Peninsula Cancer Alliance

Colorectal Cancer Site Specific Group

Constitution

Date Agreed: 10th September 2018

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VERSION CONTROL

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VERSION	DATE ISSUED	SUMMARY OF CHANGE	OWNER'S NAME
V1.0	10th September 2018	Created to reflect the formation of Cancer Alliances, changes in peer review requirements and relevant clinical updates.	PCA Colorectal SSG

Constitution of the Peninsula Cancer Alliance
Colorectal Site Specific Group (SSG)

Agreement cover sheet

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This constitution has been agreed (on behalf of the relevant MDTs) by:

Name	Position	Organisation	Date Agreed
Mark Cartmell	MDT Lead	North Devon Healthcare NHS Trust (NDHT)	10.09.2018
Melanie Feldman	MDT Lead	Royal Cornwall Hospitals NHS Trust (RCHT)	10.09.2018
TBC	MDT Lead	Royal Devon and Exeter NHS Foundation Trust (RDEFT)	TBA
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Contents

1.0 Statement of Purpose

The PCA Colorectal Site Specific Group (SSG) endeavours to deliver equity of access to the best medical practice for our patient population, promote positive patient experiences as well as ensuring that the services provided are safe, efficient and guided by evidence based best practice.

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

- That the structure and function of the services provided across the geographical boundaries of the Peninsula Cancer Alliance are conducted, wherever possible, in accordance with the most up to date clinical practice.

- That a Colorectal SSG consisting of multidisciplinary professionals from across Devon and Cornwall has been established and meets on a regular basis.

- That the Colorectal SSG has agreed patient pathways in place to ensure that a consistent approach to the coordination of patient care is maintained for each patient across the PCA.

- That there are agreed clinical guidelines in place (in accordance with the most up to date, reliable evidence) to inform clinical decision making.

- That there is a process by which patients and carers can evaluate and influence service improvements, supporting the principle of '*No decision about me without me*'[1]

- The Colorectal SSG assesses national audit data to identify priorities for improvement.

- The Colorectal SSG has 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 Colorectal SSG to

[1] Department of Health (2010) "Liberating the NHS": accessed online: available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213823/dh_117794.pdf

inform service development.

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

2.0 Background

In July 2015, the Independent Cancer Taskforce[2] set out an ambitious strategy to radically improve the services, care and outcomes for people affected by cancer; fewer people getting cancer, more people surviving cancer, more people having a positive experience of their treatment and care, whoever they are and wherever they live, and to support more people to live well after their treatment has finished[3].

The Independent Cancer Taskforce set out 96 recommendations to help transform the care provided by the NHS. One of those recommendations was the formation of Cancer Alliances, as a way of bringing together local clinical and managerial leaders from care providers and commissioners across the whole cancer pathway, to drive forward the transformational changes needed to progress existing cancer services over the coming years

2.1 The Peninsula Cancer Alliance and Site Specific Groups (SSGs)

The Health and Social Care Act (2012)[4] saw cancer networks disbanded. However, as highlighted by Macmillan (2015)[5] there are lessons to be learnt from the former cancer and strategic clinical networks, as well as many functions that should not only continue to inform the development of cancer alliances, but which are essential to enabling high quality, collaborative cancer services; these include;

- Driving forward local strategies
- Driving service redesign and integration
- The provision of expertise on cancer
- Monitoring performance and supporting providers

[2] Report of the Independent Cancer Taskforce (2015) "Achieving World-Class Cancer Outcomes: A Strategy for England 2015-2020"
[3] NHS England-Five Year Forward View (2016) "Delivering World-Class Cancer Outcomes: Guidance for Cancer Alliances and the National Cancer Vanguard"
[4] Health and Social Care Act (2012): [accessed online 29.06.2017] available at: http://www.legislation.gov.uk/ukpga/2012/7/contents
[5] Macmillan Cancer Support (2015) Cancer Alliances: A Crucial First Step: [accessed online 29.06.2017] available at: http://www.macmillan.org.uk/documents/campaigns/canceralliancesreport.pdf

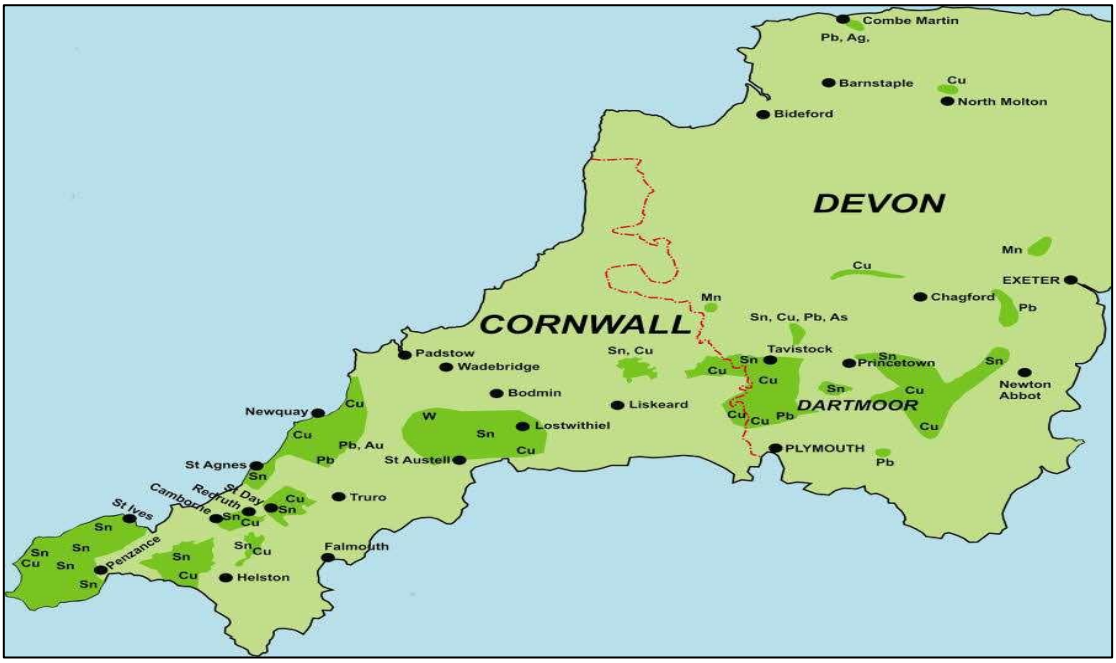
2.2 Key Stakeholders

The Peninsula Cancer Alliance is one of 16 Cancer Alliances across England; it works in partnership with the following key stakeholders (in addition to a number of charitable organisations and community hospitals);

Service Users	• Patients • Carers • Families
Clinical Commissioning Groups (CCGs)	• NEW Devon CCG • NHS Kernow CCG • South Devon and Torbay CCG
Acute Hospital Trusts	• Northern Devon Healthcare NHS Trust • Royal Cornwall Hospitals NHS Trust • Royal Devon and Exeter NHS Foundation Trust • South Devon and Torbay NHS Foundation Trust • University Hospitals Plymouth NHS Trust
Community Specialist Palliative Care Providers	• Hospiscare, Exeter • Mount Edgcumbe Hospice, Cornwall • Hospice, Cornwall North • North Devon Hospice • Rowcroft Hospice, Torquay • St Julia's Hospice, Cornwall • St Lukes's Hospice, Plymouth
Primary Care Providers	• GP Practices

2.3 Geographical Boundaries

The PCA covers a large geographical area[6] comprising of both urban and rural communities across Devon and Cornwall;



2.4 Population

The population of Cornwall and Devon are estimated to be as follows[7];

County	Population	Area (square miles)
Cornwall	556,000	1,376
Devon	1,100,000	2,590
TOTAL	**1,656,000**	**3,966**

3.0 Site Specific Groups (SSGs)

In response to the Manual for Cancer Services (National Peer Review Measures) a number of clinical sub-groups were established to address services for specific types of cancer. This manual is now obsolete (having been replaced by the NHS Quality Surveillance Programme-

[6] https://en.wikipedia.org/wiki/Devon and https://en.wikipedia.org/wiki/Cornwall [accessed 30.06.2017) and https://www.bing.com/images/search?view=detailV2&ccid=gENte6YV&id=F495CE0BAC49F76D0B1D28987745343E644C938A&thid=OIP.gENte6YVudeW1ULm8tRnXwHaGO&mediaurl=https%3a%2f%2fwww.nmrs.org.uk%2fwp-content%2fuploads%2f2016%2f02%2fa.jpg&exph=757&expw=900&q=map+of+devon+and+cornwall+uk&simid=608016850303321700&selectedIndex=0&ajaxhist=0

[7] https://en.wikipedia.org/wiki/Devon and https://en.wikipedia.org/wiki/Cornwall [accessed 30.06.2017) and https://www.bing.com/images/search?view=detailV2&ccid=gENte6YV&id=F495CE0BAC49F76D0B1D28987745343E644C938A&thid=OIP.gENte6YVudeW1ULm8tRnXwHaGO&mediaurl=https%3a%2f%2fwww.nmrs.org.uk%2fwp-content%2fuploads%2f2016%2f02%2fa.jpg&exph=757&expw=900&q=map+of+devon+and+cornwall+uk&simid=608016850303321700&selectedIndex=0&ajaxhist=0

"QSP"); however, the cancer site specific groups continue and have collective responsibility (delegated by the Peninsula Cancer Alliance Executive Board) for coordination and consistency of cancer policy, clinical guidelines, patient pathways, audit, research and service developments/ improvements across the Peninsula. The Colorectal SSG is one of the 13 SSGs across the PCA.

3.1 Key Objectives of the Colorectal SSG

The primary objective of the PCA Colorectal SSG is to support clinicians to improve patient care and achieve world class cancer outcomes for the population they serve.

Other objectives include;

- Acting as the primary source of clinical opinion for colorectal cancer, for the Cancer Alliance Executive Board.
- Advising and consulting on service planning to ensure services are in line with national guidance in order to promote high quality care and reduce inequalities in service delivery;
- Ensuring that PCA Colorectal SSG decisions become integrated into local practice;
- Monitoring progress on meeting the requirements of QSP (Peer Review) and to ensure that action plans agreed following QSP are implemented;
- Forging links between teams, across trusts and with other relevant SSGs, to facilitate a joined up approach to cancer care across the Peninsula.

The Colorectal SSG will also;

- Validate agreed patient pathways to ensure that each trust is clear on their roles and responsibilities; particularly in respect of inter-trust referrals, and in keeping with the 62 day standard.
- Agree shared clinical guidelines to inform clinical practice across the PCA (these may be in addition to trust specific clinical guidelines).
- Ensure local organisations submit full required data to the National Bowel Cancer Audit.
- Agree and support an annual audit program both at local and regional level;
- Agree a common approach to research & development, participating in nationally recognized studies whenever possible;
- Consult with cross-cutting groups on issues involving chemotherapy, cancer imaging, histopathology and laboratory investigation and specialist palliative care;

- Support the development of education and training programs for teams;
- Support effective patient/carer/family involvement in service planning and delivery;
- Produce a PCA Colorectal SSG action plan, ensuring that delegated tasks are undertaken and reviewed in a timely manner.

3.2 SSG Terms of Reference

Terms of reference are agreed in accordance with the paper *"Recurrent Arrangements for Cancer Network Clinical Groups and Responsibilities for Peer Review"* (Appendix 1) as proposed by the South West Strategic Clinical Network (SWSCN) Cancer Network Manager, Jonathan Miller (14th July 2014).

3.3 Colorectal SSG Meetings

The PCA Colorectal SSG will meet twice a year. Agendas, notes, actions and attendance records will be available on the SWCN website.

Cited in Appendix 2 is draft template agenda for Colorectal SSG 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.

3.4 Colorectal SSG Membership Configuration

Membership of the Colorectal SSG will be multi-disciplinary in nature with representation from professionals across the care pathway. All core and extended members of the relevant acute Trust MDT(s) are invited to participate in group activities via group meetings, working parties and email communications as appropriate.

3.5 Colorectal SSG Membership

All MDT participants are welcome to attend the SSG meetings.
The PCA Colorectal SSG consists of the following core members;

Colorectal SSG Chair		
Melanie Feldman	Consultant Colorectal Surgeon/MDT Lead	Royal Cornwall Hospitals NHS Trust
SSG Trial Recruitment Clinical Lead		
Nader Francis	Consultant Colorectal Surgeon	Yeovil District Hospital NHS Foundation Trust

Patient Champion & Information Lead		
Vacancy		
Patient and Carer Representatives		
1 representative from Cornwall 1 representative from Devon		
Northern Devon Healthcare NHS Trust		
Mark Cartmell Katie Cross Karen Day Mark Napier M Osborne N Ward Jenny Macpherson B Theron Sue Hammet	Consultant Surgeon Consultant Surgeon Clinical Nurse Specialist Consultant Medical Oncologist Consultant Clinical Oncologist Lead Histopathologist Lead Radiologist Consultant GI Physician MDT Coordinator	**MDT Lead**
University Hospitals Plymouth NHS Trust		
Chris Gandy Clare Adams Simon Brundell Mark Coleman Walter Douie Rajesh Thengungal Kochupapy Eric Drabble Sebastian Smolerak Wesley Lai Matthew Bowles Chris Briggs Bruce Fox Gemma Miles John Shirley Mac Armstrong Adel Abdellaoui Tim Bracey Sari Suortamo Peter Sankey Bojidar Goranov David Sherriff Magdelena Metzner Doug Hooper Pippa Knight Maria Lawson Fiona Tucker Tessa Cardell	Consultant Surgeon Consultant Surgeon Consultant Surgeon Consultant Surgeon Consultant Surgeon Consultant Surgeon Consultant Surgeon Consultant Surgeon Consultant Surgeon Consultant Gastroenterologist Consultant Hepatobiliary and Pancreatic Surgeon Consultant Radiologist Consultant Radiologist Consultant Radiologist Consultant Radiologist Consultant Radiologist Consultant Histopathologist Consultant Histopathologist Consultant Oncologist Consultant Oncologist Consultant Oncologist Consultant Gastroenterologist Palliative Care Consultant Palliative Care Clinical Nurse Specialist Clinical Nurse Specialist Clinical Nurse Specialist	**MDT Lead**

Graham Pattison Nicola Mellor Cathy Martin	Clinical Nurse Specialist Clinical Nurse Specialist Clinical Nurse Specialist	
Royal Cornwall NHS Hospitals Trust		
Core-Members **Melanie Feldman*** **Clare Ferris*** Ponnandai Arumugam Adam Widdison William Faux Petra Marsh Paul Lidder Denzil May Ilona Hopkins Tim Bracey Richard Ellis Fiona Minear Caroline Parnell Fiona Minear James Bebb John Hancock Giles Maskell Madeline Strugnell Dushyant Shetty Candida Coombe	 Consultant Surgeon Clinical Nurse Specialist Consultant Surgeon Consultant Surgeon Consultant Surgeon Consultant Surgeon Consultant Surgeon Consultant Surgeon Consultant Histopathologist Consultant Histopathologist Consultant Clinical Oncologist Consultant Oncologist Acting Consultant Oncologist Consultant Clinical Oncologist Consultant Gastroenterologist Consultant Radiologist Consultant Radiologist Consultant Radiologist Consultant Radiologist Clinical Nurse Specialist	 ***Joint MDT Lead**
Royal Devon & Exeter NHS Foundation Trust		
William Chambers Andrew Gee Ian Daniels Stephen Mansfield Neil Smart Rob Bethune Denise Sheehan Mel Osborne Mark Napier Simon Harries Richard Thomas Patrick Rogers Patrick Sarsfiled Sarah Saunders Trupti Mandalia Tanwen Wright Paschalis Chatzipantelis Dr Baines Joan Garwood Claire Kelly Emma Jenkins Ceri Martin	Consultant Colorectal Surgeon Consultant Colorectal Surgeon Consultant Colorectal Surgeon Consultant Colorectal Surgeon Consultant Colorectal Surgeon Consultant Colorectal Surgeon Consultant Clinical Oncologist Consultant Clinical Oncologist Consultant Medical Oncologist Consultant Radiologist Consultant Radiologist Consultant Radiologist Consultant Histopathologist Consultant Histopathologist Consultant Histopathologist Consultant Histopathologist Consultant Histopathologist Palliative Care Colorectal Nurse Specialist Colorectal Nurse Specialist Colorectal Nurse Specialist Colorectal Nurse Specialist	**MDT Lead TBC**

Lesley Martin-Pitt Many O'Hara Cindy Collier Bridget Cann Amanda Gunning Anna Lydon Frank McDermott	Stoma Care Nurse Specialist Stoma Care Nurse Specialist Bowel Cancer Screening Nurse Bowel Cancer Screening Nurse Lead Stoma Care Nurse Clinical Oncologist Surgical Consultant	
Torbay and South Devon NHS Foundation Trust		
Stephen Mitchell David Defriend Rupert Pullan Nicholas Kefenick Sally Ward-Booth Sally Lindsay Neita Matthews Jo Billyard David Buckley Mark Puckett Nicholas Ryley Ian Buley Consuelo Garrido John Bridger Tanwen Wright Nangi Lo Ruth Carr Maria Dabrowska Melanie Osborne Jo Sykes Pat Lye Janice Caunter Jaqui Carne	Consultant Surgeon Consultant Surgeon Consultant Surgeon Consultant Surgeon Stoma Clinical Nurse Specialist Clinical Nurse Specialist Clinical Nurse Specialist Nurse Consultant Consultant Radiologist Consultant Radiologist Consultant Histopathologist Consultant Histopathologist Consultant Histopathologist Consultant Histopathologist Consultant Histopathologist Consultant Oncologist Consultant Oncologist Consultant Oncologist Consultant Oncologist Consultant Palliative Care Palliative Care Nurse MDT Coordinator MDT Coordinator	**MDT Lead**

3.6 Colorectal SSG Chair

- Nominations for the position of Colorectal SSG Chair must be supported by at least one other core member of the group.
- Where there is more than one nominee, the Chair of the group will be elected from within the membership of the Group.
- The term of office will be for two years (unless otherwise agreed by the group members).
- The role and responsibilities of the Chair can be found in Appendix 3.

3.7 Group Service Improvement Clinical Lead

A group service improvement clinical lead will be identified from within the membership of the Group. The designated person will work alongside the PCA (when required) on service development issues specific to Colorectal Cancer.

3.8 Group Trial Recruitment Clinical Lead

A group trial recruitment clinical lead will be identified from within the membership of the group. The designated person will work with the PCA and liaise with MDT research representatives on research specific issues.

3.9 Patient/Public Involvement

"To deliver the outcomes that matter most, the NHS needs to involve people affected by cancer in designing local service delivery. User involvement drives improvement, holds organisations to account, and ensures services are based on local need…Patients need to be at the heart of local cancer systems…"[8]

The Colorectal SSG will embrace the concept of *"no decision about me, without me",* and in doing so, will make it their priority to engage with patient/carer representatives from within the geographical boundaries of the PCA.

The SSG actively seeks to recruit further user representatives. Appendix 4 contains the "*User Involvement Brief*" that is circulated for this purpose.

3.10 Patient Champion/Information Lead

A named NHS employed group member will be appointed as a Patient Champion/ Information Lead; the member will have responsibility for ensuring that the Patient (or carer) representative are aware of the aims and objectives of the group, that they are given every opportunity to engage with the SSG, and have the freedom to express their experience and views.

3.11 Patient Experience

As well as engaging with patient/carer representatives, the group will also review the results of the National Cancer Patient Experience Survey (for each Trust) at every other SSG meeting. An agreed improvement programme will be documented and monitored.

3.12 Charity Involvement

Refer to Appendix 5.

[8] Macmillan Cancer Support (2015) Cancer Alliances: A Crucial First Step [accessed online 29.06.2017] available at: http://www.macmillan.org.uk/documents/campaigns/canceralliancesreport.pdf

3.13 Reporting Processes

Issues of concern raised by the SSG and agreed to be a local operational issue, will be referred in the first instance to the relevant trust/s, via the Cancer Services Manager/Lead Cancer Nurse for local resolution.

Issues raised by the SSG which require input from the relevant CCGs and/or STPs will be directed to the STP Cancer Group for discussion. If the STP is unable to resolve the issue, additional communication may be required by an SSG representative/chair communicating with or attending the STP Board.

Issues relating to Specialist Services Commissioning will be escalated in the first instance (where appropriate) to the PCA Clinical Lead.

3.14 Clinical Trials

Discussion of Clinical Trials

Members of the SSG discuss each MDTs report on clinical research trials annually. A list of all open trials on the Colorectal NIHR portfolio, and potential new trials, is brought to each SSG meeting by the Research Delivery Manager of the Clinical Research Network (South West Peninsula).

The trials available in each Trust will be updated on the South West Clinical Network website at regular intervals so that SSG members can ensure, wherever possible, that clinical research trials are accessible to all eligible Colorectal Cancer patients.

3.15 Early Diagnosis and Bowel Cancer Screening

The Colorectal SSG will participate in health promotion activities relevant to colorectal cancer protection (such as the “Smoke Free NHS” initiative) and cooperate with programs within the Trusts.

The Bowel Cancer Screening programs within the PCA are:

BCSP programme	Colonoscopy Centre	Responsible clinician	Responsible Nurse
Cornwall	Truro	Hyder Hussaini	Rebecca Warren
Exeter	Exeter	Dr Alex Moran	Bridget Cann
North Devon	North Devon	Dr Alex Moran	Bridget Cann
Plymouth	Plymouth	Mr Ruppert Pullan	Kathryn Bird

Torbay	Torbay	Mr Rupert Pullan	Kathryn Bird

3.16 The National Living With and Beyond Cancer Initiative (LWBC)

The Cancer Taskforce is working with Macmillan to roll out the "*Recovery Package*"; a set of four key interventions which aim to better support and improve the lives of people living with and beyond cancer. The Colorectal SSG will work to ensure that all patients have access to the recommended Recovery Package.

The Colorectal SSG will also develop risk stratified pathways of post treatment management, promote physical activity and seek to improve the management and consequences of treatment.

3.17 Clinical Governance

Clinical Outcomes, Indicators and Audits

The SSG regularly reviews the data from the national cancer patient survey and the National Bowel Cancer audit. The results of this are presented at the SSG meetings and distributed electronically to the group. Additional network or local audits will be conducted and reviewed when necessary.

3.18 Data Collection

Minimum Dataset

All Trusts have previously confirmed their compliance with data collection requirements for Cancer Waiting Times, the Cancer Registry and the National Bowel Cancer Audit. This constitutes the MDS for the Colorectal SSG.

Collection of the Minimum Dataset-Responsibility for data

The Acute Trust first seeing a patient for a particular month or quarter is responsible for ensuring that the mandated data fields are complete on the database by the national deadline.

The Acute Trust first treating or giving subsequent treatment to a patient in a particular month or quarter is responsible for ensuring that the mandated data fields regarding that patient are complete on the database by the national deadline.

The multidisciplinary team responsible for the care of the patient should ensure that information is made available to allow it to be recorded prospectively and electronically.

Cancer Services teams in each Acute Trust should ensure that the information is transferred within the timescales specified and should establish robust lines of communication with their colleagues in other Acute Trusts.

3.19 Service Development

Regular review of major service developments and changes in treatment pathways are conducted at SSG meetings.

3.20 Education

The Colorectal SSG will have an educational function. Continuous 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 6 weeks, and can be applied for retrospectively. The SSG members will be required to complete a Royal College of Physicians CPS evaluation form. Certificates of the CPD points that are allocated to the meeting will be distributed to the SSG members.

3.21 Sharing Best Practice

Where best practice in colorectal cancer services outside the PCA SSG 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 provide information and advice to the SSG.

Where best practice in colorectal cancer services within the PCA SSG has been identified, information on the function of PCA services will be disseminated to other Cancer Alliances.

3.22 Awareness Campaigns

Colorectal Cancer awareness campaigns increase urgent referrals to Colorectal Cancer services. Local Cancer Services Managers will be informed when local and national campaigns are scheduled.

Advice about clinical decision making and referrals will be shared with primary care via the email bulletin, the Map of Medicine, Referral Management Systems and the SWCN website.

3.23 Funding

Clinical Commissioning Groups

In the event that an insufficiency in Colorectal Cancer services relating to funding is identified, the SSG 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 Alliance Manager for the South West who will present the evidence to the CCG clinical effectiveness groups.

3.24 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 SSG 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 SSG cancer services. The SSG Support Manager will comply with the various rules and regulations pertaining to the pharmaceutical company policies, and with the NHS rules and regulations as follows:

- 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 (2nd Ed)* (2012)".
- Ensure that where a meeting is funded by the pharmaceutical industry, this is documented on all papers relating to the meetings.
- Comply with any additional requirements as set out by the SSG Support Manager's Host Trust

4.0 Peninsula Colorectal Cancer Services

4.1 Colorectal Cancer Multidisciplinary Teams (MDTs)

The MDTs within the Colorectal SSG consist of consultant colorectal surgeons, clinical and medical oncologists, pathologists, imaging specialists and other healthcare professionals. They meet regularly to discuss and manage each patient's care individually;

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
North Devon Healthcare NHS Trust	√	√						
University Hospitals Plymouth NHS Trust	√	√	√		√	√	√	√
Royal Cornwall Hospitals NHS Trust	√	√	√					
Royal Devon and Exeter NHS Foundation Trust	√	√		√ 1st and 3rd Monday of the month	√			
Torbay and South Devon NHS Foundation Trust	√	√						

Further information on local colorectal services across the Peninsula can be found via the following web links;

North Devon Healthcare NHS Trust
Royal Cornwall Hospitals NHS Trust
Royal Devon and Exeter NHS Foundation Trust
Torbay and South Devon NHS Foundation Trust
University Hospitals Plymouth NHS Trust

4.2 Management of Anal Cancers

All five local MDT's have agreed on a video-linked monthly anal cancer MDT. This links all five colorectal cancer local MDT sites. The agreed centre is the Royal Devon and Exeter NHS Foundation Trust. The position of anal cancer MDT lead is to be confirmed. The

guidelines for diagnosis, investigations, referral decisions and initial treatment have been agreed by the SSG Chair and all the MDT Leads. All patients diagnosed with an anal cancer will follow the agreed management and referral guidance with anal cancer salvage surgery referred to the Royal Devon & Exeter Trust.

4.3 Management of Rectal Cancers

Management of rectal cancers is provided in all five localities, specific referral details and clinical protocols can be found in the PCA Colorectal Clinical Guidelines (to be agreed); when available, the guidelines will be made available to all member trusts and via a link to the SWCN website

4.4 Management of Liver Metastases

University Hospitals Plymouth NHS Trust provides the liver resection service for the whole of the Peninsula. Further details of indications, referral and services can be found in the PCA SSG Colorectal Clinical Guidelines (to be published).

4.5 Colorectal Stenting

Colorectal stenting is a useful adjunct to emergency services seeing patients with obstructing bowel cancer, either for patients too frail for resection or as a bridge to surgery or chemotherapy. Stenting is available in the network at all times. Trusts who do not have 24/7 availability can refer to neighboring centres when required.

5.0 Referrals

5.1 Primary Care Referral Guidelines

Primary Care Practitioners will refer all patients defined by the “urgent, suspicious of cancer” guidelines for colorectal cancer to the contact point of a single local colorectal team as agreed in each local MDT operational policy.

General practitioners and nurse practitioners should be aware of the various routes by which patients satisfying the high risk criteria can gain access to diagnostic services in their locality. All suspected colorectal cancers are referred to a central point in all 5 acute hospitals via one of the 3 routes (below);

1. All such referrals should be made (via primary care proforma within 24 hours usually through a dedicated fast track system). The patient will be offered a date within the 2 weeks of referral.

2. Patients who describe symptoms which don't entirely fulfill the criteria but are a source of concern to the GP can be referred urgently to the colorectal service out with the fast track system (Choose and Book).
3. Any patient with emergency signs and symptoms should be referred as an emergency to the surgical admissions unit.

If possible all referrals to the colorectal service should be prioritized by the colorectal surgeon or a gastroenterologist.

5.2 Referral guidelines for patients moving between teams

Referring clinicians should ensure that all relevant information is provided to facilitate the continuity of care and avoid unnecessary delays.

There may be occasions when patients are diagnosed unexpectedly or incidentally with colorectal cancer, or known patients are diagnosed with recurrent or metastatic disease. These events may occur outside the colorectal MDT, and such patients should be referred to the MDT within one working day of a confirmed diagnosis. Local operation policies must reflect the mechanisms to achieve this, including methods of communication, contact points and referral responsibilities.

Any patient suspected of having cancer but not referred via the urgent referral route may be upgraded by a consultant member of the MDT at any time prior to decision to treat. The upgrade should be undertaken using the internal upgrade referral proforma and following processes outlined in individual Trust operational policies.

Inter-trust referrals should be made as per individual trust operational policy.

Patients with synchronous cancer at colorectal and other site/s;

Such patients will be discussed in the Colorectal MDT. Lead responsibility will be shared with the other site specific MDT, until it becomes clear which MDT would be best to lead in each individual case.

5.3 Patients with other primary site tumours and no colorectal cancer

The 2WW criteria now identify patients with tumours in other primary sites and no colorectal cancer. These patients must be seamlessly transferred to the appropriate local MDT. This includes cancer of unknown primary.

6.0 Clinical Guidelines

6.1 Colorectal Cancer

The PCA Colorectal SSG refers to the following guidelines for clinical management of colorectal cancer;

- NICE(2011) CG131: Colorectal cancer: diagnosis and management
- Guidelines from the Association of Coloproctology of Great Britain and Ireland
- NHS England; Colorectal Cancer Clinical Expert Group (2017) Guidelines for the Commissioning of the Whole Bowel Cancer Pathway.

6.2 Patient Pathways

Local Trusts will remain responsible for producing patient pathways; however, the pathways will be reviewed and agreed by the Colorectal SSG.

The Colorectal SSG aims to follow the pathway steps as set out by the Colorectal Cancer Clinical Expert Group (2017) *"Guidelines for the Commissioning of the Whole Bowel Cancer Pathway"*.

7.0 Teenagers and Young Adults (TYA)

Details of TYA patient pathways can be access via the SWCN website.

8.0 Distribution of agreed clinical guidelines, protocols and patient pathways

MDT Leads at each respective member Trust are responsible for sharing draft documents with their MDT members. Comments will be fed back to the SSG Chair who will, in consultation with the MDT Leads, make any amendments as deemed appropriate. Documents will be considered agreed when the SSG Chair and MDT Leads have confirmed that the document is ready to be published.

Once agreed, documents will be circulated to all core and extended members of the local MDTs. The MDT Lead for each locality is responsible for forwarding them to relevant clinical colleagues within their organisations and publishing on local document libraries where applicable. All SSG agreed documents will be available via the SWCN website.

Where disagreement about policy cannot be resolved, a majority view will be accepted, with alternative views noted.

Appendices

Appendix 1

Recurrent Arrangements (link to document)

Appendix 2

SSG Meetings-Desirable Attendance

- Colorectal SSG Chair (or vice chair in their absence)
- One member of the MDT from each Trust (preferably the MDT lead) and in the absence of the MDT Lead; one oncologist, one radiologist, one surgeon, one pathologist or one CNS as a minimum.
- Lead for anal cancer
- Lead for research
- A patient group representative
- A clinician from palliative care / a hospice
- A GP from each CCG area
- A commissioner from each CCG
- The cancer services manager, lead cancer clinician for each Trust or other Trust representative

SSG MEETING AGENDA TEMPLATE

	SPRING MEETING		AUTUMN MEETING
1.	**Review of Action Plan**	1.	**Review of Action Plan**
2.	**Guest Speakers**	2.	**Guest Speakers**
3.	**SSG Matters/Alliance Updates**	3.	**SSG Matters/Alliance Updates**
4.	**Quality Indicators, audits and data collections** [i.e. Current audits/ outcomes; planned audits and data collection issues].	4.	**Quality Indicators, audits and data collections** [i.e. Current audits/ outcomes; planned audits and data collection issues]
5.	**Service development** [i.e. Early diagnosis, pre-habilitation/enhanced recovery programme; training opportunities, sharing best practice; innovation; awareness campaigns	5.	**Service development** [i.e. Early diagnosis, pre-habilitation/enhanced recovery programme; training opportunities, sharing best practice; innovation; awareness campaigns

6.	**Patient experience** [i.e. user representative input, review of patient experience survey / identified actions; QOL surveys, patient information,CNS / keyworker support]	6.	**Clinical Guidelines** [i.e. any amendments to imaging, surgery, pathology, chemotherapy and radiotherapy practices; version control process for shared guidelines].
7.	**Living With and Beyond Cancer** [i.e. Holistic Needs Assessments; Health and Wellbeing Events; Treatment Summaries]	7.	**Coordination of patient care pathways** [i.e. review of hospital referral processes for TYA / varying indications / investigations and follow up; 2ww proformas; breach example to discuss]
8.	**AOB** **Agree date and time of the next meeting**	8.	**Research Update**
		9.	**AOB** **Agree date and time of next meeting**

SSG Chair Role and Responsibilities

1.0 Ensure that the group is properly represented by all key MDT members/stakeholders.

2.0 Ensure that representations at SSG meetings are multi-professional in nature.

3.0 Take responsibility for delivering the constitution for the SSG.

4.0 Ensure that there are systems and processes in place to;

4.1 Review national standards and update local guidelines/patient pathways.

4.2 Support accreditation/quality assurance.

4.3 Agree research and development programs/common clinical trials.

4.4 Ensure that any tumour site specific issues of clinical governance are raised with key stakeholders.

5.0 Ensure that SSG meetings are held at least twice a year.

6.0 Agree an agenda for and chair the SSG meetings, ensuring that adequate time is allowed for each item under discussion and that stakeholders' views are sought.

7.0 Ensure that meeting minutes and action notes are circulated to core and extended members of the SSG within one month of the meeting date.

8.0 Ensure that issues of concern raised by SSG group members are escalated appropriately and as documented within the PCA Constitution (*"Reporting Processes").*

10.0 Lead discussions with other SSGs on issues of common interest.

Appendix 4

User Involvement Brief (link to document)

Appendix 5

Charity Involvement Brief (Link to document)

-END-