ACPGBI Accreditation of pouch units

EXECUTIVE SUMMARY

The purpose of this paper is to provide guidelines to units seeking to be accredited for pouch surgery by the Association of Coloproctology of Great Britain and Ireland (ACPGBI). Pouch surgery includes formation of ileal pouches, refashioning of ileal pouches and removal of ileal pouches. The need for accreditation comes from the 2017 ACPGBI audit report that identified that significant numbers of units were performing less than 1 pouch surgery a year.

This document focuses on pouch formation for ulcerative colitis, though it is accepted that the procedure may be performed in rare cases for FAP, certain instances of colorectal cancer, and in a vanishingly small number of cases Crohn's disease. The principles of accreditation are the same irrespective of the underlying condition.

Commissioning data from NHS England collected in 2020 showed that only 18/46 trusts who were commissioned to provide complex IBD services had any activity related to the service, and another 18 trusts were undertaking non-commissioned complex IBD activity. Clearly there will have been a lull in activity as a result of the Covid-19 pandemic, though it seems likely that there will be a significant number of patients awaiting this surgery. In view of the above it is felt that now is the time for ACPGBI to introduce accreditation in order to maintain the highest standards possible for pouch surgery.

INTRODUCTION

1. IBD broadly describes two long term conditions that involve inflammation of the gut: Crohn's disease (CD) and ulcerative colitis (UC). Often diagnosed between the ages of 15 and 40, symptoms may include abdominal pain, bloody diarrhoea, weight loss, and extreme tiredness. In 2020, a published study of over 11 million people registered

with general practices in the UK found that the prevalence of IBD was 723 per 100,000 people in 2018, roughly equating to 479,132 people living with the condition. The incidence rates are rising in adolescents aged 10-16 years and decreasing in adults aged over 40 years.

2. The term pouch "Pouch" refers to the formation of a reservoir from the small bowel, specifically the ileum. The surgery was originally described in 1978. The aim of pouch surgery when combined with a proctectomy is to remove all diseased bowel in UC or rarely FAP, whist ultimately removing the need for a long-term stoma. It is a highly complex procedure, and management of the complications can be challenging.

3. In 2019, the British Society of Gastroenterology (BSG) published consensus guidelines on the management of IBD in adults following a review of 88,247 publications and a consensus-building exercise with 81 clinicians and patients. Of most relevance to accreditation is that their guidelines recommended that all pouch surgery should be undertaken in specialist high-volume referral centres. The one piece of evidence supporting this recommendation was graded as low-quality and the cited study considered a high-volume centre to have more than 100 procedures between 1996 and 2008 (roughly 7.7 procedures per year on average).[1] Consensus to adopt centralisation of services for pouch surgery was quite high, agreed to by 97.4% of surveyed experts.

4. In 2018, the Association of Coloproctology of Great Britain and Ireland (ACPGBI) published consensus guidelines in surgery for IBD. It makes a more compelling case for centralisation/specialisation of IBD services by describing studies from Canada and Denmark that showed better surgical outcomes from higher volume IBD centres. These studies were generic to all types of IBD surgery, however, and not those that solely fall under the remit of complex IBD surgery in England, such as revisional pouch surgery. The guidelines also inferred research from other health

services to argue that the disadvantages of patients needing to travel further were outweighed by the opportunity to provide better care. There was very high (97.1%) consensus among experts with the statement "there is an association between higher surgical caseload and improved outcomes for pouch surgery" in the ACPGBI guidelines.

5. In 2015, the National Institute for Health and Care Excellence (NICE) published Quality Standard QS81 for IBD. Its four quality statements are:

    a. People with suspected IBD have a specialist assessment within 4 weeks of referral.
    b. Services provide age-appropriate support from a multidisciplinary team for people with IBD, and their family members or carers.
    c. People having surgery for IBD have it undertaken by a colorectal surgeon who is a core member of the IBD multidisciplinary team.

6. Some types of surgery for IBD, although uncommon, can be particularly complicated such as the excision or revision of ileoanal pouches. Surgeries such as these are commissioned by NHS England rather than by local Clinical Commissioning Groups, and are known as "complex IBD surgery". They are contracted to specific centres around England.

7. On comparing QSIS and NCDR data in 2020, 46 trusts in England were commissioned to provide services for complex IBD surgery, but only 18 of them had any activity related to complex IBD surgery. Similarly, another 18 trusts were undertaking complex IBD activity but did not appear commissioned to do so. The definition of complex IBD surgery is one of the following:

    a. Bowel surgery for patients at risk of short bowel syndrome that would require long term parenteral feeding (greater than 28 day duration)

b. Surgical management of multi-focal small bowel disease which may result in short bowel syndrome
c. Revisional surgery on ileo-anal pouches
d. Excision of ileo-anal pouch surgery.
e. Surgical management of neoplasia arising in a perianal fistulae in a patient with Crohn's Disease
f. Surgical reconstruction of an unhealed perineum requiring plastic surgical expertise.

8. Of 36 trusts that had reported complex IBD surgery activity in 2019/20, 33 trusts had less than 4 surgeries recorded and would be classified as low-volume centres. The current situation with pouch surgery in England is that 80% of Trusts are very low volume (<5 procedures per year) and that 126 surgeons are doing one pouch in every 5 years. The volume outcome data is very clear in that 'occasional' surgeons get poorer outcomes. This is not necessarily due to the experience and skill of the surgeon. More likely it is the availability of both pre- and post-operative support. We know from our data that nearly one third of patients end up being readmitted after surgery and this likely relates to the general lack of support received on discharge.

9. There are only about 280 pouch procedures done each year in England. With commissioning of around 30-40 centres, as is already the case, equates to less than 10 procedures per centre, a figure that could be considered the minimum to maintain standards regarding surgeon volume, support services and in particular training. And there is of course the very clear benefit to patients. Another disadvantage would be the need for some patients to travel for treatment. Research including that from NHS Choice suggests the majority of patients are willing to do this to receive better care.

10. An assessment of SWORD data from the Ileoanal Pouch Report raised concerns of the "occasional" pouch surgeon – between 2012 and 2017,

only 26 surgeons in England performed more than 15 pouch operations (equivalent to an average of 3 per year) while 126 surgeons (a quarter of all surgeons on the dataset who have done pouch surgery) have performed just one. Similarly, 108 out of 126 English institutions carried out less than five pouch procedures per year.

11. Regional-level data from the SWORD (covering years 2013-2017) suggests that regions with higher critical mass have lower 30-day reoperation and readmission rates e.g. London does by far the most number of pouch surgeries (369, including 159 at St Mark's Hospital alone), but has below average 30-day reoperation rates (4.6%) and 30-day readmission rates (26.1%). The overarching message by the 2017 Ileoanal Pouch Report is that the number of pouch surgeries nationally is decreasing, becoming increasingly laparoscopic, and being conducted as occasional surgeries.

ACPGBI Accreditation of Pouch Units

The following have been determined as being prerequisites for a colorectal unit to become an ACPGBI accredited pouch unit:

a. At least 2 named surgeons who: (i) are core members of an IBD MDT and regularly attend multi-disciplinary meetings; (ii) have evidence of training/experience in pouch surgery

b. A unit that performs more than 5 cases per year on a 5 year rolling average.

c. Mandatory submission of all data to a national surgical database *.

d. A named allied health professional who has experience of the care of pouch patients and can provide information, counselling and support for pouch patients both pre- and post-operatively.

e. A unit that can provide minimal access service at least for colectomy if the patient chooses.

*The Amplitude S database has been existence up until very recently and is accepted that some units may have submitted cases. It is also accepted that some units had local difficulties with IG through no fault of their own. It is likely that going forward there will be some vehicle for data collection to inform the national picture. It is envisaged that accredited units will engage with whatever form this ultimately takes.

Please complete the questions in the link below:

https://www.surveymonkey.co.uk/r/Accreditation-of-pouch-units