Somerset, Wiltshire, Avon and Gloucestershire Cancer Alliance

Somerset, Wiltshire, Avon and Gloucestershire (SWAG) Cancer Services

Colorectal Cancer Clinical Advisory Group

Constitution

June 2019

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VERSION CONTROL

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1. Statement of Purpose

The Somerset, Wiltshire, Avon and Gloucestershire Colorectal Cancer Clinical Advisory Group (CAG) endeavours to deliver equity of access to the best medical practice for our patient population. The essential priorities of the CAG are to provide a service that is safe, high quality, efficient and promotes positive patient experiences.

To ensure that this statement of purpose is actively supported, the consensually agreed constitution will demonstrate the following:

- The structure and function of the service is conducted, wherever possible, in accordance with the most up to date recommended best practice, as specified in the Manual of Cancer Services, Colorectal Measures[1]

- An CAG consisting of multidisciplinary professionals from across the Somerset, Wiltshire, Avon and Gloucestershire cancer services has been established and meets on a regular basis

- Network wide systems and care pathways for providing coordinated care to individual patients are in place. This includes the process by which network groups link to individual MDTs

- A process for ensuring that the CAG clinical decision making is in accordance with the most up to date NICE Quality Standards[2] (December 2014) is in place, as are local clinical guidelines that support the standards

[1] Manual for Cancer Services

- There is a process by which patient and carers can evaluate and influence service improvements that supports the principle '*No decision about me without me*'[3]

- Internal and externally driven routine risk related clinical governance processes are in place for evaluating services across the network and identifying priorities for improvement

- The CAG have a coordinated approach to ensure that, wherever possible, clinical research trials are accessible to all eligible cancer patients

- Examples of best practice are sought out and brought to the CAG to inform service development

- Educational opportunities that consolidate current practice and introduce the most up to date practices are offered whenever resources allow

- Provision of advice to influence the funding decisions of the Cancer Alliance Board.

2. STRUCTURE AND FUNCTION

2.1 Network Configuration (measure 14-1C-101d)

The Multi-Disciplinary Teams (MDTs) within the Colorectal CAG consist of consultant colorectal surgeons, clinical and medical oncologists, pathologists, imaging specialists and other health care professionals. They meet regularly to discuss and manage each patient's care individually.

Table 1 shows the CAG agreed list of MDTs, the Trusts that host them, and identifies the MDTs that discuss specific cancer types.

[3] Improving Outcomes – A Strategy for Cancer (2011)
3 NICE guidelines

Table 1

Trust	Colorectal Diagnostic Service	Colorectal MDT including management of Rectal Cancer	Colorectal MDT managing Early Rectal Cancer	MDT managing Anal Cancer	Anal Cancer Surgery	HPB Cancer MDT	Liver Resection Surgery	Cardiothoracic Service
Royal United Hospital Bath NHS Foundation Trust	Yes	Yes	No	No	No	No	No	No
Taunton and Somerset Hospital Trust (TST)	Yes	Yes	No	No	No	No	No	No
Yeovil District Hospital NHS Foundation Trust (YDH)	Yes	Yes	No	No	No	No	No	No
Weston Area Health NHS Trust (WAHT)	Yes	Yes	No	No	No	No	No	No
North Bristol NHS Trust (NBT)	Yes	Yes	No	No	No	No	No	No
University Hospitals Bristol NHS Foundation Trust (UH Bristol)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Gloucestershire Hospitals NHS Foundation Trust (GLOS) – Cheltenham	Yes	Yes	Yes	No	No	No	No	No
Gloucestershire Hospitals NHS Foundation Trust (GLOS) – Gloucester	Yes	Yes	No	Yes	Yes	No	No	No
Gloucestershire Hospitals NHS Foundation Trust (GLOS)	Yes	Yes	Yes	Yes	Yes	No	No	No
Hampshire Hospitals NHS Foundation Trust	n/a	n/a	n/a	n/a	n/a	n/a	Yes	n/a
University Hospitals Birmingham NHS Foundation Trust (UHB)	n/a	n/a	n/a	n/a	n/a	n/a	Yes	Yes

Most Trusts in the Network refer their patients with liver and lung metastases to the Bristol Hepatobiliary and Cardiothoracic units based at UH Bristol.

Patients with liver metastases are currently referred from Royal United Hospitals Bath (RUH) to Hampshire Hospitals NHS Foundation Trust. This has been a long standing arrangement between RUH and Hampshire Hospitals, with a proven history of high quality service provision.

Patients with liver and lung metastases are currently referred from Gloucestershire Hospitals NHS Foundation Trust (GLOS) to University Hospitals Birmingham NHS Foundation Trust and Leeds Teaching Hospitals NHS Trust (St. James's) for Liver disease and University Hospitals Birmingham NHS Foundation Trust, UH Bristol for lung disease, as above.

The above arrangements that constitute the configuration of the SWAG cancer network have been agreed by the SWAG Cancer Alliance Board.

2.2 Network Policy and List of Laparoscopic Colorectal Cancer Surgical Practitioners (measure 14-1C-102d)

The SWAG Colorectal CAG Policy of Laparoscopic Colorectal Cancer Surgery, in accordance with the recommendations from the Laparoscopic Surgery for Colorectal Cancer Technology Appraisal Guidelines 105 (2006), states that:

- Laparoscopic, including laparoscopically assisted resection, is recommended as an alternative to open resection for individuals with colorectal cancer when both laparoscopic and open surgery are considered suitable
- Laparoscopic surgery will be performed by surgeons who have completed appropriate training in the technique by the National Laparoscopic Colorectal Cancer Surgery Programme (NTP), or who meet the exemption criteria that, either there is an appointment letter by the CE of the Trust confirming their recognised laparoscopic surgery skills, or the surgeon has performed this procedure often enough to maintain competence, which has been agreed as 20 procedures per annum by the lead clinician of the MDT
- The SWAG CAG and constituent Trusts will ensure all local laparoscopic colorectal surgical practice meets this criteria as part of their clinical governance arrangements
- A process of informed discussion between the patient and surgeon is in place before the decision between an open or laparoscopic procedure is made. The decision will take into account the suitability of the lesion for laparoscopic resection, the risks and benefits of the two procedures, and the experience of the surgeon in both procedures

The SWAG Colorectal CAG agreed list of Laparoscopic Colorectal Cancer Surgical Practitioners:

Table 2

List of Laparoscopic Colorectal Cancer Surgical Practitioners			
Trust	Surgeon	Evidence of Training	Exempt - either there is an appointment letter by the CE of the Trust confirming recognised laparoscopic skills, or the consultant has performed 20 or more laparoscopic colorectal surgical resections last year
Royal United Hospital Bath NHS Foundation Trust (RUH)	Mike Williamson	National Laparoscopic Surgery Programme	
	Jeremy Tate		Exempt
	Steve Dalton		Exempt
	Ed Courtney		New appointment with lap colorectal skills
Taunton and Somerset Hospital Trust (TST)	Ian Eyrebrook	National Laparoscopic Surgery Programme	
	Louise Hunt		Exempt
	Chris Vickery		Exempt
	Paul Mackey		Exempt
	Tom Edwards		Exempt
Yeovil District Hospital NHS	Nader Francis		Exempt

Foundation Trust	Jonathan Ockrim		Exempt
	Andrew Allison		Exempt
Weston Area Health Trust (WAHT)	Reuben West		Exempt
	Krishna Kandaswamy		Exempt
North Bristol NHS Trust (NBT)	Tony Dixon		Exempt
	Ann Lyons		Exempt
	Caroline Burt		Exempt
	Ann Pullybank		Exempt
	Alan Roe		Exempt
University Hospitals Bristol NHS Foundation Trust	Robert Longman	Colorectal Lead. National Lapco mentor. National LoRec mentor. National Lap Colorectal fellowship in 2005.	Exempt > 20 lap resections per year
	Jon Randall	National Lap Colorectal fellowship in 2012	New appointment with lap colorectal skills
	Jamshed Shabbir	National Lap Colorectal fellowship in 2010	Exempt > 20 lap resections per year
Gloucestershire Hospitals NHS Trusts	Cheltenham MDT		
	Neil Borley		Exempt> 20 lap resections per year
	Damian Glancy	Appointed from laparoscopic training programme	Exempt> 20 lap resections per year
	Anthony Goodman		Exempt> 20 lap resections per year
	Mark Peacock (locum)		Exempt> 20 lap resections per year
	Gloucester MDT		
	Tim Cook		Exempt> 20 lap resections per year
	Michael Scott	Appointed from laparoscopic training programme	Exempt> 20 lap resections per year
	Michele Lucarotti	National Laparoscopic Surgery Programme	

2.3 SWAG Network Colorectal Stenting Policy (measure 14-1C-103d)

- Use of SEMS should be considered in patients presenting with acute large bowel obstruction
- SEMS are recommended for patients with acute left-sided large bowel obstruction caused by colorectal cancer that is not potentially curable, or for whom surgery is unsuitable
- SEMS can be considered to initially manage acute bowel obstruction as a bridge to later potentially curative surgery preferably as part of a randomised controlled clinical trial that compares emergency surgery with SEMS
- CT of the chest, abdomen and pelvis must be performed to confirm whether there is a mechanical obstruction, and to establish whether the patient has a colonic perforation or metastatic disease
- Enema studies should no longer be used as the sole imaging modality for patients presenting with acute large bowel obstruction
- After the patient has been resuscitated, it will be explained to them and to their family members or carers, that an acute bowel obstruction can initially be managed either with emergency surgery or by insertion of self-expanding metal stents (SEMS).
- Practice of inserting SEMS for colonic obstruction is limited to named personnel agreed as being competent by the network group, in consultation with the MDTs
- SEMS will not be placed in low rectal lesions; if there is clinical or radiological evidence of colonic perforation or peritonitis (unless, in patients unfit for surgery, it is appropriate to try and control a tumour perforation with a covered stent)
- The tumour will not be dilated prior to insertion of a SEMS
- If insertion of a SEMS is suitable, in accordance with NICE guideline recommendations insertion will be attempted as soon as qualified staff are available after a patient presents with colonic obstruction. If the patient deteriorates, or shows signs of imminent perforation, a defunctioning colostomy should be undertaken as a safe alternative.

Named Colorectal Stenting Personnel

Table 3

Named Hospital and Stenting Team	
Royal United Hospital NHS Trust Bath (RUH)	Position
M Williamson	Surgeon
J Tate	Surgeon
S Dalton	Surgeon
E Courtney	Surgeon
A Phillips	Radiologist
D Fay	Radiologist
North Bristol NHS Trust	Position
A Pullybank	Surgeon
A Dixon	Surgeon
A Lyons	Surgeon
C Burt	Surgeon
R Law	Radiologist
A Longstaff	Radiologist
University Hospitals Bristol NHS Foundation Trust	Position
M Thomas	Surgeon
R Longman	Surgeon
J Shabbir	Surgeon
P Sylvester	Surgeon
J Randall	Surgeon
H Roach	Radiologist
M Callaway	Radiologist
D Wilson	Radiologist
Taunton & Somerset NHS Trust	Position
L Hunt	Surgeon
I Eyre Brook	Surgeon
C Vickery	Surgeon
P Mackey	Surgeon
T Edwards	Surgeon
T Ward	Radiologist

H Thomas	Radiologist
R Keoghan	Radiologist
R Matull	Gastroenterologist
S Mittlener	Gastroenterologist
Weston Area Health NHS Trust	Position
R West	Surgeon
C Cook	Surgeon
K Kandaswamy	Surgeon
Gloucestershire Hospitals NHS Foundation Trust	Position
Cheltenham MDT	
N Borley	Surgeon
D Glancy	Surgeon
A Goodman	Surgeon
R Hopkins	Radiologist
Gloucester MDT	
T Cook	Surgeon
M Scott	Surgeon
M Lucarotti	Surgeon
D Burch	Radiologist

2.4 Network Group Membership (measure 14-1C-104d)

The SWAG CAG consists of the following members:

Table 4

Trust	Name	Position
TST	Adam Chambers	Colorectal Registrar
NBT	Adrian Pollentine	Consultant Radiologist
UH Bristol	Alan Donaldson	Consultant Geneticist
UH Bristol	Alice Stewart-Jarvie	Colorectal Clinical Nurse Specialist
NBT	Ana Terlevich	Consultant Gastroenterologist
YDH	Andrew Allison	Consultant Colorectal Surgeon
WAHT	Andrew Bell	Consultant Gastroenterologist
NBT	Andrew Heryet	Laboratory Manager Cellular Pathology
NBT	Ankur Srivastava	Consultant Gastroenterologist
TST	Anna-Lisa Saunders	Colorectal Cancer Clinical Nurse Specialist

NBT	Ann Lyons	Consultant Colorectal Surgeon
NBT	Anne Pullyblank	Consultant Colorectal Surgeon
NBT	Annie Reilly	Colorectal Cancer Clinical Nurse Specialist
NBT	Anthony Dixon	Consultant Colorectal Surgeon
RUH	Ashley Cox	Consultant Clinical Oncologist
UH Bristol	Axel Walther	Consultant Clinical Oncologist
RUH	Ben Colleypriest	Consultant Gastroenterologist
NBT	Catherine Rees-Jones	Colorectal Cancer Clinical Nurse Specialist
YDH	Cenydd Thomas	Consultant Radiologist
UH Bristol	Charles Comins	Consultant Clinical Oncologist
PHE Screening	Christopher North	QA Facilitator (Bowel)
NBT	Christopher Wragg	Consultant Geneticist
TST	Clare Barlow	Consultant Medical Oncologist
UH Bristol	Clare Maggs	Colorectal MDT Coordinator
NBT	Clodagh Hershbein	Colorectal Cancer Clinical Nurse Specialist
TST	Daniel Pearl	Consultant Gastroenterologist
UH Bristol	David Messenger	Consultant Colorectal Surgeon
WAHT	David Parker	Consultant Gastroenterologist
UH Bristol	David Wilson	Consultant Radiologist
RUH	Denise Moorhouse	Senior Specialty Manager
WAHT	Donatella Barbera	Consultant Colorectal Surgeon
RUH	Ed Courtney	Consultant Colorectal Surgeon
YDH	Edwin Cooper	Consultant Histopathologist
TST	Elaine Cousens	Colorectal Clinical Nurse Specialist
TST	Elizabeth Ladd	Consultant Radiologist
RUH	Emma de Winton	Consultant Clinical Oncologist
TST	Emma Gray	Consultant Clinical Oncologist
TST	Emma Greig	Consultant Gastroenterologist
YDH	Erica Beaumont	Consultant Clinical Oncologist
NBT	Eric Loveday	Consultant Radiologist
WAHT	Faisal Fayyaz	Consultant Gastroenterologist
TST	Gihan Ratnayake	Consultant Medical Oncologist
YDH	Gill Shire	Bowel Screening Practitioner
UH Bristol	Helen Brookes	Consultant Oncologist
Administration	Helen Dunderdale	Cancer Alliance CAG Support Manager
User Representative	Jackie Mifflin	User Representative
WAHT	James Williamson	Consultant Gastroenterologist
UH Bristol	Jamshed Shabbir	Consultant Colorectal Surgeon
UH Bristol	Jasmine King	Colorectal Clinical Nurse Specialist
UH Bristol	Jessica Jenkins	Consultant Oncologist
UH Bristol	Jim Portal	Consultant Hepatologist

YDH	James Gotto	Consultant Gastroenterologist
NBT	Jo Hulley	Locum Consultant GI Endoscopist
YDH	Jo-Ann Oliver	Colorectal Cancer Clinical Nurse Specialist
YDH	Joanna Jones	Colorectal Cancer Clinical Nurse Specialist
RUH	Joanna Smalley	Colorectal Cancer Clinical Nurse Specialist
RUH	John Bunni	Consultant Colorectal Surgeon
WAHT	Jolanda Bennett	Colorectal MDT Coordinator
YDH	Jonathan Ockrim	Consultant Colorectal Surgeon
UH Bristol	Jonathan Randall	Consultant Colorectal Surgeon
UH Bristol	Jonathan Rees	Consultant HPB Surgeon
YDH	Julie Burton	Colorectal Clinical Nurse Specialist
TST	Kajendran Balasubramaniam	Consultant Radiologist
WAHT	Kandaswamy Krishna	Consultant Colorectal Surgeon
Glos	Kate Mitten	Colorectal Clinical Nurse Specialist
YDH	Katie Smith	Consultant Gastroenterologist
RUH	Leigh Biddlestone	Consultant Histopathologist
NBT	Leonard Griffiths	Consultant Gastroenterologist
GWH	Lindsay Whittam	Consultant Dermatologist Trust Cancer Lead
UH Bristol	Lisa Lowe	Lead Colorectal Cancer Clinical Nurse Specialist
WAHT	Lisa Macklin	Colorectal Clinical Nurse Specialist + stoma
RUH	Lorraine Young	Colorectal Cancer Clinical Nurse Specialist
WAHT	Louise Panes	Colorectal Clinical Nurse Specialist + stoma
RUH	Louisa Serle	Colorectal Cancer Clinical Nurse Specialist
TST	Louise Hunt	Consultant Colorectal Surgeon
UH Bristol	Lucia Angelelli	Consultant Oncologist
TST	Maria Salter	Colorectal Cancer Clinical Nurse Specialist
UH Bristol	Manuel Ruiz-Echarri	Consultant Clinical Oncologist
RUH	Matthew Sephton	Consultant Medical Oncologist
UH Bristol	Meg Finch-Jones	Consultant Hepato-Pancreato-Billiary Surgeon
NBT	Melanie Lockett	Consultant Gastroenterologist
UH Bristol	Mia Card	Colorectal Cancer Clinical Nurse Specialist
UH Bristol	Michael Thomas	Consultant Colorectal Surgeon
RUH	Mike Williamson	Consultant Colorectal Surgeon
YDH	Nader Francis	Consultant Colorectal Surgeon
Glos	Neil Borley	Consultant Colorectal Surgeon
NBT	Newton Wong	Consultant Histopathologist
TST	Nicola Forsyth	Colorectal Cancer Clinical Nurse Specialist
WAHT	Nitya Chandratreya	Consultant Colorectal Surgeon
TST	Paul Mackey	Consultant Colorectal Surgeon
RUH	Peter Marden	Consultant Gastroenterologist
NBT	Rachel Butler	Consultant Clinical Scientist

WAHT	Reuben West	Consultant Colorectal Surgeon
YDH	Richard Dalton	Consultant Surgeon
GWH	Richard Payne	Consultant Colorectal Surgeon
UH Bristol	Robert Longman	Consultant Colorectal Surgeon
NBT	Robert Przemiosolo	Consultant Gastroenterologist
UH Bristol	Rory Spanton	Colorectal Cancer Clinical Nurse Specialist
TST	Rudi Matull	Consultant Gastroenterologist
NBT	Sam Murray	Consultant Gastroenterologist
NBT	Shoba Philip	Consultant Radiologist
RUH	Siobhan John	Colorectal Cancer Clinical Nurse Specialist
NBT	Sarah John	Colorectal Cancer Clinical Nurse Specialist
RUH	Sharath Gangadhara	Consultant Medical Oncologist
UH Bristol	Stephen Falk	Consultant Clinical Oncologist
YDH	Steve Gore	Consultant Gastroenterologist
NBT	Talal Valliani	Consultant Gastroenterologist
UH Bristol	Tim Batchelor	Consultant Thoracic Surgeon
TST	Timothy Jobson	Consultant Gastroenterologist
YDH	Tina Maddams	Colorectal Cancer Clinical Nurse Specialist
UH Bristol	Tom Creed	Consultant Gastroenterologist
WAHT	Tricia O'Sullivan	Colorectal Cancer Clinical Nurse Specialist
UH Bristol	Trudy Reed	Nurse Practitioner
NBT	Uthayanan Chelvaratnam	Consultant Gastroenterologist
NBT	Zeino Zeino	Consultant Gastroenterologist
YDH	Zubair Khan	Consultant Gastroenterologist

Terms of reference are agreed in accordance with the paper Recurrent Arrangements for Cancer Alliance Clinical Advisory Groups (2019), which is available on the SWCN website here. The CAG meetings are also conducted in line with the Manual for Cancer Services, Colorectal Measures (Version 1.0).

2.5 Network Group Meetings (measure 14-1C-105d)

The SWAG CAG will meet twice yearly. Agendas, notes and actions, and attendance records will be uploaded onto the South West Clinical Network website here.

Appendix 1 is the template agenda for the colorectal CAG meetings, which is circulated prior to each meeting to ensure that all members are aware of who is required to attend and that all subject matters requiring discussion are identified.

2.6 Work Programme and Annual Report (measure 14-1C-106d)

The SWAG CAG will produce an Annual Report and Work Programme in discussion with the SWAG Cancer Alliance Board.

3. COORDINATION OF CARE / PATIENT PATHWAYS

3.1 Clinical Guidelines for Colorectal Cancer (NS/SCS/CC-16-008)

The SWAG CAG refers to the NICE clinical guidelines (December 2014) for clinical management of colorectal cancer. A further version controlled Clinical Guideline document that provides details of the local provision of the NICE guidelines is in place. This is reviewed annually to ensure that any amendments to imaging, surgery, pathology, chemotherapy and radiotherapy practices are up to date.

3.2 Clinical Guidelines for Anal Cancer (measure 14-1C-108d)

As above

3.3 Chemotherapy Treatment Algorithms (measure 14-1C-109d)

An agreed list of acceptable chemotherapy treatment algorithms is reviewed bi-annually and available to view in the Annual Report and on the SWSCN website here.

Any treatment algorithms that require updating are listed in the CAG work programme.

3.4 Patient Pathways for Colorectal Cancer (NS/SCS/CC-16-011)

3.4.1 Patient Referral Pathways

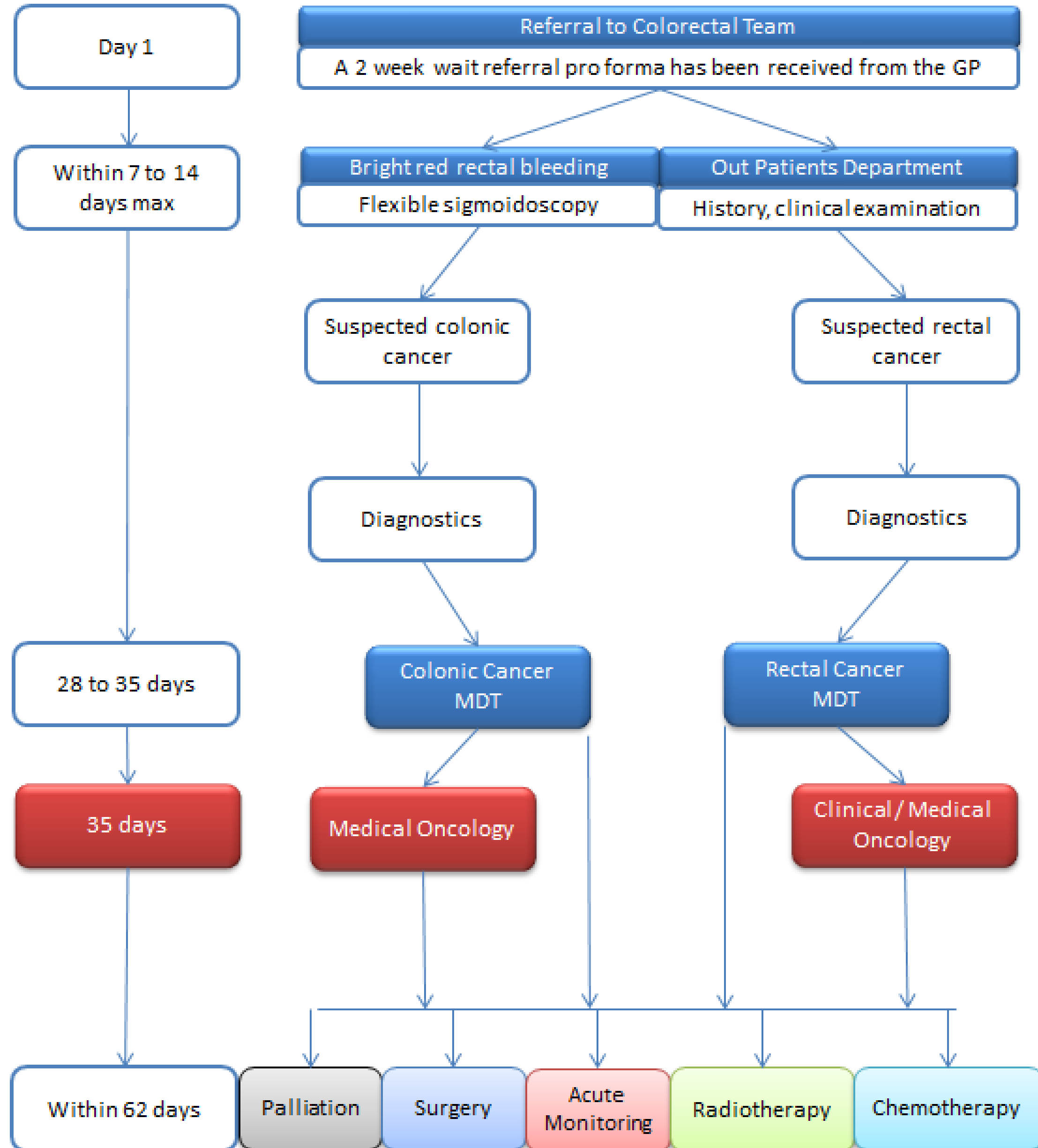
Table 5 indicates the hospitals and MDTs to which patients will be referred during their investigation, treatment and follow up. Psychological and social support and advice on rehabilitation will be provided by the patients' allocated keyworker. This will be the Colorectal Cancer Nurse Specialist situated in the hospital as shown below. For Gloucestershire Hospitals, patients from Worcestershire and Herefordshire are referred for early rectal cancer and anal cancer. Other colorectal cancers are managed by Herefordshire Hospital.

Table 5

Referring areas	Catchment population	Diagnostic Service	MDT	Surgical Treatment	Medical Oncology Treatment	Clinical Oncology Treatment	Clinical Nurse Specialist Base	Follow up
Bath and North East Somerset, Wiltshire, Somerset	347135	RUH	RUH	RUH	RUH	RUH	RUH	RUH
Somerset	287673	TST	TST	TST	TST	TST	TST	TST
Somerset	139777	YDH	YDH	YDH	TST	TST	YDH	YDH
North Somerset, Somerset	309947	WAHT	WAHT	WAHT	WAHT	UH Bristol	WAHT	WAHT
South Gloucestershire, Bristol	473263	NBT	NBT	NBT	UH Bristol	UH Bristol	NBT	NBT
Bristol, North Somerset, South Glos, Bath and North East Somerset	481603	UH Bristol	UH Bristol	UH Bristol	UH Bristol	UH Bristol	UH Bristol	UH Bristol
Gloucestershire, Worcestershire, Herefordshire	567318	GLOS	GlOS	GLOS	GLOS	GLOS	GLOS	GLOS

3.4.2 Patient Pathways for Colorectal Cancer (Measure 14-1C-110d)

Colorectal Cancer Pathway – 62 day target for patients referred as suspected cancer



The diagnostic service is responsible for investigating imaging, biopsies, laboratory results and pathology results to screen for the suspected cancer. If the results indicate a diagnosis of colorectal cancer, the diagnostic team refer the patient to the colorectal MDT and bring the results from all of the various investigations to the MDT meeting for discussion.

The colorectal MDT core members are then responsible for collaboratively establishing the patient's stage of disease. The stage is determined by using the TNM staging method, which looks at the size and classification of the tumour, T, lymph node involvement, N, and whether there is any sign of metastatic disease, M. The stage of the patient's disease will then inform the MDT members of the most beneficial treatment plan for the individual. This will result in referral as indicated in the patient pathway diagram above.

3.4.3 Early rectal cancer

Patients with early (T1) rectal cancer, may be staged by endosonography as well as CT / MR with consideration for local treatment after the opportunity has been given to make an informed decision and, where available, as part of a national randomised trial.

3.4.4 Patients with Liver Metastases

Patients with liver metastases are referred via the Colorectal MDTs to the hepatobiliary MDT in University Hospitals Bristol, (Royal United Hospital Bath refer to Basingstoke, and Gloucestershire Hospitals refer to Birmingham and Leeds). The Colorectal MDT is primarily responsible for determining the treatment of the colorectal cancer, identifying the possibility of metastatic disease and, in the event of identifying potential liver metastases, referring the patient to the appropriate Hepato-pancreatobiliary MDT (exclusions to automatic referral are agreed between the colorectal network group and the relevant HPB network groups).

The HPB MDT is primarily responsible for confirming the diagnosis of liver metastases and for deciding the treatment of liver metastases.

The colorectal and hepatobiliary MDTs have an efficient route of communication so that patients with complicated metastatic colorectal cancer may have their treatment coordinated between the two surgical teams and the oncology team.

3.4.5 Patients with Lung Metastases

Patients with lung metastases are referred via the Colorectal MDTs to the Lung MDT within their Trust who will liaise with the cardiothoracic team at UHB (or for GLOS, University Hospitals Birmingham NHS Foundation Trust). The Colorectal MDT is primarily responsible

for determining the treatment of the colorectal cancer, identifying the possibility of metastatic disease, and in the event of identifying potential lung metastases, referring the patient to the appropriate lung MDT(exclusions to automatic referral are agreed between the colorectal CAG and the lung CAG).

The Lung MDT is primarily responsible for confirming the diagnosis of lung metastases and deciding the treatment of lung metastases.

The Colorectal and Lung MDTs have an efficient route of communication so that patients with more complicated metastatic colorectal cancer may have their treatment coordinated between the two surgical teams and the oncology team.

3.4.6 Laparoscopic colorectal cancer surgery

For laparoscopic surgery, the MDTs without core surgical members approved to perform laparoscopic colorectal cancer surgery would refer patients to a named surgeon in a named MDT, who is on the network list of laparoscopic surgeons. However, all Trusts within the CAG provide a laparoscopic surgery service.

3.4.7 Contact details for the Colorectal Cancer Services:

Royal United Hospital Bath NHS Foundation Trust

Taunton and Somerset NHS Foundation Trust

Yeovil District Hospital

Weston General Hospital

North Bristol Trust

University Hospitals Bristol NHS Foundation Trust

Gloucestershire Hospitals

3.5 Patient Pathways for Anal Cancer (NS/SCS/CC-16-011)

Colorectal MDTs refer patients with anal cancer suitable for curative treatment to the MDT at University Hospitals Bristol NHS Foundation Trust for their treatment. The following hospitals in the SWAG area coordinate management of anal cancer, including chemo-radiotherapy:

Table 6:

Location of Colorectal MDT managing Anal Cancer	Lead Clinician	Referring Hospitals	Day, time and location of MDT meeting	Referral deadline	MDT Contact details	Referral requirements	Population
Bristol Royal Infirmary	Mr Michael Thomas	UH Bristol, NBT, RUH, WHAT, TST, YDH Hospitals	Friday 13:00, Radiology, Level 3, Bristol Royal Infirmary	Wednesday 13:00	01173427651, clare.maggs@uhbristol.nhs.uk	Referral letter, IPT forms, histology and imaging reports. Histology to be sent to Southmead Hospital FAO Newton Wong. Images to be send electronically to Bristol Royal Infirmary	2.1 million
Gloucester Royal Hospital	Mr Michael Scott	Worcester, Herefordshire, Gloucestershire Hospitals	12:45, Redwood Education Centre, Gloucestershire Royal Hospital	Friday 11:30	03004226229, Lorraine.minnock@glos.nhs.uk	As above	1483100

The responsibilities of the diagnostic service and the Anal Cancer MDT are as documented above for the treatment of colorectal cancer.

The base hospital colorectal MDT is responsible for the initial investigation and diagnosis of anal cancer and then referral to the anal cancer MDT in UHB or Gloucester.

The UH Bristol and Gloucestershire Anal Cancer MDT is responsible for confirming the diagnosis and deciding the treatment and management of anal cancer.

Contact details for the Anal Cancer services in University Hospitals Bristol can be found here.

Contact details for the Anal Cancer Services in Gloucestershire Hospitals can be found here.

3.6 Patient Pathways for Teenagers and Young Adults (TYA)

Details of TYA patient pathways for the SWAG CAGs can be found on the SWSCN website here:

TYA

3.7 Cancer of Unknown Primary (CUP) Referrals

All patients with a metastatic carcinoma of unknown origin are referred to the cancer of unknown primary MDTs within the network. Details of the CUP referral processes can be found on the SWSCN website:

CUP

3.8 Referral to Diagnostic Services and Onward Referral 14-1C-112d

All of the Trusts within the CAG have a diagnostic service and single referral contact point as documented in Table 7. The majority of referrals are made using the online choose and book system.

Table 7

Trust	Service	MDT Clinical Lead	Hospital Contact Point
Royal United Hospital Bath NHS Foundation Trust	Diagnostic Service	Mike Williamson	Cancer appointment centre: fax 01225 821436
Taunton and Somerset NHS Foundation Trust	Diagnostic Service	Louise Hunt	Fast Track cancer office: fax 01823 343417
Yeovil District Hospital NHS Foundation Trust	Diagnostic Service	Nader Francis	Cancer referrals. Fax 01935384640
Weston Area Health NHS Trust	Diagnostic Service	Krishna Kandaswamy	Fast Track cancer office: T: 01934 881117, fax 01934 647129

North Bristol NHS Trust	Diagnostic Service	Ann Lyons	Fast Track cancer office: T: 0117 4140536 / 0538 / 0544. F: 0117 414 0540
University Hospitals Bristol NHS Foundation Trust	Diagnostic Service	Rob Longman	Fast Track Cancer Office, T: 01173420032 / 0621 / 0663 fax 01173423266
Gloucestershire Hospitals NHS Foundation Trust	Diagnostic Service – CGH Diagnostic Service - GRH	Neil Borley Mike Scott	Email: chooseandbook@glos.nhs.uk with proforma found here.

Primary care clinicians should refer to the NICE guidelines *Suspected Cancer: recognition and management of suspected cancer in children, young people and adults* (2015) for the signs and symptoms relevant when referring to colorectal cancer services. Further details on the two week wait referral process can be found in the CAG constitution. The current referral guidelines for North Bristol Trust are available on this area of the website.

3.9 The CAG Policy for Governing Onward Referral from the Colorectal Services

The network group agreed policy for governing onward referral from the colorectal diagnostic service for either malignant or non-malignant disease has been developed to ensure that timely and appropriate communication is in place between clinicians and with the patient.

- Patients who are unexpectedly diagnosed with colorectal cancer, or known patients who are diagnosed with recurrent or metastatic disease, will be referred by the medical team responsible for their care to a core member of the MDT within one full working day from confirmation of the diagnosis. In most cases, the Colorectal CNS will be contacted

- The core member of the MDT will ensure that such patients are discussed at the next MDT
- In the event that an abnormality is identified during a sigmoidoscopy or colonoscopy that is suspicious of malignant disease but encountered outside of the local cancer pathway, the endoscopist will take responsibility for urgent referral to the colorectal cancer pathway. This entails sending biopsies for rapid processing by the Pathology Department, informing the referring clinician of the suspected diagnosis on the day of the investigation, informing the MDT coordinator of the patient's details, and contacting a key worker in the colorectal team who will take responsibility for managing the patient's pathway from then on
- The performing endoscopist is also responsible for informing the GP of the diagnosis
- If non-malignant disease is diagnosed and further investigations or treatment is required, the report is sent to the referring clinician who will inform the patient and organise further investigation
- In the event that an abnormality is identified during an imaging investigation that is suspicious of malignant disease or suspicious of recurrent malignant disease, but encountered by a non-MDT clinician or clinical service (including a general practitioner), the radiologist will take responsibility for urgent transmission of the report to the colorectal cancer clinical team. This will be done on the day that the possible diagnosis is identified via the local mechanism for transmitting urgent reports
- In the event that a diagnosis of colorectal cancer is identified in a biopsy that was not regarded as malignant by the endoscopist, the pathologist will inform the responsible clinician on the day that the diagnosis is identified via the local mechanism for transmitting urgent reports
- The GP will be informed of a diagnosis of malignancy within 24 hours of the patient being informed
- Clinical Nurse Specialists may be contacted by bleep, via Hospital Trust switchboards
- Diagnosis will be conveyed face to face in all instances
- The consultant with clinical responsibility for a patient is responsible for informing the patient of a confirmed diagnosis of colorectal cancer. Responsibility may be delegated by the consultant to an appropriately trained professional colleague, e.g. a Colorectal Nurse Specialist or SpR.

3.10 Network Policy on Named Medical Practitioner with Clinical Responsibility (14-1C-113d)

It has been agreed by the CAG, MDT and Network Imaging Group that the following medical practitioners have the responsibility for the patient's welfare at the different stages in the patient pathway, prior to the treatment planning decisions made within the relevant colorectal MDTs:

Table 6

Stage of Clinical Care		Clinician(s) Responsible
Prior to first appointment with Secondary Care		General Practitioner
Diagnostic Stage	Determined by the outpatient appointment attended Investigative Consultant may alert MDT coordinator	Investigative Consultant
Initial Treatment Phase (MDT)		Surgeon
Primary Surgery	The surgeon accepting responsibility at the first MDT if surgery is indicated	Surgeon
Primary non-surgical intervention	During Radiotherapy or Chemotherapy, the Consultant Oncologist accepting the referred patient at the MDT until the treatment has concluded and then the patient is passed back to the surgeon	Clinical / Medical Oncologist
Post Surgery	If oncology treatment is required, the Consultant Oncologist	Clinical / Medical Oncologist / Surgeon as clinically indicated
Treatment for Metastatic Disease	The clinician applying the modality	Clinician in the relevant treatment modality
Follow up	Normally the Consultant Surgeon, but can depend on the treatments given	Surgeon
Palliative Care	Palliative Care Consultant	GP / Specialist Palliative Care Team

The responsibility for acting on the result of a test remains with the clinician that has requested that test, should this be a different clinician than the one deemed responsible at a particular stage in the patient's care.

3.11 The Colorectal Network Guidelines for the Management of Surgical Emergencies (measure 14-1C-114d)

Diagnosis and Stage

Patients should be enrolled under the care of the MDT at the earliest available opportunity. Each MDT needs to have in place a robust mechanism of referral, preferably involving the CNS.

Diagnosis and Initial Care

Resuscitation

- Fluid resuscitation monitored by BP,
  urine output +/- CVP
- Early anaesthetic assessment
- Correction of U&E deficiencies.

Assessment of cause

- In the absence of perforation (established or incipient) or life threatening bleeding, surgery for large bowel obstruction should be scheduled for the next available list. Ideally this should be conducted by a colorectal surgeon
- Consider water-soluble enema to exclude pseudo-obstruction
- Consider a chest/abdo/pelvis CT scan.

Surgery

Consider endoluminal stenting in all left-sided obstructing cancers (temporary decompressing manoeuvre prior to staging and definitive resection, or for palliating non-operative cases), ideally, within the context of a randomised trial where available.

A list of personnel within the network is maintained centrally. All operators should be able to demonstrate that they are maintaining their expertise by auditing their procedures and outcomes.

Preparation for Surgery – see Appendix 1

Surgery should be carried out during daytime hours as far as possible by experienced surgeons who are part of the MDT and experienced anaesthetists.

Right sided lesions:

- Primary resection & ileocolic anastomosis
- Consider palliative internal bypass for non resectable cancers
- Defunctioning ileostomy if no alternative.

Left sided lesions:

- Primary resection +/- on table lavage +/- loop ileostomy
- Subtotal colectomy & ileorectal anastomosis
- Hartmann's procedure +/- mucous fistula

- Bypass
- Defunctioning proximal stomas.

Multidisciplinary Team (MDT) Meeting

- All emergency admissions to be discussed at the next available MDT or when pathology is available

Further Treatment Options

- Histopathology review
- Counselling by CNS
- Stoma advice.

Distribution Process for Surgical Emergencies Guidelines

The network guidelines on the management of surgical emergencies related to colorectal cancer are available to consultant upper and lower GI surgeons, all surgeons, gynaecologists and all physicians on the medical emergency take rota of their hospitals.

4. PATIENT AND PUBLIC INVOLVEMENT

4.1 User Involvement

The CAG has a user representative member who contributes their opinions about the colorectal service at the CAG meetings on a regular basis. The NHS employed member of the CAG that is nominated as having specific responsibility for users' issues and information for patients and carers is the Cancer Network CAG Support Manager. The CAG actively seeks to recruit further user representatives. Appendix 3 contains the user involvement brief that is circulated for this purpose.

4.2 Patient Experience (measure 14-1C-115d)

The results and actions generated from the National Patient Experience Survey within each Trust in the CAG will be reviewed in every CAG meeting, and the progress of the agreed improvement programme monitored. Progress will published in the annual report.

4.3 Patient-Reported Outcome Measures

The CAG will develop colorectal cancer-specific patient-reported outcome measures (PROMS) as recommended in the NICE guidelines (2014). This is necessary due to the

specific side effects that colorectal cancers can cause in relation to bowel function, and the impact on carrying out daily living activities. These will be for use in disease management, and to inform outcome measures in future clinical trials, as Quality of Life (QoL) and PROMS surveys are more frequently being used as secondary endpoints in clinical trials of cancer management.

4.4 Charity Involvement

See Appendix 3

5. THE NATIONAL LIVING WITH AND BEYON CANCER (LWBC) INITIATIVE

The colorectal CAG has agreed to conduct a review of patient follow up systems in line with the practices recommended by the National LWBC Initiative. Due to the ever increasing population of patients living with and beyond cancer, the current follow up systems are not sustainable, therefore new follow up methods need to be established to provide the support that patients require to 'lead as healthy and active a life as possible, for as long as possible'[4]. The colorectal CAG will work to ensure that all patients have access to the recommended *Recovery Package*. The *Recovery Package* consists of holistic needs assessments, treatment summaries and patient education and support events. The colorectal CAG will also develop risk stratified pathways of post treatment management, promote physical activity and seek to improve management of the consequences of treatment.

6. CLINICAL GOVERNANCE

6.1 Clinical Outcomes / Indicators and Audits (measure 14-1C116d)

The colorectal CAG routinely review and discuss the results of data collected from each MDT relating to various quality indicators. The clinical indicators that have been identified as the important elements for objective dialogue in terms of clinical practice and service delivery are listed in Section 2 of the colorectal cancer measures:

[4] http://www.ncsi.org.uk/

http://www.cquins.nhs.uk/index.php?menu=resources

The data collected provides the cancer outcome indicators required by the Clinical Commissioning Group Outcome Indicator Set (CCGOIS).

Additional audits for hospital practice are routinely conducted by each MDT associated with the CAG.

7. CLINICAL RESEARCH

7.1 Discussion of Clinical Trials (measure 14-1C-117d)

The CAG routinely discuss each MDTs report on clinical research trials within every CAG meeting. A list of all of the open trials on the colorectal NIHR portfolio and potential new trials is brought to each CAG meeting by the West of England Clinical Research Network (CRN) Cancer Research Delivery Manager.

Due to the CRNs mapping with the Academic Health Science Networks, Taunton and Yeovil are in South West Peninsula CRN. The Cancer Research Delivery Manager from the Peninsula CRN will provide the CAG with the data for these Trusts. Information on clinical trial recruitment will be published in the CAG Annual Report. Potential new trials to open and actions to improve recruitment will be documented in the CAG Work Programme. The trials available in each Trust will be updated on the South West Strategic Clinical Network website at regular intervals so that the CAG members can ensure, wherever possible, that clinical research trials are accessible to all eligible colorectal cancer patients. The NHS member of staff nominated as the Research Lead for the CAG is Sharath Gangadhara.

8. SERVICE DEVELOPMENT

8.1 Early diagnosis

The Bowel Cancer Screening Centres within the CAG

There are four bowel cancer screening centres that cover the SWAG CAG area:

- Somerset – serving NHS Somerset
- Bristol and Western, serving NHS South Gloucestershire, NHS Bristol and NHS North Somerset

- Bath, Swindon and Wiltshire, serving NHS Bath, North East Somerset, NHS Swindon and NHS Wiltshire
- Glos Hospitals, serving NHS Gloucestershire.

The Bowel Cancer Screening Centre for Bath, Swindon and Wiltshire

The Bowel Cancer Screening Programme (BCSP) centre for Bath, Swindon & Wiltshire started in 2009, and is based at Salisbury NHS Foundation Trust with satellite colonoscopy sites at The Royal United Hospital, Bath and the Great Western Hospital, Swindon.
We invite the local population aged between 60 and 74 to take part in Fobt testing via the Hub at Guildford (approx. 900,000).

On the receipt of a positive Fobt sample at the Hub, an appointment is made within 2 weeks at their nearest hospital for the patient to have a 45 minute discussion with a Specialist Screening Practitioner who will explain the findings of the Fobt test kit. The patient will be assessed for the need of a diagnostic test (normally a colonoscopy) within 2 weeks.
The date that the Fobt test kit is read at the hub is the date of referral.

In early 2015, we are planning to expand our service to include Bowel Scope - inviting all 55 year olds for a one off Endoscopy test. This will be a phased roll out over 2 years, covering all GP Practices in our area.

Details on all Bowel Cancer Screening Centres within the region will be completed as soon as the information becomes available.

8.2 The Enhanced Recovery Programme (ERP)

The CAG will endeavour to provide an Enhanced Recovery Programme for all patients. The ERP is about improving patient's outcomes and speeding up a patient's recovery after surgery. The programme focuses on making sure that patients are active participants in their own recovery process. It also aims to ensure that patients always receive evidence based care at the right time.

8.3 Educational Opportunities

The CAG meetings will have an educational function. Continual Professional Development (CPD) accreditation for meetings with multiple educational presentations will be sought by application to the Royal College of Physicians. This will involve uploading presentations and speaker profiles to the CPD approvals online application database. The approvals process takes approximately six weeks, and can be applied for retrospectively. The CAG members

will be required to complete a Royal College of Physician's CPD evaluation form. Certificates of the CPD points that are allocated to the meeting will be distributed to the CAG members.

8.4 Sharing Best Practice

Where best practice in colorectal cancer services outside the SWAG CAG has been identified, information on the function of these services will be gathered to provide a comparison and inform service improvements. Guest speakers from the identified services will be invited to present at the CAG.

Where best practice in colorectal cancer services within the SWAG CAG has been identified, information on the function of SWAG services will be disseminated to the other cancer networks.

8.5 Innovation

There is an increasing interest in the watch and wait approach to managing rectal cancer after treatment with chemo-radiotherapy. This is an agenda item that is due to be discussed in 2015.

8.6 Awareness Campaigns

In the event of a colorectal awareness campaign, the CAG have an agreed process to manage the possible impact of increased urgent referral from primary care to the colorectal cancer services. Information on clinical decision making when referring to colorectal services will be cascaded to General Practitioners via the primary care e-bulletin and the SWSCN website.

9. FUNDING

9.1 Clinical Commissioning Groups

In the event that an insufficiency in the SWAG cancer services relating to funding is identified, the colorectal CAG will gather evidence of the insufficiency via audit and research together with feedback about how the provider Trusts have tried to address them. The consequences of the insufficiencies for patients will be listed so that all key issues are documented and the required actions made clear. This information will then be fed back to the Cancer Network Manager for the South West Strategic Clinical Network, who will present the evidence to the CCG clinical effectiveness group.

9.2 Industry

The Government's paper *Improving Outcomes: A Strategy for Cancer* states that 'working together with other organisations and individuals, we can make an even bigger difference in the fight against cancer'. The CAG will forge relationships with pharmaceutical companies to seek commercial sponsorship for the meetings in order to make savings that can be fed back into the CAG cancer services. The CAG Support Manager will comply with the various rules and regulations pertaining to the pharmaceutical companies policies and with the NHS rules and regulations as follows:

- Completion of a register of interest form with the CAG support service host Trust, University Hospitals Bristol NHS Foundation Trust
- Declaration of any sponsorship offers
- Confirm with all sponsors that the arrangements would have no effect on purchasing decisions
- Ensure that all pharmaceutical companies entering into sponsorship agreements comply with *the Code of Practice for the Pharmaceutical Industry* (Second Edition) 2012.
- Obtain advice from the Medical Director or Chief Pharmacist for sponsorship agreements in excess of £500.00
- Ensure that where a meeting is funded by the pharmaceutical industry, that this is documented on all papers relating to the meetings
- Ensure that the receipt of funding is approved by an Executive Director and recorded in the Register of Gifts, Hospitality and Sponsorship in advance
- Scrutinise contracts with the assistance of Financial Services prior to providing a signature

10. APPENDICES

10.1 Appendix 1: SWAG Colorectal CAG Template Agenda

Network group membership to attend:

Chair, MDT core members, MDT nurse core member, Colorectal Surgeon, Hepatic surgeon, Thoracic surgeon, Clinical oncologist, Medical oncologist, Imaging specialist, Histopathologist, Colonoscopist, Palliative care representative, User representatives, Administrative Support.

Chair to name nominated network group member responsible for users' issues and information for patients / carers

Chair to name nominated network group member responsible for clinical trial recruitment function

1. **Clinical opinion on network issues:**

   Review of MDT membership changes / service

2. **Clinical guidelines:**

   Review if there are any amendments to imaging, surgery, pathology, chemotherapy and radiotherapy practices

   Version control process

3. **Coordination of patient care pathways**

   Review of hospital referral processes for TYA / varying indications / investigations and follow up

   Review implementation of primary care referral pro forma

   Breach example to discuss

4. **Patient experience:**

   User representative input

Review patient experience survey / identified actions

QOL surveys

Patient information

CNS / keyworker support

5. **Living With and Beyond Cancer:**

Holistic needs assessments

- To define when these should be performed

Next steps (Health and Wellbeing events)

Treatment summaries

6. **Quality indicators, audits and data collection:**

Current audits / audit outcomes

Audits in the pipeline

Data collection issues

7. **Research:**

Current clinical trials / recruitment / actions to improve recruitment

Clinical trials in the pipe line

8. **Service development:**

Early diagnosis

Prehabilitation / enhanced recovery programme

Training opportunities available

Sharing best practice

Innovation

Awareness campaigns

9. **Quality Surveillance:**

Annual Report

Constitution

Work Programme Review

- Good practice – specific areas to highlight
- Are there immediate risks?
- Are there serious concerns?

10. Any other business:

11. Date and time of next meeting:

10.2 Appendix 2

SWAG CAG User Involvement Brief

10.3 Appendix 3

SWAG CAG Charity Involvement Brief

-END-