Greater Manchester
Cancer Alliance

Personalised Stratified Follow up for Colorectal Cancers

Document Control

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Version number	Date	Revision Author	Status	Revision Made
0.1	23/10/2023	A Webber	Document Created	
0.2	30/10/2023	A Webber (discussion with S Sykes)	Draft	TEMS/TAMIS wording and changed waiting times
0.3	31/10/2023	Amanda Coop	Draft	Expanded high risk wording
0.4	28/11/2023	V Denvir (cancer voices representative)	Draft	Changed cancer survivor to cancer patient
0.5	29/11/2023	Mr C Selvasekar/ A Coop	Draft	Clock restart for recurrence and Tems/Tamis wording
1.0	05/12/2023	Pathway Board	Final	Document ratified

1. Purpose

This document provides local guidance for Personalised Stratified Follow Up (PSFU) within the GM Colorectal cancer pathway.

It applies to all Greater Manchester local units and specialist centres involved in the treatment of patients with a colorectal cancer. This model of care is aligned with the NHS Long Term Plan for Cancer, British Society of Gastroenterologists (BSG) guidelines, NHSE Personalised Care for Cancer Initiative. Phase 3 COVID Recovery Planning, the GM Cancer Plan and NHS 22/23 and 23/24 priorities and operational planning guidance.

2. Introduction

The overall aim of PSFU is to improve patient experience and outcomes with tailored aftercare and supported self-management. It is intended to meet the wider needs of a cancer patient than is possible by routine clinic follow up alone. It reduces the frequency of hospital-based outpatient appointments but must be supported with rapid access to clinical review if symptoms of recurrence are reported.

3. PSFU Process

PSFU describes the delivery of personalised ongoing care to cancer patients that supports them towards self-management based on individual risk stratification, needs and preferences rather than the traditional clinic based follow up.

To care self-care effectively, patients must have good knowledge, skills and confidence about their condition.

All newly diagnosed colorectal cancer patients should receive information about their diagnosis, treatment options and subsequent follow-up pathway at the end of treatment, including PSFU. This will include a description of the re-entry process, the support, and tools available to enable self-management and explanation of the ongoing surveillance and screening that will occur during follow up period up to 5 years.

All patients will be transferred onto the jointly agreed follow-up pathway at the end of treatment following discussion between the clinician and patient.

To ensure patients are fully informed about their PSFU decision, they should be given specific written information about PSFU for colorectal cancer. All patients should be given time to decide if they need to reflect on the information and reassured that they can convert to traditional clinic follow up at any time if they so wish.

Patients should be reassured that they will receive the following to support them:

- Tumour specific written information (usually given at diagnosis)
- End of Treatment Summary (EOTs) should be given/sent after treatment is completed. The EOT should be sent to the patient and GP and includes details of the treatment, treatment outcome, symptoms of side effects or recurrence and contact details for the

CNS. The most up to date version of Treatment Summaries can be found on the GM website.

- End of Treatment personalised care and support plan.
- PSFU information leaflet (In draft)
- Contact details for the Colorectal Cancer CNS
- Reminders/ appointments for routine follow up tests, if appropriate.
- Confirmation of the outcome of those tests
- A discharge letter at the end of the traditional follow up period for their cancer type.

4. Eligibility Criteria

Suitability is determined by the patient, the treating team and at MDT and should be assessed using the following criteria.

- Completed primary treatment for a colon, rectal or anal adenocarcinoma and clinically well
- No physical, cognitive or emotional issues affecting their ability to self-manage.
- Have capacity to consent to PSFU.
- Able to communicate their concerns.
- Are willing and able to access healthcare.
- Not on active or maintenance treatment.
- No diagnosed recurrent disease.
- No significant treatment related side- effects.
- Not on a clinical trial.
- Do not have a rare tumour.
- Not deemed inappropriate by the MDT because of oncological concerns or non-engagement

Trusts will also complete an Equalities Impact Assessment for PSFU which will include specific cohorts of patients with protected characteristics that should be included with reasonable adjustments made or excluded. The EIA should be read alongside this protocol.

5. Risk groups and schedule

5.1 Risk groups

- **Low Risk** – endoscopically removed T1 polyp cancers
- **Intermediate** – Stage 1-3 Dukes A-C tumours with curative resections. High risk patients in this group may have an additional scan at 60 months if clinically indicated.
- **High Risk** – Stage 4 disease at presentation with primary and metastatic sites resected (liver, lung, peritoneum)
- **Watch and Wait** - for clinical complete response after chemoradiotherapy for rectal cancer (recruit to OneCoRe)
- **Tems/Tamis** – Transanal endoscopic microsurgery (TEMS)/Transanal minimally invasive surgery (TAMIS)

Patients may be moved 'up' the risk categories or removed from a stratified pathway at any point during follow up. This decision will be taken by the clinical team and/or MDT and the patient.

5.2 Recurrence

A patient with recurrence within the first 5 years (liver/lung metastasis) start the pathway again from their operation date.

5.3 Schedules

First endorsed by pathway board December 2019
Tems//Tamis endorsed 2021
Re-endorsed by pathway board December 2023

Groups	Time (months)											
	3	6	9	12	18	24	30	36	42	48	54	60
1. **Low Risk** (endoscopically removed T1 polyp cancers)	Endoscopic visualisation of scar[a]	CEA		CEA CT TAP Colon*	CEA	CEA CT TAP	CEA	CEA		CEA Colon		CEA
2. **Intermediate** (stage1-2, Dukes A-C) tumours with curative resections**		CEA		CEA CT TAP Colon*	CEA	CEA CT TAP	CEA	CEA CT Tap		CEA Colon		CEA
3. **High Risk** (stage 4 disease) at presentation with primary and metastatic sites resected (liver, lung, peritoneum)		CEA CT TAP		CEA CT TAP Colon*	CEA CT TAP	CEA CT TAP	MRI F Sig	CEA CT TAP		CEA CT TAP Colon		CEA CT TAP
4. **Watch and Wait** for clinical complete response after chemoradiotherapy for rectal cancer (recruit to OnCoRe)	MRI F Sig	MRI F Sig CT TAP	MRI F Sig	MRI CT TAP Colon*	MRI F Sig CT TAP	MRI F Sig CT TAP	MRI F Sig	MRI F Sig CT TAP		F Sig CT TAP Colon		CT TAP
5.**Tems/Tamis** Transanal endoscopic microsurgery (TEMS)/Transanal minimally invasive surgery (TAMIS)	CEA MRI F Sig	CEA MRI F Sig	CEA MRI F Sig	CEA MRI Colon CT TAP	CEA MRI F Sig	CEA MRI F Sig CT TAP	CEA MRI F Sig	CEA MRI F Sig CT TAP		CEA MRI Colon		CEA MRI F Sig CT TAP***

[a] Frequency of further investigation of scar depends on findings at the 3 month flexi sig or colonoscopy
*Patients will have year 1 and 4 colonoscopy as per 2019 BSG guidelines
**High risk patients in this group may have additional scan, this will be discussed with the individual patient if clinically indicated
***CT TAP after 60 months at the discretion of individual provider

6. Re-accessing the Colorectal specialist team as required

- All patients and their GPs will be aware of how to access the Colorectal Specialist Team if concerns arise within the surveillance period. Safe robust and sustainable open access systems will be in place to facilitate this.
- Patients and their GPs will have contact numbers and guidance about when and how to access further support. Access will be via the Colorectal Specialist Team through an open access system.
- To deliver a robust rapid re-entry pathway, it is essential to ensure there is appointment capacity with the existing Colorectal and oncology clinics.
- If a patient is required to have further investigations following their routine surveillance, they will be recalled for further imaging or an appointment with face to face or remotely after discussion of the imaging in an MDT and seen within 1 week.

7. Responsibilities and Governance

It is the responsibility of the clinician, CNS and/or MDT to identify and offer PSFU to appropriate patients. Where a patient has had treatment at a number of different Trusts, follow up will be carried out by the Trust as detailed in the end of treatment responsibilities mapping document. The Trust responsible for the follow up is also responsible for the end of treatment appointment and written summary.

If patients or GP's contact the CNS with symptoms of possible recurrence, they must be offered a clinical assessment within 48 hours. It is preferable to assess at the time of contact.

Appropriate cross cover arrangements for the CNS must be in place to ensure patient contacts are not unduly delayed due to planned/unplanned leave.

The responsibility for the installation and security of the digital system, and ensuring its suitability, lies with the Caldicott Guardian, Cancer Lead Clinician and Cancer Lead Nurse of the Provider.

It is the responsibility of the CNS to enrol patients who agree to PSFU onto a secure digital system.

Updating the system, routine test requests and patient letters can be delegated to appropriately trained members of the Colorectal team.

The system must contain in-built alerts for routine tests/letters to ensure patients follow up is not missed.

It is the responsibility of the recipient of the alerts to action and follow up the alerts.