skills in reviewing and statistical analysis.

• **Development of Guideline / Research Fellowships** – this could be part of a longer-term strategy once there is some maturity of experience within the guideline committee.
• **Guideline methodology sessions and courses** could also be developed and offered at the national meeting.

Membership & Structure of ACPGBI Guideline Committee

• *6 elected members including a mixture of stakeholders (Academic Experience, DGH Type Experience)*
• *Trainee Representative*
• *Patient Representative*
• *Nursing Representative*

Membership will be for a 3-year period (renewable by application for re-election for a maximum of 6 years). Members will need to have received or will require training in Guideline Methodology. The elected members may be augmented with additional temporary external members where specialist expert input is required including Subject Matter Expertise and Methodology Expertise, (incl. Statistician etc.). Editorial advice may also be sought ay an early stage in the development process.

Accountability:

The chair of the subcommittee will report to the Chair of the MCC.

Meetings:

The guideline group will meet regularly to evaluate new guideline proposals and update regarding current guideline development. Individual members will be required to attend Guideline Development Meetings more frequently as required.

Reimbursement of expenses:

The ACPGBI will reimburse reasonable day travel expenses and second-class rail fares. Overnight accommodation and subsistence will be covered if required.

Costs of ACPGBI Guideline Development

The ACPGBI Guideline Taskforce (2023) undertook a detailed evaluation of the potential costs of guideline development. The following costs were identified:

• **Methodologist** as a consultant. If we decide to train surgeon methodologists this would only be an early cost. They will attend all guideline meetings and be available for consultation. They can provide consultation for two guidelines at a time only. This does not include providing training for GDG members.

• **Training GDG:**
- **To level 1 with INGUIDE (Option 1)** – £1500-£2000 per guideline
- **To Level 1 with Professor Jos Kleijnen (Option 2)** – £2000 for an 8 hour session for an unlimited number of members. He will include objectives covered in INGUIDE level 1 but he will also expand on topics as necessary and tailor it to our needs.
- **Additional training -** INGUIDE level 2 for each guideline and an additional member being trained to level 3 - £1944 - £2679 per guideline.

• **Patient representatives' costs -** ACPGBI should cover transport and overnight accommodation (where necessary) for face-to-face meetings. There is also an argument that they should be paid for their time.

• **Costs associated with GDG panel meetings** – it is possible to conduct meetings virtually, but other guideline-producing groups often have at least one face-to-face meeting. This could be attached to e.g. the annual conference to reduce additional travel and/or accommodation costs.

• **Publishing costs** – not defined (Open Access)

• **Research fellow (s) –** Experience from within the taskforce indicated the need for at least 1 or 2 individuals, who are required to undertake a substantial quantity of work in the production of guidelines (incl. Literature Search, Evaluation of Literature, Grading, Guideline Writing). This is often best achieved through employing a Research Fellow working on the topic area, who can submit the guideline development as part of their thesis. The Research Fellow would need to be provided by a member of the Guideline Development Committee for a guideline, since the cost of this would exceed available funding from the ACPGBI. The ACPGBI could however contribute to Guideline Methodology Training).

• **Cost effectiveness analysis (COA**) in guidelines- probably not required for ACP guidelines unless performed in partnership with NICE/funding bodies. Specialist associations are usually not expected to perform COAs for recommendations and in instances where they have in the past, it is usually through engagement and partnership with local funding decision makers or NICE. From discussions with Jos Kleijnen, the cost of performing a COA using KSR evidence will depend on the number of recommendations being assessed and can cost an additional £40,000 - £50,000. NICE guidelines usually have a budget of £250,000-£300,000 per guideline, and normally limit COAs to 1-2 recommendations due to the costs associated with producing these in the absence of appropriate evidence).

Summary of costs of producing guidelines:

From the above, it is estimated that an ACP guideline will cost approximately £15,000 to produce with the help of research fellows under the supervision of a methodologist.
Generally, the cost of a guideline depends on the scope of the guideline and the number of recommendations that a guideline is expecting to produce. For perspective, if we commissioned KSR evidence to produce a guideline then they would perform the literature search for systematic reviews and RCTs, data extraction, ROBIS assessments, GRADE, and evidence tables. They normally estimate £40,000 per guideline for this work as each recommendation costs £3000 to produce. Depending on the scope of the guideline, this estimate can increase. This estimate also does not include producing new systematic reviews or performing additional meta-analysis. It only involves a pragmatic approach to evidence, where any available high level (existing systematic reviews, RCTs) evidence is extracted to produce recommendations.

References:

1. AGREE II : www.agreetrust.org/agreeii
2. AGREE-S: www.agree-s.org
3. GRADE: www.gradeworkinggroup.org

Michael Davies, Graham Branagan, Jared Torkington.
October 2023

Appendix 8 Terms of Reference for the IBD Sub-Committee

Background

Caring for patients with inflammatory bowel disease (IBD) is an integral part of colorectal practice. The purpose of this subgroup is to ensure that the highest standards of practice are maintained going forward, training is maintained, and that new techniques can be supported appropriately. The IBD subcommittee reports through MCC.

Objectives

- Promotion of expert provision, resources and quality improvement in IBD surgery on a national level.
- Provision of oversight, direction, governance and promotion of IBD-related databases, audits, research and initiatives.
- Serve as a steering group for the national ACPGBI IBD surgery database
- Address issues related to training and the performance of IBD surgery by colorectal surgeons.
- Collaboration with other bodies and charities with shared interest in IBD care.

Membership & Structure

There will be 6 elected members including the Chair. The initial chair shall be elected by ACPGBI executive and subsequently by the members of the subcommittee. The first and subsequent chairs may be in post for 3 years only, unless exceptional circumstances dictate otherwise. There will be elected representation from Dukes and nursing as well as the PLG (Patient Liaison Group). Other co-opted members will be recruited as required and Stoma nurse and tissue viability involvement and representation will be encouraged as will formal representation from an appropriate plastic surgery society.

The subcommittee will sit within the Multidisciplinary Committee. The chair will report to Council and Executive via the Chair of the Multidisciplinary committee (MCC), though may on occasions be asked to present directly. They will work closely with the Education & Training committee as well as the elected members of MCC.

Interactions

- Nursing and Allied Health Professionals (NAHP) Group
- Charities and patient support groups
- Commissioning bodies
- Industry
- Dukes Club
- Early Years Consultant Network (EYCN)
- Royal College of Surgeons Getting It Right First Time (GIRFT) initiative
- British Society of Gastroenterology
- European Society of Coloproctology (ESCP)
- European Crohn's and Colitis Organisation (ECCO)

Accountability

The Chair of the subcommittee will report to the Chair of the MCC.

Meetings

Meetings will be held three times each year. At least one face-to-face meeting will take place at the annual meeting of ACPGBI. Other meetings will be held by videoconference
The agenda will be coordinated by the Chair, who will be responsible for minutes that will subsequently be submitted to the Chair of MCC and ACPGBI Council.

Reimbursement of expenses

The ACPGBI will reimburse reasonable day travel expenses and second class rail fares. Overnight accommodation and subsistence will be covered if required.

Thomas Pinkney and Justin Davies
July 2021

Appendix 9 Terms of Reference for the Intestinal Failure Sub-Committee

Background

Intestinal failure represents a significant burden of disease and is an important cause of long-term morbidity and mortality in the general, emergency and colorectal surgical communities. High-quality surgical efforts in both the prevention and management of intestinal failure are therefore of the utmost importance. Elective colorectal and emergency operations may be associated with a relatively bowel injury and surgical site infections (SSI) and can also be complicated by fistulas especially if reoperation is deemed necessary. Intestinal failure may follow occlusive vascular events or be associated with luminal bowel diseases such as Crohn's or malignancy or with mechanical or non-mechanical bowel obstructions. All colorectal surgeons will face disease related or iatrogenic intestinal failure patients as part of their practice; all should be able to deal with such patients acutely but patients with established intestinal failure should to be referred on to a designated surgical centre.

Purpose & Objectives

The purpose of the Intestinal Failure subcommittee is to represent and support ACPGBI members in matters relating to intestinal failure during or after elective and emergency colorectal or other abdominal surgery. This subcommittee will dedicate itself to education and best practice in matters relating to intestinal failure in the broadest sense. This will include supporting best clinical practice as well as education, training, clinical audit and research. This will include but is not limited to bowel damage and SSI prevention, optimal treatment of complications and limitation of abdominal wall deficits. It is envisaged that the subcommittee will form collaborative links with existing intestinal failure societies as appropriate to support best practice.

Membership & Structure

There will be 6 elected members including the Chair. The Chair shall be elected by the members of the subcommittee, for a period of 3 years, unless exceptional circumstances dictate otherwise. In addition, there will be:
A patient representative.
A trainee representative appointed by the Dukes 'Club.
Other co-opted members will be recruited as required, to include a specialist nurse, dietician and pharmacist.
The subcommittee will sit within the Multidisciplinary Committee. In this regard it mirrors all other clinical subcommittees including IBD, peritoneal malignancy, colonoscopy, abdominal wall, advanced malignancy and proctology subgroups that similarly report through MCC. The chair will report to Council and Executive via the Chair of the Multidisciplinary committee (MCC), though may on occasions be asked to present directly. They will work closely with the Education & Training committee as well as the elected members of MCC.

Interactions

• Multidisciplinary Clinical Committee (MCC). The subgroup reports to ACPGBI Council & Executive through the MCC Chair. • Nursing and Allied Health Professionals (NAHP) Group
• Royal College of Surgeons Getting It Right First Time (GIRFT) initiative
• Association of Surgeons of GB&I
• BIFA / BAPEN
• ESPEN
• Charities and patient support groups • Commissioning bodies

Accountability

The Chair of the subcommittee will report to the Chair of the MCC.

Meetings

Meetings will be held three times each year. At least one face-to-face meeting will take place at the annual meeting of ACPGBI. Other meetings will be held by teleconference. The agenda will be coordinated by the Chair, who will be responsible for minutes that will subsequently be submitted to the Chair of MCC and ACPGBI Council.

Reimbursement of expenses

The ACPGBI will reimburse reasonable day travel expenses and second-class rail fares. Overnight accommodation and subsistence will be covered if required

Carolynne Vaizey
May 2021

Appendix 9 Terms of Reference for the Peritoneal Malignancy Sub-Committee

Purpose

The management of peritoneal malignancy is complex and highly specialised. While Cytoreductive surgery and HIPEC has become the standard of care for patients with colorectal peritoneal metastases, pseudomyxoma peritonei and appendiceal cancers, there are still many unanswered questions in the optimal treatments for these patients. There is also a requirement for substantially developing the provision of peritoneal malignancy surgery within the UK and Ireland.

The purpose of the Peritoneal Malignancy Sub-Committee is to advise on the optimal treatment for patients with peritoneal metastases from colorectal and appendiceal malignancy, to develop and support research ideas in peritoneal malignancy and to advise NHS England on service provision. The committee will represent and support ACPGBI members.

Interactions

- Multidisciplinary Clinical Committee (MCC). The Sub-Committee reports to ACPGBI Council and Executive through the MCC Chair.
- Nursing and Allied Health Professionals (NAHP) Group
- Association of Surgeons of GBI
- The National Bowel Cancer Audit
- Charities and patient support groups
- NHS England Specialist commissioning

Objectives

- Advise on the optimal treatment for patients with colorectal and appendiceal peritoneal metastases
- Advise on the optimal treatment for patients with pseudomyxoma peritonei & peritoneal mesothelioma
- Education and training of multidisciplinary teams in the management of peritoneal malignancy
- To liaise with NHS England specialist commissioning regarding service provision and service specification within the NHS
- To develop research ideas and support clinical research and in peritoneal malignancy
- Support the UK and Ireland Peritoneal malignancy registry for defined projects

Membership

- The membership of ACPCBI will be invited to apply for 5 positions on the Sub-Committee. These will be agreed by the peritoneal subcommittee members following submission of an abridged CV. Each post will be for three years, renewable by agreement of the committee.
- Each of the 5 members can appoint a deputy who can attend meetings if the original member is absent.
  The Chair will be elected by members of the sub-committee, but will generally rotate through each of the key peritoneal malignancy centres in the UK
- A patient representative will be nominated by the Patient Liaison Group.
- A trainee representative will be appointed by the Dukes' Club.
- Other co-opted members will be recruited as required

Accountability

The Chair of the subcommittee will report to the Chairman of the MCC.

Meetings

Meetings will be held at least twice each year.

- At least one face-to-face meeting is encouraged each year usually at the annual meeting of ACPGBI.
- A second meeting will be held virtually
- A third meeting will be held at the time of the UK and Ireland Peritoneal Malignancy conference

The agenda will be coordinated by the Chair in conjunction with members and the Chair of MCC.

Reimbursement of expenses

The ACPGBI will reimburse reasonable day travel expenses and second-class rail fares. Overnight accommodation and subsistence will not be covered.

Haney Youssef
July 2024

Appendix 11 Terms of Reference for the Proctology Sub-Committee

Proctology has always been the *sine qua non* of the profession. The purpose of this subgroup is to ensure that the highest standards of practice are maintained going forward, training is maintained, and that new techniques can be supported appropriately. The Proctology subcommittee mirrors IBD, peritoneal malignancy and endoscopy subgroups that similarly report through MCC.

Interactions

- Multidisciplinary Clinical Committee (MCC). The subgroup reports to ACPGBI Council and Executive through the MCC Chair.
- Nursing and Allied Health Professionals (NAHP) Group
- Royal College of Surgeons Getting It Right First Time (GIRFT) initiative
- Association of Surgeons of GB&I
- Charities and patient support groups
- Commissioning bodies

Objectives

- Promotion of expert provision, resources and quality improvement in proctology nationally.
- Provision of oversight, direction, governance and promotion of proctology-related databases, audits, research and initiatives.
- Address issues related to training and the performance of proctology by colorectal surgeons.
- Collaboration with other bodies and charities with shared interest in proctology.

Membership

The membership of ACPCBI will be invited to apply for 6 positions on the subgroup. These will be voted by Council following submission of an abridged CV. Three year terms are encouraged to ensure continuity.
In the first instance the Chair will be appointed by the Executive of the ACPGBI. Thereafter he/she will be voted by the members of the subcommittee.
A patient representative will be nominated by the Patient Liaison Group.
A trainee representative will be appointed by the Dukes Club.
Other co-opted members will be recruited as required.

Accountability

The Chair of the subcommittee will report to the Chair of the MCC.

Meetings

Meetings will be held three times each year. At least one face-to-face meeting will take place at the annual meeting of ACPGBI. Other meetings will be held by teleconference.
The agenda will be coordinated by the Chair, who will be responsible for minutes that will subsequently be submitted to the Chair of MCC and ACPGBI Council.

Reimbursement of expenses

The ACPGBI will reimburse reasonable day travel expenses and second-class rail fares. Overnight accommodation and subsistence will be covered if required.

Charles Maxwell-Armstrong, Ciaran Walsh and Nicola Fearnhead
February 2020

Appendix 12 Terms of Reference for Robotic Sub-Committee

Robotics has become an integral practice within coloproctology over the last 10 years. The aim of the Robotic sub- committee of MCC is to provide leadership in this rapidly developing field.

Interactions

- The subcommittee reports to ACPGBI Council and Executive through the Chair of MCC.
- ACPN
- Charities and patient support groups
- Commissioning bodies
- Industry
- Dukes Club
- The Early Years Consultant Network (EYCN)
- Other committees as required as ex-officio members (R+A, External affairs, E+T)

Objectives

- Provision of leadership and expertise in the field of robotic colorectal surgery. This may encompass areas such as governance, research, and training.
- Collaboration with industry and developers of new robotic platforms.
- Collaboration with other bodies and charities with shared interests.
- Collaboration with Dukes Club, ensuring promotion of trainee interests.
- Collaboration with patient groups.

Membership

The membership of ACPCBI will be invited to apply for 6 positions on this subgroup. These will be voted by Council following submission of an abridged CV in the event of more than 6 applications. Three-year terms are encouraged to ensure continuity. Members may reapply for a further term of 3 years, though may, depending on number of applicants, need to go through an election process.

A Chair will be appointed by Executive in the first instance, and then by the sub-committee subsequently. A patient representative will be nominated by the Patient Liaison Group.

A trainee representative will be appointed by the Dukes Club.

Other co-opted members will be recruited as required.

Meetings

Meetings will be held three times each year. At least one face-to-face meeting will take place at the annual meeting of ACPGBI. Other meetings will be held by videoconference.

The agenda will be coordinated by the Chair, who will be responsible for minutes that will subsequently be submitted to the Chair of MCC and ACPGBI Council.

The Chair of the sub-committee may be required to present their activities to Council and/or Executive on occasion, either in person or by videoconference.

Reimbursement of expenses

The ACPGBI will reimburse reasonable day travel expenses and second-class rail fares. Overnight accommodation and subsistence will be covered if required.

Charles Maxwell-Armstrong, Ciaran Walsh and Nicola Fearnhead
June 2020