

EXECUTIVE SUMMARY



# Resources for Coloproctology 2015

Association of Coloproctology  
of Great Britain and Ireland



save  
lives



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Bowel Disease  
Research Foundation

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# Preface

The NHS is on a journey towards ensuring a safe, effective and responsive standard of care for all patients, a standard which the scandals at Mid Staffordshire NHS Foundation Trust and a number of other similarly afflicted providers have shown is sadly not universally available in our health service.

It will not be possible in practice to achieve this goal without the wholehearted commitment of all healthcare professions, but particularly the medical profession through the relevant specialty associations, acting in partnership with the patients whom they serve. No such collaboration can exist without a shared understanding of what is required to provide a proper standard of care.

Therefore I welcome the transparent patient centred approach to this vital area of the health service evidenced by this report. It demonstrates just what the medical profession can contribute to the development of their particular areas of expertise for the benefit of patients and how patients can be included in the understanding of what is required.

Aimed at informing patients about what is needed to ensure safe and good quality care in coloproctology, the report is written in language which is accessible not only to patients and the public, but also the boards who have to balance to competing priorities, and regulators who need to understand the resources required to maintain proper standards. As we look increasingly to a partnership between those who work in the service, and those who are served, the required mutual understanding of the challenges and solutions for them in every specialty can only be created by guidance such as contained in this report. In that way patients in particular and the public in general can play their part in the debates about where scarce resources should be allocated. These are not problems to be discussed behind closed doors, but ones where the views of all can drive constructive change and improvement.

The report offers much practical guidance, but to my mind one area which needs to be an absolute priority for any healthcare service is the identification of a measurable standard of safe staffing. Without this boards and other leaders are not well equipped to protect patients and allocate resources appropriately. In this regard I suggest this report could be a model for any specialty keen to assist in the definition of the staffing and other resources required to deliver safe and good quality care to patients, as well as demonstrating how these needs can be explained in relatively non-technical language.

I believe that this report is likely to make a major contribution towards ensuring that all those who need to understand and plan for staffing and other resource requirements, have a ready point of reference to assist them.

In short I commend to this work to all those, professional and interested laymen alike, who are interested in ensuring proper standards of care in coloproctology.

**Sir Robert Francis QC, 23 November 2015**

# Commentary

This new publication of Resources for Coloproctology has the potential to be a useful guide for patients to inform their questions before, during and after treatment for colorectal conditions. It also has the potential to highlight the complexity of the workings of the NHS, and how changes to one area of care may have unintended consequences for others.

We all need to be more questioning and critical of political sound bites which sound appealing in the first instance but which, on further scrutiny, reveal that the practical realities do not always serve patients well.

It is also important to point out that good resources are not the only factor in providing optimal care. Patients should take a wider view and weigh up the particular problems and benefits of their local colorectal services, which extend beyond resources.

## Day Surgery

Patient concern lies in the area of staff qualification and experience in undertaking day surgery, with particular regard to patient safety. Defining what types of operation are appropriate for a day case setting, together with greater clarity in its use, with established guidelines and recommendations should be the next step. For patients, such surgery is to be welcomed where appropriate (most patients would rather not stay unless they have to!) but there is a need for resource and development of this service. Patients would hope that the ACPGBI will do all it can to keep its finger on the pulse in this area.

It is good to see the emphasis on the need for follow up support, if required, in the period after returning home following day surgery. This may involve additional input so that patients feel confident and well prepared to self manage at home when they can. The obvious concern is that patients may be sent home unsupported, and that enhanced tariffs for day surgery will incentivise its use in inappropriate circumstances. Responsible selection of patients for day surgery remains key.

## Out Patients

In the outpatient setting, the problems with two-week wait pathways are noted, particularly the important issue that some patients who may be given the all clear for cancer but who continue to have symptoms can remain untreated. The two-week wait pathway may also divert resources away from patients in need of cancer treatment but who arrive via other pathways. Some patients with symptoms of rectal bleeding may wish to see if there is a local unit that provides a one-stop service.

## In Patients and Theatres

The Resource document highlights wide variation between surplus theatre capacity in some regions while others have shortfalls, so that access to theatre for patients remains a postcode lottery.

Whilst many hospitals now provide pre-assessment clinics with CPEX or Cardio Pulmonary Testing for patients, this is not universally available. Such resources can help the understanding of risk assessment for major surgery and help plan what level of aftercare the patient will need post surgery. Depending what type of post-operative care is suitable, it is important to verifying the availability of the right level of aftercare to make a good recovery; whether it be Intensive Care (ICU), High Dependency (HDU) with the availability of critical care specialists or a normal ward, where, for some conditions, the availability of a separate ward only for colorectal patients is of benefit.

## Nursing

It is good to see the emphasis that nursing should not become too academic but remain focused on holistic patient care. Their role in helping patients to self-manage at the most practical level remains crucial. CNS (Clinical Nurse Specialist) skills need to be more effectively directed towards the patient by increasing their administrative support. Where patients are admitted for cancer care being assigned a CNS (Clinical Nurse Specialist) can provide continuity of care and valuable practical advice and wide ranging support. Where a stoma is the likely outcome of surgery, then a stoma nurse, available before and after surgery can make a huge difference to patient care.

The reduction of registered nurses on wards remains a concern for patients, and the minimum recommendation of one registered nurse for every 8 patients on a ward offers patients a base guideline towards ensuring that their post operative care needs will be met. The National Cancer Patient Survey year on year cites patients reporting that there were insufficient nursing resources on wards.

## Pelvic Floor

The cross specialty coordination in the management of pelvic floor problems is to be welcomed by patients, together with an emphasis on enhanced communication, where conditions may be treated by Gynaecology and Urology as well as Coloproctology. Non-conflicting communication can be a problem for patients at the best of times – what one surgeon/clinician may tell a patient may be very different from another, and this has the potential to be even more confusing across different surgical specialties. Consensus within departments and, if possible, between departments, would be a gold standard for integrated patient care. Clinicians should be made aware of the existence of a growing number of patient leaflets on these conditions so that they can be more widely disseminated to patients.

Treatment can often be staged in a “trial and error” manner for these conditions, sometimes moving through from less to more invasive treatments, with good clinical indications. However, this may cause problems in sustaining the patient’s patience, which can be alleviated by good explanation of the process.

The report highlights other inadequacies in this emergent specialty and the need for its further development towards maturity.

## Oncology

The comments made in the section on Oncology regarding quality of life following treatment versus the chance to cure in the over 65 population are welcomed by patients. This is a very important issue with regard to current treatments available and their short and long term effects. The problematic nature of such discussions with all patients is not to be underestimated, and it takes great skill to register with patients in some distress following diagnosis, where shock can temporarily compromise cognitive and memory function, affecting the ability to weigh up decisions.

## Multi-disciplinary Teams

Cases may sometimes be discussed by a team of clinicians with varied expert skills, to determine the best treatment for the patient. This report gives sound advice that the patient’s views, preferences and needs should be expressed to the team by those who have had direct contact with the patient, so that the patient is fully represented at the meeting. A definition of the role of the MDT coordinator is also welcomed to alleviate the work of clinicians.

## Conclusion

The report provides evidence of worrying shortcomings in resources across many areas, such as Radiology and Pathology, which are vital for accurate diagnosis and subsequent treatment. If patients are aware of the important areas of care where the provision of the right resources optimizes their care, then it is to be hoped that this will raise the debate and draw attention to the need to rectify the position.

**Jo Church, Chairman,  
Patient Liaison Group**

# Introduction

The Association of Coloproctology is a multiprofessional organisation which, since its inception, has been committed to the identification of the determinants of high quality patient care and the setting and maintenance of standards, in order to achieve continuous improvement in the quality of care for patients with colorectal disorders. It aims to achieve this through various processes including audit, training, research and education.

Approximately 15 years ago the Association recognised that, in order to deliver a high quality service it was necessary to identify and describe the services necessary for the investigation, diagnosis and treatment of colorectal disease. This led to the publication of the first 'Resources for Coloproctology' in 2001. A subsequent update was published in 2006 with the aim of outlining changes in resource allocation as a result of the introduction of the new Consultant contract, and the then recently introduced 'two week wait' and 31/62 investigation and treatment pathway. Both documents attempted to define what multi-professional personnel, including consultant, nursing and non-clinical staff, would be required to provide a prompt and high quality colorectal service. This took into account the total requirements of patients with colorectal disease and conditions in the community and extra non-clinical duties now also required by all levels of staff.

A great deal has changed since 2006. The 'two week wait' is now an established part of our working practice. Laparoscopic surgery has become more common, bringing with it increased resource in terms of equipment and time in theatre. Pelvic floor services have expanded. MDTs, having been established for cancer patients and are gradually being incorporated in both pelvic floor and IBD patient pathways. Emergency Surgery has been highlighted as an area in need of increased attention and resource. Commissioning of services has also become an issue and government targets are influencing patient care more and more.

These changes alone would prompt the need for an update of the resource document. However, one further event in the last 10 years has really emphasised the urgent need for this update. In 2013 the Francis report was published and highlighted appalling levels of care in one NHS Trust, mainly due to a 'cost-cutting, target chasing culture'. Although the report concerned one Trust, the message was clear that this scandal should not be seen as a 'one-off' and that there needed to be a fundamental recognition of the danger of this attitude throughout the NHS. Patient care and safety should come first.

All these factors have led us to revisit the resource document and to update all aspects of care in order to produce something which we hope reflects the current situation in 2015 and which will endure for some time beyond.

## Methodology

The process of updating the resource document was carried out in as scientific and logical a way as possible. The document was divided into different areas of practice, representing each of the 16 chapters detailed below. For each chapter a generic framework was developed and a lead clinician identified. Each lead clinician was asked to form a subcommittee, preferably of at least 3 other specialists interested in that area of work in order to develop consensus and avoid individual bias, particularly in areas where there is little or no evidence.

This subcommittee was then tasked with the following procedure. Firstly, they were required to define the subject of their chapter. They then sought evidence via a literature search of all relevant articles connected with resource and volume related outcomes, including any DoH publications.

In order to assess current resources, it was necessary to examine current practice. Each sub-committee submitted questions relevant to their subject and all these questions were collated into an extensive questionnaire. This was then sent out to individuals from each of the 175 identified Trusts in mainland UK. Follow up email and telephone prompting was carried out over a period of 6 months. Data collected was then summarised and the relevant synopsis delivered to each lead clinician.

Using these data and evidence, the leads and subcommittees were then asked to form a consensus opinion about what resources are required to provide a service based on a population of 500,000, and to identify any resource gap that may exist.

This document has been collated and edited to a standard format, in order better to inform the reader. It has been scrutinised by the ACPGBI Patient Liaison Group, and the methodological process has enabled the widest possible professional engagement in the project. There is a commentary by the Chairman of the Patient Liaison Group.

## Conclusion

It is hoped that this document will inform clinicians, managers, medical directors, chief executives and politicians, so that any existing inequalities in care for patients, resulting in what has been described as “a postcode lottery” can be corrected, so that standards nationally will be more uniform.

This resource document will be in the public domain. The recommendations made will be made available to patients, so that they have the relevant information on which to base enquiries about whether local levels of resource are adequate to ensure good patient care.

## Acknowledgements

The process of obtaining this data and writing such an extensive document would not be possible without the funding support of Bowel Cancer UK and the Bowel Disease Research Foundation. Asha Kaur from BCUK has been invaluable in the development of the questionnaire and the chasing of the data. The project has required significant input from numerous members of the ACPGBI. These include the leads for each of the chapters and their sub-committees, but also the many members who put the effort into replying to what was an extensive questionnaire. Jo Church and the Patient Liaison Group has also provided invaluable advice and commentary.

Finally we are most grateful to Sir Robert Francis for writing the preface and giving validity and support to this document.

# Summary Recommendations

## 1. Consultant Colorectal Surgeon

Current numbers would indicate that there is a median of 8 colorectal surgeons per 500,000 population.

On call commitments vary according to local requirements

Specific session allocation also vary according to local and job specific requirements but most colorectal surgeons have 2-2.5 theatre sessions, 2 clinics and 1 endoscopy session with a median of 2 SPAs.

## 2. In Patients

The average number of beds per 500,000 of the population from our survey is 48 (including level 0-1 and short stay beds).

All colorectal units should have access to level 3 ITU beds

Critical care input to level 2 HDU beds is essential. The majority of colorectal units have level 2 beds with care delivered by critical care staff, although approximately a fifth of such beds have care solely delivered by surgical staff.

Pre-assessment clinics should be an integral part of any colorectal unit and should be fully funded.

CPEX testing is becoming more readily available with more evidence supporting its use. Over 50% of UK colorectal units offer this service and increased uptake should be encouraged.

## 3. Day case surgery

For a population of 500,000, 24 colorectal day cases a week may need to be treated, utilising approximately 5 dedicated sessions.

## 4. In patient theatres

In order to service the colorectal needs of a population of 500,000 approximately 12.5 hours of in-patient operating are required per day.

## 5. Emergency surgery

The median number of EGS admissions for a 500,000 population is 20 per 24 hours.

The surgeon on call should be free from elective commitments.

A dedicated NCEPOD theatre is available in the majority of hospitals and should be considered as essential.

## 6. Outpatients

For a population of 500,000 over 100 new patients will need to be seen by the colorectal unit per week.

## 7. Endoscopy

For a population of 500,000 there may be a future need for 32-34 lower GI lists per week.

Surgeons currently provide 30% of lower GI endoscopy demand which will equate to 11 lists per week.

## 8. Nursing

A stoma CNS workload should average around 100 new patients per year. This equates to 3 stoma care nurses per 500,000 population.

Due to the variable roles of a more generic CNS within different Trusts it is difficult to estimate the number of CNS needed per 500,000 population. Current data from our survey would suggest there are an average of 3-4 CNS per 500,000.

The ratio of ward nurses to patients on a colorectal ward should be 1:8 or more with a mix of >65% registered nurses.

## 9. Pelvic floor

The evidence supports the development of pelvic floor services in 3 key areas; the pelvic floor MDT, accreditation of units and the role of The Pelvic Floor Society.

## 10. Radiology

The minimum radiology resource to meet the coloproctology diagnostic imaging requirements of a population of 500,000 is at least 2 WTE consultant GI Radiologists in terms of time, but covered and delivered by at least 3 consultant GI Radiologists within the overall GI Radiology service.

## 11. Pathology

Approximately 2 histopathologists are required per 500,000 population to service the colorectal workload.

## 12. Oncology

To provide an adequate colorectal specialist oncological service, there is a need for 1 extra oncologist for every 2.5 million population. At least half of these should be clinical oncologists.

## 13. Palliative care

It is estimated that there should be 4 whole time equivalent consultants in palliative medicine per 500,000 head of population. In addition to consultant staff there should be an additional 4 supporting doctors of either training grade or associate specialists for this population.

## 14. Training

The average ratio of consultant to specialty trainee should be at least 1.5:1

## 15. Specialist commissioning

There are 9 conditions subject to specialist commissioning. These are all adequately provided for within the NHS. Each has its own recommendation for the provision of services – some are provided in tertiary centres and some within regular colorectal departments.

## 16. MDTs

All hospitals should aim for functioning MDT meetings adhering to the minimum standards in the following areas:

- Colorectal cancer
- Anal cancer
- IBD
- Functional bowel disease
- Polyps
- Rare diseases

These will sometimes be provided as part of combination MDTs.