TPFS Executive Meeting Bristol Hotel 07/02/2014

Present – Tony Dixon (Chair), Mark Mercer-Jones (Hon Sec), Andy Williams (Treasurer), Andy Clarke (Hon Sec Training), Karen Telford (Hon Sec Membership), Kath Gill (Co- Hon Sec RD/Website), Ian Lindsey (Hon Sec Program), Mark Chapman (Hon Sec Q&A , Clinical Governance), Ken Campbell (Scottish rep), Simon Phillips (Welsh rep), Ruth Hodgkinson (Covidien). Apologies – Charlie Knowles (Co- Hon Sec RD/Website), Mike Lamparelli (Training).

Introduction: TD thanked Covidien for sponsoring the event. He gave an outline of the function of TPFS Exec and the reasons for the formation of the group. A key impetus was governance for specialities such as ours c.f. cardiac surgery. He said that funding (from the national meeting) and TPFS website were integral to our evolution. However, he noted that ACP did not want to support our website (and TD paid 4.5 k towards it) and that The University of Southampton had withheld money from our national meeting. He went on to say that there had been mutterings about TPFS splitting away from ACP. From his point of view, he never had any intention of splitting away. However, he pointed out that some of TPFS members should not have to be members of the ACP. He asked the Exec a question – is this a good project and should we carry on? If we do then we must develop a tough stance within the ACP. He stated that he had no personal agenda and that his only wish was for any patient to be treated appropriately by well-trained people.

ACP Resources Document: AW had been asked by ACP to produce an updated resources document – National Pelvic Floor Services Census. This is designed to go some way to addressing the question of pelvic floor requirements per head of population. It should tell us "where are we now" and give a consensus on resources. The Exec were asked who wanted to help with this. The remit may include – literature review, discussion on accreditation (peer review) and national standards, commissioning? Discussion then centred around the recent e-mail traffic that had taken place between Exec members concerning Levels of Competence that may be attributed to pelvic floor services within the NHS (Proposed Levels 1-3).

MC asked if we should take a step backwards as we appeared to be moving too fast. What do we define as a pelvic floor condition – IBS? Gynae? Constipation? Pain? Posterior compartment only? He went on to ask what was our relationship with ACP. We must get this relationship right. We should stay under the umbrella of ACP.

AW agreed with this but pointed out that unlike ACP annual meeting ours is multidisciplinary and our membership must reflect this. Thus some of our members should not be required to be ACP members.

TD echoed this saying that TPFS colorectal surgeons should be in ACP and that other HCP's don't need to be.

SP pointed out that it was important also to define what our patient groups are.

AW argued that external prolapse should not be included within the remit of pelvic floor surgeons/units.

KC agreed and stated that natural evolution would bring external prolapse into pelvic floor units over time.

General discussion then took place regarding commissioning of rectal prolapse (ERP/IRP):Currently ERP: CCG, IRP:CCG, but if recurrent IRP or combined with gynae prolapse then falls within remit of Gynae Commissioning group.

MC stated that we may wish to have the CCG ask for advice from colorectal CRG wrt IRP. IL mentioned that there may be problems with capacity if IRP/ERP surgery withdrawn from the peripheral centres (referred to as level 3 in previous e-mails). Should the model be – specialist and general pelvic floor units? AW stated that we should find a way for very good units to send a patient to a "specialised unit" for investigations and for discussion of that patient within the sp. unit's MDM (with or without the referring surgeon being present). The patient would then probably be sent back to the referring unit for surgery. Regardless, of where the surgery is done it's all about audit and the MDM.

MMJ/IL/KC suggested that the point to start was with triaging in primary care as has been suggested with FI and RCS/NICE document. KG has done a lot of this work already and a model is in place in Birmingham. Getting on the right pathway is key.

MC stated that TPFS should be about advising and standard setting not policing. Policing should be done by commissioners. KC pointed out that TPFS is a national society and as commissioning does not take place in Scotland then TPFS should not link standard setting to commissioning. This may be similar to Wales.

AW – getting back to the ACP census document – we all agree that it is worthwhile doing. All agreed that this document should go to CEO, medical director and colorectal lead for every Trust. TD said the cover letter needs to be right. MC asked what we were going to do with the results?

AW said we would collate and disseminate data to the ACP. The final summary re: who/how to model pelvic floor services in UK should be via TPFS. Volunteers to help AW: KC, AC, KG, MMJ. AW to forward census doc to MMJ (attached).

KC – talked about the current pelvic floor network in Scotland. This has been driven by urogynaecology with physio and urology input, colorectal surgery input is lacking. He proposed that TPFS should be the society representing colorectal surgeons (and other HCPs) in Scotland. To promote this idea it was suggested that someone from TPFS could talk at their National Congress meeting.

AW continued to talk about TPFS setup/pelvic floor units. We should concentrate on symptoms. Constipation, FI, ODS, anal pain. Accreditation is at least 5 years away. One of our next steps should be to have a representative from co-interested specialities e.g. urogynae, urology, radiology.

MC talked about JAG and accreditation as some of the Exec felt that if endoscopy units could achieve accreditation then why not pelvic floor units. JAG driven by national screening program, which is why it works.

CRGs: MMJ talked about a service delivery work stream that has come through colorectal specialised services CRG. This is part of a five year strategy for specialised services. The only service specification that has relevance to TPFS is FI. The work stream is called an A3 proposal. Area teams, CRGs and stakeholders have been encouraged to submit an A3 proposal. A3 refers to page size. It is a simple

storyboard that describes a strategic change on an A3 size of paper. The left hand side should show how things are now and the right hand side, a view of how things could be – a future state. NHS England will score according to value for patient and cost/saving to deliver. Deadline for submission Feb 24th. LINK -http://www.england.nhs.uk/ourwork/commissioning/spec-services/five-year-strat/a3-proposals/

MMJ talked about CQUINs wrt FI service specification. CQUINs (commissioning for quality and innovation) present commissioners an opportunity to secure local quality improvements over and above the norm by agreeing priorities with their providers. CQUIN is set at 2.5% of the value of services commissioned through the NHS Standard Contract. One fifth of this is derived from national goals such as friends and family test, VTE etc. CQUINs suggested to date have been:

% of patients undergoing therapeutic intervention discussed at MDM - goal 90%

Submission of data collected by MDM coordinator - goal 100%

Compliance of attendance at MDM by core members - goal 67%

Conversion rate test wire to permanent - goal 100% recorded

Permanent lead replacement (premature) or battery failure - goal < 5%. MMJ to email Exec members with further details.

MMJ & MC talked about the need for a new service specification for complex pelvic floor problems. As indicated before in these minutes, IRP and complex gynae prolapse falls without the colorectal CRG. This is an ongoing discussion with NHS England

Membership: KT informed the Exec that Tom Dudding had been very helpful and wants to stay involved. He holds a confidential file of CVs from applications. KT produced a document relating to membership issues (attached).

Question to Exec – should membership be free to all people, and will they have voting rights? Yes to voting if full members and hope in time to bring in membership fees.

AW how do we get our money from ACP if consultants join TPFS via ACP (it has been proposed that other HCPs do not have to join ACP). ACP must contribute to TPFS via our account.

MC what is the point in having regional groups ie. Northern, Midlands, Southern. ALL – they act as networks – reference groups for surgeons to discuss who can do what, teaching, training, Quasi MDM.

IL they have run their course.

Programme: IL discussed the forthcoming Tripartite program (attached). TPFS are running the 4th day and a number of Exec members are talking etc. ACP have been working hard to get EACP in this year. Covidien are sponsoring 10K to Tripartite but this goes in ACP account. Do we write to ACP to request slice of this?

TD Hopefully we have a strong leverage to ask ACP for funding of what TPFS needs.

IL – Oxford meeting – Oliver Jones is program director. What is the relationship between TPFS and Oxford? Last year link was the training day. We need to maintain this link. There is another one this year. In the long term, however there is little point in having separate arrangements as Oxford may dilute our national meeting.

TD – proposed a day scientific meeting in January run by TPFS using e.g. posters etc not presented at Tripartite.

MMJ – need to discuss when to do AGM - ? at Tripartite?

IL/TD – next years ACP meeting is with BSG – digestive diseases week.

MMJ – will email Marie Marshall and get roster of who was at previous meetings (attached).

Finance: Website – AW has sent a letter to ACP regarding funding of TPFS website. Why do we need our own website? For our other members who are not part of ACP. There should be a link from ACP website to TPFS website. Where is money coming from to do this? A slice of membership fees from ACP/TPFS members?

We should be telling industry to give proportion of money to ACP and to TPFS. Covidien gave TPFS 5k for website leaving a shortfall of £500 which ACP have paid as an act of goodwill. In addition TD paid 4.5 K out of his own pocket. We all agreed he needs his head seeing to….we all agreed that he needs reimbursing. The website is on hold at present.

Previous meetings- AW presented figures from Bristol meeting. We are 16 K in profit. This money is held by Southampton Uni. They will charge a % if we try and take this. KN told MMJ that we could keep this money and use for eg educational bursaries. This was rather naïve on our part!

Our account name :The Association of Coloproctology of Great Britain & Ireland Pelvic Floor Society

SC 56-00-69 Acc no 39390616

We have no money in our account.

?AW and MMJ to draft letter to all of our previous sponsors c.f. Bristol meeting, regarding Tripartite and to inform them to designate money to TPFS account. This would be done after AW has informed Peter Dawson that this is our intention. This should be along the lines “we are bringing them along as pure PF sponsors so TPFS should benefit not ACP”. We are clear however that we are not requesting a 25% cut of Tripartite money. Should we involve Pharma in sponsoring??

AW to discuss with Peter Dawson costs for future TPFS Exec meeting expenses.

Training: AC/JR – Training discussed in 2 parts, trainees and consultants.

Trainees – 6/7 courses run to date by TPFS/Southern chapter. Well received and there is a paper coming out to reflect good feedback. What are future plans? Firstly Oxford meeting going ahead with trainee morning. Then roll out to North and Scotland in future. When do we reach saturation

point? Perhaps we have in the South. Thoughts – too colorectal biased – need to think about urogynae and urology trainees/content in future.

Need webpage on our website and can put PBA/DOPs on here. ISCP curriculum has been revised by JR and to be further circulated to Exec (it has been previously) by JR. He has sent to SAC for suggestions.

MC – Subspecialist training is going to be post-consultant in the future

AC/JR – TPFS should work with SAC in the future. ML – has links with them.

What about training models? Live pig model developed with Covidien in Paris – MMJ, pig model also developed in Dundee – KC. KC also developing bovine model for LVR which is more realistic than porcine. Live operating classes in Southampton and also RCS using cadavers – Dermot Burke. Could TD do masterclasses as he has links with cadaver lab. In the future we could consider animal models to run in conjunction with training days – AC to discuss with KC.

AW – we should consider pelvic floor fellows. MMJ agrees and has seen this working in Minneapolis. Fellows would rotate within region depending on the day to day opportunities.

KC – we should accredit fellows – kite mark. Census doc should find out the current situation regarding who has fellows.

TD – should we do our training courses outside RCS? At present they have stage1, stage 2 and PF courses, very expensive £800. We could have 3 trainee masterclasses per annum for live operating in UK. Porcine in morning and live in afternoon. AC/ML to take this further.

Consultants – Any assessment of consultants capability should follow after accreditation and after census doc done. For now the obvious thing is to follow LAPCO model and GAS assessments. This is good for LVR not for other ops. Perhaps we should consider informal training/assessments for consultants – peer to peer with time put aside for every consultant expressing PF interest to operate with designated TPFS trainer once/twice a year. This is good for peer review. MC thinks we should wait a while before doing this. MMJ already does this via Covidien travelling to consultants units for dual operating. But there is no formal assessment/benchmark for use. However key steps eg for LVR have been established. Tricky legal situation regarding signing off for competency – clearly TPFS need to address this.

AC thinks we start with trainees, then new consultants leaving established consultants until last.

SP said that signing off a consultant re competency is between the consultant and their Trust.

Ruth (Covidien) discussed industry help with mentorships (which is what MMJ currently does). AC suggested that preceptors are identified via TPFS and advertised on website and that these mentorships are sponsored by industry.

MC – dealing with complications esp LVR is key and TPFS should establish a network for advice. We should define which centres can do revisional surgery. TD has already thought of this and had

written a letter to be sent to Med Directors of every Trust informing them of the need. TD to forward this letter to Exec members.

R & D/Website: KG – discussed Dendrite. Initially KN/CK/KG involved. Dendrite was to collect assessments, investigations, outcomes for index procedures. The user does not have to fill in all the fields but ideally should. Dendrite was demonstrated at ACP (Liverpool) and TPFS (Bristol). The system is ready to go but dendrite are dragging their feet. ACP will pay for Dendrite – 10k from Covidien and ? 10 K from Cooke. Need to establish what this money is for. MMJ to write to KN. Do we need consent to put patients on database? Dendrite have said that we do not. How will data be analysed? There is a dataset analysis group ? via ACP and they do this and produce anonymous data. ACP retain ownership of all data. Clearly this is going to become surgeon reported outcomes in the future c.f. cancer.

The Exec asked if data was to be "everyone who walked through clinic doors or through MDM". KG – you can chose what you want to put in, it takes 3-5 minutes per patient. There should be a minimum dataset requirement, its pointless just knowing only about surgical outcomes. The drive should be that for accreditation a unit has a data manager. When can we access this? Should be ready for Tripartite.

KG - Website on hold. Designed by ForMedia (same as Lapco). Can be linked with dendrite, membership, courses and fellowships. 80% done. 12k paid and 2k short + VAT. £400 per annum to run. Where is money going to come from? TD will try and get it.

KG – studies – TPFS involved in endorsing Fenix (David Jayne), Delivar (Ian Lindsey)(LVR vs Delormes) and Program grant for constipation (Charlie Knowles). CN has asked for a working party to be established from TPFS (amongst others) to help with the surgical workstream. MMJ to email presentation and requirements for this to all TPFS Exec members. MC suggested as lead. Could this be a priority please. (attached)

Who wants to be on R&D committee? Last year CN/DJ/IL/ YY. Membership details to be forwarded to KG by KT. Need patient rep and nurse rep. MMJ to help KG via links on CRG and YY.

AOB

Representation on various ACP committees:

KG – R&D and Audit

KT – External Affairs

AC/ML – Education and Training

(AW – finance)

? Multidisciplinary clinical committee – KC volunteered (MC is already on via ACP)

MMJ will email these details to KN. Meeting closed.